Migrant I-Kiribati Women's Experience of Childbirth in New Zealand

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Abstract

I-Kiribati are among an increasing number of migrants to New Zealand. They are grouped with Pacific peoples, for whom health outcomes are poorer than for the majority of the population. Limited research exists about I-Kiribati experiences or health outcomes. This research uncovers meaning within migrant I-Kiribati women's New Zealand experience of childbirth (taken as pregnancy, birth, and the postnatal period) and enables midwives to better understand the challenges I-Kiribati face through the participants' stories.

Hermeneutic phenomenology methodology drew out meaning from unstructured interviews with nine migrant I-Kiribati women who had birthed in New Zealand or who had supported other I-Kiribati to do so. Guidance was sought from I-Kiribati Advisors regarding culturally appropriate methods. Four midwives who had cared for I-Kiribati were also interviewed. Data analysis of crafted stories from interview transcripts was carried out via reflexive thinking, and engaging in a process of reflecting, writing, and re-writing.

Findings, firstly, showed I-Kiribati women experience tension, from a feeling of unfamiliarity, equating to not feeling 'at home'. This came from challenges and changes to relationships, lack of support, unmet expectations, being torn between two cultures, not being understood or not understanding, and from everything being unfamiliar. Findings, secondly, showed the experience of silence, which can mask anxiety, uncertainty, pain, or disagreement, but it can also show cultural shyness and respect for others; silence always has meaning. The third findings theme showed relationships, care-connections, to be important to I-Kiribati and that relationships with family are central. The widespread nature of relationships supports literature showing the holistic nature of the I-Kiribati view of health and wellbeing.

I-Kiribati women bring their other relationships or care-connections, their context, to their childbirth experience. Midwives have potential to build trust for positive care by taking time to get to know I-Kiribati women by asking about, recognizing, including, and facilitating their other relationships. In this way, I-Kiribati women's holistic context of family and wider culture is taken into account. Such new understanding brings familiarity to an I-Kiribati woman and supports her to speak up about her concerns.

The research findings encourage midwives to 'see' the holistic context in which I-Kiribati women are embedded. To build relationships opens the way to 'hear' what matters to 'this' woman to feel 'safe' and 'at home'.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

	25th May 2024
Signature	Date

Dedication

This thesis is dedicated to my father who would have loved to read and discuss it, and to my five close family members who passed away over the course of this degree journey. Among them was my mother, who divulged her secret to longevity, aged 98 years, as “Just keep walking”; this has been an inspiration to me as my thesis has progressed, and will continue to be so as I look ahead.

Acknowledgements

I wish to acknowledge the many people who have inspired me and helped me get to completion of this thesis.

To the I-Kiribati women and their families with whom I have shared childbirth journeys, I thank you for your inspiration to start this study, and your patience as I have taken time to understand. To the I-Kiribati participants and their families, I thank you for giving time and effort to tell me your stories; I have been privileged to hear them. To my I-Kiribati advisors, I am indebted to you for your wisdom and support; *kam bati n rabwa*.

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I have been blessed with three supervisors, who can take much credit in enabling me to finish this thesis; Liz Smythe, who has taught me much, inspired me to think in new and creative ways, and been very patient with my progress; Sandy Thaggard, whose cultural understanding gave me confidence that this thesis was possible, and Judith McAra-Couper, who, in taking Sandy's place, brought a wide breadth of knowledge and shared it with kindness.

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On the journey to complete this thesis I have not been alone, although at times it has felt a selfish, somewhat antisocial, occupation as I withdrew into thinking and writing. Friends and fellow students have given me much support. Above all, my best friend and husband, Jonathan, has been with me throughout, with encouragement, wisdom, humour, and not a few academic discussions.

Te mauri, te raoi ao te tabamoa

(Health, peace and prosperity)

Ethics Approval

Ethics Application: 19/265 Kiribati migrant women's experience of childbirth in New Zealand

Approval letter dated 16 April 2020 (see Appendix C)

Glossary

I-Kiribati	people of Kiribati
I-Matang	white European
kam bati n rabwa	thank you very much (to more than one person)
kamwakuria	umbilical cord
Kiribati	the Republic of Kiribati
koha	a gift or donation (Māori)
LMC	lead maternity carer
mana	authority, status…spiritual power in a person, place or object (Māori)
maroro	conversation, to converse
marurung	health
matang	a European country
mauri	Hello, or, acknowledging someone's good health
migrant	a person who moves away from his or her place of usual residence
MoH	Ministry of Health
MW	midwife
NGO	Non-Governmental Organisation
palagi	a white person (Samoan)
tabu	sacred
taona tabon inaim	(lit.) to sit on the edge of your mat; an indigenous I-Kiribati methodology
TBA	traditional birth attendant
te	the
te aki kakarongoa	silence
te bwaintangira ae kakawaki	precious gifts
te kaainga	traditional ancestral place of residence or extended family
te karinerine	respect
te kaubwaia	wealth
te kora	local I-Kiribati string
te kuan	handcrafted I-Kiribati net used for fishing (using weights) or food storage
te mama	shyness
te mauri	" a...holistic health belief system" (Schutz, 2022. p 212)
te tia tobi	I-Kirbati traditional birth attendant
te utu	family unit
te mauri, te raoi ao te tabamoa	health, peace, and prosperity (an I-Kiribati blessing)

Chapter 1: Introduction

> Seeing “from here” comes naturally. That is how we normally see, from our own perspective, guided by our own values and interests that are shaped by the overlapping cultures and traditions we inhabit. But what does it take to see “from there,” from the perspective of others? (Volf, 1996, p. 251)

This chapter introduces the research on migrant I-Kiribati (Kiribati person) women’s experience of childbirth in New Zealand. Such research has only been possible because all the participants have shared their stories with me. These stories are ‘precious gifts’ or *te bwaintangira ae kakawaki,* and in them I have found much ‘wealth’ or *te kaubwaia.* The participants were I-Kiribati women, and midwives who practice in New Zealand. It has been a privilege to listen to them all. The chapter begins with the aims of this research and an introduction to the methodology. This is followed by an introduction to I-Kiribati (people of Kiribati) and where I-Kiribati women come from. The rationale for the research is then explored, along with my position as the researcher. Some context to the experience I-Kiribati women have of childbirth in New Zealand is provided, including midwifery in New Zealand and the concept of cultural safety. This chapter forms a collage of background information upon which further understanding can be facilitated.

The aims of this research, which uses the methodological framework of hermeneutic phenomenology, are two-fold:

- To explore the experience of migrant I-Kiribati women in regard to their New Zealand experience of pregnancy, birth, and the postnatal period.
- To explore the experience of midwives who have been involved in providing care for migrant I-Kiribati women in their childbirth experience.

Heidegger (1927/1962) takes us back to the meaning found within lived experience, articulated through story. Gadamer (2007) said that “…understanding is always on the way; it is on a path whose completion is a clear impossibility” (p. 239). This is true for understanding both self and others; such understanding will never reach completion. In keeping with the methodology of hermeneutic phenomenology, this thesis offers ‘my’ interpretive understanding of stories of lived experience gifted to me by the participants. The lens through which I see these stories is based on my own pre-understandings. This is what I bring to the process of dialogue with participants and, subsequently, dialogue with the text of their interviews. This thesis is the result of such dialogue and is based on reflexive thinking evidenced in the process of writing and rewriting as further understanding is revealed. Further elucidation on the methodology

of hermeneutic phenomenology will be found in the Methodology chapter and throughout the thesis. This research will reveal the experiences of migrant I-Kiribati women with regard to childbirth, particularly when they birth in New Zealand as migrants.

1.1 The Origin of the Research Question

Since 2007 I have been a Lead Maternity Carer (LMC) midwife (MW) in a rural area of New Zealand. My caseload has, at times, comprised up to 45% of I-Kiribati women. Over time, I noticed that I-Kiribati women sometimes appeared to have more serious health issues than other women in my care, that some had misconceptions about what causes complications, and, occasionally, some would not access care in a timely manner. One I-Kiribati client asked of me, “A scan caused my friend’s miscarriage so will it kill my baby?” (personal communication, 2016). I wondered what was happening and what was the story behind what I was observing.

Looking into New Zealand Government health statistics, I found that I-Kiribati are not differentiated from, but are incorporated in, those of Pacific people in New Zealand, under ‘Pacific Other’. Māori and Pacific women had ratios of 22.86 and 21.19 maternal deaths per 100,000 maternities respectively, which were significantly higher than the ratio for New Zealand European women of 12.47 (Perinatal and Maternal Mortality Review Committee, 2024, p. 95). The same report showed that higher maternal mortality statistics tend to be linked to higher levels of deprivation. The perinatal related death rates for babies, which includes both fetal and neonatal deaths, are highest for those born to Indian, followed by Pacific, then Māori and Asian mothers in New Zealand (Perinatal and Maternal Mortality Review Committee, 2024). The health of women and babies of Pacific origin in New Zealand is a concern and leads me to wonder about the meaning of their health outcomes not being as good as most others in New Zealand. While there is a gap in statistics on I-Kiribati health in New Zealand, it is concerning if trends in I-Kiribati health outcomes match those in Pacific health statistics. However, even if statistics were available for I-Kiribati, the question in my mind goes deeper, asking, ‘what is the story behind the statistics for these people?’ Answering such a question could help in development of future I-Kiribati -specific research and may highlight issues with access to and appropriateness of maternity care, and cultural safety in maternity care provision for I-Kiribati. I hope my research will positively challenge New Zealand midwives to reflect on their own understanding of I-Kiribati, and on themselves and their midwifery practice, as the voices of participants are heard.

1.2 Introduction to Kiribati

This chapter aims to give a background, a context to the arrival of migrant I-Kiribati women in New Zealand. To begin with, it is important to recognise that I-Kiribati come from somewhere, and that their stories go back a long way in time and distance; it is about 5,500 kilometres from New Zealand to Kiribati.

Approaching Kiribati's island of South Tarawa by air, one is struck by the beauty and the expanse of the blue sea, surrounding and contrasting the small size of the atolls visible below. Geographically Kiribati is just south of the equator, roughly equidistant between Hawaii and Australia. It comprises 32 atolls and one raised coral island spread over 3.5 million square kilometres (Ministry of Foreign Affairs and Trade, n.d.). It supports a population of 119438 persons, 63072 (53%) of whom reside on South Tarawa, the capital (Pacific Community, 2022). Another feature of Kiribati is that the average elevation of the atolls is very low-lying at just 2 metres (Ministry of Foreign Affairs and Trade, 2021). With climate change the sea level is rising and is already causing inundation and salination of both agricultural land and water supplies in some areas. Kiribati's population is, therefore, vulnerable to the ongoing effects of climate change such as food security and poor health (Gauchi et al., 2019). There is a well-known case of an I-Kiribati man, Teitiota, who applied for refugee status in New Zealand on the basis of being a climate refugee. While his case was unsuccessful, the United Nations Human Rights Committee "ruled, for the first time, that expelling an individual to a place where they may be exposed to life threatening risks due to the adverse effects of climate change could violate the right to life" (Aust, 2020). Climate change will continue to be an issue for I-Kiribati with some predicting that if global warming and the rising of sea levels continue, there is only 10 to 15 years before Kiribati islands are uninhabitable (Kolmes et al., 2022; Raleigh, 2023).

1.3 I-Kiribati and Health in Kiribati

Kiribati "is a low-income country and is currently one of the three least developed countries (LDCs) in the Pacific region" (Ministry of Foreign Affairs and Trade, 2021, p. 5). The World Bank (2023) places Kiribati at 139 out of 196 countries measured with regard to gross national income. Kiribati is dependent on international aid for many aspects of its infrastructure (Government of Kiribati, 2021; Pacific Community, 2022). Health is but one such sector. The Kiribati Ministry of Health and Medical Services (MHMS) has a curative emphasis and provides free health care through a number of vertical programmes; that is, those which focus on a small group of health problems at one time and are short or medium term in duration (Ministry of Health & Medical Services, 2015; Werle, 2020). They manage 87 village clinics, 22 health centres and 4

hospitals (Government of Kiribati, 2021). Care for birth in the outer islands is supported by trained nurse-midwives or by a *te tia tobi* (traditional midwife), or by a family member with experience of birth. The attendance at births of skilled birth attendants has increased in recent years (Government of Kiribati, 2021). Midwives are currently nurses who have completed extra training after their nursing qualification; however, this midwifery training is temporarily in abeyance (Smith et al., 2023). Pregnancy care and postnatal care varies between islands, but for many it is limited to visits with the nurse-midwife or doctor, if either are available, when the women themselves want to seek advice or reassurance. I observed and heard during my visit to South Tarawa that there is no appointment system at most clinics; thus, people seeking care would arrive at a clinic or hospital and wait for someone to see them when their turn came (S. Marshall, personal communication, June 12, 2019). Access to healthcare can be a challenge in Kiribati; it may not be available, there might be no suitably qualified staff, or it may be available but only on another island for which there is no transport to access care in a timely manner (Government of Kiribati, 2021). Health care through traditional healers, including the *te tia tobi,* thrives in the community in Kiribati. Some I-Kiribati traditional healers are also to be found in New Zealand. The I-Kiribati government has a policy to "Strengthen engagement…and investigate ways to work in partnership" with *te tia tobi* (Ministry of Health & Medical Services, 2015, p. 32). While there has been an improvement in many of the United Nations' (UN) Sustainable Development Goal (SDG) parameters, there are still many challenges for Kiribati. For example, in 2019, 91.9% of births were said to be attended by skilled health personnel, and there have been welcome decreases in the neonatal mortality rate (20.8 per 1000 live births in 2021) and in the maternal mortality ratio (76.3 per 100,000 live births in 2020). However, public health remains an issue. In 2022, statistics showed that just 76% of the population have access to basic drinking water services, and just 45.2% have access to basic sanitation services. Additionally, in 2020, 41% of the adult population suffered from moderate or severe food insecurity (United Nations Department of Economic and Social Affairs, n.d.).

1.4 Introduction to I-Kiribati

I-Kiribati have a rich history of which I can only begin to touch the surface. While I-Kiribati are labelled 'Micronesian', I-Kiribati I know see themselves as I-Kiribati. I-Kiribati society is a mixture of its many individual islands' characteristics, which for an outsider is hard to pin down. I-Kiribati authors capture much in their writings on history and culture and I-Kiribati understandings, and can provide some insight for people like myself who are not I-Kiribati. In Uriam's (1995) extensive written work on I-Kiribati culture, he presents some of the history of Kiribati. The broad story he records is that of

a series of migrations linking Samoa with Kiribati inhabitants, and of a loss of oral tradition prior to, then hastened by, contact with *I-Matang* (a white European person); traders, missionaries and colonial officials (Uriam, 1995). From 1916 to 1979, Kiribati was part of the British colony named the Gilbert and Ellis Islands. While colonisation is responsible for many changes, there is a significant amount of I-Kiribati history and culture documented by colonialists. With increasing contact with the rest of the world and its people and ideas, and with support from a number of colonial administrators and church leaders, there was a push among I-Kiribati to retrieve the oral traditions in the 20th century. This was vital to ensure the passing on of knowledge about I-Kiribati history and culture (Grimble, 1989; Uriam, 1995).

Prior to Kiribati becoming a colony, the presence of traders and missionaries had brought many changes to I-Kiribati. For example, there was pressure for I-Kiribati to wear clothes and not to use coconut oil on their skin. An increase in population density near where the outsiders based themselves added to these changes to create unhealthy and crowded living environments and a resultant increase in disease. While the I-Kiribati population as a whole was by no means decimated by foreign diseases, this was a factor in reducing the population in the late 1800s. Other issues negatively affecting the I-Kiribati population over this time were drought, fighting, and labour migration. Many ships arrived looking for workers for Fiji, Samoa, Hawaii, Central America, and Queensland, Australia; some went voluntarily, while others were forced. However, over half of those who migrated for labour work returned to Kiribati. Migration for work and loyalty to their homeland are not new things for I-Kiribati (Bedford et al., 1980).

I-Kiribati, like many other Pacific peoples, are very community minded. Family is not just the nuclear family but encompasses extended family (Namoori-Sinclair, 2020). I-Kiribati society is said to be patriarchal; men being seen as superior to women (Cleverley, 2023; Teatao, 2015). Decisions are largely in the hands of the men, illustrated by the proportion of seats held by women in the I-Kiribati national parliament in 2023 being 6.7% (United Nations Department of Economic and Social Affairs, n.d.). Alongside patriarchy is a traditional respect, such that one does not even ask a question of someone with perceived authority. This practice equates to a shyness or reticence to speak out (Namoori-Sinclair, 2020; Schutz, 2022; Uriam, 1995). It can be shown in many parts of life, from family to schools and workplaces. Having to speak English can bring further challenges for students or workers. Children are taught in English in the I-Kiribati education system, and basic communication skills in the English language are taught in all high schools, but not all have the chance to also practice speaking the language (Liyanage, 2023; Namoori-Sinclair, 2020). In the 2018

New Zealand Census, 85.5% of I-Kiribati in New Zealand reported themselves to be English speakers (NZStats, 2018b). How this statistic shows itself in practice may look different, given the culture of shyness described above.

1.5 I-Kiribati in New Zealand

The history of the Pacific attests to migration being seen as a potentially positive answer to difficulties such as famine or wars going on in a country of origin. Thomas (2012), in his history of the Pacific, put it into context, highlighting that being a migrant has never necessarily been a totally negative experience:

> The day of emigration has been considered 'one of the saddest'… Which is to perhaps miss a point fundamental to the whole of Pacific history. From the earliest human ventures east from New Guinea into unknown waters, through the sophisticated navigations between the great Polynesian archipelagoes, to the anxious departures of those facing famine, voyaging could mean gain, not just loss. It certainly entailed risk, it offered a path toward survival, towards new lands, new homes and new lives. (p. 20)

With a history of invasion, colonisation, forced migration and economic migration, there are an increasing number of places around the world in which I-Kiribati communities can be found. Remittances sent home by expatriate I-Kiribati contribute significantly to family incomes (Government of Kiribati, 2015). New Zealand is but one country where I-Kiribati communities are established and growing.

With the creation of a work permit scheme in the 1990s, the majority of I-Kiribati migrants to New Zealand have come on work visas. The Pacific Access Category (PAC) scheme came into being in 2002 and allows for a set number of immigrants from each participating country being accepted for permanent settlement in New Zealand annually through a lottery scheme. In 2015 up to 75 I-Kiribati were allowed to enter New Zealand per year on the PAC scheme. It has now increased to 150 per year (New Zealand Immigration, 2024a). Those who succeed then must fund themselves to travel to New Zealand and find a job within 6 months, or else return to Kiribati (Government of Kiribati, 2015). The Recognized Seasonal Employer (RSE) scheme has also brought I-Kiribati to New Zealand for horticultural or viticulture work since 2007 (New Zealand Immigration, 2024b). While this is positive, there are times when participants in these schemes struggle with establishing a life in New Zealand, whether it be housing or healthcare or other necessities of life. I-Kiribati migrants to New Zealand are commonly hosted by family while they establish themselves in work and housing (Cleverley, 2023; Namoori-Sinclair, 2020; Teariki, 2017).

The 2018 Census showed that I-Kiribati in New Zealand numbered 3225, of which 43.7% of I-Kiribati reside in the Auckland region. They comprise less than 1% of the Pacific Island people of New Zealand, and just more than half are less than 20 years old (NZStats, 2018b). The I-Kiribati community local to my area of Warkworth was initially established with the employment of large numbers of I-Kiribati by a business growing capsicums.

Compared to other Pacific peoples in New Zealand, I-Kiribati are relatively new arrivals. For example, while the percentage of I-Kiribati residents in New Zealand who have been here 20 years or more is 10%, the percentage of all Pacific people resident in New Zealand for that time is 46% (NZStats, 2018b). For I-Kiribati this can bring challenges in the form of a lack of practical and cultural support which is different to those faced by other migrants. The combined knowledge of a larger community over a longer time affords some benefits, including the influence of second and third generation New Zealand residents who understand more about New Zealand systems, New Zealand ways, New Zealand English, and thus, New Zealand opportunities.

The importance of the church in I-Kiribati life should be recognised. In Kiribati itself 89.4% of people in the 2020 census identified themselves as Protestant or Catholic Christians (Pacific Community, 2022). Thompson (2016), writing on the settlement experiences of I-Kiribati living in New Zealand, commented that the centrality of village leadership and the related life of the community in the Pacific Islands has, for new migrants and for many of their next generation, given way to the church taking central place. This is particularly true of I-Kiribati, 87.3% of whom have at least one religious affiliation (NZStats, 2018b).

As one would expect, there may be changes to cultural traditions in Kiribati over time (Gadamer, 1975/2013). However, I-Kiribati arriving in New Zealand can experience culture shock as they face New Zealand accents, different meanings in use of language, and a white western culture in which self-responsibility is expected and individualism prized (Fatehi et al., 2020; Namoori-Sinclair, 2020).

1.6 I-Kiribati and Health in New Zealand

Health care in New Zealand is very different to what I-Kiribati experience in Kiribati. Health care in New Zealand may be more available than in Kiribati, but if someone is on a minimum wage or is sending remittances home to Kiribati, opportunity costs may mean health care is not affordable, even if they are eligible for free care.

I-Kiribati in New Zealand are labelled in government health statistics as ‘Other Pacific Island’ people and they are not differentiated from others who make up the smaller groupings of Pacific peoples (Te Whatu Ora - Health New Zealand, 2023c). For I-Kiribati to be labelled as ‘Pacific’ people may be convenient for statisticians and government departments but there is widespread frustration on the part of I-Kiribati and others of smaller Pacific groups who are subsumed under a Pan-Pacific definition which masks important individual characteristics (Burnett & Bond, 2020). Statistics giving concern over health inequities for Pacific peoples may not represent I-Kiribati; they may be better, or they may be worse. For now, in the dearth of statistics on I-Kiribati in New Zealand, I too must place them within Pacific statistics.

Experience in my midwifery caseload suggests that the statistics showing poorer outcomes for Pacific women and their babies than for New Zealand Europeans, reflect those for I-Kiribati. While maternal and perinatal health statistics are limited for I-Kiribati specifically, I wondered what were the stories behind the Pacific women’s statistics showing inequitable health outcomes. In particular, what were the I-Kiribati women’s stories about childbirth in New Zealand. I, myself, had read and heard very little. If I-Kiribati women really were more reticent than most people to speak up or ask questions of those in perceived authority, this could potentially negatively affect their access to timely and appropriate health care.

1.7 The Background to My Interpretive Lens

In keeping with the methodology used in this research, I appreciated that it is not possible to bracket and set aside my own preunderstandings (Gadamer, 1975/2013; Heidegger, 1927/1962). Instead, I was mindful of their influence in conducting the interviews and analysing the data. My preunderstandings and their origins are what have led me to conduct this research, and so it is important they are shown in this introduction.

I realised early on in the research process that I was on a steep learning curve. I was constantly learning from I-Kiribati and other Pacific people with whom I had contact. My preunderstandings were, and are, constantly being challenged and updated.

The philosopher Gadamer observed that all research questions arise from somewhere regardless of how objective we think we are (Moules et al., 2015). My research question comes from my heritage and my worldview, my preunderstandings or my perspectives of understanding. I am an *I-Matang* (white person) from a middle-class background, a descendent of English immigrants who were economic migrants to New Zealand in the late 1800s. There is collective family sympathy with migrants, as

the story is told of my great grandmother travelling on her own by ship to New Zealand to marry my great-grandfather. She never spoke of the journey again; it had been so traumatic for her. My own worldview was, and is, being shaped by having been brought up in a household where overseas visitors were always welcomed. Once, while working in a refugee camp, I became friends with a young Asian man. I remained overseas but when he later contacted me to say he was moving to New Zealand, I put him in touch with my parents. Not long after that my parents arranged for him, his wife, child and in-laws to stay with them for the months while they settled; they stayed nearly 1 year. This is a heritage of which I am proud. Although New Zealand born, I also lived as a migrant for 24 years, based in the United Kingdom. I worked as a midwife in multicultural areas of the UK and worked for 17 years in aid agencies in 12 different countries in the regions of Southeast Asia, Africa, and the Middle East. Having had the good fortune to work with people of cultures other than my own, all of my working life, I returned to New Zealand to find that I often held a very different worldview to that of many New Zealanders. While being a migrant of sorts has given me clues to understanding other migrants, my Christian faith has helped me to begin to understand the spiritual nature of life for I-Kiribati, as it has done when I have worked in predominantly Muslim or Buddhist nations. All these things have shaped me as a person, and so shaped my preunderstandings as a researcher.

My preunderstandings about I-Kiribati were based mostly on my work as a midwife. In preparation for this research my supervisor conducted a reflexive interview with me. From this interview some of my pre-understandings about ‘the I-Kiribati way’ were revealed; these disclose something of the context of myself as the researcher. Yet, in later reflection, I see there is a lot that I, as a researcher, have assumed or stated without reflection.

- I-Kiribati women are used to living in community. There is always someone else around. They are not left alone in the postnatal ward but are cared for at home by relatives and try to keep the baby at home for the first month.
- I-Kiribati women gain much of their information from other women, especially older women.
- I-Kiribati babies are not swaddled and are not carried in slings.
- Although Kiribati is a patriarchal society, the I-Kiribati women I know can still tell their husbands what to do in the domestic arena.
- I-Kiribati women appear to me to search for the ‘right’ answer to give when the midwife asks a question. There may be a ‘I-Kiribati way’, but it is hidden in the need or desire to conform to local practices. It is almost as if they ‘need permission’ to do things the ‘I-Kiribati way’ in New Zealand.

I made a point of taking a trip to Tarawa, Kiribati's main island, for a 2-week orientation before beginning the research. It was a rare opportunity to be, listen, and observe in an I-Kiribati environment. I was based with an *I-Matang* couple working for an aid agency. Visits included hospitals, clinics, and chatting with people in homes and on the street, spending time. I was kindly invited to stay in a traditional village for several nights in a traditional house with my host's friends. Following my return, my supervisor conducted another reflexive interview with me.

I wondered what an I-Kiribati migrant woman's first experience of childbirth might be like in New Zealand. My assumptions that I brought back from that trip were as follows: Aspects of maternity care such as 'midwives' and even 'care' itself may mean something different to what she understands, and she may not have heard of times for clinic appointments. She does not know what should be done but is shy to ask in English. Internet helps maintain the family link back home in Kiribati, a strong connection. Like New Zealand-born women, she will take advice from family and friends but, unlike them, she would not say if she were in pain or speak up. In contrast to the privacy desired by New Zealand postnatal women, a room on her own just with baby might actually be a scary experience for an I-Kiribati woman who may never have been alone overnight in a room. To summarise, my preunderstandings at this stage (just prior to data collection) were that nearly everything for this migrant I-Kiribati woman would be different in New Zealand to how it is in Kiribati (Appendix A for poem on my post Kiribati visit reflections 2019).

In writing this research I recognise the complexity of ensuring inclusive language and have no wish to offend any readers. My pre-understanding at the start of this research was that my I-Kiribati participants had responded to my invitation to take part on the basis that I asked for 'Kiribati women'. As such, I made an assumption that they all refer to themselves as "she/her". For the midwife participants, all of whom I knew, this was also the case.

1.8 Childbirth

Childbirth is by definition "the act or process of giving birth to a baby: parturition" (Merriam-Webster, n.d.), or the point of birth. In this thesis, 'childbirth' is taken to mean not just the point of birth, but the whole journey, from conception, through pregnancy, labour and birth, and through the postnatal period. In referring to 'childbirth', I wish to emphasise a holistic view, that the 'point of birth' is dependent on what has happened in the pregnancy and in the labour, and that what happens in the postnatal period also affects the final outcome of the birth; the new baby and its new family.

1.9 New Zealand Health Care

The goal of New Zealand's 1938 Social Security Act was to bring universal and equitable access to health care as a right to the population (Gauld, 2013). In New Zealand universal access to free emergency care, hospital care and maternity care is possible for those who are eligible. Maternity care is free for eligible people such as those on a Pacific Access Category (PAC) visa, but not for those on seasonal worker visas or other work visas shorter than 2 years (Government of Kiribati, 2015). Health care is thus a challenge for some in the I-Kiribati community. The Ministry of Health (MoH), currently called Manatū Hauora, runs the New Zealand health system and has a structure to monitor quality in health which includes the consumer voice, both for development (Health Quality and Safety Commission, n.d.) and for complaints (Health & Disability Commisioner, n.d.). Despite this structure, statistics suggest that timely access to appropriate healthcare is not always equitable. Many reasons are possible for this (Dawson et al., 2019). Even if maternity care for eligible people is free, there are increasing costs for families expecting a child. While blood tests and midwife care are free, other costs exist; obstetric scans, fuel costs to get to appointments and opportunity costs to take time off work for consultations for example. Dentist and General Practitioner (GP, a family doctor for primary level care) consultation costs have increased in recent years, as have fuel costs. For some people, these barriers mean they do not access the screening or the care they need (Cleverley, 2023; Dawson et al., 2019; Thomsen et al., 2023). As most women receive their maternity care from midwives, it is of use to elaborate on midwifery care in New Zealand.

1.10 New Zealand Midwives

My starting point is the question, 'what is a midwife?' The term midwife is derived from Middle English: mid = 'with' and Old English: wif = 'woman' (Midwives Australia, n.d.), 'with woman'. The voice of women has been supported by the voice of midwives since biblical times (Exodus 1:15-17 English Standard Version), and probably earlier. Currently the International Confederation of Midwives (ICM) definition of a midwife focuses on the midwife being a qualified professional trained to international standards. In making this definition, Traditional Birth Attendants (TBAs) were not included as they have no internationally recognised training or regulation (Inernational Confederation of Midwives, 2017). For practical purposes however, women and their families worldwide choose who they wish to give them care during childbirth, although sometimes choice is limited. Countries define what this role is, and what they call it, in different ways. In New Zealand Māori culture there are also people trained or experienced in traditional roles to support women and their babies before, during and after birth (Kenney, 2011;

Tikau, 2020). In Kiribati the *te tia tobi* (Traditional Birth Attendant) cares for some women in childbirth. They tend to be older and experienced women or men, and there are other cadres of traditional healers who can give support or treatment to mother or baby during different parts of the childbirth period (L.Teatao, personal communication, April 2, 2024). Since colonial times New Zealand government departments have utilised the western traditional name of 'midwife'. Curiously "midwifery" work was said in the past to be done both by doctors and midwives, placing the meaning of the name to be more about the recipient of the care rather than to the giver of care (Donley, 1998). For the purposes of this research, I will utilise the term I know, 'midwife', so as to recognise that they are the predominant cadre of health professional I-Kiribati women know, and from whom most receive their care during childbirth in New Zealand.

The current New Zealand midwifery care model arose from a social context, coming into being after years of lobbying and work by midwives and by women ('consumers') in the New Zealand community (Donley, 1998; Guilliland & Pairman, 2010). The 1990 Nurses Amendment Act "returned the right to practice autonomously to midwives…without the supervision of doctors" (Guilliland & Pairman, 2010, p. 21). Midwives from then on could be paid for their services by the MoH, and currently through Te Whatu Ora (Health NZ), the result of midwives and women's voices joining forces in both a political and practical sense. The New Zealand midwifery care model developed at that time reflected what was happening politically and was based on 'partnership' between women and midwives. This model is also widely called the 'partnership model', and is characterised by continuity of care, women-centred care, and informed choice (New Zealand College of Midwives, 2015). An illustration of the complexities of 'partnership' can be seen in New Zealand's history. The Treaty of Waitangi signed in 1840 between the British Crown and Tangata Whenua (Māori) is the basis for New Zealand (NZ)'s constitutional and legislative structure. Partnership in New Zealand is said to emanate from the Treaty of Waitangi and the word continues to be used widely across New Zealand institutions (Ministry of Health, 2007). Morrison (2005) disagreed, as do others, stating that the word was first used in 1975 within the Anglican Church, on establishment of the Māori Bishopric of Aotearoa. Thereafter, it was a concept increasingly utilised in government policies and continues to be open to interpretation in all sectors. "For Māori, partnership meant sharing power and control; for representatives of the Crown, partnership was a rather vague notion that need not involve any real power sharing" (Morrison, 2005, p. 18). As in midwifery, there are differences in interpretation of both the word partnership and its origins.

The (Collins Dictionary, n.d.) defines a partner as "the person you are doing something with". Partnership is thus a joining of partners, with the sense of working together. The

New Zealand College of Midwives (n.d.-a) have defined the midwifery model as a partnership:

> Midwives work in partnership with the woman and her family/whānau, providing or supporting continuity of midwifery care throughout the woman's maternity experience. This partnership is based on a relationship of trust, shared decision making and responsibility, negotiation and shared understanding.

Such an elaboration of partnership shows that its characteristics are relational. Further emphasised are continuity of care, informed choice, cultural safety, and woman centred care. 'Partnership' is currently a principle embedded in midwifery definitions both in New Zealand and internationally (Guilliland, 1994; International Confederation of Midwives, 2023).

While 'equality' was in original descriptions of partnership (Guilliland & Pairman, 2010), the emphasis is not to expect total equality but that "equitable partnerships are the ultimate aim…" (Guilliland & Pairman, 2019, p. 13). Although practical guidance on how equity is achieved is not specified, how a 'partnership' works is reflected in what is written in the first competency for the entry to the Register of Midwives; "the onus is on the midwife to create a functional partnership. The balance of power fluctuates but it is always understood that the woman has control over her own experience" (New Zealand College of Midwives, 2015, p. 5). For some women, as with those who for whatever reason feel disempowered in their lives, taking control could be hard to do, especially if the midwife is taking more responsibility to make it work.

Some question therefore, if partnership can work in all situations. There is a power differential between the midwife, holder of knowledge and position in the healthcare system, and the woman in her care (Kenney, 2011; Skinner, 1999). Some midwives do not use the word partnership for this reason (Skinner, 2023). Krisjanous and Maude (2014), in their analysis of the partnership model using marketing tools, observed "not all customers can or will choose to engage to the same extent in partnership" (p. 235), for example, the vulnerable, the young, or migrants. They recommended the partnership model may need to be broadened for further value to be added. One way this may happen is exemplified in stories from women about their birthing experience in Howarth et al.'s (2011) research. They reported that relationships were important to them at this time, but while their relationship with the midwife was important, birth satisfaction was greater when the midwives acknowledged the importance of the women's partner and wider friends and family. The partner was their main support, and it seems these women saw the practical partnership as working best when it included 'their' people.

The New Zealand (NZ) maternity services have changed in the 30 years since the NZ midwifery care model was established. The New Zealand population and social context has changed and an increased diversity in culture in the broadest sense of the word has emerged. The younger generation has grown up with new cultural norms of communication, and a variety of migrants from all over the world, including I-Kiribati, bring their own distinctive cultures. Over this time, “the expectations of both the MoH and women have increased” of midwives (Dixon & Guilliland, 2019, p. 48). Women from diverse groups face many challenges to negotiate their care for pregnancy, birth, and postnatal period, in the context of midwives being challenged to establish partnerships with a diverse clientele. In this changed context, while midwives and women continue to adapt to the environment in which they find themselves (Wakelin et al., 2023), the midwifery partnership model remains constant. While the official definition is elaborated, individual midwives must interpret the midwifery model and ‘partnership’ for themselves, according to the individual clients they care for and the social context within which these clients live.

In recognition of the many changes in New Zealand’s social context, a revised Scope of Midwifery Practice has been produced by the New Zealand Midwifery Council (2024), concomitant with the New Zealand Health Strategy (Te Whatu Ora - Health New Zealand, 2023b). In this new scope there is recognition that the person being cared for has their own worldview and is part of a wider context. They may determine this ‘context’ to be their whānau and for them to be included in their care journey. The rights and interests of the person cared for are not subsumed by the midwife’s recognition of the collective around them, and there is potential in the revised scope for both cultural and clinical safety to be increased.

Women in New Zealand requiring maternity care choose a Lead Maternity Carer (LMC), whether midwife, obstetrician, or GP, for their childbirth period, incorporating antenatal, birth, and postnatal care. Most women, 93.9% (87.4% of Pacific women) registered with midwives as their LMC for their maternity care in 2021 (Te Whatu Ora - Health New Zealand, 2023a). This is the sphere in which I myself work. LMC midwives are self-employed but contracted to the government. They practice autonomously, but with guidelines as to when referrals to other health professionals should be made. Other midwives work in birth centres or hospitals.

While there is currently a shortage of midwives (Te Whatu Ora - Health New Zealand, 2023a), there is a long-term lack of representation of all cultures in the New Zealand midwifery workforce, notably Pacific and Māori midwives. Pacific people make up 8.12% and Māori make up 16.5% of the population (NZStats, 2018a). The New

Zealand Midwifery Council (2023) Workforce Survey reported midwives identifying Pacific as their first, second or third ethnicity were 3.3 %, while those identifying Māori as their first, second or third ethnicity were 12.9 %. Moves are being made to rectify this imbalance, and a higher proportion of Pacific and Māori students are currently in midwifery training than in previous years (Macdonald, 2023). From these statistics it could be assumed that I-Kiribati migrants are unlikely to find familiar I-Kiribati or even Pacific midwives when they access maternity care in New Zealand. More about New Zealand midwives will be detailed in the Literature Review chapter.

1.11 Cultural Safety

Many years ago, I was a community midwife for a deaf girl expecting her first baby. In my ignorance I found out little during pregnancy about how communication would work during labour. Communication was ‘okay’ from my point of view, we prepared for birth, and I arranged to be there for her labour in the hospital, knowing that we could call an interpreter if needed during the labour. We reached a point where I was unable to communicate with her because she was not opening her eyes and she was too focused on what was happening to her to have the energy to lip read. The interpreter was called, and with the familiarity of sign language, my client was able to communicate from then on. I learned from the interpreter that direct translation was not always possible. Many concepts or words I would say did not exist in sign language; the interpreter had to build a picture for my client using the basic signs, the pictures, she did know. I wished I had been able to involve the interpreter earlier in this young woman’s journey. I had assumed much, and I knew then that by waiting until communication was in crisis, I had not facilitated a culturally safe environment for my client.

Irihapeti Ramsden (2002), one of the key architects of the concept of ‘cultural safety’ in New Zealand, said that cultural safety focuses on “understanding of self, the rights of others, and the legitimacy of difference” (p. 200). A key aspect of ‘cultural safety’ is that care can only be determined to be ‘culturally safe’ by the person in receipt of the care, the client (New Zealand Midwifery Council, 2012). Although arising from the New Zealand context where the indigenous people are Māori, cultural safety principles are relevant to all interactions between cultures. The New Zealand Nursing Council notes that “Cultural safety implies a reciprocal obligation of accountability and responsibility and includes all minority groups…” (New Zealand Nursing Council, n.d.). Cultural safety is part of the New Zealand midwifery model of care and according to the New Zealand College of Midwives (2015), it is

> the effective midwifery care of women (from other cultures) by midwives who have undertaken a process of self-reflection on their own cultural identity and recognise the impact of their own culture on their practice. Unsafe practice is any action that demeans or disempowers the cultural identity and well-being of an individual. (p. 6)

Another term, 'cultural competency' is utilised in midwife competencies to describe how 'cultural safety' should be assessed (New Zealand Midwifery Council, 2012); although it is still, ultimately, the midwife's clients who can truly assess if a midwife is culturally safe. The true extent of cultural safety, or lack thereof experienced in the health professions of New Zealand is unknown, as there are many reasons why clients might not give voice either to their satisfaction or concerns about their care.

The onus is on the midwife to be aware of cultural safety and her part in it. Cultural safety is, therefore, shown (or not) in the arena of relationships between women and their midwives. Cultural safety can also show in clinical safety, as evidenced by the restating of previous recommendations in New Zealand's Perinatal and Maternal Mortality Review Committee (2022) report; "Regulatory bodies to mandate cultural safety education for all individuals working across all areas of the maternity and neonatal workforce" (p. 100).

Cultural safety is relevant to any research where the researcher is working with people of a culture different to themselves. As is consistent with the methodology I have used, reflection begins with searching for the question to be asked and continues throughout the research process (van Manen, 1997). Prior to this research a number of people told me they were looking forward to reading my findings and were expecting a list of things they needed to know about I-Kiribati and about caring for them. While information on a client's culture can be useful, it is not the whole answer. Cultural safety cannot stand apart from the context of relationship. The New Zealand Midwifery Council's (2012) Statement on Cultural Competence reinforces this point stating "a midwife cannot acquire an understanding of culture through checklists, or a standardized approach based on assumptions about culture". Each person, each client, is an individual within their own culture. Take myself as an example; as a New Zealander who has lived outside the country for 24 years, I know how different my own culture can be compared with a New Zealander who has never lived abroad.

Cultural safety is relevant in the client-midwife relationship, and it is relevant to the reading of this thesis and its findings. I invite readers to self-reflect as they read, to reflect as they relate to the participants through their stories of I-Kiribati women's childbirth experiences, and to reflect as they see them as both individuals and part of their social context.

1.12 Research Overview

This hermeneutic phenomenological research asks the question, “what is the experience for migrant I-Kiribati women of childbirth in New Zealand?” The research and its documentation began with this introduction to the participants and their context, and to myself as the researcher, and the background to my preunderstandings. The origin of the research question has been discussed, followed by an elaboration of the context which will be of use to understand the findings.

A literature review will follow in Chapter 2, carried out according to the research methodology of the hermeneutic methodological approach; that is, looking at research and other writings which have been an inspiration to ‘think’ about the research question. Chapter 3 focuses on the methodology of hermeneutic phenomenology, a phrase which took a couple of years for me to pronounce fluently. This in itself is a picture of how the methodology works, continuously listening and reflecting and modifying one’s thoughts while continuing to ask questions. Methods, Chapter 4, flows from the methodology and is the practical chapter, the ‘how’ of this research. The three findings chapters then follow. Chapter 5 is the finding of ‘Tension’. Chapter 6 is the finding of ‘Silence’. Chapter 7 is the finding on the ‘Care-Connection’. In Chapter 8 there is a discussion on the findings, the ‘so what?’ of this research, the point of what is important in the findings already laid out. The conclusion can be pre-empted, in part, by saying that questions will remain, and more questions will be provoked; this should be so, for understanding to continue to be ‘on the way’, long after this thesis has been completed.

Chapter 2: Literature Review

2.1 Introduction

This is a hermeneutic literature review informed by the work of Gadamer (1975/2013) and Heidegger (1927/1962). A more traditional literature review would aim to review all that is written about the subject in question, to gain an unbiased view of the literature, make a reproducible database search, and highlight where the gaps in research exist (Grant & Booth, 2009; Lim et al., 2022; Zaccagnini & Jie, 2023). While this approach is valid for some areas of inquiry, particularly in the quantitative sphere, not all researchers believe it to be universally relevant. Boell and Cecez-Kecmanovic (2010) questioned whether any selection of literature can be truly "unbiased, complete and reproducible" and stated that "a review of relevant literature cannot be achieved following a structured approach" (p. 130). Thus, they recommend a hermeneutic approach for such reviews to bring deeper understanding on a subject area or research problem. Moules et al. (2015) suggested a hermeneutic review is "a practice driven not by formal logic, but by the way revealed by carefully examining the phenomenon, by a practice driven by substance not procedure" (p. 68). While a hermeneutic literature review is not against scientific method, Moules et al. said, it is "committed to the recovery of its phenomenological and hermeneutic dimensions" (p. 68).

For researchers taking a hermeneutic approach to the literature review, there are limited rules; but what is strongly present is a call to "be attuned and engaged" with the literature (Smythe & Spence, 2012, p. 17). Heidegger (1992), in his discussion on modern technology and the scientific age, observed that despite the wealth of knowledge held in so many technological advances, there was no questioning of it, no response to a call to think deeper, writing repeatedly, "Most thought-provoking is that we are still not thinking" (p,370). He expressed the need for human beings to learn to think, to think about what is not seen or what withdraws from us, to wonder what it is that calls to us to be unconcealed; to look for "what turns away from man." (p. 372). Thus, while using a hermeneutic approach still aims to reveal gaps in inquiry on the subject and provide context, "the key purpose of such an endeavour in hermeneutic research is to provoke thinking" (Smythe & Spence, 2012, p. 14).

Alongside revealing the need for this research, what is important in this investigation is that the literature provokes thought. Further, that research chosen for this review should either allow the voice of migrants to be heard or show something of the context of migrants' lived experience of childbirth.

In this chapter, I will first discuss how the hermeneutic literature review journey has been navigated, and how I have drawn on the philosophical notion of the hermeneutic circle (see Methodology, Chapter 3) to assist understanding. The question asked in this thesis is “what is the experience for migrant I-Kiribati women of childbirth in New Zealand?” In the dialogue between researcher and literature or text or someone’s story, I asked “what is the context and experience for migrants (including I-Kiribati), experiencing childbirth in New Zealand?” The literature review will both aid reflexive thinking and inform future dialogue in this inquiry; resulting in new understanding (Gadamer, 1975/2013; van Manen, 1997). My hope is that what is discovered in this chapter will create for readers a background to participants’ stories and bring challenges to taken-for-granted assumptions.

Following an overview of the methodological approach, I will give an overview of the literature which has inspired my thinking during this literature review, of which written text, mostly research articles, forms the major part. This literature, along with talks, historical writings, and novels, has sparked my thinking over the thesis journey from the beginning through to the end of writing (Crowther et al., 2014; Smythe & Spence, 2012); an end which, paradoxically, will be a mere beginning to understanding the phenomena in question.

2.2 Philosophical and Methodological Approach

The literature review in hermeneutic phenomenology research is focused on developing understandings of phenomena (Boell & Cecez-Kecmanovic, 2010; Kusnanto et al., 2018; MacLeod et al., 2023; Smythe & Spence, 2012). Hermeneutic phenomenology has several important assumptions which influence the way a review of literature is carried out.

2.2.1 The Certain Existence of Prejudices

As a researcher, I begin my research with prejudices; that is, pre-understandings from my background, culture, and personal experience. I bring these pre-understandings, as outlined in the Introduction chapter, to the text. Being aware of my history allows me to dialogue with text and to create new understandings. Smythe and Spence (2012) pointed out that we cannot take a “historical text (albeit a recent publication) and examine it from a neutral and objective stance. As reader, we are always interpreter, and as such always bring our past understanding and experiences” (p. 14). There is then interplay between reader and text in whatever form that text takes, opening deeper understanding as prejudice is revealed and further meaning is gained.

2.2.2 The Importance of Dialogue Within the Hermeneutic Circle

As a researcher with prejudices, I dialogue, have a conversation as it were, with the literature or text or stories encountered. Smythe and Spence (2012) stated that the "place of literature is not to 'tell' but to act as a partner in dialogue" (p. 23). Dialogue with the literature is crucial to this way of reviewing literature; it contains the dialectical element of questioning and answering which creates new understanding. Dialogue continues as other texts are encountered, and other parts are added to bring more new understanding to the whole that is the context.

The dialogic process is dynamic, iterative, non-linear, as the dialogue moves between the parts and the whole of the understanding (Boell & Cecez-Kecmanovic, 2010; Gadamer, 2007; Smythe & Spence, 2012). This describes the hermeneutic circle (Gadamer, 1975/2013; Heidegger, 1927/1962). "The anticipation of meaning in which the whole is envisaged becomes actual understanding when the parts that are determined by the whole themselves also determine this whole" (Gadamer, 1975/2013, p. 302). As such, understanding is seen as circular, always moving from the understanding of the parts building to the understanding of the whole, and this new understanding building further understanding of the constituent parts. Understanding continues to grow in this way.

2.2.3 The Traditional Process Began to Provoke Thinking

I recognised in myself a need to provoke my thinking, as I knew little about my subject. I wondered about the I-Kiribati women I had met, their experience of childbirth, and the context in which their journeys occurred. Therefore, I began this review looking widely for literature relevant to my topic. Doing so, in a systematic way, also contributed to university requirements for submission of the proposal for the research. I grew into the hermeneutic approach as I became immersed in the methodology.

As an English speaker I only had access to documents written in English. I searched the databases of Google Scholar, Scopus, MIDIRS, and CINAHL for the terms "migrant women" and "experience" and "childbirth". My initial search from Scopus was indicative of what was found; 49 articles were brought to light, of which I kept 5. The rest were excluded for reason of being focused on one small aspect of the childbirth period, focused solely on perinatal outcomes, or on beliefs and practices of one particular group. Other articles excluded were those with just health professionals' experiences, those not clear that women's own experiences were reported, refugee rather than migrant focused, or discussion papers. Such papers were excluded because my focus was on migrant women's experience of childbirth; the voice of women themselves. Searches were repeated at different times, and a further 5 articles from the

international sphere were found by this means and by manually searching reference lists from the above articles. While these numbers are not large, I found a wealth of women's experiences reported in these research articles.

I then narrowed my focus to research with "migrant women" and "New Zealand", which initially showed no studies with I-Kiribati, but one with African women's experience. Another search entailed a broad search for "Kiribati" and "women", recognising that most I-Kiribati women in New Zealand, at that time, would be migrants, and that studies of such a small group would be few. This was correct, and I only found one article, which did not have the attributes needed for inclusion. In 2020 I signed up to Google Scholar alerts for "Kiribati" and "Health" and this brought 6 articles to my attention, all by I-Kiribati authors, in whose references I found another 7 articles of relevance, including some of which focused on Pacific women in New Zealand, a group of which I-Kiribati are a part; of these 13, I kept 11. I have so far found no research specifically about the experience of migrant I-Kiribati women of childbirth in New Zealand, with the exception of a few stories in two of the above studies. Literature about 'women's experience of maternity care' or the 'woman-midwife relationship' similarly showed two out of 37 articles to be relevant, and another 11 were found by hand searching other research articles.

Not all types of literature review include a specific quality assessment tool for evaluating the research reviewed (Grant & Booth, 2009). However, while embracing the hermeneutic call to engage with the literature and be open to having my thinking provoked, it was still important to assess the worth of each study under review, even after my initial exclusions described above. For this purpose, I devised a table format as an aid to assess the relevance of each study. One listed international research with migrants, another listed research with migrants in New Zealand, and a third table listed research about women's experience of maternity care (Appendix B), focusing on New Zealand, which forms part of the context for migrant women in New Zealand. The three tables listed the author, study aim, location, methodology, participants, data collection methods, and key findings. On reviewing the tables I was able to clearly see which studies met my 'attributes' needed for inclusion, which were:

- research in which the voice of migrants was heard, or
- research that showed context for migrants going through the lived experience of childbirth, and
- research that showed trustworthiness.

Trustworthiness is described in the Methods chapter and follows Im et al.'s (2004) five areas evaluating cross-cultural studies: the interests of the cultural group in focus are

served, contextuality is shown, appropriateness of communication is clear, mutual respect is shown to participants, and the process is flexible to participants' needs. I added methodological congruence. I discerned if the studies I included showed these six attributes. An example of one exclusion was where the authors did not show the difference between the terms, 'Arab' women, who are sometimes Christian, and 'Arab Muslim' women, which suggests that participants beliefs were not respected. For each study included I documented notes of critique and relevance on the table.

The value of the tables was that I then had an overview of emerging themes found by researchers. I could compare and contrast these themes and could situate my own research into a wider context. With this context, and thinking provoked, I could ask further relevant questions of the research I read.

Throughout this process, I was reading books and articles, listening to other health professionals talk at conferences and online courses, listening to clients and to radio interviews and other fora, taking in all I could regarding Pacific people and history and culture. They all provided me with further provocations to think.

Using the hermeneutic approach for this literature review allowed me as a researcher, with my own historical lens, to have an interpretive dialogue with the literature. I asked questions, the text told me things; I imagined what others would ask, the text told me more; and I came to new understandings and new questions. This is an example of the philosophical notion of the hermeneutic circle; the continuous movement denotes the iterative nature of this process, reminding me that it takes time to build understanding and is illustrative of how understanding is "always on the way" (Gadamer, 2007, p. 239). It is a journey of discovery more than a technical process. To show my thinking that emerged through this process, I pause throughout this chapter to engage in a 'thinking space' as evidenced below.

Thinking space

> *While reviewing literature on migrant women's experience, I saw that the researchers had taken the voices of participants and brought their own interpretation to what participants were saying. As a reviewer I was bringing another layer of interpretation to what was said. While there were some interpretations that I questioned, this was not to deny the validity of findings, but a reminder that each person brings their own self and preunderstandings into the interpretation process.*

2.3 Who is a Migrant?

2.3.1 A leaving, a loss

This quote by Natalia Sylvester (2020), a migrant herself, immediately resonated with my own experience as a migrant in several countries:

> There is nothing easy about migration. It is a search for a better life, but in this way it is also a death. How easily would you choose to leave this life? How quickly, if the decision were made for you? It is a line you cannot uncross, whether you are lucky enough to visit every few years or if you left knowing you will never return. Everyone and everything you knew and loved are gone. (pp.194-195)

While every migrant has their individual story, the wide definition of 'migrant' serves to emphasise their only commonality to be that of a movement away from the familiar. Regardless of whether they find their current status positive or negative, there has, in every case, been a leaving, a loss of some kind. The International Organisation of Migration (2019), in their definition of migrant shows the same thing, stating it is:

> An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons.

2.3.2 An Ill-Defined Place and Space to be

Being a migrant is an uncertain place and space to be. My own experience of living months on a friend's lounge floor wondering if I would be granted a work permit was difficult. I came to this review asking, 'how much harder is it for someone with few contacts and lacking language and cultural knowledge of their receiving country?' There are those who argue that the lack of definition of the word 'migrant' leaves uncertainty in many lives and results in a failure to identify the individual needs and challenges migrants face. This is particularly evident in looking at international research on migrants, where the result can be a failure to facilitate provision of health care that is tailored to particular groups of migrants (Balaam et al., 2017; Hili et al., 2022; World Health Organization, 2023). A recent systematic review of perinatal outcomes and care for asylum seekers and refugees looked at 29 systematic reviews in the English language (2007 to 2017). The authors found that 28 of the reviews "grouped asylum seekers and refugees with wider migrant populations" (Heslehurst et al., 2018, p. 1), thus creating one homogenous group out of many and varied migration experiences. Each person represented in these reviews is an individual with their own background which influences their current well-being; all different reasons for migrating, place of

origin, past experience of health care, length of time in the receiving country, and experience and knowledge of the host country's language and culture (Balaam et al., 2017). Homogenisation is not limited to migrants. For example, a person born and living in New Zealand who identifies with one of the Pacific Island ethnic groups can identify their actual ethnicity in official documents, or they can choose "Pacific not defined", or "Other Pacific". "Other Pacific" includes numerous smaller Pacific Island ethnic groups such as I-Kiribati, even though I-Kiribati is one of the eight largest Pacific groups (Pasefika Proud, 2016). Regardless of practical reasons for placing small ethnic groups together, it is understandable that some people find it hard to have their distinctive culture labelled together with other distinct but different cultures (Burnett & Bond, 2020).

Thinking space

> *There is no 'one' experience of being a migrant. My quest is to be attentive to the meaning of each person's story. That means being very aware of my taken-for-granted assumptions.*

2.4 The Experience of Migrant Women Internationally

Internationally, studies with migrant women show a mix of issues and statistics, from perinatal outcomes different to those of women in receiving countries, to issues with communication and relationships, unmet expectations, and the resultant tensions. The challenges are many, and migrant women show themselves strong in response.

2.4.1 Migrant Women May Experience Different Perinatal Outcomes Than Women of their Receiving Country

While statistics do not represent migrant women's childbirth experience, they represent a context in which all of them exist, as each have a 'perinatal outcome' whether positive or negative. As such, this section helps to understand what women might expect and experience. Research shows a link between migration and an increased risk of poorer perinatal outcomes compared to receiving or host country nationals (Bollini et al., 2009; Gagnon et al., 2014; Heslehurst et al., 2018; Hili et al., 2022; United Nations Population Fund, 2018), although there is some variation (Balaam et al., 2017). The term 'migrant' does not mean the same thing for everyone. Bollini et al. (2009) showed in their systematic review that migrants are at increased risk of poorer perinatal outcomes. However, in receiving countries which support migrants to integrate and to participate "in the life of the receiving society" and thus face "decreased stress and discrimination", perinatal outcomes are better than in countries without such support; thus these (integration) "policies may be protective" (p. 452), This suggests that the reasons for poor perinatal outcome are not only in what is "brought-

with" migrants themselves but are related to migrants' relationship with their receiving countries systems, people, and culture.

Research suggests that perinatal outcomes for migrants can be similar to, or even better than, women of receiving countries (Hili et al., 2022). In a survey of 5,332 women, including migrants, Henderson et al. (2018) found that all migrants had "lower rates of pregnancy problems, such as hypertension" (p. 89) compared to UK-born women. In Henderson at al.'s study, migrants from Accession countries (those who had joined the European Union since 2004) were also more likely to have normal births. However, the same study showed that recent migrants from the rest of the world were more likely than UK-born women to have a preterm birth and to give birth by caesarean.

Thinking space

> *What is 'brought-with' and what is 'given-to' a migrant woman in her new country, which will impact her perinatal outcome?*

In reading and in dialogue with international research, key themes emerged. These aligned with those found in Crowther and Lau (2019), and I have made use of them here; communication and understanding, relationships, and expectations and values. I have added one other, opportunities. These are all parts of the whole which make up the migrant experience.

2.4.2 Migrant Women's Experiences with Communication and Understanding

"Struggles with communication are one of the major difficulties faced by migrant women, midwives, and other health providers during maternity care encounters" (Hili et al., 2022, p. 142). This is perhaps unsurprising, as communication is two-way. It involves two sides with different preunderstandings. An example is that of migrant Polish women accessing maternity services in Scotland, who reported feeling vulnerable about their language proficiency. They also reported that the quality and type of information given was crucial to them (Crowther & Lau, 2019). It appears that it is not just words that matter, but words of value, timely words. Lack of language skills can mean that problems experienced by migrant women are not voiced; therefore, health professionals do not know about them. Half of the migrant women in Newall et al.'s (2012) study in Birmingham, England, experienced feeling unable to communicate during their births. They felt ignored and did not feel in control of their labours. In Small's (2014) systematic review of research in five Western countries with migrant

and non-migrant women, migrant women reported communication difficulties negatively affecting their experience of maternity care.

Thinking space

> *I have noticed that English skills can be much reduced for overseas born clients in strong labour, and have often wondered, what does it mean to be unable to communicate at such an intense and crucial time of their lives?*

Poor language skills were observed to bring out rudeness in staff and resultant poor understanding on the part of migrant women (Thomson et al., 2022). Thirty four percent of women of minority ethnic groups in this same study reported being treated differently to women of the majority white population. Numerous studies report migrant women's experience of discrimination, stereotyping, not being respected, and of wrong assumptions being made about them when accessing maternity care (Benza & Liamputtong, 2017; Heslehurst et al., 2018; Korukcu et al., 2018; Ouanhnon et al., 2023; Small et al., 2014; Thomson et al., 2022). Of itself, this is disturbing, but the implications of discrimination stretch wider than personal offence. Many of these women will be less likely to seek help, will have poorer mental health, less satisfaction with care (Thomson et al., 2022), will access care less (Heslehurst et al., 2018), and will receive poorer care if they do access it (Small et al., 2014).

Thinking space

> *While racism and discrimination may not be something immediately obvious to some people, it may deeply affect the maternity journey of the migrant women who experience it. Do my participants talk of such experiences?*
>
> *I wonder whether I would be able to listen well, let alone understand in a second language if I was not treated with respect? Or if health professionals make wrong assumptions about me? Perhaps I, too, would hesitate to voice concerns or prefer to leave questions unspoken.*

While the maternity care communication experience may be improved by interpretation, it may not be straightforward. Crowther and Lau (2019) found that a woman may prefer to have a family-member translate at an intimate time such as birth. However, health professionals' view of interpretation by family may not be positive and may be seen as getting in the way of developing a relationship with the midwife (Goodwin et al., 2022) or as risky behaviour, given that the woman herself cannot reveal to the health professional intimate partner violence or other information she wishes to keep confidential from her close family (Hili et al., 2022). Migrant women in Newall et al.'s (2012) study echoed this concern of feeling "unable to disclose problems" (p. 12) with families interpreting for them.

Thinking space

I wonder how many of my migrant clients have remained quiet about problems because they are using family to interpret.

Perhaps there are other reasons for migrant women to prefer family over professional interpreters, such as not wanting to risk leaking personal information into a small migrant community?

Britz's (2017) study of interpreters in New Zealand brings out the complexity interpreters face. For example, he reported they were not just translating "word-for-word" but would at times also "provide cultural and social interpretations" (p. 155). It is clear that communication and understanding is more than just words. A study in France interviewed migrant women with different countries of origin and found, too, that it was not just the "language barrier" which was a challenge to accessing gynaecological care, but "the difficulty to understand a totally new healthcare system" (Ouanhnon et al., 2023, p. 1). Language and lack of understanding of the system were among the challenges experienced by migrants in the UK from 28 different countries in Newall et al. (2012). Women migrants from the Accession countries in Henderson et al.'s (2018) research "were significantly less likely to feel that they were spoken to so they could understand and be treated with kindness and respect" (p. 87). Despite the positive perinatal outcomes for migrants from Accession countries, "overall satisfaction with care was lower in all migrant groups at each stage, especially labour and birth, compared to UK-born women" (p. 89). This may have something to do with how they were treated by those caring for them, which appears to be in deficit mode of relationship. The quality of the relationship reflected what migrant women in France felt they could or could not ask of their health professionals (Ouanhnon et al., 2023). Language proficiency is clearly not the only component of communication and does not guarantee communication and understanding between health professionals and their clients.

Thinking space:

What part does relationship play in migrant clients' experience of understanding the information they receive from their health professionals?

2.4.3 Migrant Women's Experience of Relationships in the Time of Childbirth

Relationships were a common theme in the literature. Migrant women 'bring-with' them many pre-existing relationships with close and extended family, friends, and community to their receiving country. Polish migrants to Scotland revealed that their relationships

and social connectedness with family, as well as continuity of care relationships with midwives, brought meaning to their childbirth experiences (Crowther & Lau, 2019). Both family and the midwife's relationship were important to them.

Others have different experiences. Migrant women in Goodwin's (2016) study placed "high importance" (p. 350) on the midwife-woman relationship in their maternity experience, as did the midwives. However, the midwife-woman relationship was not as important to the women as family relationships, which to them was as important as "culture and religion", and "understanding different health-care systems" (Goodwin, 2016, p. 351). Women were focused on "the importance of family involvement in their maternity care" (p. 353). Women and midwives had different expectations of the care relationship.

Thinking space

I continue to reflect on my own experiences as a midwife. I had assumed that migrant women in their childbirth journeys placed a higher level of importance on their relationships with their midwives than the research reveals. Perhaps other midwives assume the same.

If migrant women value family relationships more than the relationship with the midwife, how do midwives encompass family relationships in their care?

2.4.4 Migrant Women 'Bring-With' Them Expectations and Values

It is the expectation of many migrants that life will be better in the receiving country; better life, better housing, better employment opportunities. Henderson et al. (2018) showed that migrant women tended to live in the most deprived areas, although not always. Lack of adequate housing and lack of employment are linked to poverty, which can affect migrant women's experience in many ways (Newall et al., 2012).

Thinking space

I wonder what the experience is for migrants when their expectations of life in their new country are not met. I wonder how this then affects migrant women's childbirth experiences.

Tension may arise in the midwife-woman relationship when expectations of the relationship or care differ, and when there are unmet practical expectations of maternity care. Migrant Polish women in Crowther and Lau's (2019) study reported a lack in care which appeared to result in part from the Scottish maternity services giving less scans than what the women would expect to receive in Poland. Some women even returned to Poland to access extra checkups. South Wales midwives experienced frustration that some Pakistani women were attending clinics but were focussing on getting them to fill in forms related to social issues (Goodwin et al., 2017). This was what these

migrant women expected. The authors concluded that these women were focused on the expectation that services adapt to the women's needs.

Thinking space

Do migrant women accessing maternity services sometimes expect that maternity care will be the same as in their country of origin?

How do migrant women know or learn what they can expect of maternity care in New Zealand?

Midwives and women also differed regarding what was expected to be seen and accepted as legitimate 'knowledge', particularly regarding traditional practices (Goodwin et al., 2017). The subject of maintaining traditions can influence the midwife-woman relationship. Pakistani women migrants reported "confusion and possible tensions from trying to balance sometimes incompatible professional/midwifery and traditional/family ideologies" (Goodwin, 2016, p. 351), and sometimes this knowledge was contradictory. What also showed in Goodwin's (2016) study was that midwives tended to be less judgemental of traditional practices if they already had a good relationship with the migrant woman.

Thinking space

Migrant women 'bring-with' them languages, cultures, knowledge systems, traditions, and pre-understandings about health systems and how life is 'done', encapsulated in expectations; I wonder if health professionals always recognise and acknowledge what is 'brought with' migrant clients? And do they recognise and acknowledge that they themselves 'bring with' them these things to their communication with migrant clients?

What are migrant women's experiences of what they 'bring with' them, being acknowledged (or not) by health professionals?

It may be midwives' expectations of the midwife-woman relationship and appropriate care which are not met. For example, midwives may negatively assume that migrant women do not understand or are not adapting to the health care system because they come late to appointments or do not attend (Goodwin, 2016). However, migrant women may have priorities and demands other than pregnancy, such as financial issues (Hili et al., 2022). This is borne out by migrant women in France who did not prioritise healthcare as they were "often too preoccupied by their daily problems to be able to project themselves in an uncertain future" (Ouanhnon et al., 2023, p. 8). Migrant women in Newall et al.'s (2012) study experienced continuity of maternity care as limited by poverty and controlling relationships.

Although the current review is focused on migrant women, it would appear that their overall expectations are not much different than other women accessing care in childbirth. In Small et al.'s (2014) large review, immigrant and non-immigrant women wanted the same things of their maternity care; that is, "safe, high quality, individualised care…adequate information and support" (p. 1), but immigrants gave poorer ratings for their care. Similarly, migrant women in France, while not always prioritising healthcare, valued competence and "human qualities" (Ouanhnon et al., 2023, p. 8) in their health professional or midwife and felt that trust was important. In Balaam's (2013) study, migrant women wanted carers to treat them with respect, kindness, and no discrimination; to be safe, have good communication and be able to understand the system.

Thinking space

There are many things such as housing, employment, or poverty which can encroach on every space of a migrant woman's life experience, so perhaps childbirth is sometimes just 'one more thing' in her life. Perhaps not attending is seen by some migrant women as a positive attempt at prioritisation of their and their family's myriad needs. I wonder how they experience communicating this to their midwife.

Reflecting on my own experience as a midwife, I wonder how many clients have not attended appointments because they or their partners cannot afford to take time off work, or to pay for petrol? And I wonder if I have ever assumed that such a client does not care about her pregnancy, or does not care that her midwife is inconvenienced?

2.4.5 The Experience of Migration May Bring Opportunities

Thomas (2012), in his history of the Pacific, put the challenges of migration into context, highlighting that being a migrant has never necessarily been a totally negative experience.

> The day of emigration has been considered 'one of the saddest' in Rapa Nui's history.... Which is to perhaps miss a point fundamental to the whole of Pacific history. From the earliest human ventures east from New Guinea into unknown waters, through the sophisticated navigations between the great Polynesian archipelagos, to the anxious departures of those facing famine, voyaging could mean gain, not just loss. It certainly entailed risk, it offered a path toward survival, toward new lands, new homes and new lives (p. 200).

Migrant women, worldwide, are heterogeneous, and so are their lived experiences. While some do not have their expectations met, others find opportunities and positive aspects in their migration. Migration to them may not be a 'problem' as such. To see it so is to prejudge the outcome for migrants and to deny the breadth and depth of their

strengths and skills (Crowther & Lau, 2019; Hili et al., 2022). Crowther and Lau's (2019) study of Polish migrant women accessing maternity services in Scotland countered this problematisation by using a salutogenic framework. While they found that maternity staff often problematise migrant groups, rather than see what strengths each person or group possess, the participants showed a "vast array of adaptive and coping strategies" (Crowther & Lau, 2019, p. 35). One of the authors' conclusions was that "migrant women can adjust and mobilise their resources to find meaning in their maternity experience with support" (p. 37).

Others, despite difficult circumstances or experiences, saw their current experiences, including their births in the new country, as positive (Benza & Liamputtong, 2017; Bollini et al., 2009; Goodwin, 2016). Migrant women in France reported they were very satisfied with the French health system and with the human qualities of health professionals (Ouanhnon et al., 2023). There are more questions to be asked and much more to understand in the migrant women's experience, particularly because there is not just 'one' experience.

Thinking space

> *Has my image of migrant women been that they are passive victims of negative circumstances? Or has it been one of strong women working out their own and their family's future with the resources and strengths they have 'brought with' them?*

2.5 The Experience of Being a Migrant in New Zealand

New Zealand's population is composed of Māori, Indigenous inhabitants, New Zealand Europeans and other, smaller, ethnic groups. There is an increasing number of migrants of many cultures in New Zealand society, including I-Kiribati. For example, the percentage of Pacific peoples in New Zealand, which includes I-Kiribati, has increased from 6.9% in 2006 to 8.1% in 2018 (StatsNZ, 2018). In the year ending September 23, 2023, the net inward migration of non-New Zealand citizens was 163,600 persons, more than double that of the pre-COVID figure of 73,600 in the year 2016/17 (Ministry of Business Innovation & Employment, 2018; StatsNZ, 2023). Documenting the experience of migrants arriving in New Zealand therefore, is and will be, increasingly important for future planning in health care and other services.

While I could find no I-Kiribati women's specific health statistics, it is possible that as Pacific women they may experience poorer perinatal outcomes than New Zealand Europeans who make up the majority of New Zealand's population, as seen in the Introduction chapter. In the absence of research specific to I-Kiribati migrants' experience of childbirth, understanding will be assisted by looking at research on I-

Kiribati and other migrant's experience of general life and health in New Zealand, which includes some experiences of childbirth. Each research study shows 'parts' of the experience for migrant women in New Zealand and continues to add to a 'whole' picture of their experience and the context in which they find themselves.

2.5.1 Migrant's Experiences with Communication and Understanding in New Zealand

Thompson (2016) found with her migrant I-Kiribati participants that "language proficiency (was) one of the most important influencers of settlement outcomes" (p. 239). Cleverley's (2023) I-Kiribati participants, all professionals, said language barriers were one thing preventing access to healthcare and other services. Conversely, for I-Kiribati participants in Schutz's (2022) study on I-Kiribati wellbeing, language and health literacy appeared not to be major issues as long as adequate reassurance and explanations of procedures were given. While this is an apparent contradiction, it does point out that experiences differ; as with other cultures, I-Kiribati are not one homogeneous group, and that the role of relational support is important.

Thinking space

I wonder, what is the meaning of reassurance and support for migrant I-Kiribati women in the context of childbirth. From where does this reassurance and support come?

Japanese migrant women in New Zealand had difficulties with the technical English language encountered during the childbirth period, even if English was not normally a problem (Doering et al., 2015). Antenatally, these women had preferred to read material about childbirth in Japanese, sent from Japan, rather than the English material given by New Zealand midwives. This may just be true for this small group of Japanese migrant women who may have moved in similar circles and shared ideas or resources, but it still provokes thought.

Thinking space

Perhaps returning to the nuances of a familiar and understandable language and culture of childbirth in Japan, gave meaning to these women's childbirth experience?

What are migrant I-Kiribati women's experience of finding information in the childbirth period? Is information about childbirth, advice 'brought with' them from family in Kiribati? Or received from knowledgeable I-Kiribati in New Zealand? Or 'given to' them by midwives?

There is more to understanding than language. DeSouza (2006) asked migrant mothers from European, Arab, Chinese, and Korean cultures about their experiences of motherhood in New Zealand. Many expressed a lack of both information and

knowledge of what community resources were available for all stages of their maternity care. Research by McPherson (2020) brought voice to Pacific women navigating colposcopy services in New Zealand. Women in this study were concerned that they lacked knowledge and understanding concerning their results; results which showed more than words, but implications for the future of these women. Participants' stories in Namoori-Sinclair's (2020) study with I-Kiribati in New Zealand on PAC visas also emphasised that knowing English does not equal health literacy or guarantee being understood. One participant blamed a midwife for not giving enough information, being unhelpful, and not understanding that in her culture there was a community responsibility for the health needs of an individual. Cleverley's (2023) participants suggested that providers need to know and understand more about the I-Kiribati culture when they are working with I-Kiribati to facilitate access to health and social services. Words conveying information make up part of understanding, but it takes more than this for understanding to increase.

Schutz (2022) found that some participants feared unnecessary hospital intervention, such as episiotomy or caesarean. While this can be true of anyone, it is a concern. Some I-Kiribati participants in Schutz's study struggled to manage illness in a timely manner and lacked understanding of western health practices. Participants reported navigating their way between their traditional I-Kiribati beliefs and practises; and western, Māori, and other Pacific health practices. Such navigation is perhaps a strategy of strength in these circumstances.

Thinking space

> *What is it to experience being unfamiliar with the meaning of words, and being unfamiliar with how the health system functions; lacking both English skills and health literacy? Perhaps a lack of cultural literacy on the part of both client and health professional can also preclude understanding?*

Migrants may experience a lack of familiarity with New Zealand's society and systems and, worse, they can experience discrimination or institutional racism. There are participants experiences in the research I reviewed in which discrimination or racism can be suspected; I-Kiribati participants reporting lack of support and help by immigration services (Namoori-Sinclair, 2020), or Pacific participants alluding to lack of recognition of cultural needs in primary birthing units (McAra-Couper et al., 2018). Participants in De Souza's (2014) study, too, reported being 'othered' for their cultural views, and overt racism was reported in Adelowo's (2012) study with African migrant women in New Zealand, participants perhaps more willing to disclose because the

researcher herself was an African migrant; “racism experienced was in the form of verbal abuse, discrimination and marginalisation at different settings” (p. 111).

Thinking space

Do health professionals like myself assume there is no ‘othering’ or ‘discrimination’ or ‘racism’ because no one discloses such things to us?

I wonder at the strength it must take in a new land, and possibly in a new language, to voice the experience of being discriminated against, of racism. And to whom?

2.5.2 Migrant’s Experience of Relationships in New Zealand

A vital role was played by family and friends in supporting settlement, particularly in housing new arrivals and finding work (Teariki, 2017). Just over half of I-Kiribati participants in Schutz’s (2022) study lived with extended family, and the rest in nuclear families. Extended family was valued for giving connectedness and support, with housing, jobs, healthcare, and other services; as well as, for maintaining health and wellbeing. Schutz noted that the role of family was to give both physical and psychological help, particularly mothers to daughters before and after birth. One I-Kiribati participant in Namoori-Sinclair’s (2020) study only sought maternity care when her residency was approved because of encouragement from family. Family, too, is where knowledge of traditional health practices is often passed on. For example, pain management, managing specific illness, support of pregnant women and mothers, and supporting child health and wellbeing (Schutz et al., 2019). Family and community is important in all aspects of life.

Burnett and Bond’s (2020) study asked New Zealand born I-Kiribati students about their experience in New Zealand. They showed that participants moved back and forward between the I-Kiribati and New Zealand cultures in what authors called “identity dancing” (p. 332). This is suggestive of making purposeful, known actions in order to identify with a particular group. Community relationships played an important part in establishing and maintaining identities in this minority group. Adelowo’s (2012) migrant women participants agreed, too, that communalism was their most significant coping strategy.

Thinking space

I wonder what the experience of migrant I-Kiribati women might be, as they seek to balance maintaining their I-Kiribati identity and, at the same time, become more familiar with New Zealand ways?

For many migrants it seems extended family and community are important, and for many reasons; what is their experience of the role of family relationships in maternity care? And what is their experience without family and community nearby?

Sometimes the support of family relationships is not 'brought-with' migrants to New Zealand. I-Kiribati migrants in Namoori-Sinclair's (2020) research reported this to be very stressful. The stress was not just about practical support, although that is important, but it was also about the cultural support given by family. DeSouza (2006) found that cultural, language and information needs were not always met as a result of a lack of family support. For some, this meant there was a need for women and their partners to take up more responsibility in the childbirth process. For some this was positive, while for others the lack of support was keenly felt.

Thinking space

I have seen that many I-Kiribati women have their partners with them at the birth. I wonder if this is traditional or if it represents a culture change, a response to the need for support in a new country?

2.5.3 Migrants 'Bring-With" Them Expectations and Values to New Zealand

Each migrant has expectations they 'bring-with' them to their new country based on their own pre-understandings; expectations about communications, culture, and how one 'does' day to day life. Doering (2015) found that among Japanese migrant women giving birth in New Zealand, "the cultural inheritance of humility and respect apparent within Japanese society is clearly at odds with that of New Zealand society" (p. 9). This resulted in participants not always saying what they thought or were concerned about, but expecting health professionals to understand their needs. This phenomenon, I have been told is culturally known as "reading the air" (H. Mori-Robertson, personal communication, March 24, 2024). I-Kiribati migrant participants in Gillard and Dyson's (2011) study spoke of the I-Kiribati culture of being shy to speak in front of others because of upbringing and fear of being mocked for poor English. As migrants in New Zealand, Namoori-Sinclair's (2020) participants reported finding jobs a stressful process, especially if they retained the I-Kiribati culture of shyness (*te mama)*. At work shyness made it difficult to ask for a raise or to ask for help. Cleverley's (2023) I-Kiribati participants spoke about how they are taught to exhibit shyness, to not be up front but to wait to be helped; and that it is not their way to ask help from people they do not know. Such cultural aspects of communication are just part, but a significant part, of the whole that is communication.

Thinking space

What is the experience for an I-Kiribati woman of meeting a midwife for the first time, of asking for information, or expressing a concern, if she has a limited confidence in speaking English and/or is constrained by cultural norms which preclude speaking out questions? Have I, as a midwife, assumed such things are easy to do for all women?

Women migrants to New Zealand come to a health system built on a different worldview to the one they 'bring with' them from their country of origin, and may have expectations that are not met. De Souza (2006) found that migrants' health literacy in the form of maternity literacy varied greatly. "It was evident across all migrant groups and at all stages of motherhood that a lack of familiarity with the health system, cultural differences, and the need for information that was timely and accurate were important factors" (p. 31). There is not just one thing which constitutes understanding of maternity care, there are many parts. De Souza pointed out that these factors are experienced as important to both migrants and New Zealand-born women.

Thinking space

Do New Zealand midwives assume that migrant women have the same expections of New Zealand maternity care as New Zealand-born women?

In Doering et al.'s (2015) study, Japanese migrant women's practical expectations of maternity care were not met. In Japan they would receive regular monthly scans; while in New Zealand, the number of routine scans is limited to particular times or indications. Most of Doering's participants felt that while the Japanese system might do too much checking, the New Zealand system did not do enough, and they were not totally satisfied with their experience of the New Zealand maternity system.

De Souza's (2014) migrant Korean women spoke similarly about their experiences of New Zealand maternity care. They saw the biomedical culture in Korea as central to the well being of the mother and baby. In New Zealand they experienced a lack of monitoring, compared to Korea where "the medicalisation of childbirth is constructed as a benevolent process" (DeSouza, 2014, p. 351). Issues such as not being able to go to hospital as early as they would have liked to, not having scans as often as expected were seen as a problem. The Korean women saw a biomedical emphasis in care as "empowering", while experiencing "the Western ideals of maternal independence and autonomy as cooercive in the context of their culturally different framing of the maternal body as vulnerable" (p. 354). These conclusions highlight the disconnect between the world views and expectations of these migrant women participants and the health professionals who cared for them.

Thinking space

I wonder if, and how, migrant women speak of their expectations to their health professionals? And if they speak up, are they heard? Or are they merely told what is 'done'?

Some participants in De Souza's (2006) study were surprised at a focus on the baby postnatally in New Zealand and what they saw as a lack of nurturing of the new mothers. A lack of understanding about rituals, such as differentiation between hot and cold foods, was also reported. In their experience, a "loss of rituals was a critical aspect of maternity" (DeSouza, 2006, p. 33). McPherson (2020) found that cultural values and beliefs were an essential part of Pacific women's experience of colposcopy, either helping or hindering their access to services. She concluded that "there needs to be an improvement in cultural responsiveness" (McPherson, 2020, p. 206) on the part of colposcopy staff. More was needed from health professionals for clients' needs to be met.

Thinking space

What is the experience for migrant women to be denied opportunity, by not speaking out or by not being heard, to carry out the rituals around childbirth they have 'brought with' them and which they believe to be important?

Gillard and Dyson (2011), investigating I-Kiribati migrant participants' experiences in New Zealand, found that the migrants' needs and aspirations were on the themes of housing, employment, language and culture, and global warming. One participant articulated regretfully that they missed the slower pace and less pressure of life in Kiribati. Not all expectations are met in migrating. This was shown in Teariki's (2017) study, who found that new arrivals from Kiribati were surprised at the poor quality of rental housing and the overcrowding. Namoori-Sinclair's (2020) participants arriving in New Zealand on PAC visas with expectations of a better life were also challenged to find that they had to sort out their own housing, jobs, and healthcare; as well as learn the New Zealand culture and language. Namoori-Sinclair reported that they found the government's immigration system to be unsupportive and not helpful. The author suggested that the participants' expectations and interpretations were based on the traditional community-based governmentality they are used to in Kiribati, where care is more the responsibility of community than of an individual. A group of I-Kiribati professionals spoke of how each of them found it hard to adjust to the culture and way of life when they first arrived in New Zealand (Cleverley, 2023). They thought that there were some who were still unwilling to adapt to and learn the New Zealand system.

Thinking space

What is it for migrant women to experience having 'left behind' familiarity with maternity care in the time of childbirth, and what facilitates their journey to familiarity with maternity care in their new country?

I-Kiribati, too, 'bring-with' them to New Zealand particular health beliefs and practices which influence their expectations and understandings. Some of Schutz's (2022) I-Kiribati participants expressed that it was hard when they fell pregnant before their formal engagement and marriage, as this went against I-Kiribati cultural values and could bring shame to parents. Concealing such a pregnancy would also mean a woman did not receive the nurturing by family required in I-Kiribati culture at such a time. Traditional massage was commonly used in pregnancy and for general health, but they often did not tell health professionals giving Western maternity care about this intervention. It was common for them to adhere to the tradition of keeping infants in the house so that they were not exposed to the outside environment in the first months. (Schutz et al., 2019) observed that in the childbirth period each navigated their path between traditional and western practices differently but that most used both, and some used Māori or other Pacific traditional practices.

Thinking space

As a midwife, have I been aware of I-Kiribati clients experiencing navigation between traditional and western beliefs and health practices during childbirth? Have I asked about traditions and what they mean to my clients? Have I understood the meaning of what is said? Have I assumed what values and beliefs they do hold?

Most of Schutz's (2022) participants saw 'health' (*marurung*) as "not just about physical health, but …when a person has healthiness of body, mind and spirit" (p. 149); that is, a holistic view. It follows that causes of illnesses suggested "varied from supernatural power, to not adhering to health protocols, and not respecting senior family members" (p. 152). Participants believed in "engaging and adhering to their ancestors' cultural *tabu* (sacred) practices to maintain their health, to find out the causes of their illnesses, or seek healing methods for their illnesses" (Schutz, 2022, p. 156). It was unusual for participants to take Western medicine for pain relief and some reported anxiety and feeling overwhelmed during experiences of Western medical care. In writing on I-Kiribati needs in health care, Schutz et al (2019) pointed out that "the dominance of the medical model in New Zealand's health system has been perceived as alienating for the broader Pacific population in New Zealand" (p. 26) and, therefore, many reject interventions through not understanding them and preferring traditional healing.

Thinking space

I wonder if I-Kiribati migrants experience holistic care in the New Zealand health system? In maternity care?

I wonder if some I-Kiribati migrant women experience feeling overwhelmed and anxious about their experience of maternity care in New Zealand? Or are other issues more pressing?

2.5.4 The Experience of Migration to New Zealand May Bring Opportunities

Migrants' expectations of a better life in a new country are sometimes met. However, De Souza (2006) said that much research is focussed "on the negative consequences of immigration for families and for parenting" (p. 36), concurring with international research and representing a problematisation of migrants. Some research, however, does show strengths of migrants and opportunities in migration. DeSouza reported that some participants found a new self reliance on migrating to New Zealand. Adelowo et al. (2016) wrote that while some of the participants migrated for negative reasons, such as political and economic instability in their home country, some also migrated for education, professional development opportunities, or to join family. Adelowo and Smythe (2012) reported of African migrant women in New Zealand, "It is important to note that despite (the) challenges faced by the women, they had not seen themselves as victims of these circumstances; they used their necessary skills to take charge of their situations" (p. 161). Thomson's (2016) I-Kiribati participants reported that their children were healthier in New Zealand, with better air, more fresh fruit and vegetables, and better health services. Their common view was that they would be able to provide a "better life" for their children in New Zealand than they could in Kiribati (p. 83).

Thinking space

I suspect that sometimes I have unconsciously seen the problems in migrant clients' situations rather than the strengths they have to deal with them. Perhaps there are other health professionals who do likewise.

2.5.5 Further Meaning in Research with Migrants to New Zealand

The amount of research on the experience of migrants to New Zealand is small; therefore, I included more than the maternity experience. Differences to international findings can be shown in the New Zealand research; for example, interpreters do not feature, although this does not mean they are not important to migrants in New Zealand. This may indicate a gap in services or a low level of willingness by clients to access professionals for this purpose. What is different in the New Zealand research is that there is more detail and deeper meanings. These are more able to be

shown in a smaller number of research studies and participants than in large reviews where practical homogenisation can drown the voice of the individual and that of ‘different’ participants or of those who are ‘more open’ to share their views.

The themes of communication and understanding, relationships, expectations and values, and opportunities found in the international research, can also be found in the experiences of migrants to New Zealand. Communication is further emphasised to be not just words but includes migrants’ understanding of the new country’s culture and societal systems. Their experience does not always appear to show a health system that communicates understanding of migrants. Family relationships are shown to be very important in I-Kiribati culture, something not always visible in the international research I accessed. Tradition and culture are important for migrants to New Zealand, as is also shown in international research, and informs migrants’ preunderstandings which, in turn, informs the expectations they ‘bring with’ them. Recent research with I-Kiribati in New Zealand has resulted in models of wellbeing which show I-Kiribati experience life based on a significant holistic or, rather, “wholistic” worldview (Cleverley, 2023; Kewene et al., 2023; Namoori-Sinclair, 2020; Schutz, 2022).

Thinking space

> *I assumed I could gain an understanding of I-Kiribati migrant women’s experience in New Zealand, but in pursuing the research on migrant women, I find myself wondering - is their experience not one thing but many parts? And so those many parts, the many experiences, make up the whole; the whole of a holistic worldview.*

2.6 Women’s Experience of Maternity Care in New Zealand

The background and organisation of New Zealand midwifery is covered in the Introduction chapter; here, I look further into women’s experience of their maternity care. While most migrant I-Kiribati women experiencing childbirth in New Zealand may see a number of health professionals, midwives are the ‘face’ of their maternity care, the health professional they are likely to have the most contact with during the childbirth period. Given that relationships are shown, internationally, to be an important theme in migrant women’s experiences of childbirth (Bradfield et al., 2018; Crowther & Lau, 2019; Goodwin et al., 2022; Ouanhnon et al., 2023), New Zealand midwives and the woman-midwife relationship are relevant context in this research and may affect women’s experience of maternity care.

Internationally, the woman-midwife relationship appears to be important both to midwives and migrant women. It can be protective (Almorbaty et al., 2022; Bridle et al., 2021; Sandall et al., 2024); although there can be a marked difference between women

and midwives in defining what the ‘care’ relationship should be (Goodwin et al., 2022). They each come with their own preunderstandings. A Cochrane review covering over 18,000 women found that continuity of midwifery care (thus implying on-going relationships between women and midwives), meant that women had less caesarean section or instrumental birth than women who had care through fragmented maternity care models (Sandall et al., 2024). Not only did continuity of care result in more spontaneous births than in other care models, but women receiving continuity of care reported their experiences of their care to be more positive. It is sobering to see in the MBRRACE-UK (2023) report on maternal mortality that improvement in care could have made a difference in the outcome in 52% of cases. Although this report is from the UK, and ‘maternity care’ there is given by a wide range of health professionals, there may be relevant issues for maternity care in other locations. The MBRRACE-UK report elaborated further that, what was missing in many cases was ‘personalised care’. This is defined as care that “accounts for individual’s values and preferences and is based on choice and control through genuine partnership with health professionals to improve care outcomes” (The Royal College of Midwives, 2022, p. 3); for example, being sensitive to a person’s culture or religion. In this context, statistics emphasise the importance and the potential of the ‘care’ relationship.

Thinking space

> *I wonder how New Zealand’s woman-midwife care relationship appears to migrant I-Kiribati women experiencing childbirth in New Zealand? With what expectations do they meet their midwife, and are they met?*

Documentation specifically about women’s experience of maternity care in New Zealand is limited, but some does exist. In the 2014 national consumer survey of satisfaction with maternity care, 77% of women were satisfied or very satisfied with care. This would be positive if it were not for the response rate having been low, at 29.2%, and especially low among Māori and Pacific women. Women in areas of high deprivation were less satisfied with information provided to them and with physical access to services (Dawson et al., 2021). This may be true for I-Kiribati women also, as Pacific women are more likely to live in such areas than those of the New Zealand European population (Pasefika Proud, 2016).

The midwifery model in New Zealand is based on a relationship of a negotiated ‘partnership’, as described in the Introduction chapter. “The woman decides who else enters this partnership with her but the midwife’s primary client is the woman” (Guilliland & Pairman, 2019, p. 17). These ‘partnership’ relationships “evolve”, they are “dynamic by nature”, and they are “individual to each woman and her midwife.” (p. 12).

A study by Freeman et al. (2004) with midwives and women showed that midwives' most common description of partnership was "working together with the woman towards a common aim" (p. 8). However, for the women in that study, 'partnership' was mostly "defined in relationship terms", then "teamwork, joint decision-making, and sharing information" (p. 9). Each comes with their preunderstandings and, again, there is seen to be a difference in women's and midwives' view of what the 'care' relationship is or should be.

Thinking space

> *I wonder how women and midwives' different enactment of 'partnership' affects the experience of women in the time of childbirth.*
>
> *I wonder if I-Kiribati women also prefer to include others such as family, in their 'partnership', and do they know this is possible?*

Use of the word 'partnership' emphasises that the woman-midwife relationship is not one of a traditional biomedical model where 'patients' are told what to do. Rather, there is potential for the 'client' to have a say, to participate and, share in their care decisions. If the word 'partnership' is now embedded in New Zealand's midwifery model and health system, so is one of its main components, 'informed choice' (Health & Disability Commisioner, n.d.; MacDonald, 2018). Standard Two in the Midwife Standards of Practice reads, "The midwife upholds each woman's right to free and informed choice" (New Zealand College of Midwives, n.d.-b). Informed choice is sometimes used synonymously with informed consent, informed decision making, and shared decision making. For the purpose of this thesis, I will take 'informed choice' to be a broad term covering all of the aforementioned.

"The concepts of informed decision making, and informed consent are inherent within the midwifery partnership and provide a mechanism for empowerment for women and midwives" (Guilliland & Pairman, 2019, p. 12). To aid decision making, the midwife is seen to be responsible to give up-to-date information, while the woman is responsible to give relevant information to the midwife about herself and her family (Guilliland & Pairman, 2019). The importance of the partnership relationship is emphasised here. MacDonald (2018) researched the history of informed choice in midwifery in Ontario, Canada, which has some similarities to New Zealand in the development of the midwifery profession in the late 20th century (Donley, 1998). MacDonald concluded that informed choice was originally just one part of the whole of midwifery care;

> informed choice was deeply embedded in a model of care from which it was never meant to be extracted…The idea that one could offer care

> without choice was not possible in the social movement of midwifery; nor could one offer choice without care (p. 289).

This quote suggests that informed choice is part of the whole picture of the woman-midwife relationship. Noseworthy et al. (2013) researched decision making with women and midwives in New Zealand and Ontario, Canada and found that, decision making in the partnerships between women and their families, and their midwives, was based on relationships. However, the decision making was also influenced by their social contexts and locations. Informed choice is seen here to be complex and not an isolated event or conversation. In New Zealand, one factor which increased women's right to 'informed choice' was the legislation passed following the Cartwright Inquiry of 1987-1988 (Coney, 1988). This inquiry looked into cervical smear practices in one New Zealand hospital where some women were left without treatment, with fatal consequences. Revelations in that report revealed a culture of medical care far from being patient-centred, and a long way from 'informed choice'.

Thinking space

> *How do health professionals explain informed choice to those for whom it is new? Is it about legislation? Is it about relationship? What is the meaning of being 'informed' enough to be able to choose?*
>
> *How do migrant women experience informed choice in New Zealand if it is not part of the health system from which they come? With uncertainty and tension? With clarity or confusion? With a welcome?*

DeSouza (2006) reported that an overarching feature of women participant's maternity experience was that choices and control in their situations were central to their levels of satisfaction, feeling empowered by the role of the "informed consumer" (p. 35) inherent in the New Zealand Health system. However, other participants, from a more medicalised background, found such an idea difficult, as medical intervention was normal for them in their country of origin. Korean women participating in De Souza's (2014) study saw biomedecine and medicalisation of childbirth as positive, and as playing a major role in theirs and their baby's wellbeing. In childbirth in New Zealand they felt there was an emphasis on achieving natural birth when they would have welcomed intervention; they felt disempowered by their experience, as their choices would have been different. For some women it is hard to make informed choice because cultural norms require of them to act a certain way with health professionals. Japanese participants in Doering et al.'s (2015) research seemed to focus on what was expected of them and doing what they 'should' do, rather than letting their preferences

be known. They had ‘brought with’ them to New Zealand their culture for interaction with health professionals.

Thinking space

As a New Zealand European midwife do I recognise when women prefer to choose on the basis not of their individual choices are what their family or community does, or have experienced? Or perhaps their choices are informed by what they have experienced or stories they have heard. For others, perhaps their choices are made on the basis of what their midwife suggests, or on the basis of what they think ‘should’ be done in New Zealand.

In McAra-Couper et al.’s (2018) study on Pacific women’s choice of birthplace, their choices were not so much about knowing or not knowing the choices offered between the hospital and the primary birthing units. Rather, their choice was made on the basis of trust in, familiarity with, and proximity to the hospital; and was influenced by their community and possibly their midwife. While these relationships were a factor in the choice, the place itself appeared to be more important in choosing where to birth. “For this woman Middlemore Hospital is where you give birth… It is what she knew. It is where you go” (McAra-Couper et al., 2018, p. 17). Informed choice to these participants was about what is ‘done’ by themselves or their communities. Researchers highlighted the challenge of “how to offer informed choice in a manner in which midwife and woman come to a shared understanding of the reasons that lie behind that choice” (p. 19). Similar results showed in Farry’s (2015) quantitative study of five perinatal outcomes for low-risk women, according to place (hospital or primary unit) and model of midwifery care (continuity of care versus fragmented care). It showed that while place was significant in outcomes, the model of care had no significant impact on the five measured outcomes. These two studies contradict the international research which showed continuity of care improved outcomes for women (Sandall et al., 2024; Sandall et al., 2016). However, perhaps ‘fragmented care’ in the New Zealand studies still represents a quality in relationships (possibly in a particular hospital setting) where there is recognition of cultural differences and needs. The basis of informed choice appears to be different in every case; it is affected by many variables.

Thinking space

I wonder if the information conveyed by the midwife and heard by the client depends on ‘how you say it’?

Who says what should be chosen? Is it really the individual? The family? The community? The midwife? And does this indicate whose knowledge is most valued?

How do I-Kiribati women experience informed choice? With reference to relationships with family, or family experience? Or with reference to their relationship with a midwife? Perhaps for other reasons. I wonder if a culture of shyness makes a difference.

A survey of routine feedback by women about midwives for the year 2019 gave both positive and negative feedback. Women reported feeling valued when there was positive relationship building, emanating from establishing and maintaining trust, honouring women's decisions, and empowering the women (Dixon et al., 2023). This highlights the value to individual women of a positive woman-midwife relationship. The survey was based on a low response rate for that year's births, and it would most likely have been midwives who asked for feedback, thus introducing a bias. However, it also shows the converse is true, which is that negative relationships were built where women's decisions were not honoured.

James' (2020) study showed that women experienced both negative and positive relationships with their midwives. One felt too scared to tell her midwife her preferences, while another felt unable to express herself or to ask questions of the midwife. Another did not perceive her midwife as compassionate, while another felt her midwife just did not recognise how vulnerable and overwhelmed she was after her birth. Each brought their own experience and expectations to their relationship. The 'right' midwife for James' participants was responsive and had relational skills. Underpinning such a relationship was found to be trust. Some similarities were found by Pullon et al. (2014), whose participants said that good communication was a key to satisfaction with the New Zealand model of care.

Howarth et al.'s (2011) research showed that relationships were important to women but not just the midwife; significant support was gained from friends and family. This finding is echoed in some international research. Women's relationships with midwives in a mixed method study on one midwifery practice set in a high deprivation community, and which included Pacific migrants, were said by the midwives to be positive (Priday & McAra-Couper, 2016). Although women were not interviewed in this study, there was evidence that there was early access and engagement with midwifery care in that practice, and that "midwifery care… is socially and culturally accepted by the community it serves" (p. 90). If this is so, a relationship may be assumed, most likely a positive relationship. Yet, perhaps other factors supported community acceptance, such as location or the way appointments are organised. Māori and Pacific women and midwives participated in a qualitative study asking how women from high socio-economic deprivation areas access and engage with midwives (Griffiths, 2019). Accessing a midwife showed itself to be complicated for these women, especially in

what appeared to be a maternity system that tried to treat everyone the same when they are not. However, “building effective relationships”, that is, the women-midwife relationship, alongside continuity of care, helped them to work together to meet the women’s needs, giving support and advocacy to navigate her way through the system. “Women … valued the quality of the relationship they developed with midwives more than any other aspect of care” (Griffiths, 2019, p. 200). Relationship and working together were important.

Thinking space

How would most migrant women in New Zealand describe their relationships with their midwives? What do they do if they do not like or trust their midwife?

Do I-Kiribati women experience trust, feel valued, feel empowered in their women-midwife relationships?

How do I-Kiribati women understand and experience the role family relationships play in their maternity care?

2.7 Conclusion

There is, in fact, no conclusion to this literature review but a recognition of further ‘parts’ having been added to our ‘whole’ understanding of the context of and experience for migrants, internationally and in New Zealand. This understanding remains ‘on the way’. The question I asked of the literature was “what is the context and experience for migrants (including I-Kiribati), experiencing childbirth in New Zealand?”

In New Zealand there is a changing sociocultural environment or context for midwives and those for whom they care. There are more migrants arriving in the country than ever before, while long term inequities in health outcomes for Māori and for Pacific people, some of whom are I-Kiribati migrants, still exist. The New Zealand model of midwifery care, as one of relationship termed a partnership, is the context these women experience. It includes ‘informed choice’, a concept the meaning of which may not be understood by those who have not experienced it before.

While there is no research focusing on migrant I-Kiribati women’s experience of childbirth in New Zealand, and limited documentation of their experience, the holistic nature of I-Kiribati beliefs about health and wellbeing is clear. Research with migrants from other groups on their experience focuses on the need for two-way communication and understanding, the importance of relationships, of ‘bringing-with’ expectations in all areas of life, and of seeing opportunities in their migration. The woman-midwife

relationship is seen as a potentially positive factor in women's experience but does not overshadow the importance of family and community; nor that sometimes, women struggle with the system and the relationships therein.

Conducting this literature review in a hermeneutic manner has allowed me to now bring new understanding, to better dialogue with the participants stories (MacLeod et al., 2023).

Thinking space

What IS the experience for migrant I-Kiribati women of childbirth in New Zealand?

Chapter 3: Methodology

3.1 Introduction

This research has been carried out utilising the methodology of hermeneutic phenomenology. Writing here about hermeneutic phenomenology serves to enlighten those unfamiliar with this methodology, sets the scene, and presents the framework which has informed how I have proceeded on this research journey. For this research I have drawn on the work of philosopher Martin Heidegger [1889-1976], a major contributor to the methodology. I have also drawn from another philosopher, who built on Heidegger's work, Hans-Georg Gadamer [1900-2002]. Others, whose philosophical notions are part of this research, will be mentioned when relevant.

In this chapter I first explain my choice of methodology, then introduce the methodology and key notions it holds which are relevant to the research. I include a short section about controversy regarding Heidegger and conclude by briefly highlighting the lens through which I, as the researcher, interpret and show the findings of this research.

3.2 Choosing the Research Methodology

Research begins with the process of choosing a question or topic. Of itself, this is a reflexive process, which results in a research question. The research question then determines which methodological approach will best bring answers. For a research question seeking to find meaning in the lived experience of participants, the methodology needs to be qualitative.

Health professionals may think, and indeed have commented, that the research question posed in this research could lead to a list of facts by which they can classify or 'deal' with I-Kiribati women. This represents a scientific or positivist model which, while they have their uses, do not elucidate deeper meanings. Gathering a list of facts would not be appropriate to the research question. Heidegger himself would concur that lists of facts about people or persons do not reveal who and how they are (Heidegger, 1927/1962; Steiner, 1978/1989). While some methodologies could utilise participants' stories to make a classification of 'what I-Kiribati women do or think' in childbirth in New Zealand, others may use the findings to create generalisations or a 'carer's checklist' about I-Kiribati. Researchers can risk creating overarching classifications without seeking to understand the situation for individuals or individual groups within the whole (Burnett & Bond, 2020; Said, 1978; Smith, 2021). I sought a methodology which would acknowledge that people are complex beings and recognise that there is always more to understand about them. Again, the choice of methodology is always

linked to what is being looked at or looked for, and the focus of the current research needed to be the meaning of the lived experience of the participants.

A methodology is “a strategy for guidelines, principles and philosophical underpinnings used to address a research question by gathering information and assessing evidence” (Crowther & Thomson, 2023, p. 8). In short, the philosophy behind the whole research undertaking. Vaioleti (2017), the author of the widely used Pacific methodology, *Talanoa*, pointed out that the “methodology deals with the philosophy, the assumptions, and values that underlie and guide the methods used” (p. 3). Thus, the methodology is deeper than the practicalities of gathering information; it goes to the heart of understanding what is revealed by the participants.

Many Pacific methodologies are in existence (Anae, 2019; Vaioleti, 2017). One in particular that resonated with me was the nature of *Talanoa*, which has similarities to some qualitative research methodologies of western origin, in particular, phenomenology. Vaioleti (2017) described *Talanoa* as “non-linear” and “responsive”, which he said describes it as a “phenomenological process” (p. 4). Non-linear and responsive suggest both an openness to participants choosing the direction for their stories to take and an emphasis on participants taking a lead in relating their stories. Looking further, at least three I-Kiribati methodologies have emerged in recent times. Some of these make use of metaphor to render the research relatable to the participants and, in turn, help to weave in and reveal I-Kiribati values and philosophy in the respective research findings (Namoori-Sinclair, 2020; Schutz, 2022; Teatao, 2015). I am neither a Pacific person nor I-Kiribati, so it is not appropriate for me to utilise a culturally specific methodology, as I could not carry it out accurately nor adequately according to the nuances contained therein. My cultural understanding would not be deep enough to do it justice. However, while not able to implement every aspect, it remained important to me to show respect for Pacific and I-Kiribati cultural principles. An example of such principles is documented by Schutz (2022), who wrote of “Three key (I-Kiribati) principles of cultural etiquette” (p. 122) which she incorporated in her research. “Firstly, the principle of…*kaomataaki*…means ‘honouring and inviting a person with dignity to participate in the study’” (p. 122). “Secondly, the principle of *bauariria* is about the researcher’s accountability and responsibility surrounding reciprocity” (p. 123). This principle builds on the previous one and includes both updating participants and the dissemination of research outcomes. “Thirdly, the principle of *iokinibwai;* the reciprocal gesture and actions to honour the kind contribution of the other party” (p. 124). These principles are seen as a whole, influencing the research process and practicalities. Respectfully keeping some of the broad principles of culture specific methodology in mind was also important in the

choice of research methodology, and such respect needed to be a vital part of the research planning and in the practical methods used. How this was done will be described in the Methods chapter. The Pacific Health Research Guidelines remind researchers, like myself, to recognise and uphold the importance of communal relationships, reciprocity, holism, and respect (Health Research Council of New Zealand, 2014).

Whichever methodology was chosen, I needed a qualitative methodology that could allow I-Kiribati women's stories to take centre stage. I needed a way of answering the research question with minimal direction from or distraction by myself as an *I-Matang* researcher working with a culture different to my own and with participants for whom English is a second language. I was looking for a methodology which, as Vaioleti (2017) described, is "non-linear" and "responsive"(p. 4.) in its philosophy; one where I, as researcher, would be free to value whatever stories the participants chose to gift, and likewise, value the free-flowing direction of conversation. While giving the opportunity for stories to be heard well, the chosen methodology also needed to have a focus on understanding, finding meaning in the gifted stories.

I came to see hermeneutic phenomenology is an ideal philosophical basis for this research. In hermeneutic phenomenology, stories gleaned from participants' face to face interviews, stories of their experience, would be given and remain in their own words. This is relevant, as most Pacific Island communities, including I-Kiribati, have an oral tradition, a storytelling tradition, for passing on information (Uriam, 1995; Whincup, 2006). Meaning is then sought in these stories. Hermeneutic phenomenology has the best potential to give a clear account of, and show meaning in, the phenomenon of I-Kiribati women's childbirth experiences in New Zealand.

3.3 Introduction to Hermeneutic Phenomenology

Crowther and Thomson (2023) stated that hermeneutic phenomenology is "an interpretive methodology that values and honours changing contexts, historicity and myriad perspectives" (p. 8). Hermeneutic phenomenology finds meaning in people's lived experience (Gadamer, 1975/2013). This meaning found is, as it were, straight from the source. "This method(ology) is most useful when the task at hand is to understand an experience as it is understood by those who are having it" (Cohen et al., 2000, p. 3).

Hermeneutic phenomenology is always growing an understanding of the topic in question, recognising that with time, more continues to show itself about how things are. As Gadamer said, in an interview by Dutt (2001) "Certainly, every understanding is

always ‘underway’” (pp. 59-60). I began this research journey with certain understandings and even now these continue to be developed. Heidegger’s whole career focuses on clarifying “the insight that being is not presence” and so “a thing is more than its appearance, more than its usefulness, and more than its physical body” (Harman, 2007, p. 1). This suggests that understanding meaning of a thing, or a person, is more than what is seen on the surface, whether physically or metaphorically; and understanding will always be ongoing, as more is revealed. Conversely, it also reminds one that there will always be that which remains hidden (Heidegger, 1927/1962). In hermeneutic phenomenology, the meaning of everyday lived experiences is revealed firstly, as those who have experienced describe them; and then through the researcher’s lens, in this case, my *I-Matang* midwifery understanding, which I expand on at the end of this chapter (Heidegger, 1927/1962).

On-going understanding is a feature of hermeneutic phenomenology. It is supported through a process of reflection and reflexivity. Reflection is part of a normal life process for a researcher. Reflexivity, however, is described as “an active self-awareness of one’s own judgements beliefs and perceptions during (a conversation)” (Dibley, 2023, p. 92). While I reflected on and thought about what happened in interviews and on the stories presented to me, reflexivity occurred as I, the researcher, thought through how my own pre-understandings influenced my interpretations of those stories (Smythe & Spence, 2023; von Unger, 2021). van Manen (2016), in defining the hermeneutic phenomenology methodology, highlighted the importance of focused reflection/reflexivity at every stage of the research process so that ongoing understanding can continue. “Hermeneutic phenomenology is a method of abstemious reflection on the basic structures of lived experience of human experience” (p. 26). ‘Abstemious’, in this context, speaks of refraining from jumping to conclusions and alludes to the need to take time to uncover meaning in the research. Reflection/ reflexivity is the ‘how-to’, the powerhouse, of ongoing understanding inherent in this methodology.

While I will go on to define hermeneutics and phenomenology, I prefer not to divide them any further to talk about them separately, as they are a whole in terms of this research. van Manen (2016) himself wrote of his book, “Phenomenology of Practice”, that in it he does not differentiate between phenomenology and hermeneutic phenomenology. Phenomenology and hermeneutics as parts of the whole are both in operation at one time. This is consistent with the notion that understanding is ongoing, and it echoes the reluctance of these philosophers to focus on definitions which are static for all time (Gadamer, 1975/2013; Heidegger, 1927/1962).

The starting point of hermeneutic phenomenology is phenomenology which, put simply, is the study of phenomena or a phenomenon. In this research, the phenomenon is migrant I-Kiribati women's experience of childbirth in New Zealand. Phenomenology attempted to distinguish philosophy from science by abandoning all theories of how the world operates outside our perception of it, and focussing instead on describing the manner in which things appear to us (Harman, 2007, p. 176). 'The manner in which things appear to us' is what is referred to as 'lived experience'. Lived experience is a much-used word in this current age which goes deeper than most realise. It is the "prereflective or prepredicative life of human existence as living through it" (van Manen, 2016, p. 26). Here van Manen shows lived experience to be experience as it happens before being is thought about, reflected upon, or analysed.

In phenomenology, as defined by Heidegger, the meanings of the Greek words, "*phainomenon* and *logos*…converge" (italics in the original) (Inwood, 1999, p. 159). The word 'phenomenon' comes from the Greek verb "to show itself", so "the expression, '*phenomenon*' signifies *that which shows itself in itself,* the manifest." (italics in the original) (Heidegger's history of the concept of time, quoted in (Steiner, 1978/1989, p. 279). It is significant that Heidegger reminds us that it is possible that a phenomenon can also "show itself as something which in itself it is *not*" (italics in the original) (Steiner, 1978/1989, p. 279). When it comes to *logos*, also from the Greek, Heidegger takes it to mean 'discourse'. Here he sees it as a word linked to 'phenomenon', as he says, "Discourse 'lets something be seen'…that is, it lets us see something from the very thing which the discourse is about" (p. 282). Heidegger described phenomenology as "*the science of phenomena"* (italics in the original) (Steiner, 1978/1989, p. 282). Heidegger wrote at length about phenomenology but in the quote that follows it is very simple. In defining phenomenology, Heidegger described a call to focus on the story or text, as it says and as it shows itself to be; a commitment to the showing or revealing of what really 'is' in the story or text being told or read.

> Thus phenomenology means…to let that which shows itself be seen from itself in the very way in which it shows itself from itself. This is the formal meaning of that branch of research which calls itself "phenomenology". But here we are expressing nothing else than the maxim …: 'To the things themselves!' (Heidegger, 1927/1962, p. 58)

Heidegger also wrote, "…the meaning of phenomenological description as a method lies in interpretation" (p. 61). Such interpretation is known as hermeneutics which fits with phenomenology. van Manen (2016) described hermeneutic phenomenology as "primarily a philosophic *method for questioning*" (italics in the original) (p. 29.) It is

through such questioning that the ‘things themselves’, the phenomenon of childbirth in New Zealand, will show themselves for interpretations to be made.

Hermeneutics is known as the philosophical theory of interpretation and is important because, as Harman (2007) wrote, “Since things can never be fully seen, they must be interpreted” (p. 175). To continue a theme already repeated, there is always more to be revealed. The hermeneutic framework brings focus to understanding the meaning of lived experience. While Heidegger wrote about hermeneutics and hermeneutic notions, Gadamer, a former pupil of Heidegger’s, took these notions further. Gadamer’s focus was on hermeneutics; he summarised his main life’s work as being the philosophy of understanding, finding meaning and understanding in language. However, the origin of hermeneutics goes further back than Gadamer and Heidegger into the study of biblical scripture and legal texts. Gadamer (1975/2013) wrote of hermeneutics,

> In the nineteenth century, the hermeneutics that was once merely ancillary to theology and philology was developed into a system and made the basis of all the human sciences. It wholly transcended its original pragmatic purpose of making it possible, or easier, to understand written texts. (p. 164)

While originally hermeneutics was held to be seeking meaning in the text in an objective manner, the later developments by Heidegger and Gadamer looked for deeper meaning, recognising the existence of the observers own ‘fore-meanings’ in play when developing an interpretation or understanding of the text. Here, Gadamer described the need for the interpreter to examine the nature and source of their own assumptions and pre-existing interpretations of the meaning of the text as a prelude to interpreting what is before them. This is the beginning of the journey to understanding.

> …understanding realises its full potential only when the fore-meanings that it begins with are not arbitrary. Thus, it is quite right for the interpreter not to approach the text directly, relying solely on the fore-meaning already available to him, but rather explicitly to examine the legitimacy - i.e., the origin and validity – of the fore-meanings dwelling within him. (Gadamer, 1975/2013, p. 280)

In the above quote, Gadamer is talking about the reflexivity of the researcher. Reference to my own fore-understandings is made in the Introduction chapter. The research has at every stage of the journey required me to maintain a thinking journey of reflection and reflexivity. I bring both fore-structures and pre-understandings to the research. I elaborate more about this in the current chapter as I explore the philosophical notions included in the methodology and informing this research.

3.4 Philosophical Notions

Heidegger developed philosophical notions of how human beings are. In the current research, these notions have come to underpin my understanding of participants' lived experience by giving me insight into how human people are and giving me questions to ponder. While I recognise the origin of Heidegger's perspective to be that of a male German philosopher from the 20th century, it appears to me that he also went beyond all that to articulate what it means to be human, regardless of gender or culture of the day or the place. Nevertheless, I am mindful of this tension as I interpret the stories of I-Kiribati women.

3.4.1 Heidegger's Dasein

Heidegger's philosophy is a major part of the hermeneutic phenomenology methodology. Although, like Gadamer, he wrote as a philosopher not a researcher, his work is widely used to inform and guide research using hermeneutic phenomenology. In his first major work, "Being and Time", he set out to examine what "being" is, stating in his first chapter, "We are ourselves the beings to be analysed" (Heidegger, 1927/1962, p. 42). He broke with philosophical tradition which, until then, had categorised all things, including humans, as substances. A substance "needs no other entity in order to *be*" (italics in original) (Inwood, 1997, p. 95). This is a significant statement in view of the importance of Dasein's 'being-*in*-the world'. Humans can be studied, they can be counted, but they are more complex than any substance; according to Heidegger, they are Dasein, a being for whom being is an issue for itself, or who takes a stand on its own being, a human being (Heidegger, 1927/1962). That there is more to Dasein than substance needs to be emphasised; if Dasein were merely substance, then research approaches with human beings would seek only to categorise people and their characteristics. Such research is based on the Western scientific mindset (Heidegger, 1927/1962). There are times when this is a valid and important way to research, but for my research question, categorisation of Dasein (human beings), is inadequate to reveal deeper meaning in their lived experience (Heidegger, 1927/1962). As Inwood (1997) rightly pointed out, "We start off, at least in adulthood, viewing ourselves as whole human beings, and need a special sort of abstraction to see ourselves simply as animals or as bodies" (p. 24). The participants do not see themselves as pieces or separate parts, but as whole human beings. Their stories reflect this truth.

Understanding something of Heidegger's notion of Dasein will give insight into participants' stories. The name Dasein is "a normal German word that usually means existence or presence. Heidegger redefines the term to refer solely to human

existence" (Harman, 2007, p. 174). Inwood (1997) wrote that it is clear that "Dasein is embodied" (p. 23). Dasein is a physical being, a human being. Early translations of Heidegger's writings gave Dasein the traditional translation of "being there" (Heidegger, 1927/1962). This remains valid, but more recently it is viewed as "being open" or "*having-to-be* open" (Sheehan, 2001, p. 12). This description of Dasein as 'being open' suggests a link between Dasein and the world around them and suggests possibilities of various ways of 'being open' in that world. Dasein can choose various ways of being in the world (Heidegger, 1927/1962; Inwood, 1997).

Dasein is "grounded in language" (Steiner, 1978/1989, p. 94). This is how we live as human beings. Communication is part of Dasein's being and how it functions. More basic characteristics of Dasein will show themselves as this chapter progresses, including being-in-the world, being-with-others, and care.

3.4.2 Dasein in the World

A key feature of Heidegger's thought was that human beings do not exist in separation from the world in which they find themselves. Dasein is characterised by being 'in the world'. 'World' here is used not in some ethereal sense but in the ontical sense of what is physically around us (Heidegger, 1927/1962). "The concrete, literal, actual, daily world…it is here and now and everywhere around us" (Steiner, 1978/1989, p. 83). There is a relationship, in whatever form that takes, between Dasein and their physical and social surroundings which cannot be denied. This can be seen clearly in participants' stories, in the way they link themselves in the telling, to their physical and social surroundings, as well as linking themselves to the details of what is happening in that environment. Dasein's 'being-in-the world' is not just an accidental or random locating of Dasein in the world, but "this 'being-in', …applied to man's *Dasein*, it is the total determinant of his 'being-at-all'" (italics in original) (Steiner, 1978/1989, p. 83). Put another way,

> Dasein is essentially in the world, not simply in the sense that it occupies a place in the world together with other things, but in the sense that it continually interprets and engages with other entities and the context within which they lie, the 'environment' or the 'world around us'. (Inwood, 1999, pp. 17-18)

Dasein is deeply connected to the world, not in a passive sense but is by its nature dynamically relating to the world in which it finds itself. This alludes to the complexity of Dasein's being but, more particularly, to how basic is the nature of relationships of all kinds for the human being's existence.

That Dasein is ‘being open’ gives a clue to the relationship between it and the world. Dasein ‘being open’ cannot but be affected by the world around it, and neither can the world around it be unaffected by Dasein itself. Sheehan (2001) goes so far to say that Heidegger should be translated not just as “being-*in*-the-world”, but as “*being*-the-world” (italics in original) (p. 12). There is a sense of holism expressed in the description of Dasein ‘being open’ and having a close connection with the world around it. Dasein is connected to and is part of its physical environment as well as being connected to and part of the community of other Daseins with which it is located. In cultures based on dualism (which Western cultures tend to be), where mind and body, the physical and spiritual, are believed to exist separately, an understanding of Dasein’s close connection with the world, that is, its ‘being-in-the-world’, is an anathema (Heidegger, 1927/1962). In contrast, many non-western cultures have world views in which dualism holds no place; the physical and spiritual are one, and life and lived experience is seen in a holistic way. Pacific worldviews tend to hold to such holism (Health Research Council of New Zealand, 2014), and I-Kiribati are no exception (Cleverley, 2023; Schutz, 2022). Namoori-Sinclair (2020) wrote that community and connections are important in the I-Kiribati worldview. This leads me to believe that an understanding of Heidegger’s notion of Dasein ‘being-in-the-world’, its being so closely connected to the world around it, and its holistic nature, helps me to understand I-Kiribati participants’ stories of their lived experience.

3.4.3 Dasein Thrown into the World

Dasein is “’thrown into the world, proclaims Heidegger. Our being-in-the world is a ‘thrownness’” (Steiner, 1978/1989, p. 87). Dasein is ‘thrown’ into a world that they/we “never chose” so are not necessarily in control of this reality (Harman, 2007, p. 177). The word ‘thrown’ conjures up an unexpected or traumatic event or process, even with the sense of being delivered over to something without choice. While being thrown into the world, even if there is no choice in it, Dasein is ‘in-the-world’ and connected to it. Steiner (1978/1989) further unpacked the meaning of ‘thrownness’ by saying that it has “clear connotations of ‘responsibility toward that into which we are delivered’ – to an actuality, to a ‘there’” (p. 88). Dasein is not only ‘in-the-world’, but has a responsibility, a commitment, a connectedness with the world that is there, positive or negative, that cannot be taken away. “*Dasein* is inseparable from (the world)” (italics in original) (Steiner, 1978/1989, p. 87).

Dasein’s ‘thrownness’ is reflected in Dasein’s ‘mood’, something which Dasein always has, and which is their “primary mode of access to the world” or their “way of being-in-the-world” (Steiner, 1978/1989, p. 68). Dasein has many ways of ‘being-in-the-world’ (Steiner, 1978/1989), but this one, ‘mood’, is a key to understanding Dasein. Otherwise

described as ‘attunement’, or awareness of how things are, Dasein then, has a ‘mood’ during whatever action or interaction it is experiencing or ‘way-of-being’ it is currently showing.

Dasein is in the world, and is, for the most part, living in what Heidegger called “average everydayness” (Heidegger, 1927/1962, p. 69), or what you and I might call ‘normal life’. For most of us, this rings true of our human experience with occasional exceptions to which we are forced to take notice. In this state of ‘average-everydayness’, one is ‘at home’. In the state of ‘being at home’, Dasein has the know-how to deal with this sort of living and the know-how to deal with the ‘equipment’ or ontic tools of the life they live, often without thinking about them (hence the reference to ‘average’ and ‘everydayness’) (Steiner, 1978/1989). It is only when something is not working or out of order that the place or the equipment are actually even noticed. This brings one to a situation where one is no longer able to ‘deal’ with this living situation and so no longer ‘familiar’ with their surroundings. Heidegger said that when someone is ‘not-familiar’ with the world in which one is, one is ‘not-at-home’. The result is that they find themselves experiencing ‘anxiety’ or, in other words, ‘unease’ (Heidegger, 1927/1962; Steiner, 1978/1989). Such philosophical notions as ‘being-at-home-in-the-world’, ‘familiarity’, and the ‘unease’ when one it ‘not-at-home’, would likely ring true for some participants.

3.4.4 Dasein with Others

“The world into which our *Dasein* is thrown and on which it enters has others in it” (Steiner, 1978/1989, p. 91). ‘Being-with’ others is inescapable, an important part of what constitutes Dasein, and can be in a passive or an active sense (Heidegger, 1927/1962).

> Our understanding of the ontological status of others, and of the relationship of such status to our own *Dasein*, is itself a form of being. To understand that presentness of others is to exist. Being-in-the-world, says Heidegger, is a being-with. (Steiner, 1978/1989, p. 91)

Many Western cultures are characterised by individualism, with individual rights and responsibilities predominating over that of the larger group or community (Ingle, 2021). However, according to Heidegger, Dasein is unable to not ‘be-with’ others, for even if Dasein is ‘being-with’ in a deficient mode, for example, ignoring those whom they are alongside, they are still ‘with’ (Heidegger, 1927/1962). The ‘other’ is always present, and ‘otherness’ can be an issue in relationships between individuals or between communities, as evidenced by the wars around the world in the present day. The individual experience may be more relatable than the wider world. van Manen (2016)

discussed the importance of using someone's name in an interview and concluded, unsurprisingly, that actually the 'other' person is far more than just a name; "To understand we would need to listen and speak in a manner that is attentive to his or her true otherness that is ultimately unnameable" (p. 389). It is important to note that there is more to the 'other' than what is seen or heard on the surface. While it may seem obvious, some of the I-Kiribati participants described how this is not always understood by some health professionals.

Steiner (1978/1989) described Heidegger's thought that "*Dasein* comes to realise that beyond being *Dasein*-with and *Dasein*-in-…modes of the everyday – it must become *Dasein-for*. *Sorge*, signifying 'care-for', 'concern-for and -with', is the means of this transcendence" (italics in original) (p. 100). Care takes many forms but, again, it is part of the basic state of being of Dasein. "It is S*orge* that makes human existence meaningful…" (italics in original) (Steiner, 1978/1989, p. 101).

3.4.5 Dasein and the-They/Anyone

A particular case of being-with others was highlighted by Heidegger. When living in average-everydayness, Dasein is said to be doing what everyone or 'anyone' does. 'Anyone' refers to 'the-they', or 'others.' Therefore, doing what 'anyone' does is conforming to what most people do, or to what the majority do or say should be done. It is likely that from one country to another, and from one culture to another that what is expected, what others say should be done, will show itself differently. Dasein tends to conform to what 'anyone' does, or what 'the-they' or 'others' do (Heidegger, 1927/1962; Sheehan, 2001). Heidegger linked this to 'being at home' and 'familiarity', as mentioned above. It can be an important notion to help understand the situation for those who are not familiar with their surroundings, let alone not being familiar with what most people do, such as migrants to a new country.

3.4.6 Care

Heidegger wrote of Dasein 'being-with' others as care. "Dasein when understood ontologically, is care" (Heidegger, 1927/1962, p. 84). Heidegger's use of care is not likened so much to a moral attribute or to a state of worrying but like a 'mattering' to Dasein. "To care about ones being is for it to matter to one, to make a difference to who one is" (Blattner, 2006, p. 37). The same applies to care for others. Care or S*orge* encompasses both concern (*Besorgen*) and solicitude (*Fürsorge*). "*Sorge* pertains to Dasein itself, *Besorgen* to its activities in the world, and *Fürsorge* to its being with others" (italics in original) (Inwood, 1999, p. 95). For each aspect of care, negative, positive and indifferent modes are possible. For example, take solicitude: "Being for, against, or without one another, passing one another by, not 'mattering' to one another

– these are possible ways of solicitude" (Heidegger, 1927/1962, p. 158). Philosophically one cannot divide care, just as one cannot atomise Dasein into circumscribed parts. However, it is the positive mode of solicitude which is most discussed in the participants' stories in the current research.

"Everyday Being-with-one-another maintains itself between the two extremes of positive solicitude – that which leaps in and dominates, and that which leaps forth and liberates" (Heidegger, 1927/1962, p. 159). In terms of health care, leaping in and taking over from the other leans toward treating people as dependents or as them needing to be directed, or even treating them as a 'what' not a 'who'. Of course, this may be appropriate, within certain limits, in an emergency. However, leaping ahead (leaping forth) speaks of authentic care, which "favours helping others to stand on their own two feet over reducing them to dependency" (Inwood, 1999, p. 36). While Heidegger himself admitted that care is "not *simple* in its structure" (Heidegger, 1927/1962, p. 240), he is clear that, even in the negative or indifferent modes of care, others impact our Dasein.

3.4.7 Preunderstandings or Prejudices

Understanding how human beings or Dasein 'are', or how they function in the world is an important background to this research. Further philosophical notions assist this ongoing understanding.

Unlike the natural sciences where researcher objectivity is thought to be possible, even vital, this methodology recognises and accepts that a researcher has 'pre-understandings' or 'prejudices' about the world and the people in it, which remain throughout the research process. "Dasein is characterised by its historicity, meaning that Dasein is constituted by its past experience in the world, whether a Dasein is conscious of this or not" (Crowther & Thomson, 2023, p. 10). It includes their 'historically effected consciousness', their culture, and their personality.

'Pre-understandings' or 'prejudices' cannot be bracketed or set aside, as they will always influence the research. 'Bracketing', also called the 'phenomenological reduction', was a feature of Husserl's [1859-1938] phenomenology. Husserl believed these personal understandings could be set aside in order to reach objectivity about the subject being studied. This is not possible according to Heidegger. There are always both conscious and unconscious prejudices in us, feeding into our current interpretations (Crowther & Thomson, 2023; Gadamer, 1975/2013; Heidegger, 1927/1962). Heidegger and Gadamer said that a dialogue, whether verbally with another person or when reading a text, will always contain the 'pre-understandings' of

the researcher, their prejudices. In hermeneutic phenomenology methodology, 'pre-understandings' are seen not as negative judgements, but as existing, although without positive or negative value, unlike the common present-day interpretation of 'prejudice'. The benefit of 'pre-understandings' showing up is that they contribute to both the understanding of the participants' stories and to the critique and understanding of the researcher themselves (Janz, 2014), which is part of the hermeneutic process. The pre-understandings or prejudices contribute to, not detract from, the dialogue between researcher and participant, researcher and text (Gadamer, 1975/2013; Heidegger, 1927/1962). I bring my own pre-understandings to this research as described in the Introduction chapter. In recognising my pre-understandings, there is an ability to take these into account and utilise them in dialogue with participants and the text from their stories, and so be open to new understandings about their lived experiences.

3.4.8 Historically Effected Consciousness

The 'historically effected consciousness' held by a person is related to their 'pre-understandings'. It is part of the hermeneutical experience, and its main characteristic is that of experience, which exists in the past, present, and future. More particularly, it is "the openness to tradition" (Gadamer, 1975/2013, p. 369) or awareness of the history of the researcher or that of the individuals or text being researched. This reflective openness is key for the progress of the researcher in their hermeneutic phenomenological research. Part attitude, part process, the practicality of reflective openness in my research began with a pre-research interview with my supervisor to explore my pre-understandings, as seen in the Methods chapter.

3.4.9 The Hermeneutic 'As'

The philosophical notion of forestructures is another helpful reminder that an interpreter does not interpret from a mind devoid of history and thought. As researcher, I will always interpret the participants' stories 'as' something. Heidegger (1927/1962) wrote that, "Whenever something is interpreted as something, the interpretation with be founded essentially upon fore-having, fore-sight, and fore-conception" (p.191). Another term for these three is the "forestructure of understanding" (p.192). Fore-having is "our preliminary approach" to a matter (Inwood, 1999, p. 88), or the "general understanding of the entity to be interpreted and the 'totality of involvement' in which it lies" (Inwood, 1999, p. 107). What I bring to the table to begin my interpretation of the participants' stories includes training and experience in western midwifery and past experience of working with people from cultures other than my own, including I-Kiribati. Fore-sight is literally when I "set my sights on what I want to interpret" (Inwood, 1999, p. 107), which in this case is childbirth. There is a focus on what I look at. The last part of the fore-

structure I bring is the fore-conception, the “anticipation” (p.107), or the expectation of what concepts might be encountered and the “specific attitude towards” what is to be encountered (Harman, 2007, p. 34). Informed by my experience and my reading, I expected to notice in the stories some degree of challenge in communication for the participants.

The forestructure of understanding is important to consider. It reminds me that I do not interpret in a vacuum. The fore-structure is the basis on which I, ‘as’ a researcher, interpret part of a story ‘as’ something, and is the basis of the “as-structure of interpretation” (Gadamer, 1975/2013, p. 192). What stands out to me in a story is intelligible to me ‘as’ something. For example, in the second findings chapter, ‘silence’ is interpreted ‘as’ a number of different things in different participants’ stories. Such interpretations are based on my ‘forestructures’ of understanding. As Heidegger (1927/1962) wrote, “An interpretation is never a presuppositionless apprehending of something presented to us” (p. 191). We know this, it is part of us, but we do not always think about it. In first meeting a participant, although I was open to the idea that they might decline consent to take part in the research, I was already seeing them as a fellow human being who will have some form of two-way conversation with me about the issue. “The ‘as’ is essential to Dasein” (Inwood, 1999, p. 107).

Reading and thinking about participants’ stories further over time, one aspect often revealed itself in a different way and my interpretation of it was then ‘as’ something else. One meaning is revealed or un-concealed while another is concealed. There is a ‘play’ in the interpretation, like the changes in appearance under a different light, as the aspect under question is seen over time from different angles and points of view. At one time it may have the semblance of appearing ‘as’ this, another ‘as’ that (Heidegger, 1927/1962). This suggests a depth in meaning and alludes to how the hermeneutic “as” works in an ongoing journey of understanding which is always on the way (Dutt, 2001; Gadamer, 1975/2013).

3.4.10 Culture and Tradition

As a person and a researcher, I have a ‘historically effected consciousness’. I will always remain culturally different to the participants and will bring a worldview and history of my own to the current research (Gadamer, 1975/2013). This is also true of my participants. The I-Kiribati participants come from a culture or cultures different from that of most people in New Zealand. The midwife participants may come from the predominant culture of New Zealand but originate from different family cultures and traditions. Culture and tradition are a complex mix of beliefs, values, mores and practices. As Gadamer commented on societal culture in relation to taste in art, “What

is considered valid in a society, its ruling taste, receives its stamp from the commonalities of social life. Such a society chooses and knows what belongs to it and what does not" (Gadamer, 1975/2013, p. 77).

Culture changes over time (Gadamer, 1975/2013). Migration and intergenerational differences can account for some of this change, as shown in Burnett and Bond (2020). The capacity for culture and traditions to change is important to be aware of in seeking to understand the stories from migrant I-Kiribati women. This showed itself to be true with some participants expressing regret at not having access to traditional family support, while others were torn between modern and traditional I-Kiribati ways.

As a researcher I must acknowledge the existence of my own tradition in my historically effected consciousness. It is not necessarily a barrier to understanding; rather, it can be a facilitator. "In seeking to understand tradition…To be situated within a tradition does not limit the freedom of knowledge but makes it possible" (Gadamer, 1975/2013, p. 369). While the I-Kiribati tradition is not my own, there is value in knowing where I myself come from in order to better understand the I-Kiribati perspective. At the most basic level, I understand something about coming from a tradition, despite it being very different to that of my participants.

3.4.11 Horizons

An 'horizon' is another notion, which seeks to describe the development of understanding. It might be best described as a 'perspective', a way of seeing and, in the context of research, an 'interpretive perspective'. Interpretation is also used synonymously with understanding; so a 'perspective of understanding' is another way to describe a 'horizon'. "The horizon is rather, something into which we move and that moves with us" (Gadamer, 1975/2013, p. 315). Horizons, like culture, are not static.

Gadamer (1975/2013) talked about the concept of the "fusion of horizons"; in other words, a fusion of 'interpretive perspectives' wherein "…understanding is always the fusion of these horizons supposedly existing by themselves" (p. 317). By this he means the horizon of one person's understanding meets with another person's perspective which, in the course of a dialogue, merges to form a new horizon or perspective of understanding. The same can be said of a researcher reading text with a view to finding its meaning.

> one intends to understand the text itself. But this means that the interpreter's own thoughts too have gone into re-awakening the text's meaning. In this the interpreter's own horizon is decisive, yet not as a personal standpoint that he maintains or enforces, but more as an opinion and a possibility that one brings into play and puts at risk, and

> that helps one truly to make one's own what the text says. I have described this as a "fusion of horizons". (Gadamer, 1975/2013, p. 406)

This quote from Gadamer suggests an attitude of openness to the "play' of conversation between participant stories and the researcher. To venture what one thinks is perhaps a risk, as Gadamer said, but it then moves into the play of the dialogue, meets with the other perspective(s) and the risk is found to be one merely of change, a positive development of one's thoughts and understanding, assisted by having met the 'other' person's or text's perspective. Interviewing participants required that, as the researcher, I was mindful that I come to the interview with my own horizon, as does each participant. As one participant commented in her story about a midwife's actions, I should "not assume" what that horizon is.

3.4.12 Hermeneutic Circle

The hermeneutic circle is a feature of both Heidegger's and Gadamer's work. It describes increasing understanding by dialogue with and reflection on information, text, or a person's story. As such it is a process rather than a geometric shape to visualise. In this research, one part of a participant's story needed to be considered in the light of their whole story. One person's story (a 'part' within this research) needed to be considered within the understanding from the whole collection of stories. Time was needed for such a hermeneutic circle to function optimally, and required constituent parts to be fitted into the whole picture that formed with every exchange that brings new understandings. The hermeneutic circle is an iterative process (Gadamer, 1975/2013). The data analysis, in particular, reflected this iterative process, as shown in the descriptions in the Methods chapter and evidenced in the three Findings chapters.

While the image of a circle is useful to understand what happens in the research process in the interaction between participant and researcher, text and researcher, I would add a caveat; if the research process is functioning well, understanding does not return to the same point as does the circle but with continued interaction the understanding moves on, as though to a new and larger circle of understanding. Some describe the understanding as moving in a spiral, recognising that one never returns to exactly the same point (Crowther, 2019). While this is true, to me a spiral suggests a path which has the potential to get smaller and smaller and more specifically defined and confined, while equally suggesting the possibility the opening up or widening of meaning to become more extensive. As with understanding, it depends which way you are looking.

Interpretation and the understanding upon which it is built, is who we are, it is how human beings function. Seeking meaning is part of human nature. The process of understanding is not arbitrary; rather, true understanding focuses on the phenomenon itself, 'the things themselves'. Heidegger (1927/1962) reminded us;

> In the circle is hidden a positive possibility of the most primordial kind of knowing, and we genuinely grasp this possibility only when we have understood that our first, last and constant task in interpreting is never to allow our fore-having, foresight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves. (Heidegger, 1927/1962, p. 195)

The progress of the hermeneutic circle is such that the meanings I projected based on my understanding of the participants' stories were constantly revised as more was shown.

Again, Heidegger (1927/1962) emphasised the primordial nature of the search for meaning; "The 'circle' in understanding belongs to the structure of meaning, and the latter phenomenon is rooted in the existential constitution of Dasein. That is, the understanding which interprets" (p195). As Gadamer (1975/2013) said, Heidegger is setting out "a description of the way interpretive understanding is achieved" (p. 279). The dynamic nature of understanding is evident, and it is clear that the structure of meaning and the seeking of meaning is part of Dasein's basic nature.

3.4.13 The 'Play' of Conversation and Dialogue

Although reading stories after an interview is not a dialogue in a physical sense between people, there is a dialogue between researcher and text to bring an understanding. Gadamer (1975/2013) utilised the word 'play' to describe the progression of a conversation or dialogue with another person or with a text. It is a practical description to understand what happens in a conversation or in the reading of a text, and emphasises, as does the 'hermeneutic circle', that understanding is developing and ongoing. Gadamer described a "to- and fro- movement of play" in a conversation or dialogue so "you cannot have a game by yourself" (p. 110). He shows us that "The movement of playing has no goal that brings it to an end; rather, it renews itself in constant repetition" (p. 108). In this research there was a play of dialogue in the interviews. I had no set questions to complete, and only began with a subject, childbirth, and an invitation to talk. Short responses from me, as interviewer, continued at different times to encourage the continuation of the 'play' of dialogue. Later, in dialogue with the text of participants' stories, there was 'play' too, as I posed questions

and read further, then posed possible meanings. This would be followed by further reading to again challenge the meaning projected so far.

Researching in the play between my own culture and I-Kiribati (Janz, 2014), I asked questions of the text to bring opportunity for the dialogue between researcher and text, and reader and text, to occur. In keeping with hermeneutic research, I offered tentative insights, always knowing that 'I could be wrong' and that there is still much to be understood.

3.5 Questioning Heidegger's Background

Heideggerian philosophy suggests that one cannot separate the man from the philosophy; therefore, it is significant to say something about Heidegger the man. In the prelude to World War II, he became a member of the Nazi party (Young, 1997). Gadamer was clear that he, himself, had no choice but to sign the teacher's agreement with the Nazi Party or else submit himself and his family to exile from his country (Dutt, 2001). Heidegger was also a man of those times but continues to be criticised, initially for remaining silent on his Nazi party membership and his personal views even after the Second World War. Subsequently, with the publication in 2014 of three of his "Black Notebooks", written in the period 1931 to 1941, many people declared they would abandon Heideggerian philosophy altogether on the grounds of him being antisemitic. Others labelled this reaction as sensationalist, suggesting the former gave little analysis of what was actually found in the Black Notebooks and little knowledge of the context of Heidegger's philosophical writing at the time (Fuchs, 2015; Kocijančič, 2022).

The question I needed to ask, with regard to my use of Heideggerian philosophical notions in my research, was whether Heidegger's philosophy is tainted by the tenets of National Socialism, exemplified by commitment to antisemitism (racism) and totalitarianism (Young, 1997).

A comprehensive analysis of Heidegger, the man and his philosophy, by Young (1997), written prior to 2014, reveals culpability of Nazi sympathies and rhetoric on Heidegger's part over the period between 1933 and 1934 when he was a Nazi party member. Young surmised that Heidegger was not being true to his own philosophy, and possibly had in mind that as an academic he could influence the philosophy of the new regime. Young went on, as he says, to "de-Nazify" Heidegger when he had not begun with this intention (p. 214). He could find no taint of antisemitism or racism, and no commitment to totalitarianism in his philosophical writings. "Heidegger did, in late 1934, embark upon a fundamental public critique of Nazi ideologies and sustained it… to the end of

the Nazi period…From at least 1936 his lectures were placed under Gestapo observation" (Young, 1997, pp. 117-118). Young says that while Heidegger does write about the importance of strong leadership, it is 'spiritual leadership' by philosophers, and is not about compelling people to conform but "is thus essentially a *waiting* (for people to hear) rather than a *making happen*" (italics in original) (p. 131). On the accusation of Heidegger remaining silent after the war on what had happened and his part in it, Young goes to great lengths to show Heidegger's writings post war to be far from silent.

Some key points emerged from a review of the Black Notebooks by von Herrmann and Alfieri (2021). One is that the supposed antisemitic references were found on barely 3 pages out of a total of 1,235 pages in these books. The authors wrote "the critical tone of the relevant textual passages derives, in the first instance, from Heidegger's being-historical critique of modernity." (p. 6). Other entries in these books criticise National Socialism and Hitler himself. A statement summarises the authors' thinking; "(Heidegger's) field of research remained unchanged for decades; namely, to ask, how life is lived" (von Herrmann & Alfieri, 2021, p. 6).

Heidegger the man is a complex and difficult subject. While I have not read the Black Notebooks, and neither am I a philosopher, what is undeniable is that Heidegger's philosophical notions assist in understanding how humans are and provoke the questioning which brings increased understanding of others. I have not seen in my own reading a promotion of antisemitism or any other Nazi ideology. If I did, I would not have wanted to use Heideggerian philosophy as a tool in this thesis.

3.6 The Lens of the Researcher

As a health professional I have always sought to find the deeper meanings of what people do or say, and to find the background stories behind statistics. The hermeneutic phenomenology methodology allows this to happen. Each individual approaches an interpretation with their own lens. Harman (2007) summarised Heidegger's notion about reality, saying it is "always interpreted in a specific way and from a specific standpoint" (p. 32). The lens through which I have chosen this topic to research, conducted the research and, in particular, the lens through which I interpret findings within it, is particular or individual to me as a researcher. I am an outsider researcher. I come with the lens, the understanding, of an *I-Matang* (*Palagi*) self-employed (independent) midwife. The lens from which the researcher views the research findings is an important part of the conversation between the text and the context to bring forth meaning from, or interpret, the participants' stories. The lens I bring to this research, in

keeping with the hermeneutic phenomenology methodology, informs the findings I present.

3.7 Conclusion

Hermeneutic phenomenology was chosen as the methodology for this research to fit both the research question and the researcher. This methodology assists in describing human beings at the most basic level and illuminates how people may be understood. Using hermeneutic phenomenology allows me to illuminate the question stated in the research, and to take the reader on a journey of thinking, not in the calculative mode of the natural sciences but in a meditative, sometimes even a poetic, way of wondering and questioning. This is the way of hermeneutic phenomenology research and, as such, is a fit for both myself and the topic chosen.

Chapter 4: Methods

4.1 Introduction

This chapter explains the method for doing the research; the way towards finding out more about the phenomenon in question. This 'way' lay in following and being consistent with the chosen methodology, that of hermeneutic phenomenology (Smythe & Spence, 2020). Heidegger (1927/1962) did not set out to prescribe a research method. However, the philosophical notions in his writings, and those of other philosophers influenced by him lead the way as to how to go about understanding a phenomenon in question. There is no prescription as to how to conduct hermeneutic phenomenological research; indeed, a feature of research based on this methodology develops in a non-linear manner. However, there are principles which have informed the method here used, making it consistent with Heideggerian philosophical notions. Such an approach begins with an attitude of being open to look for the way to proceed.

> *The Way:*
>
> *I look for the way…to follow;*
>
> *I look for the way…it lies ahead;*
>
> *I look for the way…it follows me;*
>
> *I look for the way…it finds me…and we go. (Journal entry, 12/3/21)*

4.2 Ethics

The description of the way taken in this research begins with a section on ethics, because the study involves people, human beings. Heidegger (1927/1962) wrote that what makes Dasein, a human being, different to other entities is that Dasein takes a stand on it's being and that this is a basic fact about Dasein. Therefore, in considering ethics in this research, the following principle needed to be upheld; nothing I did should impinge on my participants ability to 'take a stand on their own being'. While initially seeming a little vague, on thinking it through, this statement contains a wealth of aspects included in ethical guidelines for research. The phrase 'do no harm' is apt. One example is from one interview with Tara in which, by taking a stand on my own being as a researcher, I tried to comport myself in such a way as to actively listen. Tara was struggling to find the confidence and the words to express what she felt. It was near the end of the interview and near the end of the day. We were both cold and low in energy but it was important for me to let her finish. Tara was talking about finding a midwife for her first New Zealand born baby. If I had pushed on to finish quickly or not listened,

Tara's honest and heartfelt story might have remained unspoken. The following is an excerpt from that part of her story.

> *All that is what I was looking at on my first day when I knew that I was pregnant, and then I was dealing with the midwife and thinking, is she going to…? I was just a bit uncomfortable with a white person looking after me. I was kind of scared. I'd rather it be someone from my country to do that job for me… that's what I was thinking, but it wasn't a big deal though because I had to deal with it and I had no choice, so I had to rely on someone. I liked the midwife I had. Yeah, I worried, would she respect me, would she understand me if she was not an Island midwife? If she was a different race, then am I, is she….? (Tara)*

I utilised guidance mainly from the Auckland University of Technology Ethics Committee (AUTEC, n.d.) as found on their website, and the Pacific Health Research Guidelines (Health Research Council of New Zealand, 2014). Principles that were key to proceeding ethically with this research are participation, partnership, and protection; such as are found in the Treaty of Waitangi, the basis of New Zealand ways and laws. An example showing all three principles is in how I sought to protect participants privacy and maintain confidentiality. All participants were asked to give me a pseudonym to go with their stories. Most chose a name, some asked me to choose one for them, and one insisted she kept her own name. Hence, those reading the stories will not know who the participants are. In returning crafted stories to participants, as discussed later, I encouraged participants to tell me if there was any further identifying information in their stories which I needed to remove in order to main confidentiality. One participant in particular required further changes so she would not be identified. Changes were therefore made. In one case where the participant's actual name is no pseudonym, only I as the researcher know this, so while she may claim it in conversation, no one else should be able to work out which person kept their original name.

I submitted an application to AUTEC, which was approved on August 29, 2019. I sent AUTEC updates on progress as required. A few months into the process of interviewing participants I submitted a request to AUTEC for amendments (See Appendix C).

The amendments were for three things; the inclusion of one or two male partners to be interviewed, the removal of a time limit since I-Kiribati participants had given birth, and the extension of the time since midwives had cared for I-Kiribati women, to 5 years. I wished to include male partners as participants because they are an important part of the context of childbirth for I-Kiribati women and could shed light on women's experiences. I had begun to see that the women interviewed remembered their

childbirth experiences vividly many years later, and midwives too remembered significant things about their clients and their experiences. Removing the restriction of 'time since birth' for recruiting I-Kiribati women and increasing the possible 'time since caring for an I-Kiribati woman' for midwives to 5 years was therefore appropriate. The ensuing discussion highlighted to me the need for care to carry out research in an ethical manner, and to reassure me that I was doing so.

AUTEC, in response to my amendment application, asked for an explanation of my recruitment methods. This seemed to me to be nothing to do with what I had asked to be amended; the original having been accepted. The summary of this person's concern, new to the role, appeared to be that they wanted to know that my intermediaries or other participants had permission to give me, the researcher, contact details for potential participants. My supervisors discussed this issue and helped AUTEC to see that my approach was consistent with cultural norms in the communities with which I had contact.

My then supervisor (since retired), Dr Sandra Thaggard, who is of Fijian ethnicity, sent me this email in the midst of our discussion:

> *Pacific cultures have rules, beliefs, and customs and going about things like interviews etc the right way within these groups requires a culturalist framework that requires most of all trust in the researcher and the researcher's ability to ethically reason based upon the set of beliefs, moral values, traditions, language, and laws (or rules of behaviour) held in common by the cultural group, their community. This should apply for any other defined group of people, not a blanket approach.*

My primary supervisor, Professor Liz Smythe, sent this email to AUTEC:

> *Kathy had her original Ethics proposal approved. She now wishes to include some male partners in her research. Her manner of accessing these participants is the same as how she has been accessing I-Kiribati women…. Kathy is familiar with the I-Kiribati community in her own community and has networks into the I-Kiribati community throughout New Zealand. She has handpicked her intermediaries as being wise respected members of those communities. The very nature of this research is that people are known because they belong to an I-Kiribati community. Their manner of interaction is through relationship. To ask, "do they have permission to approach potential participants?" undermines the understanding of how community relationships operate amongst small cultural groups.*

This discussion reinforced my understanding that cross-cultural differences can bring tension in expectations. In this situation, AUTEC accepted our explanations and approved the amendment on April 14, 2020.

4.3 Reflexivity

Reflexivity is the beginning of the research process. It determines why a researcher has chosen a particular research question, where researchers analyse the context of their research and, in particular, how the context of the researcher influences the research (von Unger, 2021). Reflexivity recognises that the researcher always comes from somewhere or looks at the phenomenon from a particular point of view. I have approached this research with a particular methodological lens, hermeneutic phenomenology, and with a particular cultural lens, as detailed in the Introduction chapter. These are threaded throughout this research process.

Reflexivity for this research began with my choice of topic, as described in Chapter One. To deepen my understanding of my participants and where they might have come from, as well as to help my communication with I-Kiribati I would meet during this research, I chose to spend 2 weeks of 'orientation' in Kiribati. This was an unusual time for me in that I had no timetable. It was a gift of time for reflexivity, and influenced the subsequent directions I took in this research journey. Pre- and post-orientation interviews with my primary supervisor in relation to my Kiribati trip further helped with the process of taking into account my own influence on this research. The poem I wrote in September 2019 after the post-orientation interview, can be seen in Appendix A. Another interview was held with my primary supervisor prior to beginning interviews with a similar purpose, that of exploring my prejudices in a positive way, to recognise the historical horizons which I brought to this research (Gadamer, 1975/2013). The interviews, as expected, helped me clarify and document the research process (van Manen, 1997). Reflection throughout the research was assisted by recording thoughts, ideas, and observations in a journal, the four volumes of which I entitled "Journal of Learning". If I could begin again with a new title for my journals, it would be "Journal of Thinking". This would be consistent with hermeneutic phenomenology, which involves ongoing thinking shedding light on the phenomenon thought about, as opposed to completion of a checklist of a body of knowledge to be grasped, or the analysis of a phenomenon which is definitive for all time.

4.4 Cultural and Academic Accountability

As I mentioned in the ethics section, participation, partnership and protection were key principles to consider in every part of the research process, to ensure both cultural and academic accountability. Accountability was supported by two research supervisors, and I considered them as an important part of my research heritage. One supervisor is a *I-Matang* researcher skilled in hermeneutic phenomenology research; the other, was a researcher of Fijian ethnicity who has had a number of I-Kiribati friends. Part way

through the writing of this research, my Fijian supervisor left and was replaced by another *I-Matang* supervisor who is very experienced in research, including with other cultures. All three supervisors helped guide me in the research process. They challenged me to maintain cultural rigour or trustworthiness (Lock et al., 2021), explained later in this chapter, and to maintain the principles mentioned earlier, important both for I-Kiribati and *I-Matang* participants as follows.

4.4.1 Participation

Participants took part voluntarily, and were recruited through an intermediary, who was either an I-Kiribati community member or a local midwife. I chose not to interview women for whom I had been midwife in case they felt obliged to participate. An element of reciprocity is shown in this research process, in that the participants gifted me their stories, and I have returned each transcript to its source as a crafted story to keep.

4.4.2 Partnership

Partnership began with participants deciding when and where interviews would be held. They were given the time to both review the information sheet and consent form with me and to ask questions about the research before the actual interview. In doing so I aimed to be respectful. This process also shared inside knowledge about the research, by which I aimed to give power or confidence into the hands of the participants. Partnership was further supported by the process of returning participants' stories. Partnership between the I-Kiribati community and myself, as the researcher, was built in a number of ways.

I had planned to form a consultation group of three I-Kiribati women with status in the community and a midwife experienced in working with I-Kiribati women to advise me on cultural issues regarding the research. What formed was an informal collection of four busy people (three I-Kiribati and one *I-Matang* midwife) in four locations throughout Kiribati and New Zealand, all at a distance from me, with whom I had periodic email contact. How I approached participants was particularly important, so the input of these cultural advisors on this and other aspects of the research was invaluable. I asked questions regarding meanings of words and appropriate greetings, and when it came to how to approach men to interview, they helped me do so in an appropriate way. An example was the advice to take time to review the information sheet and consent form verbally with I-Kiribati participants at the start of interviews, with the advisor explaining to me that verbal information exchange would be valued. Another advisor gave input regarding how to relate to I-Kiribati families. Further assistance was given by all in the group with networking to help recruit I-Kiribati participants.

While I had planned to approach local leaders and formally present the research study, the local leadership situation was not well defined at the start of my research, and I was unwilling to publicise my research too early in the process as it may have risked raising unrealistic expectations. COVID lockdowns then meant that it was more difficult to plan visits. I settled on discussing the research with one of the male I-Kiribati elders with standing in the community and a female I-Kiribati elder in a local church. Between them they had the ear of a large percentage of the local I-Kiribati population from both Protestant and Catholic communities. Intermediaries were also leaders in their local communities.

Opportunity also arose to talk about the research at the local women's culture group, where the majority were I-Kiribati women. I felt the informal nature of these discussions enabled the communications needed for the research. For the future, my hope is that dissemination of the plain English research summary will develop a further sense of partnership.

4.4.3 Protection

Protection was key to my belief as a researcher that my study should 'do no harm' to participants and their communities. At a basic level it involved maintaining confidentiality and privacy, and for this reason I chose to interview in several locations around New Zealand so that it would be less likely for participants to be identified within the small communities of I-Kiribati and LMC midwives in New Zealand. At an individual level, 'doing no harm' also meant accepting several potential participants' decisions not to be interviewed when it could have been easy to use personal connections to encourage them to agree. There were no physical health or social protection issues that arose in the course of the research for participants or myself that I am aware of. At one interview I listened in depth about a subject that was an upsetting memory, and tears flowed. We took a moment of time-out and continued, and, after the interview she said everything was fine. However, I made a point of making contact the next day to ask how she was, in case she wanted further support on the issue she had raised (for this I would offer referral to an appropriate support person or group). She reported being fine and expressed that she appreciated me asking how she was.

4.5 Participant Recruitment

4.5.1 Sampling

Purposive sampling is the best definition for how I accessed participants. Taking opportunities that arose, might be a better description. There are two main points relating to sample size that are important in hermeneutic phenomenology. One is to

gain enough rich data from the interviews to shed light on the phenomenon in question. The other is to not have too much data for the time allocated for the research. There are some methodologies, such as grounded theory, which lend themselves to determining the number of participants by deciding on a saturation point of data or on when data analysis is completed. In an analysis of saturation and identifying four uses of this concept, Saunders et al. (2018) concluded that "saturation should be operationalized in a way that is consistent with the research question(s), and the theoretical position and analytic framework adopted" (p.1893). In hermeneutic phenomenology the number of interviews completed must be determined by the participants gifted data shedding enough light on the chosen research question to be able to do justice to the data in the time available, recognising that the research will be just one stage in a continuous journey of understanding. Reaching this point of pulling aside from seeking further interviews is described by Smythe (2011) as:

> The thinking that emerges from such an analysis becomes embodied. One reaches a state of 'knowing' that one more interview will be too many. Already the insights are emerging like a river of thoughts. To keep pouring in more runs the risk of overflowing the banks which somehow hold the thoughts in a coherent whole. (p. 41)

I chose to stop interviewing after I had done 13 interviews, knowing that I had so much rich data that I would not have time to work with more.

Inclusion Criteria

In planning this research, I sought to interview three groups of individuals, as follows:

First, three to four I-Kiribati women who were migrants and had given birth in New Zealand within the previous 2 years. They would be from at least two locations in New Zealand to assist the maintenance of participant anonymity.

Second, three to four I-Kiribati women who were migrants and had either given birth in Kiribati and in New Zealand, or who had given birth in Kiribati and seen other women close to them birth in New Zealand. They were also from at least two locations in New Zealand to assist the maintenance of participant anonymity.

Third, four to six midwife participants who are registered to give lead maternity care and who had cared for at least one I-Kiribati woman in New Zealand in the last year.

The second and third groups were an important part of building an understanding of the context in which I-Kiribati women go through childbirth. As mentioned earlier, I was able to amend my ethics agreement with AUTEC to include one or more husbands of migrant I-Kiribati women who had birthed in New Zealand. This addition was to further

increase my understanding of the context. In practice, focussing so much on context as I had planned, particularly interviewing husbands, threatened to take me in directions beyond what I sought in my research question. I came to see that the data assisting me the most to focus on the research question were the interviews with women who themselves had birthed in New Zealand and those who had seen women close to them giving birth in New Zealand.

Therefore, I focussed on interviewing migrant I-Kiribati women who had birthed in New Zealand or had birthed in New Zealand and Kiribati. A total of seven participants. The remaining interviews supported these interviews by giving context to what I was hearing. This included I-Kiribati women who had themselves given birth in Kiribati and seen, or been with, I-Kiribati women giving birth in New Zealand (n=2), and LMC midwives who had cared for at least one I-Kiribati woman (n=4). One of the I-Kiribati women who had given birth in both Kiribati and New Zealand agreed for her husband to be interviewed with her, thus their story combined (n=1).

For all participants it was important that they spoke enough conversational English so that they could read and sign the consent form. I do not speak the I-Kiribati language and I felt that an interpreter would put another layer of personal understanding or interpretation on what they translated. Until recently, all I-Kiribati who went to high school were taught in English, so the level of English fluency is high among I-Kiribati in New Zealand. In the 2018 census, 85.5% of New Zealand based I-Kiribati self-reported that they spoke English (NZStats, 2018b).

Exclusion Criteria

Former or current clients were not interviewed in order to mitigate any possibility of coercion; it was felt to risk abusing a relationship based on a perceived uneven ‘authority’ or ‘status’. It may have meant that ex-clients would say yes to being interviewed when they did not want to do so and may have been less than open in their relating of stories. For example, it would have been hard for them to say “You, my midwife, did not listen to me or make me feel safe”.

Initially I had planned not to interview partners, in case one of them brought up something that the other might not know and later identify, thus causing stress in their relationship. On deciding to include interviews with the husband of I-Kiribati women who had given birth in New Zealand, I was advised by my cultural advisors to ask permission of the I-Kiribati woman to see if she would be willing for her husband to interviewed, and if she wanted to attend or not. One woman agreed for her husband to be interviewed and decided to attend, and she also contributed to their story.

Ensuring Consent

The original recruitment plan was for potential participants to be invited to take part in the study by a third party or intermediary without my initial contact. The intermediaries for I-Kiribati were people with links and acceptance in the I-Kiribati community. There was one intermediary for the midwives in the study and she was well-known and respected by midwife participants. The intermediaries were given an introduction letter (Appendix D) outlining brief details about the study, including what a participant could expect to happen and the importance of participation being voluntary. This letter was aimed to increase understanding about the research, and it was made on the advice of one of the advisory group. If a potential participant was willing for the intermediary to pass on their phone number or email address to me, I then sent them the same introduction letter with a copy of the information sheet and consent form (Appendix D) and asked them to contact with me within 3 weeks if they were still interested to meet for an interview. In practice, two midwives volunteered to me personally before receiving written information about the study. One I-Kiribati woman approached me directly after hearing me speak to others and also volunteered. Two I-Kiribati women who had said they would participate, decided later they would not participate for different reasons. That people who did not want to be interviewed felt able to say no, was a sign of the success of the recruitment process.

Who Participated

The following list shows the range of participant demographics. Participants are not specifically listed because both the I-Kiribati and the midwifery communities of New Zealand are not large. Therefore, to preserve anonymity, a broad picture of participants is provided.

I-Kiribati women

- I-Kiribati women (n=9, plus 1 husband who was interviewed with his wife) came from five locations around the North Island of New Zealand.
- One participant was 54 years of age, but I did not ask the rest their ages. However they all fitted the definition of childbearing age in New Zealand, which is 15 to 44 years (StatsNZ, 2019). Six women had tertiary education.
- Women who had just had births in Kiribati (n=2) had had their last children 6 and 19 years ago, respectively.
- Women who had had births in Kiribati and New Zealand (n=4) had had their last children between 2 and 6 years ago.
- Women who had just had births in New Zealand (n=3) had birthed their infants between 14 months and 3 years ago.

- The number of babies each woman had birthed ranged from one to eight.
- Of the six women who had had births in Kiribati, two had experienced homebirths, and all had experienced hospital births. Of the seven women who had had births in New Zealand, one had experienced a homebirth, and six had experienced hospital births. Six of the nine women who gifted their stories experienced serious obstetric complications requiring specialist intervention around the time of at least one of their births.

Midwives

- The midwives were from three locations in the North Island of New Zealand.
- All worked as LMCs (caseloading midwives) at the time of the interview.
- They had a range of midwifery experience, approximately 10 to 47 years.
- They had varied experience working with I-Kiribati women; ranging from one who had worked in Kiribati with many I-Kiribati women, through to one who had cared for only one I-Kiribati client in New Zealand.

4.6 The Pacific Way

In wanting to develop my skills as an interviewer, I began interviewing with those I knew best, the midwives, trusting that they would be vocal as to what worked and what did not work in my interviewing technique and regarding practicalities of the interview. Once my confidence grew as an interviewer, I began the interviews with I-Kiribati but as an I-Matang researcher, I needed guidance on how to do so.

Pacific researchers write of appropriate ways to approach Pacific participants. Tunufa'i (2016), writes how methodologies merge with method; culture and tradition affect what is done practically. Samoan researcher Anae (2019), highlights similarities in Pacific methodologies, referring to the *va,* "the secular/sacred and social/spiritual spaces…of all relationships." (p.1). Anae (2019) continues;

> Whether Kaupapa Māori (land, community land family considerations); kakala (flower garland); Talanoa (face to face dialogue); fonofale (holistic house); tivaevae (patchwork quilt); faafaletui (woven "houses"); vanua (land); tuli (heritage art); bu ni Ovalau (coconut tree); 'iluvatu (mat); fetuutuunai (navigation), what is important is the context of the relational social and sacred va between the researcher and the researched and how PRE (Pacific Research Ethics) is embodied and enacted in their interactions (p. 8).

Elaboration of this common theme of the va is in the Samoan reference to 'teu le va' (Wendt, 1996), or the Tongan reference to 'tahui vā' (Ka'ili, 2005). Both terms encompass "…the maintenance of positive social relationships" (Sa'iliemanu, 2020, p. 150), or the description "to take care, to tend or to nurture" (the va) (Ka'ili, 2005, p. 92).

So, as well as the interview being relational, there was need to nurture the relationships between researcher and participants.

The theme of relationships is also seen in the I-Kiribati research methodology of 'taono tabon inaim', which was utilised by two I-Kiribati researchers (Burnett & Bond, 2020; Korauaba, 2012). "'Taono'…is to sit down, 'tabon' is the end of, and 'inai' is the mat" (Korauaba, 2012, p. 53). Taono tabon inaim is literally "the request to sit down with the host family for very important matters, engagement, wedding arrangements and sorting out disputes and differences (p.53). The author also elaborates that "it is a very low and humble status in society that a visitor seeks to adopt by sitting on 'te inai'" (p.51), and that "This cultural methodology is the most appropriate method to assist in re-establishing the relationship and trust so he can collect his data with the support of the participants and receive their traditional blessings…" (Korauaba, 2012, p. 53). In summary, this methodology emphasises the importance of the researcher-participant relationship in conducting interviews, and in this way informed the way my interviews with I-Kiribati participants. Thus, the practicalities of conducting the interviews were important. I had to be respectful to the people who participated, both *I-Matang* and I-Kiribati. Knowing that I do not have an innate sense of what is right and wrong in I-Kiribati culture, I was more aware of what I was doing in interviews with I-Kiribati. I made a point of giving participants a choice of venue for the interviews. Some chose their own residence, others chose the University premises or the Women's Centre, and others my clinic rooms or birth centre. In all of the interviews I sensed the importance of taking time with explanations both before and during the interviews. Also important was taking food and drink to the interview and allowing time for greetings and introductions. The research also needed to be verbally introduced as not everyone understands what research is. Overarching all these things, the attitude I brought to the interview was one of the most important aspects of the interview.

In an email to my supervisors on April 17, 2020, I reflected on how I conducted myself when meeting the person I was to interview:

> *I read a Master's thesis sent to me …The main concept was 'Taona Tabon Inaim' (Burnett & Bond, 2020). My summary of it is that this is a cultural concept of how you politely and respectfully visit people in formal, not so much a social setting. It is waiting to be seated, an attitude of humility; sitting on the mat, seeking the blessing and peace of your hosts, taking an entry and an exit gift. The attitude of the visitor is said to be important; one of humility. The interviews I have had have mostly been on 'neutral territory' (nothing is really neutral actually, but it is not mine and not theirs), so that is different. I know that the majority of I-Kiribati families here (in NZ) probably don't have a strict expectation of what I-Matang visitors should do/shouldn't do*

> *but reading this gives me hope that what I do and how I am might not be too different to what is expected. K.*

My understanding of how I needed to go about relating to participants was further informed in an email from my supervisor at the time, Sandy Thaggard, herself a Pacific woman April 17, 2021:

> *Pacific people out of survival in another culture have an internal radar that instinctively imprints a palagi's humility because actions that convey humility are considered to be good manners. When I used to be a support lecturer for Pacific students I had to coach them on how to promote themselves, to push themselves forward in as much as what they were achieving in clinical etc for it does not come naturally - it is considered to be boastful so they would be quiet as a mark of respect and get called dumb for it. It is expected that someone else talk of your achievements, never yourself. Everything you do is done in humility and in deference to others. You have already been mentioned no doubt and your reputation would have gone before you as someone to be trusted. (Sandy Thaggard)*

Thus, I strived to conduct the research (recruitment and interviewing) consistent with 'the Pacific way'. I cannot completely do it 'the Pacific way' or 'the I-Kiribati way' because I am not a Pacific nor an I-Kiribati woman, but I did aim to respect their ways and conduct myself in a manner congruent with what is seen as respectful and acceptable in I-Kiribati culture.

The interviews were unstructured. I did have a list of indicative questions (Appendix D), but these served as an orientation rather than a specific guide. 'The way' to go inevitably emerged, as stories tend to do when people are given the opportunity. In starting the interview, I would remind participants I am a midwife and say I was interested in childbirth which to me encompasses the whole of pregnancy, birth, and the early 1-2 months after birth. Most participants needed a lead as to what to then talk about, so I would ask them to start at the beginning and tell me about their first birth, right from when they first found they were pregnant. In the case of the midwives, I asked them to tell me the story of one or more I-Kiribati women who stood out in their mind. Depending on the individual, we ate the food I had prepared before, during, or after the interview. I took my lead from the participant, as some appeared to appreciate an informal chat over food prior to starting our more focused interview. At the end of the interview, it was important to thank participants for taking the time and effort to share their stories. I tried to comment on one particular thing that stood out from what they had said which had enhanced my understanding, and asked if they would like to have copies of their crafted stories and the plain English summary at the end of the research. All said yes. I also gave a koha to each person in the form of a grocery voucher, although for some of the midwives the koha was in-kind (i.e. goods such as a

flowering plant of similar value). The koha was to recognise their contribution and the opportunity cost of participation in the research. Some field notes were written, mostly at the end of the interview, as writing would have interfered with communication. I wrote down anything that would aid the process of interpreting participants' meaning in their stories. For example, in interviewing Maria, I wrote "*I commented on the 'comfort' she received from the doctors' voices being Island voices, which then helped her go into a lot of detail!*"

4.7 Discovering Meaning: Working with the Data

With participants' permission, interviews were recorded on an audio device and my phone for backup. I sent transcripts to a professional transcriptionist, knowing that my time would be better spent reflecting on the stories rather than on the minutiae of documenting words. She signed a confidentiality agreement (Appendix E). Reflection began before the transcript was returned, as I was able to utilise my work travel time to listen to the interviews. This offered the advantage of clarifying meaning or emotional context of words when I later read and re-read the written transcriptions. What arose from the transcriptions were what I labelled 'full stories'. These resulted from taking out repetitions, diversions and features which would identify individuals or places, tidying the grammar and sometimes changing the order of passages to make the transcripts read as a coherent story which the women themselves could read and recognise themselves talking. Still, the women's own words, the 'full stories', then became a collection of short 'crafted' stories in the women's own words (Crowther et al., 2017). (For examples of excerpts of a transcript, full story, and crafted story with initial reflections, see Appendix F). The 'full stories' could also be used by the women, if they chose, to pass on to other members of their families, perhaps their daughters, to share their experiences. There were often many stories in one interview, and as the researcher I made the decision which individual stories would be selected. Selecting stories from such a wealth of material would have been hard had it not been for the reminder of the methodology to return to the phenomenon (Heidegger, 1927/1962). In this case, to return to what was the experience of the migrant I-Kiribati women in the stories of childbirth in New Zealand. In writing about the selected stories, writing a description in my own words helped clarify the story and promote my reflections. Interpretations of what the women's experiences meant to them continued to surface the more time I spent time reading and reflecting on the stories.

This process took time. The cycle of re-reading, reflecting, writing, re-writing was ongoing, as further insights appeared. Reflecting involved thinking (van Manen, 1997). Thinking about women's stories, or 'dwelling' on them, continued, and as this

happened themes began to emerge. I looked for three or four main themes showing themselves in the stories. I was diverted in my thinking in a way that was trying to draw out concepts, as in grounded theory, but on my return to hermeneutic phenomenology I chose three ‘clusters’ of stories to work with, ‘Tensions’, ‘Silence’, and ‘Trust’ (later to become ‘Care-Connections’). The ‘working out’ of these themes can be seen in Appendix F. I gathered the stories on paper, having printed out the smaller stories and my initial reflections. The visual collection of stories allowed me to see where stories sat in relation to each other, something that several files open on a computer would be difficult to replicate. The stories gathered, I put them on paper and continued to write, both following the reflections already documented and continuing to reflect. With time, reading on philosophical notions came to the fore and shed more light on the women’s lived experiences, and with more reflecting I could determine more of the meaning in their stories. Writing and rewriting continued. One may expect in a research methodology to see a linear process, but hermeneutic phenomenology shows more of a continuous building and a returning to refashion the understanding which surfaces.

In the middle of this process, I sent the ‘full stories’ back to the participants, all of whom had said they would like a copy. (All but one said they would prefer an electronic copy.) I chose to return one participant’s story at a time in order to learn if there were alternative ways needed to communicate what I needed them to do with their story. When returning the ‘full stories’, that is, the tidied transcripts of the full interviews, I was not sending my interpretation of the stories to the participants, neither was I asking for further data or for corrections. That would be labelled ‘member checking’ and I am in agreement with Morse (2015) who said, “It is not clear why one should provide the participant with such an opportunity to change his or her mind; it is not required in other types of research” (p.1216). Rather, I asked the participants to let me know if there was any part of their story they no longer wished me to use in the research, and to say if there was anything in their story which would identify them or others. As a result, I had permission withdrawn for the use of two parts of a participant’s story, as there was a risk of people and issues being identified. I consider this a positive result from the process, as it meant that the integrity of the participants and, therefore, the research process was maintained.

Dwelling with the data continued as I added to my initial reflections on each story and placed them next to other stories within the same theme. Describing what was happening in the stories was then not needed, rather an interpretation of what those stories contained. As the stories were thus grouped and I dwelt on the interpretations, the strength of the stories came through and something called the interpretive leap would occur. This refers to the use of philosophical notions to ‘surface meaning’ in what

the data show. In the iterative process of reading, thinking and writing and repeating such a cycle, further insights continued to be found (Crowther & Thomson, 2020). “Seeing is always about making an interpretive leap. It is to leave behind the firm hard ground of reporting. It is to wonder, in writing, about possible meaning” (Smythe & Spence, 2020, p. 4). A poem from my journal, written on hearing the phrase “what brings it to life is us”, describes what it was like to be in this part of the process.

“What brings it to life is us”, The Interpretive Leap:

- *It is a responsibility*
- *It is a privilege*
- *It is a caring-for a gift,*

the weight of which

I would dare to lift…

and carry on… (July 28, 2021)

4.8 Openness to Bias

Openness to bias on the part of the researcher is relevant to discovering meaning. I must be honest as to who I am and where I come from, and what historical horizons (understandings) I bring to this research. My pre-understandings are detailed elsewhere but to summarise my origins; I am a white New Zealand midwife with a middle-class upbringing, an *I-Matang*, (pakeha, palagi), a midwife with 24 years work experience in more than a dozen countries, married with no children, and I do not speak the I-Kiribati language. In terms of the I-Kiribati community, I am an outsider. It is possible I could be classed as a non-insider, one degree closer than an outsider, as like most I-Kiribati, I have been brought up in the Christian church, and regularly a third of my clients are I-Kiribati. However, this classification is not mine to make.

Before beginning this research, I reflected on the prospect of doing the research, and recognised my starting point:

> *I need to develop the ability to get into someone else’s shoes; to LISTEN, not to try to reinforce my own polemical ideas. (Journal of Learning, September 11, 2018)*

Closer to the start of the research, after my pre-research interview with my supervisor, I reflected on the little understanding I had to start with:

> *In summary, it (the interview) shows that I don’t have much of an idea about the ‘I-Kiribati way’ (Journal of Learning, May 25, 2019)*

In hermeneutic phenomenology such preunderstandings, rather than negating a researcher's interpretations, build with the text of the interviews to feed into the process, the play, of the hermeneutic circle; that is, the circle of understanding (Gadamer, 1975/2013). This circle of understanding can be found in the findings chapters where at times I reflect as a midwife. Although this is not 'normal' in research, I feel justified in doing so. I bring to this research years of experience being a midwife for I-Kiribati families and as such probably have birthed more I-Kiribati babies than most other midwives in New Zealand. The role of midwife is where I am coming from, and it is an important part of my preunderstandings in this research.

4.9 Trustworthiness

Research, whether quantitative or qualitative, begins with the researcher. With time the researcher finds the research question and works at the emerging design of the research. From the beginning of this research journey I needed to keep in mind how, at its conclusion, this research would be termed 'trustworthy'. My goal for this research was that it would be of high quality, that it would show itself to be trustworthy (Koch, 1996).

4.9.1 Terms for Trustworthiness

Trustworthiness is often used interchangeably with the term rigour. It is an issue at the heart of this research. Trustworthy is defined as being "worthy of being trusted; honest, reliable or dependable" (McLeod & Makins, 1995, p. 1272). Trustworthiness is my preferred term for this research.

Rigour is, "strictness in judgement or conduct" (McLeod & Makins, 1995, p. 1002). It is said to be the basis on which to determine the trustworthiness of a research project (De Witt & Ploeg, 2006). In keeping with its primary definition, the meaning of rigour shows it is helpful for use in the methodology of hermeneutic phenomenology but the emerging nature of 'the way' means it is not the same as the constrained methodological rigour of quantitative research.

Cultural integrity in qualitative research is a term used by Pelzang and Hutchinson (2018), who pointed out that it is achieved by being "responsive to the cultural and linguistic nuances of given research settings" (p. 1).

Cultural rigour was called for by Lock et al. (2021), who contended that "conventional critical appraisal tools for assessing study quality are built on a limited view of health that excludes the cultural knowledge of First Nations peoples" (p. 210). They proposed a definition of cultural rigour as "the detailed attention to protocols of engaging with

First National people in all research processes to ensure the cultural validity of the results." (Lock et al., 2021, p. 211).

4.9.2 Determination of Trustworthiness

Rigour (trustworthiness) is a widely used and desirable term in quantitative research, and its achievement or otherwise is held to be determined by fulfilling the goals of reliability, validity, replicability, and generalisability (Bryman et al., 2008). Some qualitative researchers translate these criteria into those of credibility, confirmability, dependability and transferability, following the lead of Lincoln and Guba (1985). In contrast, Sandelowski (1993) in her critique of the concept of rigour, made the point that being too rigid in following criteria may become restrictive, and suggested "we can soften our notion of rigor to include the playfulness, soulfulness, imagination, and technique we associate with more artistic endeavours, or we can further harden it by the uncritical application of rules" (p. 8). De Witt and Ploeg (2006) agreed and pointed out the potential incongruence of such criteria with methodology, stating that in undertaking research, "the use of a generic set of qualitative criteria of rigour…is problematic because it is philosophically inconsistent with the methodology and creates obstacles to full expression of rigour in such studies" (p. 215). Koch (1996) gave a brief summary of a solution, writing, "I recommend that each inquiry determine its own criteria for rigour (trustworthiness)" (p. 174). This I have done, as follows.

In planning for the research, a checklist of criteria for ensuring trustworthiness did not seem to fit with the hermeneutic phenomenology methodology, but some principles from a framework proved a useful beginning. De Witt and Ploeg (2006) proposed a framework of openness, concreteness, resonance, and actualisation to ensure the "expression of rigour" (p. 224) in research. In my research proposal, I stated I would follow De Witt and Pleog's framework. I remained committed to the principles in the framework but, to shed further light on the trustworthiness of this research, I wanted a clearer way to communicate it, a way that would address the cross-cultural aspect of my research. I found this in the work of Im et al. (2004). They evaluated 222 cross-cultural quantitative and qualitative studies for 'rigour' according to five evaluation criteria, which, although labelled 'criteria', are broad enough to fit with the hermeneutic phenomenology methodology. Their criteria were cultural relevance, contextuality, appropriateness, mutual respect, and flexibility. While these focus on cross-cultural aspects of the research, they underpin a focus on the phenomenon in question, the experience of migrant I-Kiribati women of childbirth in New Zealand. In proposing these criteria, the authors suggested that they should be developed further. While there is sometimes a separation in the literature of cross-cultural 'criteria' and those of a methodological nature, to determine trustworthiness, it is consistent with hermeneutic

phenomenology that the research is seen as a whole. Therefore, I propose to add another to the list, that of ‘methodological congruence’.

Determination of trustworthiness was supported by very positive feedback following the presentation of preliminary findings from this research in 2023. The findings and their interpretation resonated with midwives of different cultures, including Pacific midwives, at the International Confederation of Midwives Conference and at the New Zealand College of Midwives Conference.

4.9.3 Cultural Relevance

The question posed in the research should “serve a specific cultural group’s interests in improving their lives” (Im et al., 2004, p. 894). The research should be relevant to the I-Kiribati community. The quality of this research benefited from my 2-week orientation visit to Kiribati and the support from the knowledge and understanding of my supervisors and consultation group. The voices of I-Kiribati women, though interpreted by me, speak for themselves in the pages of this research, and it is indeed a voice that is rarely heard. This is an immediate benefit. For the future, understanding gained by health professionals through the research will show this research to be culturally relevant.

In May 2023 I had the opportunity to speak to a group of local I-Kiribati women, attending an open invitation to hear something of my findings. I shared three stories with the group, and they talked in three small groups about their own impressions of the stories and my interpretations. Documentation of this feedback session can be seen in Appendix G. While I did not expect my interpretations would be challenged given the social norms and situation, it was evident that the stories resonated with those who heard the stories, and some of my own interpretations were indirectly confirmed by comments or similar stories arising from those attending. This includes a validation of I-Kiribati voices being heard through this research.

I-Kiribati participants might choose to share their stories (as returned to them) with their children and grandchildren. Many I-Kiribati youth are not growing up in New Zealand and the sharing of such stories may support intergenerational communication and cultural understanding; relationships may thus be nurtured.

4.9.4 Contextuality

“Without contextual understanding, cross-cultural (nursing) phenomena cannot be fully understood” (Im et al., 2004, p. 895). The Kiribati visit and the consultation group, supported my understanding of the context of participants stories. Sensitivity to the

participants' context meant that it was wise to recruit through I-Kiribati intermediaries. As an increased understanding of participants' context came through I-Kiribati clients and I-Kiribati advisors, I could more safely recruit, plan, and carry out interviews, then make interpretations of data they gifted me in their interviews. Increased understanding also came as I took time to listen, rather than assume, the endings of the stories participants told. My interviews with midwives who had cared for I-Kiribati women, and one husband of an I-Kiribati woman shed further light on the wider context experienced by the I-Kiribati women.

4.9.5 Appropriateness

"Communication styles, conceptualisations and the translation process" should be appropriate (Im et al., 2004, p. 895). To begin with, I tried in both written and spoken communication with I-Kiribati participants to use simple words in I-Kiribati language in greetings or thanks or in parting ways. Although I do not speak the I-Kiribati language, I-Kiribati participation in the research required enough English to understand the consent form and sign it. This signified a reasonable level of English comprehension and, as mentioned previously, one woman who did not want to participate clearly said that it was because she felt she did not have adequate English. Occasionally in an interview we would discuss the clarification of a word or the meaning of a concept, but the women were given the opportunity to say their own stories in their own time and in their own way. Non-verbal cues were also important in the interview setting; for example, when a participant was obviously ready to close the interview even if I wanted to continue. In some interviews there were sensitive memories that resurfaced, and it was important that I took my cue from the participant as to how long they wished to talk on such subjects. Listening to the interview transcripts was superior to reading in being able to ascertain the emotional meaning of what was said. Sometimes it was in the fourth or fifth time of listening that I would gain some understanding of the meaning of a particular story. It is important to remember however, that with more time and more understanding of I-Kiribati culture, understanding of the gifted stories will continue to grow.

4.9.6 Mutual Respect

"In cross-cultural research, mutual respect is essential to the rigor of the study" (Im et al., 2004, p. 896). This aspect is basic to all parts of the research. Respecting involved valuing participants beliefs, values, and viewpoints. In a practical way, respect also meant abiding by participants' choices; of timing, location, when they chose to eat the food I brought, and how long they wished to talk. Respect develops trust, and was helped by having visited Kiribati, having cared for many I-Kiribati women, and using

one or two words of the I-Kiribati language in contact with participants. There are potential imbalances of power in the participant-researcher relationship. Respecting the participants' ownership of their stories was shown by returning the full stories and showed reciprocity in the relationship. Mutual respect requires humility and respect on the part of the researcher. In such an environment, a relationship of trust can grow, as shown in the taono tabon inaim methodology.

The question, 'does this research show respect for I-Kiribati and all the participants?' should be asked by the reader. Is there respect in the methods, respect in the process, and respect in the interpretation of the stories gifted to me as the researcher? The reader can judge for themselves.

4.9.7 Flexibility

Flexibility can be shown in use of the first language of participants but was not a feature of this research for obvious reasons. However, flexibility in time was vital at every stage of the journey as it allowed "participants to express themselves more completely" (Im et al., 2004, p. 897).

Perhaps trying to take time to listen, time for the introductions and the interview to happen at the participants' own pace, fostered mutual respect. Time had to be held loosely, flexibly, in this research process; from the beginning of seeking participants through waiting for responses, to giving time at the interviews for introductions and for participants' questions and comments at the beginning and end. Time was important for all participants. The requirement to 'take time' continues to positively impact my work as a midwife in conducting consultations with clients, as I try to take the time needed and to say at the end, "is there anything else you want to ask about/say?"

4.9.8 Methodological Congruence

What is documented in this chapter about the research methods should fit the methodology of hermeneutic phenomenology. The question of methodological congruence will, along with the other aspects mentioned here, assist in determining trustworthiness, the need for which is just as important for any methodology. For a hermeneutic phenomenology expert this research should speak for itself. For those not so familiar with hermeneutic phenomenology, there are key features that resonate with the methodology. Flexibility, as described above, is one key. Linked to this is the thinking and rethinking, the writing and rewriting, detailed earlier (van Manen, 1997). What is also obvious is that I openly bring my historical horizons or understandings to the fore to meet with the data, the stories, to bring new understandings, as in the hermeneutic circle (the circle of understanding). The parts of this research come

together to create a larger ‘whole’ of understanding which feeds back to further develop my understandings. Likewise, readers will bring their historical understandings to the reading of this text and themselves, join in this process so that their understanding is changed. As to whether or not this has occurred, the reader, expert in the methodology or not, will judge. Further, my attention to the writings of Heidegger and Gadamer has ensured the notions that informed my thinking remained congruent with the methodology.

4.10 Conclusion

In this chapter I have tried to demonstrate the way taken, articulating the details of the research design and, in keeping with my chosen methodology, hermeneutic phenomenology. Importantly, I have attempted to preserve cultural integrity with my interactions with the participants, their contributions and communities, while creating a research study in which trustworthiness is evidenced. As an *I-Matang* I do not possess an insider’s depth of cultural knowledge and understanding; however, I have sought to minimise imposing Western patterns of behaviour or assumptions on the method of recruitment and other aspects of the research. I have tried to follow the way of cultural trustworthiness. I now move on to share the findings of this research.

Chapter 5: The Experience of Tensions

5.1 Introduction

The telling of these stories begins on the atolls of the country of Kiribati with generations of I-Kiribati women who have been born and who have given birth in their homeland. Like the question of this thesis "What is the experience for migrant I-Kiribati women of childbirth in New Zealand?", these are stories that have no ending. The 'findings' of this thesis are a beginning of the telling of these stories, a raising of more questions than securing answers, in the hope that those reading it are inspired to continue the dialogue and seek to understand.

Many aspects of life change for I-Kiribati migrants with their move from Kiribati to New Zealand. What happens in and around childbirth is no exception. This chapter begins with birth in Kiribati, and then highlights the challenges, changes, and sometimes resultant tensions that I-Kiribati women face with their move to New Zealand.

5.2 Where it all Began: Uauang Takes a Stand in Kiribati

For some I-Kiribati women, their first experiences of birth have been in Kiribati, where the choice is to birth at home with a *te tia tobi* (traditional midwife) or at a hospital. Only four islands in Kiribati have hospital birth as an option (Government of Kiribati, 2021). Uauang's story is situated in Kiribati and brings out the background from which I-Kiribati women might come. She experiences second thoughts about having her baby at the hospital where she had her first baby. Her family, with no connection to or knowledge of a *te tia tobi* or how they work, and expecting a hospital birth, are shocked when their daughter/wife demands to be cared for by a *te tia tobi* at home. I-Kiribati culture, including the culture of birth practices, has changed over time and continues to change, as do other cultures (Gadamer, 1975/2013). Such changes can be from traditional to 'modern' or from 'modern' to traditional. Uauang challenges family beliefs about what is 'normal' for birth and, in the process, challenges family ways for making decisions.

> *Late in my second pregnancy I slipped over in the bathroom, and I went with my mum to the hospital. They told me to go home and prepare and to return the next day. So, I went back home and got my things sorted. But I have this thing that I want to make the decisions myself; that's my pregnancy nature! So, my husband came back and saw my stuff was all packed. He panicked, and said, "You need to go straight there, we need to go right now!" So that triggered me. I said, "No I don't want to go. I want to give birth in this house", out of the*

> *blue. And then mum's like, "We don't have anyone". And I'm, "Well, you'd better go and find someone because I don't want to give birth in the hospital!" My husband's like, "Why?" I replied, "Because you guys told me, and I don't want to be told by you!" And so, I sent mum to look for a local midwife, a te tia tobi… Mum came back with a te tia tobi. My husband was so worried because it was someone new and we cannot just allow her to touch my belly. It's like we're giving my life and my baby's life, into her hands. But me being so stubborn I said, "No I'll go with it, it's okay"….By the evening, dad was at home. He knows that I cannot listen to anyone except him, so he advised me to go to the hospital. I said that no, everything's done, it will be okay, and as long as you're here I can do it.*
>
> *The te tia tobi started her work of caring for me. I was so comfortable, and my mum was so mad, because it was the first time she'd seen someone give such care, and especially when we don't know her or her history… It went quick because baby just came out. When the placenta came out, the te tia tobi put it aside. Mum was going to take care of it and the te tia tobi said, "No, where's the father, he needs to come and take care of it". It is something to do with bonding because he is very close to this child.*
>
> *Yes, there was a big difference between my births. The hospital birth was much more painful and took more time. The birth at home was a bit fast, but it's more comfortable because I'm in my own space. It's near, so my son and me and my husband, we get to sleep as a family, so I think it was a wise choice behind my stubbornness to have my second one at home. (Uauang)*

This story shows a paradox. While Uauang recognises the reasons for the family's concern, she disobeys the instructions or directives of both hospital staff and family. Similarly, she recognises how decisions are normally made in the family, especially when she talks about her dad, but chooses to continue with what she has decided. Uauang seeks care from the *te tia tobi*, a complete stranger, and does what this woman says. She leaves the known for the unknown and feels "*comfortable*". Maybe there are aspects of her first hospital experience which she finds herself dreading to repeat. It is perhaps not the attraction of the *te tia tobi*, but the attraction of being in her own environment, with all that means to her, and to avoid the hospital environment, which are behind her "*stubborn"* decision to stay home. The *te tia tobi* is the means to these ends.

On the face of it, Uauang's family are a modern family who support what is current practice, or 'modern' health care for birth. Uauang is wanting a home birth but the family are worried there is something wrong after the fall and that the hospital is the normal place to birth. It is definitely the normal place to go if something is not right. They appear not to have known much about traditional care in birth. Perhaps this story represents the changes in I-Kiribati culture, that knowledge has lessened of what is traditional for I-Kiribati.

While Uauang's family possibly lack familiarity with the traditions of the *te tia tobi*, they definitely lack familiarity with this particular *te tia tobi*. The family have, in acceding to Uauang's wishes, taken a risk; who is this *te tia tobi*? What is her safety record? Is she to be trusted? There is a potential threat to the family in seeking care from an unknown source. I wonder if going to the hospital and being cared for by someone not known to the family brings the same concerns. It appears that for them, the hospital, its institutional status and the uniforms and roles of the staff, represent an authority which is to be accepted and listened to. The traditional *te tia tobi* cadre does not appear to have such status for this family, at least not at the start of the story. However, by the end, the mother is listening to directions from the *te tia tobi* and stepping back for her to direct Uauang's husband as to what to do with the placenta. There has been a challenge to what family see as normal for birth and health care. There is also a change, a progression in this story, from suspicion to acceptance, from unfamiliarity to familiarity.

Something that remains strong in Uauang's story is the importance of the family, despite Uauang's challenge to the way decisions are made therein. Even as Uauang declines her dad's insistence that she go to the hospital, she reinforces the importance of his role in her life and pending birth. Still, there is a reaction to Uauang's challenge. The tension is high, and it sounds like it is a stressful situation for all concerned, resolved only after the birth of the baby with retrospective proof that all was okay. Uauang shows strength in suggesting something new and carrying through with it; she knows her own mind. She takes her family and their support along with her.

There can be challenges to who traditionally makes decisions in a family and to how these decisions are made. There can also be challenges to what is expected to be the norm in childbirth; traditional or 'modern'. If these things are true in Kiribati, how much more so in a new country? This story of Uauang's homebirth back in Kiribati shows the strength of a woman in her own environment, taking a stand for what she wants and believes is best. It reveals that trust in traditional ways can win over hospitalised birth. The question is raised as to whether women's strength to take a stand on what they think is right, and to trust in traditional ways, comes with them as they experience childbirth in a new country.

5.3 First Baby in New Zealand: Amy Veronica Needing Support

Amy Veronica had a stillbirth in Kiribati and now gives birth to her first live baby in New Zealand. She faces the challenges of being a first-time mother in anticipating how she will care for her new baby. Added to this experience is the challenge of living in overcrowded accommodation.

> *Going home from the birthing centre the first time, I felt nervous, because I had to wash my baby on my own! I was nervous the first time, but it's good because the midwife always came and checked on the baby. I'm quite lucky to have my midwife, because those years were quite a struggle when I first moved there. We lived with a Kiribati family in one bedroom. The family slept in the lounge, and it was very crowded, overcrowded. The lounge chair and the toilet were inside our room, so the people had to go through our room to the toilet. It was very hard for us. I didn't want to stay there; I wanted the space for my baby. After the 3 days at the birthing centre, my midwife let me stay there another week, which was good, because we were looking for a house, but we had to save up for the bond to rent one and so my husband was looking for a job. (Amy Veronica)*

Amy Veronica feels "*nervous*", like many first-time mothers before her. Suddenly it is up to her to care for her baby. She must bring together the knowledge and expectations from her own upbringing in another culture and country, whatever her own family and family she lives with have said to her, and what staff at the birth centre have told and showed her. She must now trust herself that what she has learned and observed and instinctively knows will be enough to care for her baby. There is much to take in, to learn, to process, and she must wonder if and how she would do it 'right'. There is a depth of meaning behind Amy Veronica being "*nervous*" about taking baby home which may not be immediately obvious to the observer.

Overall, Amy Veronica rejoices in placing baby at the centre of her story; however, there are more challenges than learning what to do with baby. She appreciates the midwife visits to check her baby and give advice, but she has concerns about going back to her accommodation. There she has support from another I-Kiribati family, who have gone out of their way to accommodate the new parents. This is not unusual. Many I-Kiribati are given accommodation by other I-Kiribati family or friends on arrival in New Zealand (Teariki, 2017; Thompson, 2016). Amy Veronica knows that their living situation is overcrowded; she finds it *"hard"* and knows they need more *"space for my baby".* There may be tensions between the two families when they are living in such close proximity. Amy Veronica and her partner clearly do not want to remain in that overcrowded situation which, in itself, creates a tension for her.

As a midwife I may see a first-time mother and think there are certain skills and information to be conveyed, to be learned and achieved by new mothers regarding newborn care. How many tired postnatal women misunderstand or do not hear advice they are given? And how much more if English is their second language? How do you see and learn when your focus is on other things? Amy Veronica shows herself to be a mother very open to learning information and skills, but this is not all she seeks; she maintains a holistic view of her life and family's needs, meaning there are other pressing concerns for her and her new family. Perhaps her story is echoed in the

experiences of other migrant I-Kiribati women in New Zealand facing challenges in the time of childbirth.

5.4 Unexpected Pregnancy: Sonia's Disappointment

Sonia and her husband came to New Zealand to secure a better future for their children. They had hoped for their daughter to graduate and find a good job. They had worked hard for this prospect, and their expectations are disappointed. While this story is from the mother, Sonia's, point of view, it is possible also to imagine something of the daughter's experience.

> *My daughter was the first one in the family to go to university. And all of a sudden, she told us she was pregnant… I didn't expect her to do that. For me it was so difficult, we felt angry and sad. We'd already explained to her the main thing we wanted her to do was to focus on her study. After that, you can do everything; you can have a relationship, get married, have a baby afterwards. But she did the opposite. It was very hard, and heart-breaking as well. Everything she needed; we were there. Even if it was late, if she needed anything, we didn't care about our tiredness or anything, we had to be there. But when she told us that she was pregnant, the thing I thought at that time was that you've been wasting our time, you never listened to me so it's your own problem if you finish your study or not...*
>
> *I was so angry and upset but, in the end, she's our daughter, so we have to support her, again! It's hard the first time you hear something like that from your child, but at the end, you look at them, and you have pity on them and then you just, oh…your heart is still there, and your anger is already gone. She moved back home near the end of her pregnancy. If she hadn't got pregnant, she would have reached her goal and finished her study earlier... That's the main thing, we already told them that's why we came from Kiribati to New Zealand. It was for them to have a better future, not for us. We wanted them to have a good job to support their family. Not like us doing labour jobs, it's very hard work. (Sonia)*

Sonia's daughter suddenly breaks the news of her pregnancy to her parents. Their expectations have been established years before, along with the plan to move from Kiribati to New Zealand. Sonia thinks their expectations of their daughter have been clear; "*the main thing we wanted her to do was to focus on her study. After that, you can do everything".* The news of her daughter's pregnancy is the last thing Sonia expects and leaves her feeling "*angry*, *upset, heartbroken"*, and that her daughter has "*been wasting our time".*

"Our time" has been given freely to their daughter, but at a cost to Sonia and her husband. They have provided everything that their daughter needed, often at times when they were tired themselves. Up to this point, they have seen 'their time' as synonymous with 'her time'. Her time was to be studying and completing her degree,

and they were supporting her time to be achieving the degree. Her goal was their goal; to be *"finished her study"*. Practically speaking, at least for now, the daughter's and parents' goals are now different, and they occupy different 'times'. Tension results and family relationships are challenged.

The heart of this story is not that there is moral shock and censure at the daughter's pregnancy before marriage, so much as a deep sense of disappointment, even betrayal, of the parents' dreams for their children, betrayal of the reason they moved from Kiribati to New Zealand. But there is more. This story shows the ongoing commitment of these parents to their children, as eventually relationship prevails and Sonia and her husband continue to support their daughter; "*you look at them, and you have pity on them and then you just, oh…your heart is still there, and your anger is already gone".* Circumstances and relationships may have changed but their daughter is still part of the family.

We do not hear Sonia's daughter's experience and what this story means to her. We do not see how hard it might be for her to admit to her parents that she is pregnant. Does she approach her parents knowing that she may be rejected and out on her own with no family? Does she feel torn between I-Kiribati culture and a very different New Zealand youth culture, something which is experienced by others (Burnett & Bond, 2020)? Perhaps for her, becoming pregnant seals links to both sides; to the New Zealand culture because societal rules are not strict on what order to have children and partner and marriage or none of these things, and to the I-Kiribati culture because she eventually knows that her place in the family remains secure and she is still a part of it. What we do see is that the relationship between this mother and daughter cannot be denied, much as either of them might, at times in this narrative, wish to do so. "*She's our daughter, so we have to support her".*

While this story could be one of any family with its clash of expectations in the midst of changing intergenerational cultures, it is Sonia's story and both she and her daughter are faced with challenges. There is the challenge of an older generation having to reconcile unmet expectations with the rapid changes in what is 'normal' in a new country. There is the dilemma of a younger generation of I-Kiribati women of how to balance the norms of the society they come from with the norms of a new country without being torn apart.

As an *I-Matang* midwife in New Zealand I am likely to see Sonia's daughter in a different light to how her mother sees her, and am unlikely to know the history of family expectations that exist or of admonitions to wait for children and marriage until after qualification. Like many other midwives, I might see this story in the context of

individual rights and choices, and thus focus on the daughter, the pregnant student. Sonia's story, however, has a wider perspective; the perspective of the long-term, and the perspective of the family and the individual's place in it. She shows the past expectations and the here and now, with her present grief at expectations disappointed. Sonia also shows her hope, her continued belief in the future, as she accepts the situation and reiterates the importance of family relationships. Whatever her daughter has done to disappoint she is and remains family; past, present and future. In the end, this story is not just about two individuals but about their family of which they are a part. The family remains whole, the parts having adjusted; different than before but still a family.

Perhaps there are other migrant I-Kiribati women, mothers or daughters, who experience the tension of their family expectations not being met. Like Sonia's daughter, the beginnings of their pregnancy journey is a time of tension. I wonder how hard it must be for there to be such a reaffirmation, as Sonia's, of commitment to family, and to establish 'family *"again"* within a new country and culture.

5.5 Seeking a Midwife: A Tense Time for Roi

Roi leaves her husband and parents in Kiribati to birth her first baby in New Zealand, with her sister and an aunt for support. For Roi, the hardest thing is finding a midwife.

> *I found out I was pregnant in Kiribati. I came here to New Zealand when I was 6 months pregnant, and I lived with my sister. The hardest part of it was finding a midwife because it was late. They didn't know about me from when I was first pregnant. So, it was very hard. We called around 3 or 4 midwives and they apologised and said they couldn't take us because we were so late. My aunty, she recommended someone for us, a Pacific midwife. So, we called her, and she was like, "Oh I'll find someone for you". Then we had a meeting with her for the first time and somehow, I think she felt sorry for us because we were all like, "oh we don't know what to do", because it was our first time here. And then she took over, and she became our, my midwife. She was with me the whole way. She sent me for a scan and did home visits pre-birth. (Roi)*

Roi has gone to some lengths to make the move to New Zealand while pregnant with her first baby, leaving all that is familiar. The way to maternity care, midwifery care, is then blocked. Expectations of receiving care are not easily met. She is "late". Having planned and prepared and been organised to get to New Zealand in good time for the birth, she is "late" according to the New Zealand system. It must have been a shock, as later in the interview, she repeats her comment that finding a midwife was the hardest thing for her and expects that other women like her would find it the biggest challenge too.

Roi found midwives, nice midwives, three or four of them even, but no midwives available to care for her. And then, connections are found. Aunty knows someone who is a midwife, a *"Pacific midwife"*. This midwife promises to help. There is a meeting, and Roi is connected to midwifery care. She and her sister, and their pregnancy, have been successfully taken into the care of this midwife. They now belong to a midwife, they have a midwife who is *"theirs"*, who is with them *"the whole way"*. In fact, Roi was never *"late"*, she just needed to make her connections.

It really is 'they'. Roi sees her sister and herself as a unit, already connected. Together they ARE family in this situation and the ones responsible to bring this baby into the world. There is a lack of family around Roi but she has adapted; there is family, albeit re-formed, with Aunty for advice, and sister for support in this new situation (and possibly there were others). What would Roi have done if she and her sister did not have her Aunty with connections? It is hard to find a midwife in many locations if booking later in the pregnancy, let alone trying to do so with no idea who to ask or where to go. What would Roi have done without her sister to support her throughout this time? It is together that they find a midwife, as 'family'.

There are challenges for a woman in her first pregnancy when everything is new, let alone negotiating care in a new country and in an unfamiliar system. For Roi it is a big issue; nothing is familiar. The connections that facilitate finding the way to maternity or midwifery care need to be found from the start. Such connections may become an extension of family, even if they were not family in the beginning. Women adapt and so does Roi; she persists and finds a midwife she can trust. Such trust comes from the fact that this midwife is someone she sees as sympathetic to her situation, someone with whom she can connect, someone with whom she can have a relationship. All of which appear to be helped by the fact that her midwife is a *"Pacific midwife"*. Care from someone of familiar culture and language has been shown to facilitate appropriate care in other health fields (Chang Wai et al., 2010), and the incorporation of "Pacific values and aspirations in their service delivery" (Tanuvasa et al., 2013, p. 720) has been said to improve Pacific women's satisfaction with midwifery care (Walker et al., 2019). I would assume such things would be so much more likely when a Pacific midwife is available to give care.

Roi's story shows that a woman-midwife relationship based on connection can be vital to pregnant migrant women new to the country. Such connections add to, rather than replace, family connections, which are even more important. Roi's story shows family connections are vital, and that connections to care as she experiences have the ability to build trust and replace unfamiliarity with familiarity in the crucial time of childbirth.

5.6 Meeting a Midwife: Tara Moves From Fear to Familiarity

Tara had her first baby in Kiribati in a hospital with some support in early labour from a *te tia tobi*. She had her second baby in New Zealand. Tara anticipates meeting her *I-Matang* midwife, and worries that she might not be understood, not respected.

> *Kiribati people have different thoughts about what they like and what they don't like, but with our people all I know, our privacy, our dignity, or whatever you call it, is a huge thing. Especially my first time having a baby, that was the only bit I was scared of, and I was doing it back home in Kiribati, so it wasn't too bad. …Here, I was scared about meeting the midwife, especially because I could think, she's a Palagi and I'm an Islander. I don't know what she's going to think of me…that's the only thing I could think of, because I had that feeling as well with my second baby here. I felt that I'm from another place and I'm not from New Zealand, and I don't know how she would deal with me and then, is she going to look after me well or, I don't know. All that is what I was looking at on my first day when I knew that I was pregnant, and then I was dealing with the midwife and thinking, 'is she going to…?' I was just a bit uncomfortable with a white person looking after me. I was kind of scared. I'd rather it be someone from my country to do that job for me and then that would…*
>
> *Yeah, that's what I was thinking, but it wasn't a big deal though because I had to deal with it and I had no choice, so I had to rely on someone. I liked the midwife I had. Yeah, I worried, would she respect me, would she understand me if she was not an Island midwife? If she was a different race, then am I, is she….? But I was wrong, because getting to know my midwife, she was so great. She was helpful and a great supporter, and I never noticed any of those things that had given me the idea that I would be uncomfortable with it…When I was doing it back there in Kiribati, I was scared. I had to go to the hospital, and there you don't know the nurses much. I'd have much rather had one of the local ladies, the te tia tobi. But here, you know someone's going to help you with it because you've been talking with her, like the midwife I had. There, it is just the one who's on duty who is going to do it for you. Here, the good thing about it is that you're comfortable that you know who is going to help you on that day. She gives you a lot of advice, like your mum, while you're pregnant. So, then you know your midwife. I like it here, and if I have another baby, I'm going to have it in New Zealand not back there. (Tara)*

Tara explains that, although I-Kiribati are all different, *"our privacy, our dignity"* is a *"huge thing".* In her first pregnancy, even though she was in her home country, she reports that these were issues that made her scared and that it might have been worse if her first was in New Zealand where midwives are of a different race and culture. For Tara these memories resurface and are magnified.

Tara experiences the anticipation of having to choose a midwife and it makes her *"scared"*. In the midwife she sees the obvious; *"she's a Palangi and I'm an Islander", "I'm from another place and I'm not from New Zealand",* she is *"a white person"*, *"not an*

Island midwife", "a different race". Tara's feelings about what she sees show a rising tension and discomfort; *"I don't know what she is going to think of me", "I don't know how she would deal with me", "is she going to look after me well?", "would she respect me?",* and *"would she understand me if she was not an Island midwife?"* One wonders if Tara has heard, seen, or experienced things that makes her think she might get treated badly by a white midwife because of her skin colour or race or culture. Perhaps she has heard of other I-Kiribati women's experiences which lead her to fear being exposed to view, of being shown up publicly (and at this early stage, the midwife is the 'public'), a fear of somehow being shamed. Maybe there is fear of the Kiribati ways not being respected or honoured, or a fear that she, as an I-Kiribati woman, is not respected as having a legitimate standing in this new country, a fear of her wishes and preferences being ignored or not understood. Maybe Tara has a perception that her English skills are not adequate, and this perception exacerbates her fears.

Tara must do something with what she sees and feels. Someone else might choose to listen to her worries and not seek care, or at least not until she has a problem or is in labour. Yet, Tara is brave and pragmatic, makes a choice, despite feeling afraid of what is unfamiliar and not knowing how it will work out. It is a huge step of faith. Perhaps someone less confident might not have chosen to do so, and delayed seeking care because of such fears. In New Zealand, where informed choice in maternity is protected in legislation, Tara says *"I had no choice".* What she means is that she felt she had to do something to secure care for the wellbeing of her baby and herself. As such she had no other choice than to book with a midwife, an *I-Matang* midwife. I wonder if Tara's midwife has any idea what it cost Tara to make this choice. Tara is correct, she had no choice; a real choice would have included being able to choose a midwife who she could look at and immediately feel comfortable with and trust to understand her, perhaps an Island midwife (Chang Wai et al., 2010; Tanuvasa et al., 2013).

In choosing a midwife, Tara finds she has been "*wrong"* to worry as she did. One does not hear what the midwife is like, but it seems Tara pushes herself to "*rely*" on and "*get to know*" her midwife, despite the lack of trust that she has spoken of earlier. Tara highlights what helps to build her connection with the midwife; "*talking with her*", "*someone who is on duty…for you*", "*you know who is going to help you on that day*", "*she gives you a lot of advice, like your mum*". Her summary is; "*you know your midwife*", there is a connection. There is obvious relief in Tara as she relates this part of her story; *"getting to know my midwife, she was so great…helpful…a great supporter",* Admittedly, Tara is talking about a New Zealand midwife to another New Zealand midwife (myself), but the fact that she spontaneously brought up this

story suggests that she is saying what she really thinks. From a position of *"discomfort"* with the unfamiliar midwife, Tara moves to seeing the midwife as someone familiar, who she now feels is like her "*mum".* This story is about Tara experiencing knowing her midwife, connecting with her midwife to such an extent that she respects the commitment of the midwife and places her in a slightly elevated position in which someone can tell you what to do. *"Like your mum"*, there is a closeness, someone with whom a connection exists, with the status of being included in and connected to the family.

That her story is told here is testament to the positive connection Tara made with her midwife. From this positive connection comes a relationship of trust, bringing her from discomfort to being comfortable, from being scared of the unknown and unfamiliar to feeling familiar and confident in the midwife's care. Tara's story is a call for midwives to respect I-Kiribati women, a call to treat them with dignity, and a call to understand what it may cost for them to seek midwifery care. Tara's story is also a testament to the strength of migrant women who, like her, must face the tensions and challenges of finding and accessing maternity care in a new country and culture.

5.7 Missing Support: Marewe is Overwhelmed

Marewe has her first baby in New Zealand. She does not have the support she needs to prepare for her birth, from family or her midwife.

> *I'm a typical Kiribati which means I leave things until late!! I didn't prepare anything for baby because in my culture I've heard from when I was young, back in the Island, the superstition is that you should not prepare the bed of the baby because it can maybe cause bad luck or things like that. I don't really believe that, but also I didn't have help. I didn't have anyone to advise me on what to bring and to prepare. It was only me and my husband and we never had any experience…I remember before my mum came, I just went with what was inside the booklet that the midwife gave me, and I tried to get everything in that booklet! I had an aunty nearby and she was like, you don't have to get it if you don't need it. And I said…I have to get everything. I just went with what the booklet says. It was hard, because if you don't have help and you live here in New Zealand, you're on your own. Everybody else has their own responsibilities, and even though we're relatives we hardly see each other…It became overwhelming when it was nearly my due date, and I panicked about what to do. Especially because I wasn't sure how I would deal with the baby, how I would be at home, how would I be coping with the baby on my own, because my mum's arrival was still not guaranteed; it depended on the visa…So, it became overwhelming my husband and I didn't know how to deal with a baby…I was thinking more about what I would do with baby than about my labour and birth.*

> *I heard from work colleagues about antenatal classes. My midwife…didn't mention any of that to me. And I wish she did you know, because maybe that would have helped me too…maybe she just assumed that I was okay, because in our culture we've got families that can help us. But I thought she shouldn't be assuming, maybe she could have just told me it is there, and you have an option to attend or not, or suggested other things to me. But I think she always just checked how my baby was and then my blood pressure, my weight, and that's it, she didn't really give me all the information for what's out there to help me…Maybe there were no antenatal classes in my area, I don't know. So yeah, maybe because she assumed that I have family support or things like that, but I didn't! (Marewe)*

Marewe follows what she knows of cultural norms in Kiribati in not preparing things for baby too early, although she does not believe in the superstitious reasons for doing so and is not *"late"* for I-Kiribati. On realising the need for preparation she experiences a lack of family support, including an aunt, who does not sound close, questioning information in the midwife's booklet, the only guidance Marewe does have. Marewe's awareness of her lack of family and community support is thus heightened.

In comparing how it would be different in Kiribati, Marewe speculates she would maybe *"get lots of family visiting"*, along with their advice. Tension is raised further as it is not certain that her mother will get a visa and when her mother, let alone her baby, might arrive. Marewe is in an unfamiliar situation and feels overwhelmed by her lack of support; from community, relatives, her Mum who is trying to come, but also from her midwife.

It is not just the family support and advice that Marewe is missing, she regrets she does not have the midwife's support. Despite preparing for baby all she is told in the booklet, perhaps wanting to do what is 'right' or what is 'done' in New Zealand, she still does not feel prepared. There is a gap between how much information she is given and how much she wants and needs to prepare for baby, how to *"deal"* with baby. Having found that antenatal classes exist, there is worry that she is missing out on something that might have helped and that her midwife has not told her about them. Marewe's worry and tension build; she is desperate for more information and support. However, she seems to feel torn between wanting to know why she cannot access these things and not laying blame anywhere, least of all her Pacific midwife. Factually she wonders if this midwife assumes she has adequate family support as a Pacific woman and so does not need classes, or if there were no classes in her area. Astutely she sees that her midwife confines her role to a practical one of checking her health and baby's health.

For Marewe the net effect of this absence of support and information is a feeling of being *"overwhelmed"* and *"panicked"* as the time for baby's arrival approaches. It is no surprise that she is thinking *"more about what I would do with baby than about my labour and birth".* She feels the tension of knowing about traditional ways in which family support pregnant women and experiencing the reality of missing family being nearby. She feels the tensions of being unfamiliar with what 'should' happen or be 'done' in baby care, alongside the uncertainty of arrival times of her mother and her baby. Feeling overwhelmed is shared by others in the migration situation (Benza & Liamputtong, 2017; Goodwin, 2016; Korukcu et al., 2018). Perhaps Marewe also feels torn between wanting to ask her midwife how to access support and information, and is constrained from doing so by cultural shyness. Perhaps too, the midwife has not asked, and Marewe has not said.

Marewe's story encourages all those who support first time mothers, especially those new to the country, to think more widely about what these women are experiencing. While she experiences feeling clinically safe, her wider, holistic needs are not being met. There is a need to recognise the gaps; where family supports are lacking, where there is a struggle to reconcile between expectations and reality, where there are challenges to finding information and support to prepare for birth and baby's arrival. Marewe and others show that midwives *"shouldn't be assuming"* no gaps exist, but to think holistically about their clients and their care.

5.8 Keeping Our Culture: Maria Feels Torn

Maria had her first baby in New Zealand and has thought a lot about how midwifery care should be. I asked her what advice she would give to a midwife who is about to care for an I-Kiribati client, hoping to find out indirectly about her own experience of midwifery care. Maria shares her experience of both accepting the I-Kiribati tradition of having people stay, and personally struggling with it.

> *I think a midwife looking after a Kiribati client should be mindful that there's cultural aspects of a person's life, like with me when I wanted to be on my own in my home. It was when I was just back from working overseas and I was pregnant for the first time. You know there was a lot of family who came. My midwife at the time was experienced and was fine with it, she didn't see it like, 'oh you're in an overcrowded home'. All she said was as long as you're okay and as long as you're safe and you have your own space…*
>
> *…I don't know why, but in (the time of childbirth) I just didn't like a lot of people around me. Maybe it came from being unwell, or from work, but I think it was my social situation that got me. I was living in an overcrowded home, because there's extra children and extra*

> *adults…I had no say in it so I was keeping it to myself so maybe that was one of the reasons, but I couldn't change it, that was my life…*
>
> *…Midwives should be aware that we're quite family orientated people, and so the women's decisions or ideas will probably be based around family, accepting that family will be heavily involved in the pregnancy too, rather than just the mum! Some things were not my decisions but were based on family and I accepted them and understood how it had to be. If I could change any of the things I would but going back on my own culture and my own practices, that would be disrespectful, or it would be out of our practice. My family were quite supportive, and understood…It's all about understanding I guess, making sure that the person is happy with her decisions, and safe and that she's being supported by family…So, I guess it's important to accept that people have a cultural background which will also contribute to their journey, important to accept who we are as well as our practices. (Maria)*

Maria's description of their home being *"overcrowded"* suggests from the start that she is of two minds about accepting the situation. While she is pleased her midwife accepts her home situation, inside she is torn; otherwise, this story would not have been told.

Behind Maria's living situation is the reality that in her culture, she is not always able to make the decisions; it is traditional that some decisions are up to family. Although Maria expresses that if she could have changed things she would, she is very clear that she *"accepted"* these decisions, she *"understood how it had to be"*, she would not be "*disrespectful"* and she would not go against *"our"* cultural practice. Maria's "*our*" is significant; she owns for herself both the family making decisions and the cultural practice of having people to stay when they need to stay. It is ***"our"*** as well as **her** cultural practice. Maria's I-Kiribati traditions are intertwined with her family relationships, which is the basis for her connections and the most important thing she sees she has. It is no wonder she makes a conscious choice to whole heartedly accept her family's social situation, even though there is a part of her which recognises she is torn in wanting to be on her own. She feels one thing but is expected (and expects herself) to accept something different. In the future Maria's child may not face the same experience as their mother, as this experience may change how Maria and her husband adapt their own family culture; but, for now, this is Maria's experience.

Maria's description of her own midwife is positive and that of a respected health professional. There seems, on Maria's part, to be a connection which is supportive; but one wonders what difference it would have made to Maria if her midwife had been judgemental or told her something should be done about the overcrowding. Perhaps no difference, except that of alienating Maria from a potential supporter during her childbirth experience and increasing the tension in an already tense time in Maria's life. Perhaps Maria's midwife is not aware of Maria's dilemma of feeling torn about the

crowded house. Or maybe if her midwife is aware she might encourage Maria to get her own place to live, given the context of New Zealand society's emphasis on individual responsibility and personal choice, while being unaware of the resultant reduction in hands on support and the long-term effect on family relationships.

Ostensibly this is a story about an overcrowded house and Maria feeling torn about her social situation, but it is also about Maria wanting these things to be understood by her midwife. The midwife maybe trusts that Maria would tell her if she has a problem and assumes she is fine because family are supportive. Maybe she does not see Maria feeling torn or does not ask any further. Perhaps Maria does not say because the midwife is Maria's health professional and does not have enough connection for Maria to divulge her dilemma. Maybe this is just an issue which needs to be dealt with at a family, not at a professional, level. The midwife does not feature.

In telling this story, Maria is not complaining but is explaining, eliciting understanding about how it is to be torn but personally accepting how it is. Maria hints that her experience could have been less positive if she were in another, less supportive family where relationships were not as good. She is emphasising that I-Kiribati are *"family-oriented people".* As such, decision making is not always done by an individual but by a family. This, too, is her experience.

Maria's experiences in this story illustrate her message to midwives caring for I- Kiribati women to accept *"who we are as well as our cultural practices"*. She is asking for everything to be taken into account; not just one cultural practice and not just the external appearances, but the whole *"cultural background"* that has and will continue to *"contribute to their journey".* It begins with recognising the relationship between client and family and how important it is to her. Maria is urging for there to be no assumptions, no mere surface understanding, but for those caring for I-Kiribati women to go deeper in understanding the women they care for and their social context. There is so much more about Maria, and others like her, that influences her journey into motherhood and, is yet to be asked about, yet to be revealed and understood.

5.9 Discussion

This chapter has begun to illuminate the experience of I-Kiribati women in their period of childbirth in New Zealand. Threaded through all of the stories is the importance of connections, the importance of family and its relationships, and what happens when these things are changed or challenged.

Family and relationships and connections, and the lack thereof, feature in participants' stories; but there are many other issues which can impact their experience of childbirth. The world around them, the social context into which they are thrown, may be very different. Their stories show a lack of familiarity, anxiety or unease, tensions, a sense of not feeling 'at home' in this new place. However, what also shows is strength; strength to bring change, strength of women focusing on seeking what is best for them and their families, seeking to be 'at-home'.

The philosophy of Heidegger helps to understand participants' experience in a deeper way. Aspects of his philosophy are described in the Methodology chapter. His view of being was more holistic than philosophers who had gone before him, and he believed that a human being could not be categorised merely as a thing or a thinking substance (Heidegger, 1927/1962). He recognised that external or physical things may be easily seen and known, but that a thing is more than "its appearance", "its usefulness", "its physical body" (Harman, 2007, p. 1). There is always more that remains hidden from view, and recognising this leads to ongoing understanding rather than getting lost in static definitions (Heidegger, 1927/1962). The deeper I go into understanding these stories, the more I realise there is more to know, and that one can go deeper than what is observed on the surface. There is much more to be seen in their experiences of childbirth than just outward appearances; they relate a holistic view of their experiences.

Heidegger's (1927/1962) idea of what the structure of 'being-in-the-world' is for a human being is Dasein (human being), for whom its being is an issue for itself, and who goes about life in a sense of "average everydayness" (p. 69). Being-in-the-world is the way Dasein is, not separate from the world, but an integral part of the world around it. Unlike other entities, "Being-in…is a state of Dasein's Being" (Heidegger, 1927/1962, p. 79). Dasein is also characterised by 'being-with' others and 'being-open'. Dasein cannot help but be affected by the world around it. While Heidegger's structure of being-in-the-world and being-with others is lengthy and detailed, he shows that what is most important is Dasein's experience of the phenomenon in question. The experiences of these I-Kiribati women illustrate this. They are in the world where they find themselves, but are not always experiencing a sense of living life in 'average everydayness', because it is unfamiliar. They are, on the one hand, relating to the world and people around them; and, on the other hand, being affected by it. It is an integral part of them and they of it, and alludes to a holism which reflects the experiences in their stories. This understanding calls into question the common western view that people exist only as individuals and are not closely connected or linked to the world and the people around them (Ingle, 2021).

Heidegger (1927/1962) has a term of finding oneself *"thrown into a world*" (italics in original) (p.236). We have been thrown into the place where we are. To our modern ear it is perhaps an appropriately dramatic description, but which is appropriate for what is experienced by these I-Kiribati women in their new land and culture. They may experience a lack of control, or lack of familiarity, in their new environment and would not all choose the tense times or situations they experience. In Heidegger's description of 'thrownness' there is no choice, you are where you are. "Dasein gets dragged along in thrownness", and that thrownness continues to move Dasein on in the world (Heidegger, 1927/1962, p. 400). Such 'thrownness' is exacerbated by being in the mode of not having something, as it is noticed even more (Heidegger, 1927/1962). This is shown by Marewe, who feels her lack of family support acutely.

In a perhaps gentler description of just not choosing oneself what happens, or where one is at a given time, Heidegger wrote of an alternative to being 'thrown'; that of Dasein 'dwelling' and 'being-at-home' because they are familiar with this place and familiar with being in this place. It is "familiar" (Heidegger, 1927/1962, p. 119). In this place where they dwell, they have particular know how to deal with this dwelling and know how to use the sets of skills needed to be in this world (p. 405). Blattner (2006) describes the notion; thus, "We do not just exist or live in a world, but rather *reside* or *dwell* there; that is, we are fundamentally *familiar with the world*", and that "being-in-the-world is our *basic constitution*" (italics in original) (p. 42). If someone is suddenly 'unfamiliar' with their world, does this mean that their 'basic constitution' is under threat or deeply challenged? Dramatic as this sounds, perhaps that describes what some of these I-Kiribati women experience. I imagine the I-Kiribati participants in this chapter would like nothing better than to avoid the tensions shown in their stories, and experience a mood of 'familiarity', to 'dwell', to feel 'at-home'.

Uauang's mother is 'thrown' into a world of tradition, albeit her own I-Kiribati tradition, that neither she nor her daughter are familiar with. For the I-Kiribati women seeking midwives for the first time in New Zealand, the system is not familiar. In Roi's interview she expressed the joy of making the connection with a midwife that was hers, theirs; they connected, and she was familiar. For some participants, such as Tara, it is not pregnancy with which they lack familiarity, it is New Zealand midwives. "Overwhelming" is how Marewe describes being thrown into a situation she knows little about; childbirth, an unfamiliar territory. She has no control and little choice over the fact that she does not have close family nearby. Had she been more familiar with the maternity care system she might have asked more of her midwife with whom she has limited connection. All of these examples exhibit an element of tension at the women's lack of familiarity with the world into which they are thrown. Tension in the deciding, tension in

the changing, tension in the seeking, tension in the lacking, and tension in the challenging of identities and traditions. In this tension, they are not ‘at-home’.

Heidegger (1927/1962) speaks of tension in terms of anxiety, angst, dread, or uneasiness. While ‘uneasiness’ may give a better sense of the meaning, I will refer to ‘anxiety’ as it is more commonly used. It must not be confused, however, with a medical condition requiring treatment. Anxiety, according to Heidegger, is the normal state of being-in-the-world for Dasein (human beings). It is also normal to seek to feel ‘at home’ (Heidegger, 1927/1962).

“Being-in-the-world itself is that in the face of which anxiety is anxious” (Heidegger, 1927/1962, p. 232). He observed that “In anxiety one feels uncanny” (Heidegger, 1927/1962, p. 189). ‘Uncanny’ or ‘Unheimlich’ is translated literally as ‘unhomelike’, or feeling ‘not-at-home’. ‘Anxiety (uneasiness)’ resonates with the mood of tension described in various ways in participants’ stories; and so the description of them feeling ‘unhomelike’ or ‘not-at-home’ appears appropriate. While this may be a normal state of being for human beings, according to Heidegger, for some, like Marewe, it is “*overwhelming*”.

Yet, in the ‘they’-dominated everydayness, Dasein does feel ‘at home’ (Heidegger, 1927/1962). There is, for many migrant women in New Zealand, a sense of trying to get it ‘right’, to do it ‘right’, according to what is supposed to happen. This sense in itself is stressful. One could say this is a desire to follow what ‘they’ say, ‘they’ being the faceless society who dictate what ‘one does’ in order to fit in. It is perhaps more aptly described as wanting to feel ‘at home’. These words were not said by the participants, but it is what I surmise because of the tension or anxiety shown in many of their stories. What complicates any desire to ‘get it right’ for these women is the incredible amount of change they are facing, both in personal circumstances and in their social contexts.

Homelessness is our primary condition and impels us to seek a home (Heidegger, 1927/1962). Other philosophers, such as Augustine and Pascale, have also spoken of everyone having a yearning for something ‘more’ in their inner beings. Heidegger (1927/1962) takes a complicated route to describe this phenomenon, suggesting that such anxiety about ‘being-in-the-world,’ turns Dasein inwards to itself and reinforces its individualised nature of being, still in the world but separate from it. I wonder if this is true for these I-Kiribati women. They may be pushed to use their own resources by their circumstances provoking the anxiety of not ‘being-at-home’, not being familiar. However, such a mood seems also to inspire them to seek connections, to seek what it is they need; not in a passive way, but in a considered way, from a position of strength.

This is perhaps the strength of their identity as women, as mothers, as individuals, regardless of what the world they are in appears to be.

5.10 Conclusion

Participants' stories suggest that I-Kiribati women do not initially feel 'at home' in New Zealand and in their maternity care. However, these stories show strong women working out how to navigate their childbirth journeys and make the connections they need, despite the challenges and tensions of doing so. Perhaps this is a striving to do as is normally done, a desire to again feel as though they are doing just what is 'average' and 'everyday', a desire for things to be familiar, for anxiety and tensions to be eased, a desire to feel 'at home'. While I-Kiribati women interviewed may share this desire with all women going through childbirth, they are faced with particular significant challenges to experiencing familiarity and a mood of 'being-at-home'. They are 'thrown' into a whole new world, which affects the 'whole' of their wellbeing.

Chapter 6: Silence As…

> "And the silence that enfolded me, spoke to me, and spoke louder and more eloquently than any voice…"
>
> (Merton, 1948, p. 321)

6.1 Introduction

How do you tell a story in silence? Every person knows the answer; a person who says nothing is not without thoughts or opinions or feelings. When Heidegger (1927/1962) speaks of the phenomenon and semblance of the phenomenon, he is clear that what you think you see or do not see, what you think you hear or do not hear, is not necessarily how it 'is'. "Indeed, it is even possible for an entity to show itself as something which in itself it is *not*" (italics in original) (p. 51). It can show itself 'as' something it is not. Perhaps this is also true for what is 'shown' by silence. Silence can appear as an absence. It can mean different things to different people, and its meanings can vary from culture to culture.

This chapter presents the findings on silence and something which may give rise to silence, shyness. Some I-Kiribati participants show or describe themselves as being shy in their stories. Some midwives perceive them as such. To attempt to answer 'why' I-Kiribati are sometimes silent or shy has the potential to complete and shut down the dialogue with a definitive answer without really listening to what the individual's silence is saying. There is also a tendency to try to 'fix' the reasons for silence in order to do away with it. The English phrase 'break the silence' is telling in this respect. The question that can more profitably be asked is 'what might be the meaning of silence for these women?' or 'what is this person's silence saying?'

As in the previous chapter, each story is a fresh opportunity to increase understanding about the question of this thesis; "What is the experience for migrant I-Kiribati women of childbirth in New Zealand?" In this chapter I bring stories from I-Kiribati participants and introduce stories from midwives who have cared for I-Kiribati women. In doing so, I remind myself and the reader that our starting place for thinking about this question is the I-Kiribati women themselves. They, not the midwives, are the focus of this research.

6.2 Silence as Meaningful Communication

The first story is one related by a midwife, Sulu, about two I-Kiribati women in the postnatal ward of a hospital in Kiribati. Sulu observes one woman, a nurse, having a conversation with a new mother who is recovering from a recent caesarean.

> *There was a woman lying flat on her back on the bed following a caesarean and with a drip going. The nurse started a conversation with her, and the woman used her eyebrows to communicate. Maybe it was up for yes, and she frowned for no, but it was this incredible dialogue going on between the nurse and the woman. I think the conversation was about would she be happy to have some information about family planning, and then talking about what family planning is and what the methods were and what was available and was that something she would be interested in, and would she like to have that information or get some method arranged before she went home. The nurse was giving her information, and she was receiving the information and then responding to questions by these expressions using her eyebrows. Absolutely incredible! (Sulu)*

Sulu sees that this I-Kiribati woman is able to communicate in depth with the nurse, but in silence. The nurse seems to know what this woman's facial movements mean and verbally communicates a range of information to her. In turn, despite that fact that the woman is not talking, she receives answers from the nurse. From what Sulu observes, there is a satisfactory conversation for both the nurse and the postnatal woman, and the dialogue is concluded.

For Sulu, looking on, it could be easy to assume there is no real dialogue, only one-sided telling and no questioning. The sceptic will indeed say that in fact there is no communication, and the vulnerable woman lying in the bed is just agreeing with everything the nurse suggested. This may be true. Such a one-sided conversation could be mirrored by others held in many New Zealand clinic rooms; the health professional telling and the client (or patient) listening, assumed to have understood and accepted whatever is said. It is indeed possible this postnatal woman was agreeing with the nurse because she could not do otherwise, given the status of a health care professional and the vulnerability of a 'patient' in such a situation. We are not told clearly about the outcome; although Sulu does not appear to automatically assume that family planning was accepted. What is clear is that Sulu saw that the two I-Kiribati women she observed were communicating; one with words and one without words. The meaning of the 'conversation' was not clear, but it was clear that communication occurred. Sulu may not know the language or the meaning of facial expressions but this story shows a wider picture of knowing; interpretation is possible on many levels and through many ways of communicating.

As a midwife working in New Zealand with women from Kiribati, I am reminded that there is more to find than what appears on the surface. It is only by continuing the dialogue that the picture shows itself more clearly. There may be no verbal question from a Kiribati client of her health professional, but questions still may exist. The fact that there is no verbal dissent, may not mean there is assent; and the fact that there is verbal agreement on the part of a client may not mean that there is full understanding from which to give complete agreement. The client's silence is not empty of meaning. The question could be safely asked in every consultation; what is the silence of this person saying to this health professional? Sulu's story suggests that silence can harbour complex communications, much more than is obvious to the outsider.

Silence can communicate meaning without words in a conversation. Silence can also show itself as meaningful ritual for the future.

6.3 Silence as Meaningful Ritual

One way in which meaning can be shown in silence is with action. Several participants spoke about I-Kiribati traditions regarding the umbilical cord. The baby passes a significant developmental milestone when the cord falls off; baby is no longer connected to its mother and is its own self. There is often a family celebration and, for many, though not all I-Kiribati families, there is more. This story is from Roi, who had her first baby in New Zealand.

> *After the umbilical cord drops off someone should wrap it around their wrist and do things with it. Like my sister, she wrapped it around her hand, and she went to school with it. She did her writing and everything with it on. They say it should be worked, so that in the future that kid, that baby can do like what has been done with it. Like writing well or being keen in study. It shouldn't be given to someone lazy that does nothing and sits around all day, because they think that when he grows up, he's going to be like that, and nothing's done around the house. So, every time my sister came back from school, she didn't go straight back to bed. She cleaned and was busy for the three days she had the cord on. It should be kept moving, not sitting around all day. So that's just the way it is, so that in the future the kid, the baby will do the same thing. It should be very active and very clean and do what was being done with it. In the Islands, the fishermen most of the time take a baby boy's umbilical cord when it's dropped and then they go fishing and work on the house and working in the pit and cutting toddy, and doing local stuff, building houses so that in the future that baby will be very keen and very good at those skills. So that's how it's done.*
>
> *Normally it should be that after 3 days, in the old days, some of them they threw it in the sea, so that he's very keen on fishing and he has good catches. Some of them, they buried it beside the church so that he's a Christian boy. Then others, they put it by the door of the*

> *university, and they bury it underneath, so the baby is very keen in learning and succeeds in whatever he's learning. (Roi)*

After the celebration there is more of the process to follow in the belief that it is for the future benefit of the child. The dried piece of umbilical cord is given to someone whose attributes are admirable; whose character, work ethics, and skills are valued by the new mother. The piece of cord (called '*kamwakuria'* in I-Kiribati language) is then *"worked"* by the responsible person or persons who go about their activities. To complete the process, the cord is then disposed of in a meaningful location which reflects where or what the family want this infant to be in the future. The person in this story is entrusted with the cord, entrusted with the future of this little human being. They do not shout about it; they 'do', they *"work the cord"* as described above, setting an example of working diligently for the 3 days, in both the public and private spheres of their life.

While some families may follow this process because they fear that to neglect such a process will bring harm to the child, I have not heard this view in discussions with *I-Kiribati* about the practice. It can be seen as an unspoken, holistic expression of a universal phenomenon; a family's practical and spiritual hopes for their child's future. Families from other cultures may express such hopes in different forms, such as religious ritual as in offerings, christening, prayers of dedication, or in family celebrations.

While there may not be silence within the family about the *kamwakuria* tradition, it just may not be obvious to the midwives caring for the mother and baby. I am mindful that for many years as a midwife caring for I-Kiribati clients, I did not often ask about I-Kiribati customs and unsurprisingly, had not been told much about them. Had I asked, it is likely I would have been told. The rich meaning of such a custom existed but I-Kiribati were silent about it and I did not know until I asked. Perhaps it is assumed that if someone does not ask then they are not interested. Not that the women and their families were hiding the fact that such a tradition exists, or not trusting the midwife would understand, but that it is a family thing.

Silence can communicate meaning with actions which may be unseen for outsiders to the community. Silence can also communicate in ways not easily determined, such as shyness.

6.4 Silence as Too Shy to Seek Help

Silence as shyness (*te mama)* is something I am familiar with as a midwife among my clients. Shyness to an *I-Matang* mind could appear as a reluctance that makes

someone decide not to divulge information, a withholding, a hesitancy which falls back into silence. Then, too, silence could be taken for consent or even appear as there being no problems. However, for I-Kiribati reading Vai's story, which follows, the meaning seen in Vai's silence is not simple.

Vai had her first baby, who had special needs, in Kiribati. Her experienced midwife, Hilda, cared for Vai through her second and third pregnancies in New Zealand.

> *Vai confided to me during that last pregnancy that when she went to the toilet, she had faeces that came out her vagina. I'd had no knowledge of that with her first baby, no evidence that that would be the case. So, I made an appointment for her to see a specialist, and we couldn't really identify there was a problem, but she was quite adamant that it happened. Even when she had the baby, I couldn't see any evidence…but she did have a fistula which was quite high up. I think she didn't really know much about it, but I presume that it had perhaps happened with the baby who had the special needs. She said about how it was a hard birth…She had a repair and it was really quite complicated…*
>
> *So, I think what happened was that she was too shy to say anything to me in that first pregnancy...I just think that it's from their culture they're quite shy…maybe not so much within their own community but when they're interacting with us, with other cultures, they are quite shy. Kiribati women may have anxieties, they may have issues. But they certainly from my experience don't seem to bring them to us…So, she'd kept all that to herself. It was quite a big sort of burden for her to come out with. (Hilda)*

Vai shows herself to her midwife to be shy. Just how shy is only revealed to Hilda when she cares for her the second time. In the first pregnancy when Hilda cared for Vai, Vai said nothing about her problem. Perhaps a cultural respect for her midwife and the position the midwife holds plays a major part and in this Vai is showing a culture of not questioning. In her unfamiliarity with New Zealand culture, she is unlikely to know she is expected to ask questions and speak about her problems. Perhaps she believes nothing could be done and that she should just accept her problem as a normal occurrence after birth. No one knows about what she is experiencing, so no one has disabused her of this fallacy. Another issue Vai may face as a new migrant may be a lack of adequate English words to describe clearly what was happening. There may be other factors in Vai's silence, but she does not say. It may be as simple as Hilda not asking Vai if she has such problems, so Vai has not disclosed them. With little connection and not knowing Hilda well, one can imagine Vai's lack of comfort in talking about something that is so personal. For whatever reason, Vai's experience in her second pregnancy with midwife Hilda is different, and she is no longer silent or shy with Hilda.

Hilda reflects that I-Kiribati women do not ask *I-Matang* midwives about their anxieties. As a midwife, I see what Hilda is saying, having sometimes sensed that clients have concerns about which they are too shy to tell me, even when I ask if there are any questions. However, in the above story, Hilda shows the opposite occurring. Vai does tell her midwife about her anxiety. Vai is an example of an I-Kiribati woman losing her shyness, being "*brave"*, and confiding in her midwife about a serious concern. I wonder, as a midwife, what brings the breakthrough, what is the point at which Vai can express her anxiety to her midwife? One wonders what would have happened if Vai had not had another child and been unable to speak up to a midwife she knew; perhaps she would have continued to suffer in silence.

Shyness may, therefore, have much to say from what Vai's story reveals, but not everyone can be *'brave'* like Vai eventually shows herself to be. Not everyone is in an environment conducive to asking questions, as shown in Marewe's story of feeling overwhelmed in the previous findings chapter.

Silence can communicate meaning behind shyness; but sometimes its meaning can remain unheard.

6.5 Silence as Not Having a Connection

Here, Marewe continues her story about struggling with lack of support in her first pregnancy. She is overwhelmed without support to prepare for birth and learn how to care for her baby. Marewe does not feel she can ask about it from her midwife, who is also silent on the subject.

> *Yes, it was hard, but I didn't talk to her about it. I could have, but I didn't, I don't know why! I'm not sure, but I think it is maybe a cultural thing as well. I-Kiribati people are shy people, they're not very assertive, like me, I'm not confident to ask. But I think that's what was stopping me asking her, because I just went with what she told me and what she advised me. And maybe it's because she didn't have any worry about me because I was very healthy when I was pregnant. I think we didn't have that connection, or rapport. I was just there during her clinic hours and she's the person I had to see to get everything checked out, I was not expecting to be a friend, but maybe more rapport with your patients might have helped. (Marewe)*

While Marewe is very aware of the lack of information and support from her midwife, she does not ask for it. Marewe is a professional person with experience working and living in New Zealand, but her story here is not one of a professional. It is of a first-time mother-to-be. She is also I-Kiribati, and she tells me her shyness is a cultural thing. She is not assertive in this situation, not confident to ask questions, although she appears a confident person.

Marewe summarises well how she could have received more support from the midwife, which would have helped her to ask questions; *"I was not expecting to be a friend, but maybe, more rapport …might have helped",* a *"connection".* Marewe also links her midwife not asking, assuming she is fine, to their lack of *"connection"*. Midwives in New Zealand are responsible for initiating 'partnership' with their clients, a connection between the midwife and the client in her care, as has been discussed in the Introduction chapter. Marewe may not know these details but her story expresses that she knows such a connection, some form of relationship, is preferable.

Such a client-midwife connection is not easily developed in the context of appointments where the focus is clinical well-being and nothing else. Perhaps Marewe's midwife assumes there is a connection and would be surprised at no questions being forthcoming or that Marewe feels she has missed out. The midwife may think that Marewe is free to ask anything, as she herself may have done so in her own pregnancies in the New Zealand maternity system.

If Marewe finds it hard to express to her midwife that she has need for more information, one wonders what it is like for other young I-Kiribati women who are less articulate, and how they voice their needs and concerns, especially if their midwives are *I-Matang*? Women with less skill in the English language may struggle to put their questions into words, let alone voice them. Shyness may be from wanting to not 'get it wrong'. Women from a health system such as Kiribati, where minimal antenatal and postnatal care is offered might struggle to know what they can ask support with, or how to access maternity care (S. Marshall, personal communication, June 12, 2019).

In Marewe's story there are elements of Vai's story. However, whereas Vai's shyness with her midwife Hilda decreases with time, Marewe's shyness remains throughout her pregnancy; she does not say anything to her midwife about her concerns. For both Vai and Marewe there is a sense of connection being sought. While Vai and Marewe both have concerns which are very important to them, and both have midwives with whom to potentially make a connection, only Vai is successful. There must be something which makes a difference to these I-Kiribati women's level of confidence in approaching their midwives with their concerns. Marewe tells us it is about the woman-midwife relationship, their *"connection"*, their *"rapport"*; or lack thereof. Such a connection may have helped Marewe voice what she finds difficult to express, but she remains silent on that which concerns her.

As a midwife, I can think of many times when I have met with shyness in a client but I do not remember thinking much about the meaning of being shy. I might wonder if my

client has understood the information I have given rather than ask, ‘what does this person’s silence mean to them?’

Silence can sometimes communicate a meaning that remains unheard. Silence can communicate uncertainty.

6.6 Silence as Uncertainty

Violet, another midwife, tells the story of Rata, who moves to her care late in pregnancy from a midwife in another city. Rata is living with her cousin, who is to be one of her birth supporters and who attends her clinic appointments.

> *She was already planning to birth at a birthing centre… I presented the options as we’ll continue with that plan, just in a different birthing centre, and if we need to, for any obstetric reason, there is the hospital. And she’d gone “yes, yes”, and agreed with that. So, then we talked about the fact that she could actually birth in the hospital if she really wanted to but there was no need, and she was happy to come here to the birthing centre. That was always fine until we got a bit closer to the end, and the cousin she was staying with said, “oh no, in this place we just birth at the hospital”. I was taken aback. I thought, oh I haven’t explained this properly. So, I talked about the primary unit and the hospital again, and said, “she does have the choice to go there, but she doesn’t need to”. Rata wasn’t confident that her English was fine, so she’d let her cousin do the talking. So, I tried to engage her, are you happy with that plan to continue? She said “yes, yes, yes” and her cousin accepted it, but I could tell her cousin still wasn’t happy about it because she crossed her arms and leaned back and wasn’t smiling. She was not convinced, not until they came for an appointment here at the birth centre. And then they looked around at everything and they went oh, okay! (Violet)*

Rata, an I-Kiribati woman faces challenges which include unfamiliarity with both English language and the New Zealand maternity care system. Violet reviews the plan for birth and Rata says, *“Yes, yes”*, seemingly *“happy”*. However, later in the pregnancy, Rata’s cousin questions the plan with, *“in this place we birth at the hospital”*. With further discussion, Rata again says, *“Yes, yes”* to birth at the birth centre. While verbally Rata’s cousin is accepting this, Violet suspects that she is *“not convinced”*; in silence, her body language speaks loudly. As Rata’s closest female family member at the time, Rata’s cousin is fulfilling her role, a motherly role, a caring-for-family role, of making sure Rata gets the best care possible. Her care for Rata is vital in the consultation. She takes care of Rata by questioning the midwife’s plan.

In this story, Rata and her cousin are family, and while neither say a lot about where to birth, Rata’s cousin expresses her view strongly. Maybe she gave birth at the hospital. If things went okay for her there, her experience tells her hospital is normal. There is, therefore, a strength in her testimony because she knows the hospital, she has birthed

successfully there. If Rata and/ or the midwife choose a different place, then the cousin might find it harder to give good support as she does not know the place or the system, does not know what to expect, nor what is expected of her. Alternatively, it is possible that Rata's cousin remembers a story of her own which has left her with a lack of trust in the New Zealand maternity system. She could have experienced having decisions made for her by health professionals which were not what she would have decided for herself.

Rata's cousin may think that a birth centre is not as good quality care as one finds in a hospital setting, and may be concerned that New Zealand midwives are like I-Kiribati traditional midwives, *te tia tobi*, who have no formal training and only birth women at home, a primary setting. In Kiribati, hospital birth is encouraged, if available. Hospitals have more people with qualifications, nurse-midwives to help women to birth (Ministry of Health & Medical Services, 2015). Rata's cousin may assume that properly qualified midwives in New Zealand also work only in hospitals, and so worries about having Rata's midwife for birth. She may also want to fully embrace all that New Zealand medicalised health care offers, a hierarchy of what is best care, peaking at 'hospital care'.

It is possible that Rata's cousin knows nothing about any of these reasonings, and I suspect that her response *"we birth…"* is exactly that. It is what we, I-Kiribati women, in this area do. Pacific women in a small New Zealand study were asked about their choice of birthplace, hospital or birth centre; hospital was what was known, it was convenient, and it was what the community did (McAra-Couper et al., 2018). This may be so with Rata's cousin's response.

Rata is central to this story but she must feel torn in this place of birth discussion; should she choose what her cousin knows or what her health professional knows and recommends? Maybe she wonders what the midwife really thinks because the midwife keeps saying that Rata has a choice, as though it does not matter or as though the midwife does not even know which is best. Perhaps Rata solves the dilemma by thinking that she just wants to have a baby and agreeing that the 'right' choice is what she believes her midwife thinks is best, trusting in her midwife to know her job and to do her job in Rata's interests. For Rata then, maybe it is not so much a choice of birthplace, as a choice to trust that what the health professional thinks is best will, in fact, be best for her. Again, I wonder if Rata's reaction is actually undecided, that her *"Yes"* means 'Yes, I respect you Violet in your position as midwife, but we will see where my cousin takes me to birth on the day of my labour; because she is the one I am closest to, she is my family, and I am in her hands'.

In the end it appears, on the surface, that the decision of where to birth is made by Rata with her midwife; but, in fact, the role of family, namely her cousin and possibly others (the *"we"* who birth at the hospital), is vital for Rata. This story appears to show that for Rata and her family, doing what is normal and right is what is important; possibly that safe care, at least care that is known, is the most important thing. This may indeed be the case, as once they have seen the birth centre facilities, the birth centre plan is accepted. Rata's cousin has the answer to her questions. Violet was uncertain what Rata's cousin really thought but, in the end, she was clear; Rata's cousin was certain, and she agreed with Violet.

Silence can communicate uncertainty, and silence can communicate respect for the perceived hierarchy.

6.7 Silence as Respect for Perceived Authority

Maria came to New Zealand with her family as a child. She is a university graduate, and has given birth to one baby in New Zealand. Maria talks about reasons for shyness.

> *In our culture, as I have learned from my experience with my family and my elders, when they are with an I-Matang (white person), they look up to the person so much, and think they are so important, that they can't speak to them. I think it's to do with colonisation. When they used to live with the British, they said that they were so important, they lived separately from the Kiribati people, and people didn't really interact with them because they were so superior. I think that until now, Kiribati people still have that kind of mindset, that the I-Matang is the important one! And that's why sometimes it stops them from communicating what they need, or what they want to know, or share what they think, because to them, they're not on the same level. It's complicated, but that happens too in the workforce, and when you go into the hospital or to the GP; you see a white person and you feel like, I need to talk to them on their level, but I can't because I don't really speak English. Things come through your mind like that. But it's about understanding and speaking plain English words, that are easy to understand. Even me, and I'm a Uni graduate, up until now I still struggle to remember the medical terms that are being used on me in my pregnancy and birth. It's a different language again; it's medical terms and I feel bad that I don't know them, and how am I going to explain myself in English without really explaining those medical terms that I don't even know? For other Kiribati women who are newer to English than me, I always wonder, how are they coping? How are they explaining themselves? What they're going through? It's so hard, and sometimes that's why they prefer not to talk. If they are asked, Are you okay? Anything to say? It's still hard to comprehend, how do I word it, what words do I say? And sometimes, too, medical people they forget that they're talking to people who have English as their second language. That's why when I experience things and my midwife says medical terminology, I say what's that? It's just a whole different level of talking. (Maria)*

Maria speaks about communicating with I-Matang from a personal point of view. It is not some theory but comes from her experience and that of others she knows. Maria summarises; "*until now, Kiribati people still have that kind of mindset, that the I-Matang is the important one!"* The implications for the present are important; (that mindset) *"stops them from communicating what they need, or what they want to know, or share what they think, because to them, they're not on the same level"*. Maria suggests this to be true when receiving healthcare, when at work, in many places. Those at the top of the perceived hierarchy make the rules for what language, what jargon is used, and what can be talked about.

Maria, herself, has difficulties understanding the medical terms in her own pregnancy, and she has decided not to learn them but to just ask for explanations as needed. If this difficulty is true for Maria, a university graduate fluent in English, how much more is it an issue for those who do not have a strong grasp of the English language. Maria wonders how other women less confident in English manage to ask explanations for the terms they do not understand.

Medical terms and health jargon help health professionals to communicate easily but can be a barrier to understanding for lay people; even more so if the English language is also a challenge, such as for some I-Kiribati women. The indiscriminate use of jargon that is not understood has potential to keep women 'unfamiliar' with meaning, and to silence their questions.

For someone who has never been pregnant before there are added challenges as it is 'all' new. If I-Kiribati women are challenged in this way, it is understandable to imagine that they have few questions. Maria can ask what words mean, but for another I-Kiribati woman, less fluent in English than Maria, and less confident of her position in relation to the midwife, less certain of New Zealand culture and the 'rules' for communicating with New Zealand health professionals, it must be hard. Even if such a woman were confident to ask the meaning of a word, a sentence, or for an explanation, she would not necessarily understand a detailed answer.

Maria shares her analysis of her historical cultural background and that of other I-Kiribati women. She describes a silence on the part of Kiribati women that is full of history, knowing one's perceived 'place', a desire to communicate that is often kept hidden, an absence of language skills, perhaps also a fear of misunderstanding, fear of being misunderstood, or fear of getting it 'wrong'. In her story, Maria indirectly encourages Kiribati women to ask more, and encourages health professionals to speak in plain English.

As a midwife, do I ever think of myself as part of a hierarchy when I am consulting with a client for whom English is not their mother tongue? Do I ever think of myself as having a position of power when I am faced with a client who appears uncertain, and from whom there are no questions? Do I assume that a lack of verbalised questions means that none exist? And do I ever remember that I have a colonial heritage when I speak with a client whose heritage is one of coming from a former colony? My initial thought might be that it should not matter, we are just two people together trying to communicate. However, given what Maria is saying, perhaps that is just the *I-Matang* view. Maybe it is that professionals of the predominant culture do not always have a historical awareness, an awareness of their pre-understandings and from where these come.

Silence can communicate respect for perceived hierarchy, and silence can communicate acceptance of a process.

6.8 Silence as Assumed Acceptance of the Process

Grace is an *I-Matang.* She speaks about an I-Kiribati woman for whom she is midwife. Her client, Erana, had previously birthed one child in Kiribati.

> *Erana had inductions for all her babies. There wasn't a lot of dialogue around birth. She just wanted me to tell her what to do, I guess. There wasn't a big birth plan or anything. She didn't have anybody with her at her births, no partner with her… She'd sort of shrug when I asked if she wanted this or that or the other thing. I guess Erana submitted to the process, whereas other women might kind of fight the medicalisation a little bit more. She didn't really fight it, she just wanted to get the baby out. She didn't do anything in particular during her labour. She was very still. Erana had to be monitored and she would just lie down and get on with it very quietly… I think Kiribati women generally birth quite well. I find that all of those I've looked after in labour are quite silent, and it's very hard sometimes to even know if they're having a contraction...So quite quiet, not complaining, just getting on with it I suppose. (Grace)*

This story shows Erana to be unsupported by family in her labour. With just the midwife, is it stressful having to think so much in English? I wonder how lack of family support affects Erana's experience of this birth. It is not shown here but Grace hints that maybe Erana was just thinking about birthing her baby.

Grace makes observations about her client in labour. Erana is quiet and this may be because she feels shy to express herself or it may be that she does not have anything to say, there being no other option apart from submitting to and enduring the labour, as Grace suspects. Grace does not mention the tradition of not crying out with the pain of labour (see the stories that follow), so maybe she does not know about it, although

Erana may do, and remember being told not to cry out in previous births. When Erana is not being vocal, something must be happening inside; even if there is calm externally, there may be turmoil internally, made even more unfamiliar by the strange birthing environment, the new country, and birthing with no family members present.

There will always be assumptions made by others of those who remain silent. Sometimes these assumptions are right and sometimes they are not right. Having assumed that Erana wanted to be told what to do, Grace does just that. Grace does not see or hear anything that contradicts this assumption, so it is natural for her to think her assumption to be correct. Having birthed in Kiribati, where I am told it is common for I-Kiribati midwives to be directive, Erana perhaps expects to be told what to do. She offers no resistance to her *I-Matang* midwife. As Grace surmises, it is as if Erana submits to the labour process and to being directed by her midwife. Only Erana really knows.

Grace speaks of her general observations about I-Kiribati women in labour. She thinks that "*Kiribati women generally birth quite well".* Grace describes the women as being "*quiet," "not complaining", "just getting on with it",* in labour. She is perhaps noting that, while there is no lack of pain, there is a difference to other women in the way the pain is expressed; and it is not obvious to Grace whether or not her I-Kiribati clients are in pain. As a midwife, Grace sees this as positive, as a coping with the pain of labour, and she sees a submission to the process.

Thinking as a midwife myself, I wonder how often I have taken a woman's silence during labour and birth to mean that she is coping well. What are women really thinking? Are they really coping or are they hiding their pain? Are these women being strong? Are they immobilised with fear to speak? And can a midwife know if a woman's silence is really saying she wants to be told what to do?

Silence may communicate assumed acceptance of the process and silence may communicate a semblance of strength and avoidance of shame.

6.9 Silence as Being Strong and Avoiding Shame

Uauang has had two births in Kiribati, one in hospital and one at home, as seen in the previous findings chapter on the Experience of Tensions. Her younger sister has arrived in New Zealand near the end of her pregnancy to stay with Uauang, and Uauang supports her at her first birth.

> *To help my sister in labour I was just being, I have to say, sarcastic….*
> *I said to her, "I can give you words, but words cannot get you through this. This is on your own, you need to get it, you need to do it on your*

> *own". So, I said what my mum used to say to me. "You need to be strong because only you and you alone can give life. I, I'm just here to support you but I cannot share the pain. I cannot give you strength, but you know me, I'm here at all times". So in between she smiles and then her pain comes through again.*
>
> *What I was doing with my sister was a bit like what my mum was doing with me, but mum was more of a softie. She'd be like, "You've got this, you can do it". But me, when my sister said, "I can't make, I can't, I can't bear the pain I want to cry", I said, "You know if you cry now, you're wasting your energy on tears, and if you cry now trust me how many more babies you're going to have, you're going to cry through your labour all the time. And in Kiribati that's fine, you'll be mocked if you cry during birth because they'd be like, 'Oh they can get the baby in, but they can't get the baby out!'" We have that saying, "You were smiling then, now you're crying!" The nurses and midwives working at the hospital in Kiribati would definitely have that attitude as well. Some, they wouldn't say it, but the more respected ones, because they're older they feel, you know culture, and they can say anything. There are those kinds of sayings which are true, there is a point to them. Like you have to be strong and all. (Uauang)*

Uauang shows that she knows her sister well. She explains to her sister what she needs to do, echoing the words that she had heard from her mother with her own babies; *"I can give you words, but words cannot get you through this".* Uauang tells her that she is on her own and *"you alone can give life".* Uauang reiterates that she is her sister's support and will continue to be there but can neither share the pain nor give her strength.

Uauang shows sincere and deep care in her words. There is much contained in what she says. Like how her mother supported and 'mothered' her, during labour, Uauang takes on the role of 'mother-figure'. In doing so, she utilises her personality and makes the role her own.

The consequences of crying in labour are detailed in Uauang's account, as though there can be no contradiction. *"If you cry"* you are *"wasting your energy"*, you will cry the same through all your future labours and *"you'll be mocked"* by everyone, including health professionals. The implication of not having enough energy, is that the baby will not be birthed in a timely fashion, which is a safety concern for mother and baby. If not for herself, the woman in labour needs to be strong for her baby. The implication of crying now, leading to crying in labour in the future, is mentioned elsewhere as an accepted belief but no explanation is offered. There is an assertion by Uauang, and from other participants' comments, that a woman who makes a noise or cries during her labour will automatically do the same with future births. This is not something I have heard from New Zealand midwives. Its origins perhaps go deeper than even

Uauang and her mother know, perhaps a part of Kiribati tradition that is hidden from public view and kept silent.

Crying will also bring mockery. The phrases *"you were smiling then, now you're crying"*, and *"oh they can get the baby in, but they can't get the baby out"* are owned by Uauang as being common. Is there something in such comments which indicate a belief that the birth of a child should be in private, just as its conception is a private happening? Something which should not be broadcast in public? For some, the comments bring laughter; but behind the laughter there are perhaps other meanings of a deeper nature, such as reference to the sacredness of birth and, as such, one does not bring attention to it. However, Uauang does not speak about a deeper meaning of crying out in labour and birth; just that it should not be done. The fact that she does not say anything about it, however, does not mean deeper meanings are absent.

In New Zealand contemporary birth culture, midwives can be heard responding to a woman crying in her labour, especially when pushing, with the exact same phrase as Uauang; *"you are wasting your energy on making a noise"*. The energy should not be wasted by making a noise but directed into pushing the baby out. This idea surfaces in other participants stories. I have also heard mocking comments from some midwives as they hear a woman crying out in labour. While this, too, might appear to be universal, it would be erroneous to assume this response to crying out in labour has the same meaning as that of I-Kiribati culture.

As a midwife in New Zealand, it seems that a woman's silence in labour is because she is being strong. I wonder how often women in labour who cry out are thought to be not strong enough, not coping, wasting their energy, or even seen as annoying. It may be that sometimes women are offered pain relief at this point, for themselves or for their midwife's relief. There appears to be a universal assumption that crying out in labour shows weakness, and that it can be mocked; perhaps also a universal unspoken convention that such expression should not be public.

Silence can communicate a semblance of strength and avoidance of shame; silence can also communicate hidden pain.

6.10 Silence as Hidden Pain

Tara's first baby was born in a Kiribati hospital. Her second baby was born at home in New Zealand.

> *In my first labour…I tried not to cry hard. There was one lady…, who came, and the baby just came out. But the way she cried, she was screaming out, and everybody could hear it from outside and*

> *everywhere. The nurses were saying, "You stop that", and the husband was enjoying telling her off. It was so annoying! And I just didn't want to hear someone to say that to me! I thought, I'd better not cry like her. I had had that pain so long and I had had enough. There was nothing that made it better, I just had to deal with it. And that's what my Mum kept saying, "you can't get help from anyone. Once this baby comes out the pain will go". I just couldn't wait for the baby to come out of me…*
>
> *For my second baby the only reason I chose to birth at home here was because I didn't want to be in people's sight. When you are in terrible pain and there could be people walking around or something like that, I'd rather be just by myself at home and be crazy! In the end I wanted to keep my voice down because the midwives were trying to have a rest! I was trying hard not to make any noise! I just wanted them to sleep until they had to get up for me. Every time the pain came, I was like trying to grab my husband! It's like I was going to kill him but no, it was just the pain. I was screaming in his face, but not in a loud voice, nobody heard it. And then, it was getting harder and harder and then the midwives had to sit with me.*
>
> *I heard the midwives telling my cousin, it was so painful but looking at her she's just not in pain! And they were saying that I was just so strong, and not screaming with pain, I just kept it in me. Nobody had told me you should not make a noise with the pain. I just had in mind that my Mum told me that it's your load, and no one can help you. And if you're going to cry, then you're going to get weaker, because you are just focusing on pain. I just kept thinking during all that time about being positive, telling myself I'm going to do it, I can do it, pushing myself to do it, and thinking it's going to be good afterwards, when the baby is going to come out. (Tara)*

Tara remembers her reaction, in her first labour in Kiribati, to hearing another woman *"screaming"*. Tara hears the woman being told off, and she thinks *"I'd better not cry like her"*; she does not want the same things said to her. Tara appears to work hard to do the opposite. Rather than vocalising, she tries to suppress her reaction to the pain. The public nature of what is happening to the woman she has heard stands out. Tara does not want this for herself.

While Tara has *"had enough"* of the pain, she admits that she *"just had to deal with it".* In this she echoes her Mum, *"You can't get help from anyone".* This is similar to Uauang's admonition to her sister. Tara's Mum offers the encouragement that the pain will go *"once the baby comes out".* Tara *"couldn't wait".* Tara reaches her own conclusion, that she should not express her feelings of pain vocally in labour.

Her Mum's words return to Tara at her second birth, as Uauang's mothers words returned to her as she cared for her sister; that *"no one can help"* her, and "*if you're going to cry, then you're going to get weaker, because you are just focusing on pain"*. Instead, Tara focuses on being positive, encouraging herself that the arrival of her baby

will be the end of the pain, as her Mum has said. Her Mum is still with her; although she is not with her in person, she is a silent voice speaking to Tara still.

Tara's choice of birthplace in New Zealand is home. She speaks of wanting to be private and not wanting everyone to see her or hear her in pain. She does not want to be like the woman whom she heard crying out during her own first birth, at least not in public. She wants to "*be just by myself at home and be crazy!",* to make a noise if she wants. Ironically, it is in her own private home that she must try to keep quiet, as she does not want to be heard by the midwives sleeping there. The assumption of the midwives is that Tara is "*just not in pain!",* that Tara is *"just so strong",* as she is "*not screaming with pain"*. In fact, Tara was grabbing her husband so hard that she felt as though she was *"going to kill him but no, it was just the pain".* She felt and expressed the pain but only to her husband, *"I was screaming in his face, but not in a loud voice, nobody heard it".* Her screams are silent to the midwives attending her. Tara is either listening to her mother's advice and not wanting to cry out and become weak, or else she is just thinking of the midwives' need to sleep before they help her at the birth, perhaps both. However, her reason for not crying out loudly may not be because anyone told her she could not, but because she just feels that it is not something she should do in front of others; it is something she does in private, with those closest to her. Crying out loud is for a private setting, such as her own home, and when she is alone. The presence of the midwives at the Kiribati hospital at her first birth, and now in her home at her second birth, mean that both births are in a public arena. Tara remains (mostly) silent and saves her energy for the birth of her baby, looks forward to its' arrival.

As a midwife looking on at Tara's New Zealand midwives who are sleeping, while Tara is establishing in labour, I wonder if they know how she feels. Perhaps they know nothing of Tara's reason for homebirth being that she wants to have her baby in a private place where it is possible to cry out in privacy. The midwives are probably still impressed at Tara's composure, as she does what is "expected" for someone who is "strong" at their birth. How often do I take a woman's silence in labour as a 'coping' and a woman's noise in labour as a 'lack of coping' or 'out of control'? To be honest, I have not often asked the question, but have assumed that silence equates to 'strength' during birth.

Silence can communicate hidden pain, and silence can communicate fear of the consequences of crying out.

6.11 Silence as Fear of Consequences

Amy Veronica births her first baby at a hospital in Kiribati.

> *With my first-born baby, my Mum was there. Some of the mums around they cried, but for me I didn't cry. If you're crying you just waste your time. You can't get rid of that pain, even if you cry. When I was in pain, my Mum, she had a stick and she said, "if you cry, I'll smack you! Don't cry!", and "if you cry, you will get tired and you just have to face that pain, you won't be able to push the baby out". Yes, if you're crying that doesn't help you stop the pain.*
>
> *She was saying this because she didn't like the baby's dad. They kept telling me when I first met him, they warned me, not to go with him, not to marry him, but I still married him. And that's why she was so strict. If she had liked him, she would have gone with the flow, just let me cry if I wanted to... If my Mum hadn't had a stick and was telling me not to cry, I would have cried, because I couldn't face that pain. But I was scared at my first birth, I was scared of my Mum, so I didn't cry… And she said if you cry, I'll smack you because that doesn't help. It makes you more tired and you're going to get in trouble or something. But I think she was a bit worried as well for me, that I would cry and there would be no energy for me to push the baby out, that crying would use up all my energy.*
>
> *They think it is bad in the Island if you cry. Most of the mums, they try not to cry in labour, because a lot of people there will laugh at you. They think, "why she's crying, she wanted to have a baby and then she cries!", "No one will help her with the baby so why is she crying?" "She wastes her time to cry". For them you look funny if you cry. … Yeah but if you cry for some other reason, people don't mind.*
>
> *When I had my second baby, in New Zealand, I could hear some of the mums crying in the next room. Oh my gosh. That's why my midwife said, "oh you're doing good, you don't cry, you're doing good". I knew it was so painful, but I was trying to face it and control it. Yes, I was focussing on that, and focussing on getting the baby out as soon as I can!*
>
> *Some of the nurses at the hospital in Kiribati are the same! There is just one birthing room, so you make a noise and are loud, people get annoyed with you. They say, "oh look at her, she can't control her pain". It's so different from New Zealand! Some of them, they don't encourage, or they don't support the pregnant woman. It's easy for them to judge. I think to me, it's not good. The other thing is, they should have a private room for pregnant women so they can have their own space. If they want to cry, they cry, and they don't annoy other people.*
>
> *In Kiribati there are no other ways that can help me with the pain, you have to face that pain through the labour. Here in New Zealand it's good. With my other babies, I had an epidural. Because I just thought, I'm getting older and I just couldn't quite handle the pain. So, they gave me the epidural to face that. In Kiribati there's nothing while I am in pain. Here I had some gas, and they warmed up the wheat bag and put it on my back. In Kiribati no there's just no way you'll get that. It's just so different. (Amy Veronica)*

Amy Veronica brings up the subject of crying in labour; "*for me I didn't cry".* As her mother before her, she sees it as a waste of time, that it is pointless, as you "*can't get rid of that pain, even if you cry",* and, if you cry then there are consequences. Amy Veronica would be smacked with a stick if she cried and is told she "*won't be able to push the baby out"*, that it would make her lose energy, be more tired. Alongside this, Amy Veronica sees that her mother is also worried about her.

That said, Amy Veronica concedes that if her mother had been supportive of the relationship in which this child was conceived, she might have allowed her to cry and there would be no stick. In such a situation, Amy Veronica thinks that if she were allowed to cry, she would have cried, "*because I couldn't face that pain".*

A little later in the conversation, Amy Veronica mentions that another consequence of crying in labour is that "*if you're in labour and cry they will laugh at you".* They laugh because *"you look funny"*. There is only one birthing room at the hospital, "*so you make a noise and are loud, people get annoyed with you".* Crying is not accepted, and the reason is tied up with all of the consequences mentioned.

Perhaps it is as we heard in Tara's story, that birth should just be private; and if physical privacy is not possible, then quiet must suffice. Needing to face consequences may also account for the reaction of Amy Veronica's mother being strict. She does not want her daughter to cry in labour. Maybe she does not want public attention to be drawn to her daughter. Maybe there is shame about a baby who has been conceived in a relationship not favoured by the family. Maybe, as she sits with her daughter, in her mind is the thought that the labour pain is a punishment for going against family wishes. In this story we are not told.

Laughter at women crying out in labour may be a sign of embarrassment at hearing the crying and what it represents; the knowledge that the origin of the pain is in the intimacy of the conception, and the powerful showing of its result, the birth of a baby. A negative view of crying in labour may have also been reinforced by the literal Christian belief in the bible verse in which God says to the woman in Genesis Chapter 3 Verse 16 (ESV), "I will surely multiply your pain in childbearing; in pain you shall bring forth children". This verse implies, to some in the Christian world, that the pain of labour is decreed by God so the woman should accept it without complaint. While the majority of I-Kiribati identify as Christians, none of the participants volunteered this interpretation as the reason for silence in labour.

Amy Veronica advocates for privacy for women who are birthing. This means that the women can then choose how they will respond to the pain of labour so "*If they want to*

cry, they cry, and they don't annoy other people". She recognises that there are more options and, therefore, more choice in New Zealand than in Kiribati. In New Zealand there is privacy, there is gas, wheat bags, and epidurals. She is an advocate for informed choice of pain relief in labour. I wonder how many midwives assume incorrectly that women do not want pain relief because the women they are looking after are silent in labour.

Amy Veronica's midwife's attitude to crying in labour has similarities with those in other participants' stories, both New Zealand midwives and I-Kiribati women; she does see not crying in labour as positive, a sign of coping or, being in control. Was her midwife aware of any fear of consequences? On hearing the other women crying in pain and observing that Amy Veronica is not crying in pain, the midwife compliments her, *"you don't cry, you're doing good".* This midwife's encouragement may originate in the belief, in much of Western culture, that not showing emotion is good and being in control is good. Therefore, the midwife may think that silence shows Amy Veronica is coping with the pain. This may be true but the pain is severe enough for it to be a strong negative feature in Amy Veronica's memory of her labour, and for her to choose epidural in her next two labours. I try now to remember how much information I have given to my clients about pain relief options, and wonder if I have given this to everyone or have I assumed that some, such as I-Kiribati clients, will 'cope well' with the pain, will be 'silent' and 'strong' in their labours? One wonders what role the community idea of what is 'done' plays in both New Zealand and I-Kiribati women's decisions of where to birth and what to do for pain relief, and whether or not it is really the information or relationships which make the difference in such decision making.

Silence can communicate fear of the consequences of crying out, and silence can be questioned.

6.12 Questioning Silence

Can silence say?

Can silence show?

Does silence hide away?

Is silence what 'they' say? what 'should' be done?...

…What do I, as midwife, do with silence?

Give it a name, say this is that?...

…I wait to listen; it will speak.

(Poem by Kathy Carter-Lee)

6.13 Discussion

There is meaning in silence. Silence can exist for many reasons and serve many purposes. The stories in this chapter have highlighted that even in silence there is the possibility of communication. Meaning can be sought in the participants' stories by asking, 'what is this person's silence saying?' Sometimes the meaning is revealed. This discussion builds on what participants' stories have shown about silence and is further developed by what others have written about how silence 'is'.

Silence is complex. There can be silence that positively speaks through actions, as in Roi's story about her baby's cord, whether or not it is heard by outsiders. Midwives communicate to clients through non-verbal opportunities to 'show' what care is possible. While one wonders sometimes how actions are interpreted, they can overcome the need for 'talk'. Heidegger recognised that people show what they are by their actions much more than by what they say. How we perceive others also depends on how they show themselves to us by what they do. "In that with which we concern ourselves environmentally the Others are encountered as what they are; they *are* what they do" (italics in original) (Heidegger, 1927/1962, p. 163).

Sometimes silence indicates the presence of tensions, as seen in the previous findings chapter. Maria chose to keep silent with family about her own feelings out of respect for her cultural traditions; Marewe was silent and did not question her midwife about how to prepare for baby. Tensions are raised when a midwife wrongly assumes the meaning of the silence, as with Marewe's midwife, who assumed everything was fine when it was not.

The silence of shyness may mean there is a value of respect, a politeness being shown; yet, it may also mean there are unanswered questions, even serious unmet need, such as in Vai's situation with the fistula. Such silence waits to be broken. The silence of shyness may be waiting for connections to facilitate communication before answers are found, and it is clear that connections are important to the I-Kiribati women interviewed. Marewe, articulate as she is, does not feel able to ask questions of her midwife, saying "*Kiribati people are shy people, they're not very assertive"*. Do midwives see shyness? Or do they assume silence means agreement with all they have said?

From a western perspective, it might be assumed that an individual can choose to speak up or remain silent. Such 'choosing', however, may not be easy if one has been brought up in other cultural ways. Namoori-Sinclair (2020) wrote in her thesis that "*Te aki kakarongoa* or silence is part and parcel of *te mama* (shyness)" (p. 154) in the I-

Kiribati culture, as revealed in the stories in this chapter. “Parents teach their children from an early age to respect their elders. It is forbidden for a child to answer back to someone older …and anyone with authority” (Namoori-Sinclair, 2020, p. 56). “Kiribati people are brought up to be respectful and humble, so *te mama* and *te aki kakarongoa* are another way of demonstrating respect …” (p. 182). They may avoid asking questions in public in case they are mocked, especially in front of an *I-Matang*; there is concern about being judged or laughed at, or being seen to be proud or showing off. It seems knowing when to be silent is deeply embedded in I-Kiribati culture. It is not so much a conscious decision not to speak but more a mood of shyness, of respect, of behaving as one ‘should’. Do midwives pause to wonder at the questions ‘not’ being asked by the woman? And what would give invitation to the woman to voice her questions?

Several stories are about the meaning of silence in the context of labour and birth. While I have heard *I-Matang* midwives speak of silently labouring woman as ‘doing well’, the I-Kiribati participants suggest that in their culture there is more to be understood. They have to be strong and conserve their energy in order to remain so. Crying out in pain and breaking their silence means they will get weaker, or risk being mocked. But the birth stories shared are not just about individuals; the voices of their own mothers still speak through the silences, their voices echoing through their daughters, even though the mothers are not physically present. In this tradition the voices of generations of mothers speak against crying out in labour. It appears that silence through labour has ‘*mana*’, shows strength, and is something to strive towards. It is participants such as Amy Veronica and Tara who suggest that this is not the full story, as they both speak of how they expect things would be easier in a private place where they could cry out in labour and no one would hear. However, their labour stories show that they are still constrained by their upbringing and present circumstances.

To understand more about the meaning of silences a wider view can be taken. Clues may be found in Heidegger’s view of Dasein, whose ‘basic constitution’ he described as ‘being-in-the-world’. Dasein is thus characterised by how they are related to the world around them, related as a whole being rather than a disembodied voice (Blattner, 2006; Heidegger, 1927/1962); the voice or speech are, therefore, not separate from the rest of the being. For example, holding silence through the pain of labour is about ‘being-there’ with others, even in their absence, going back through generations. It is about ‘being-there’ in the public gaze of ‘now’. Further, it is about ‘being-there’ with one’s reputation for the future; to be known as having-been strong.

Heidegger (1927/1962) pointed out the potential of silences, and that they are not necessarily empty; "*Keeping silent* is another essential possibility of discourse…in talking with one another, the person who keeps silence can 'make one understand'" (p. 208). van Manen (1997) suggested that silences speak, and loudly. He likened silence to the planned spaces which an architect creates in a building plan. Bollnow (1982) similarly likened silence to the background canvas of a Japanese painting which, characteristically, has a white background upon which is superimposed the featured subject. Silence in these examples is the background upon which the building or the artist's painting is created and is thus an integral part of what is presented, a valuable and indispensable part of the meaning of the whole. "Silence is the ground from which all speech emerges and into which it falls back" (Bollnow, 1982, p. 41). Nabobo-Baba (2006), in writing about their local Fijian culture, stated that "all spaces are occupied", referring to the belief that the spiritual world is present alongside the physical (p. 95). This has similarities to another Pacific way of understanding silence; that is, in terms of the Vā (Reynolds, 2019). Samoan writer, Albert Wendt, is often quoted in his description of the concept of the Vā.

> *Important to the Samoan view of reality is the concept of Va or Wa in Maori and Japanese. Va is the space between, the betweenness, not empty space, not space that separates but space that relates, that holds separate entities and things together in the Unity-that-is-All, the space that is context, giving meaning to things. The meanings change as the relationships/the contexts change. (Wendt, 1996).*

This concept of the Vā or the 'relational space between', may or may not have an equivalent in I-Kiribati culture. The phrase alludes to there being more than is apparent on the surface and helps to background the holistic nature of wellbeing which is seen in many Pacific cultures (Ministry of Health, 2014), including the I-Kiribati culture (Cleverley, 2023; Namoori-Sinclair, 2020; Schutz, 2022).

Just as silence can be likened to the spaces in a building plan, the canvas background of the painting or, indeed, the 'space between' of the Vā, silence too is a space between, a 'relational space between'. In this context it will show itself needing to be filled or broke, in order to reveal a question or a need; or, alternatively, needing to be understood and supported. Silence is an indispensable part of the whole communication which puts the subject of silence for I-Kiribati in a fresh light. Silence is not the void that Western thinking assumes it is, no terra nullus, no empty uninhabited space that waits to be filled or occupied. Silence may contain what is hidden on purpose, while also containing what longs to be revealed if the courage were there. Silence shows itself to hold much more than is audible, shows itself to be integral to other ways of communicating such as speech or actions, integral to understanding.

Silence speaks. If this is true, then perhaps the first question is not ‘what does the silence mean?’ rather, ‘how do we listen to the silence?’

6.14 Conclusion

Silence is indeed complex; but one thing it is not, is empty. In reading participants’ stories, there are reasons for silence which need to be understood. However, silence does not necessarily need to be filled or broken, it may need to be understood; only I-Kiribati themselves can decide which form of silence is required. For the purposes of this research, it is the migrant I-Kiribati women experiencing childbirth who will give more understanding, more parts to make up the whole. This perspective will continue through the next chapter which considers the ‘care-connection’.

Chapter 7: The Care-Connection

7.1 Introduction

Everybody has connections. We are connected to the world and to others as Dasein-in-the-world and as Dasein-with-others, having care for others. Heidegger suggested we are connected to others by care. Whether in a positive, negative, or indifferent mode, Dasein cares for other human beings; they matter, or not, to Dasein, they are important to Dasein. The mode of care called 'solicitude' or 'caring for others' is a part of who we are, as opposed to the mode of care called 'concern' which is how 'things' matter to Dasein (Heidegger, 1962/1927). 'Solicitude' may describe, for example, the care a midwife has for a client or the care a mother has for her baby. More about care has been detailed in the Methodology chapter.

For the purposes of the current research, I will refer to the 'care-connection'. This is a tautology which I use in order to emphasise Heidegger's notions of 'care'; that is, others mattering to Dasein and 'Dasein-with-others'. Both are Dasein's nature. Dasein, the human being, has care-connections with others that are not always or easily recognised but pre-exist the interactions and stories described in their shared humanity, as "Dasein is already in the world" (Inwood, 1997, p. 52). Alternatively, it may be that if someone is weary or distracted, they may come to a relationship with 'care' in an indifferent or negligent mode. The idea of care-connections will be discussed further in the discussion section of this chapter. While a care-connection already exists in the midwife-client relationship, there is potential for it to be established further and for trust to be built in the relationship, making positive care possible. It exists, as does Dasein, in the past, present, and future. Care is made possible by the dynamic fusion of horizons between two Dasein with a care-connection; for example, when the midwife's and client's perspectives of understanding meet to make a new understanding. On the basis of this new, shared understanding, positive care is possible. These notions show themselves to assist engagement with the I-Kiribati experience of childbirth in New Zealand that is seen in the participants' stories in this chapter.

In their childbirth experience in New Zealand, I-Kiribati women encounter care in their connections with family, midwives, and other health professionals. There is some degree of care-connection as soon as there is contact between them; the care-connection 'is', they are Dasein-with. The care I-Kiribati then experience, positive, negative, or indifferent, can affect how the mother and baby are nurtured in a practical and emotional or social way.

The tensions and silences seen in previous findings chapters are raised again in this chapter; however, here there is a greater focus on what makes a difference to these ways of being. The stories in this chapter are answers from I-Kiribati and midwife participants to the questions of how tensions are relieved or even prevented, and how silences can be broken. They help to understand what can help when there are tensions that are not immediately resolvable or when silence needs to be understood while it is maintained.

This chapter begins with Tara's birth experience in Kiribati which, as for many I-Kiribati, is the background to the perspective of understanding she brings to her subsequent birth in New Zealand. Tara's story highlights, among other things, the intangible and the practical nature of care-connections.

7.2 A New Care-Connection

Tara has her second baby in New Zealand but, in the following story, Tara speaks positively about her first labour in Kiribati. There, the traditional midwife (*te tia tobi*) she happens to meet at the hospital gives her treatment which makes a positive difference in the progress and outcome of her labour.

> *If I had been birthing in Kiribati for my second child, I would have preferred to birth at home with the te tia tobi. I had that feeling I trusted her more than the nurses. Maybe the nurses were good, but when you are in that situation you can feel who you are more comfortable with. I don't know why, she's a stranger but because she was just there looking at me and then I asked her to help me, and she did, I could trust her more than the nurses because they didn't pick up what was happening before she did. She was saying she knew what was going on inside and what's going to happen. And the nurses, they were just checking and saying I was not ready yet. And then I was thinking, what if that lady wasn't there? I don't know what would have happened, I had no idea what they were going to do… With that lady I just felt more comfortable and so I asked if she would come inside with me. She said she was not allowed to go in but would be outside and could come in (the labour room) if I really needed her…The te tia tobi came to my house sometimes after baby came, and gave me some local medicine, some drinks made from plants. I don't know what was in them…but she told me the drink cleans you out,… She also gave me a pad,…and put something on the tear to help with healing the wound…She was so helpful that lady. (Tara)*

There is something that draws Tara and *te tia tobi* together, to connect wordlessly as they observe each other. Perhaps it is a look of understanding or sympathy from the *te tia tobi* which Tara observes at a time she is desperate for help in her labour progress, a proffered care-connection with traditional I-Kiribati ways. This is a time of unfamiliarity for Tara, as a first-time mother giving birth, so it is no surprise that her mood is one of tension and unease. From their unspoken care-connection, their perspectives of

understanding, their horizons, meet and fuse in their joint goal of a safe birth. Trust builds as the *te tia tobi* takes time for Tara, makes her feel comfortable, encourages her; they dialogue, she tells her things, she does things, makes a difference. As Tara says *"if that lady wasn't there? I don't know what would have happened".* While Tara trusts the *te tia tobi* from her experience of a positive practical outcome, her reasons for trusting are more than that. She says, *"you can feel who you are more comfortable with".* Tara describes a mood, perhaps a mood of connection, possibilities of care, comfort, encouragement, or hope that more can be done to progress her birth journey.

Tara senses an authority in the *te tia tobi* 's confidence and response to her, one which is sealed by what Tara has seen of her. Tara trusts the *te tia tobi* enough to take the medicines without knowing what they are. This may not be 'informed choice' about the specific treatments given but Tara has been informed by her experience with this *te tia tobi*; she can be trusted to give good care, care that works. Tara's choice is that she does not need to know what the medicines are; it is enough that she trusts the *te tia tobi* and the care-connection between them.

I-Kiribati women bring their own experiences to their care-connections which influence their childbirth experience in New Zealand. They know what is 'positive care'. Tara's story shows that practical outcomes are important determinants of establishing a care-connection conducive to the building of trust. However, it is clear there is more involved. It is perhaps a mood; a mood of feeling comfortable, of encouragement and hope, arising from an attitude or a responsiveness in the *te tia tobi*. Such a care-connection is conducive to building trust, and trust sometimes means that advice can be taken without knowing the details. For others, it is possible that advice is taken out of respect for the other's reputation or authoritative position. Still, others may take advice because they have nothing with which to compare the new information they receive. In Tara's story, the mood belies any suggestion of these things; she sees no deficit in her care-connection with the *te tia tobi.*

In the next story, Marewe shows she has heard enough about birthing in Kiribati to feel grateful for birthing in New Zealand; this, despite her own difficult birth experience in New Zealand.

7.3 Grateful for a Care-Connection

Prior to this story, Marewe has described to me her traumatic first labour experience in New Zealand in which she did not have her own midwife present but had multiple hospital staff caring for her, some with limited practical and communication skills.

Marewe then had an emergency caesarean. Here she looks back at her overall childbirth experience.

> *But it's really good in New Zealand compared to if I were giving birth in the Island…I feel that I am lucky to be here and give birth here. The biggest thing for me is the care during the pregnancy, the check-ups, everything. Having a midwife, someone that you know, that you can call whenever you need to, and feel that there's someone there for you if you have any concerns. I am always grateful I'm here. I've heard of some of my friends in Kiribati that have had complications and they lost their child because of poor care. We're from a third world country, so I always appreciate what I get and I'm very thankful. (Marewe)*

Despite her negative birth experience, Marewe remains positive, and her mood is one of feeling "*thankful*" to be in New Zealand for her pregnancy and her birth. Other I-Kiribati birthing in New Zealand, like Marewe, have the pre-understanding that care in New Zealand is safer than in Kiribati. Like Marewe, two other participants verbalise that New Zealand maternity care is better than in Kiribati and that they are "*lucky*" to have maternity care in New Zealand. This represents a pre-existing care-connection which Marewe and others have with the New Zealand maternity care system.

The fact that Marewe says she is "*lucky to be here and give birth here*" is perhaps an example of a cultural dialectic where two realities or beliefs can be held to be true at the one time. Here, her two 'truths' are that of a difficult birth experience in New Zealand and that of birth reputedly being safer in New Zealand than in her home country. These truths remain suspended in tension and, for Marewe remain unresolved, despite being positive in relating her story. I wonder if her midwife after birth recognises this aspect of Marewe's understanding and the tension in which she still holds her positive and negative thoughts of childbirth? Perhaps, in the end, Marewe's own difficult experience is tempered by knowing that it could have been worse, and she could be grieving at the loss of her precious child.

For Marewe "*the biggest thing*" is "*care during pregnancy*". There are practical "*check-ups*" which are reassuring to her but there is more. One midwife cares for her, "*someone that you know*", a continuity of carer. This suggests Marewe has seen her midwife numerous times in her pregnancy, enough times to "*know"* her and feel comfortable to say confidently that she is able to "*call whenever (she) needs to*". She alludes to a care-connection based not just on practical checks but on something deeper when she speaks of knowing "*there's someone there for you*". Marewe expresses that as she navigates pregnancy, her perspective of understanding meets her midwife's perspective of understanding and together there is a fusion of horizons, a new understanding as they get to know each other and establish a care-connection.

Their understanding is that ‘care’ is to be seen as ‘good care’. Contrasting with the “*poor care*” Marewe has heard about, she and her midwife have a care-connection which brings with it a mood of feeling cared for. While it is important to note the previous issues raised by Marewe about her care in the findings chapter, the Experience of Tensions, which shows aspects of her midwife’s care which did not go well for her, she focuses here on the practical side of care which did seem to work well.

Marewe speaks positively about her pre-existing care-connection with the New Zealand maternity system which is further established by the familiarity and time afforded by continuity of carer and by the availability of the carer to address her concerns. For Marewe and others, this suggests that a positive care-connection has both a practical side that gives a mood of safety and a relational side that brings a mood of being cared-for. Maria, in the next story, shows that even when birthing in an emergency situation, a care-connection can be more than just practicalities.

7.4 A Comforting Care-Connection

Following Maria’s exhortation in the Experience of Tensions findings chapter that “*it’s important to accept that people have a cultural background which will also contribute to their journey”*, her story about the birth of her first baby in New Zealand illustrates how important cultural background can be.

> *“My husband was with me in the theatre. We felt so vulnerable, just the two of us and the whole team around us doing their own work and it was obviously quite an emergency. It was traumatising but I knew that they were in a rush to help me. That gave me some reassurance.*
>
> *All I could hear was the doctor talking to the senior doctor and the senior doctor said “yeah, you’re doing the right thing”, giving her advice. And I remember that the doctor sounded like she had a strong Fijian accent and for some reason it gave me some comfort knowing that it was an Island doctor providing care for me. I don’t know why, but it just gave me some comfort. And the senior doctor was an Island man as well. So, for some reason I was kind of comfortable…*
>
> *It was just such a relief when they took the baby out and they said this is your baby and they showed him to me, and I started crying!! (Maria)*

Maria is ‘thrown’ into an emergency caesarean section with her husband. ‘Thrown’ is a good description as neither birth nor being in an operating theatre is a familiar situation for either of them, especially not being in her home country and communicated with in a language that is not her mother tongue. She experiences tension, a mood of unease, and most definitely unfamiliarity, acknowledging, it is ‘traumatic’. Initially Maria is reassured just by the fact that the team is “*in a rush*”, rushing to help her and her baby. Already she recognises the wordless meeting of perspectives of understanding

between them and the hospital team. A new understanding from their united perspectives in the rush of theatre; that Maria and her baby's safety is important. A care-connection already there but further established as the team rush to organise and carry out her caesarean.

Further reassurance, even comfort, comes without being sought in the form of a voice, an Island voice, in fact, two Island voices. Maria describes how she connected with the voices of two Pacific Island doctors in the operating room who are working together for the sake of her and her baby's wellbeing. She is "*kind of comfortable*" in hearing the Island doctors talk, their voices leading Maria to feel familiarity and to feel at-home. The mood changes from tension and unease to one of feeling comfortable, unfamiliarity to familiarity. The doctors and their team are probably unaware of the effect their voices have on Maria. They are doing their job by caring practically as they have been trained to do; but they are unconsciously doing more, in speaking and showing Maria something of their cultural background. As a result, Maria's own cultural background is supported. She is not sure why she feels comfortable but perhaps she feels affirmed in who she is and, with further reassurance of being cared for, regarded, she is able to be more confident that her needs will be met as a Pacific woman. Perhaps she feels it is more likely they will understand who she is and how she is through this vulnerable time.

Overheard voices are seldom perceived as mattering, except that health professionals are likely schooled to take care of what they say in the hearing of clients. Maria, however, shows that in her situation what mattered to her was not so much 'what' was said, but the sound of the familiar voice. When someone comes from 'my' part of the world, there is a sense of sharing cultural ways and understandings. Hearing the familiar cadence of Pacific language brings a sense of comfort in the midst of vulnerability.

The midwife participants interviewed have thought about strategies to give positive care, to build up care-connections with their I-Kiribati clients, to increase the sense of 'being-at-home'.

7.5 A Care-Connection Across the Gap

Grace is a New Zealand-European LMC midwife. She relates her experience with one I-Kiribati client but also interprets some of her experience with other I-Kiribati clients.

> *I felt very much that she [I-Kiribati client] would look upon me as the health professional up on a pedestal… giving me respect because I was someone in authority...It wasn't like I tried to make a cultural*

> *difference or a gap, but there was a gap; there was something that couldn't be reached across that gap, no matter how I tried. We had a good relationship through all her pregnancies, but I was always the professional, and her eyes lowered if she talked to me. Her communication with me was always a little bit guarded, and it made me be a little bit guarded. When I was worried about her, I couldn't just go straight to the point. Because she skirted around things, I had to skirt around things in order to for us to communicate properly…If I poked at the things I was worried about, I felt that she wouldn't be honest with me because she would say to me what she thought I wanted to hear, not what was really happening…So, I then had to back up a bit, and go in on a less confronting way to address the issue. That takes a lot of time and energy when you're busy…If I felt like she was ready to tell me something a bit deeper, I would turn away and…write…while I was listening, because I felt that she could talk more freely if she wasn't confronted with me looking at her…*
>
> *I'm quite chatty and talkative, so I have had to be a bit more guarded with how I say things, in case it inhibits their [I-Kiribati clients] ability to take on what I'm trying to say. So, I try to step back and draw them out and then I think about my strategy of how to communicate what I need to communicate to them, because it's not one size fits all... I'll tend to be very much more professional and do my tasks for the first 15 minutes with the I-Kiribati women, especially with a first pregnancy. This helps them relax and feel comfortable, because they're coming to me for that role. They're not coming to me to be a friend. They're coming to me for me to do a job, and so I have to make sure I do that job in a way that they feel like it's being done. (Grace)*

Grace senses there is a "*good relationship"* between herself and her I-Kiribati client. This is likely as this client has returned to Grace for another pregnancy; they have a care-connection. However, Grace observes that there is always *"a cultural difference or gap"*. If so, it is her client who is likely to notice this gap more, entering as she does into Grace's 'space' of work. I wonder if Grace's client has the same view as Grace on what is a "*good*" relationship. Grace observes that her client is "*guarded*" in her conversation, and that she "*skirted around*" rather than addressing things directly. Such indirect communication is a challenge for Grace as culturally it is normal for her to speak straight to the point. However, for her client it can be normal and polite to communicate in this way (Namoori-Sinclair, 2020). Grace wonders too if this client is not being honest and is saying what she thinks Grace wants to hear. However, rather than not being honest, perhaps her interaction is based on *te mama*, I-Kiribati shyness, part of her upbringing, where respect means one should not contradict or question someone with perceived "*authority*", nor challenge such a person by looking at them directly (Namoori-Sinclair, 2020; Uriam, 1995).

Speaking generally about her I-Kiribati clients, Grace explains she does practical tasks at the start of her consultations with I-Kiribati in an effort to allow her clients to relax with her. She is sure this reassures them she is doing the "*job*", as *"They're not coming*

to me to be a friend". There is no indication in the shyness to indicate anything else but neither is there anything to confirm her assumption that her I-Kiribati clients are just there for her to do a "*job*". Maybe it is the extra time she takes before chatting which helps her I-Kiribati clients relax rather than seeing her do her "*job*". Perhaps her I-Kiribati clients do not divide their relationship, their care-connection with their midwife, from the "*job*" she does. Perhaps it is seen as a continuum along which each client finds their place, and which changes according to individual need. As Grace says, it is "*not one size fits all*". Do Grace's I-Kiribati clients see more than a "*job*" being done? Do they see the energy put in by the midwife, feel 'listened to'? Or perhaps it is just all new and overwhelming. Are they focused not on their midwife but on how their baby is doing? Or just trying to work out what they 'should' be doing or saying at the appointment?

Grace's care shows thoughtful strategies with potential to positively build on her care-connections. She learns from her experience, and in this way, she is 'present' in her care. She describes care which is what Heidegger (1927/1962) calls "leaping ahead" when she speaks of how she *"steps back"* from her clients in order to *"draw them out"* (p. 158). In doing so, Grace is paving the way for her clients to move ahead as needed at their own pace. Grace takes time and energy to improve communications with her clients, a challenge for a busy midwife. It is an investment, both for the present and for the future in their midwife-client care-connection, a 'leaping ahead'. The ability for a client to communicate well could be vital at a time of crisis. It seems Grace has other strategies to communicate and to build the care-connection; learning indirect communication, suppressing her own "*chatty*" personality, backing up and remaining silent, not seeking eye contact but listening.

I-Kiribati can be perceived as being shy, and this may be so. Midwives see shyness in terms of their own culture and assume what is behind it. That is all they have to go on until there is more dialogue on the subject. Maybe I-Kiribati clients are there just for a midwife to do a "*job"* but maybe there is more they are seeking from their midwife. Other participants suggest this is so, as in Merieti's story later in this chapter. Grace, herself, talks about more being possible, citing her "*good relationship*", a positive care-connection with the first client she mentions. However, Grace shows there are strategies possible to support communication and build on the midwife-client care-connection. In the end, it is clients themselves who are best placed to say if these strategies are working or not.

The next three stories are also from midwives; Sulu, Hilda, and Violet. They, like Grace, have reflected a lot about their care for I-Kiribati clients.

7.6 Care-Connection and Partnership

Sulu has worked with number of I-Kiribati women. Like the other midwife participants, she gives something of the context for the midwifery care experienced by I-Kiribati. Here, she gives both description and interpretation of her own experience caring for I-Kiribati.

> *I think the New Zealand midwifery model of partnership works really well…In New Zealand (it) is important because this is a woman that lives outside of her community and her Kiribati culture…It is important, because you can help her navigate the system and you can form a connection that maybe provides her with a sense of being cared for and being safe in the pregnancy and the process of childbirth…*
>
> *The aspects of partnership that help are firstly the consistent care provider. The partnership is her voice and the midwife's voice, so if she feels safe in the partnership, then she can be more involved in her care, and so ask questions. But she can also understand some of the things that may be required of her, for instance…having a blood test. If she trusts her care provider, she will trust that this is important. There needs to be explanation as well, but I don't think women always understand the explanations we give them about why they have to do things. We think that we've given them information, but they still don't necessarily understand… Like early screening, or Vitamin K...So, to some extent the partnership maybe allows a woman to feel okay about what she's doing when she's being given…advice or instructions, because although she understands to some extent, she may not really understand, so she can trust. It's about trust I think, and confidence. So, to some extent the partnership allows you to help women navigate complex situations, so that the care becomes possible. (Sulu)*

Sulu recognises the tensions I-Kiribati women are under as migrants and sees the lack of familiarity they have with their environment. The maternity system and its expectation that women are involved in choosing their path of care is just one part of this New Zealand environment which migrant I-Kiribati may experience as unfamiliar. It echoes the tension in the face of unfamiliarity highlighted by I-Kiribati participants in the chapter on the Experience of Tensions. Sulu recognises her I-Kiribati clients need for relational as well as practical care, for a care-connection to "*navigate*" the system and for feeling "*cared for and being safe*".

For Sulu, partnership between an I-Kiribati client and midwife is a positive aspect of midwifery care in New Zealand for I-Kiribati women. She sees it is *"the consistent care provider"* or 'continuity of carer' which is important. Research shows that continuity of carer increases women's satisfaction with their maternity care (Bowden et al., 2023; Forster et al., 2016; Sandall et al., 2024). This is again a 'leaping ahead' aspect of care, paving the way for timely care in the future. Sulu describes the partnership as

“her [the client’s] *voice and the midwife’s voice”*. This evokes a mood of relaxation or trust at the sound of a familiar voice, or a mood of comfort as seen in Maria’s story. One imagines that if she describes partnership as her voice and client’s voice, then she is continually listening for her client’s voice as they continue their care-connection. In such a context, the I-Kiribati client is facilitated to be “*involved in her care*” and the mood is conducive for her to “*ask questions*”. The care-connection is established, described by Sulu as a partnership, bringing a *“sense of being cared for and being safe*”. This shows both Sulu and her client’s understanding is always ‘on the way’.

Sulu also highlights a challenge for the care-connection between I-Kiribati and their midwives; that of balancing the need for clients to understand with the need for care to be made *“possible”*, a plan of care to be made. From her experience, Sulu recognises that explanations do not always bring understanding, but where understanding is lacking, trust can help. *“She may not really understand, so she can trust”.* Is what Sulu sees happening in the context of partnership which *“allows you to help women navigate complex situations, so that the care becomes possible”.*

Here, Sulu observes what seems to be a fusion of horizons, the development of a new understanding between her and her I-Kiribati clients. While the client may not fully understand the details, there is a shared new understanding of the goal of care, a healthy mother and safe birth of a healthy baby. In this newly developed understanding, Sulu’s clients would trust what their midwife advises. While this goes against the philosophy of informed choice, it is what Sulu observes. Sulu ‘leaps ahead’ by developing such a care-connection, and as a result the client accepts the “leaping in” as Sulu offers the direction (Heidegger, 1927/1962, p. 158). Would her clients have wanted more time for questions or more in-depth translation to find out more details about their choices, or is trust enough? It may not be until a subsequent pregnancy that a client confides she has unanswered questions, as for Vai, in the previous findings chapter on Silence, who only asked her midwife about her fistula when they met for a subsequent pregnancy.

Sulu describes partnership as relationship, as continuity of carer, as communication and, understanding; a positive care-connection which helps I-Kiribati clients to “*navigate complex situations*” in the new and unfamiliar environment of the New Zealand maternity system. Sometimes however, I-Kiribati clients do not understand a midwife’s explanations, might not ask questions, and the midwife, knowing this or not, may need to ‘leap in’ to act anyway “*so that care becomes possible*”. This ‘leaping in’ is expected in an emergency but it sounds as though, from what participants say, that ‘leaping in’ occurs also in routine care.

While Sulu focuses on continuity of carer as a positive part of partnership, Hilda focuses on the difficulty with informed choice, as previously discussed in the Literature Review chapter.

7.7 Care-Connection and Informed Choice

As an LMC, Hilda has cared for numerous I-Kiribati clients. Like Sulu, she has thought a lot about her own perspectives of understanding. Hilda sees the challenge for her I-Kiribati clients as their perspectives of understanding (their horizons) meeting those of a New Zealand midwife in the New Zealand maternity care system. She describes her experience of her care for I-Kiribati clients and shares her interpretations.

> *I think the New Zealand midwifery model of partnership is a very strange concept for (Kiribati women). I don't think they're used to being included in decision making and they tend to want you to suggest things and they are quite acceptant of what you say… They're probably used to just being told this is what you need to do and it happened. For example, with the Vitamin K…They didn't really understand that you wanted to discuss with them… what it's for… Informed consent is probably not a concept that they were very familiar with. They'd just say, do what you need to, do what you think or do what's best. Yes… a trusting response that you'd make the best decision for them and for their baby. Yes… they certainly didn't question why they would not have it…they didn't really probably appreciate that there could be some negatives…I think it was more that the Kiribati women seemed to have the trust that you would be doing what you were meant to do or doing what you had decided…To give midwifery care to these women, what is important I think is just explaining things really well…I think they were appreciative…that you had explained it and they weren't used to that happening… It used to take longer for an appointment because you had to just be aware of all of that and try to explain there were choices and options. But still I don't think a lot of them really understood that concept... So I think it will take a wee while to maybe change. The next generation will probably question things a bit more, have more of an understanding. (Hilda)*

Hilda's clients perhaps see that she tries to do all she should do, that she takes time and gives information, so they have opportunity to make informed choices. Hilda suspects her I-Kiribati clients do not always understand that they can make choices, nor do they always understand her explanations, but give a "*trusting response*" that the midwife will make the "*best*" decision for them and their babies. Hilda suspects there is also an element of preferring to do what the midwife says because that is what they would do in the I-Kiribati health system, perhaps thinking they have only one choice: to do as the health professional says. Regardless, it is Hilda's experience that decisions are not usually based on personal choice from understanding of the information given.

There is more that is not known by Hilda in her discussions with clients but she has to base her care on the agreement they verbalise. She discerns that they do not question. What is harder to confirm is whether they might understand more than she thinks; and are accepting, saying nothing, constrained by the cultural politeness of *te mama* (shyness). Alternatively, they may not be accepting and hold back for the same reason. Hilda takes time, she explains a lot, she puts effort into her care but, in the end, she feels they are doing as she says, even if they "*appreciate*" the relational aspect of her care that takes time and shows her effort. She does not see 'doing as she says' as lack of care or interest on the part of her clients; they are making a choice of sorts in doing what she says or suggests. Theirs is perhaps a decision to do the best for themselves and their babies based on a trust that their health professional is to be respected for her position and knowledge on how to achieve the goal they share. This shared new understanding is to do what is best for mother and baby. As with Sulu, it is a fusion of horizons in a care-connection creating trust for the possibility of care.

Hilda's care-connection with her clients is initially built through the practicalities of her care and continues with her taking time and making an effort to communicate information. It is seen by her I-Kiribati clients and such effort appears to strengthen their relationship. Hilda does not describe a separation between practical and relational care but uses both in building this care-connection; thereby, 'leaping ahead' to free her I-Kiribati clients to make informed choices in their maternity care. Such 'leaping ahead' also serves to facilitate the acceptance of her need to sometimes 'leap in' when a decision needs to be made urgently. For now, this has the 'semblance' of working.

As Sulu also found, while a midwife and an I-Kiribati woman with a care-connection may make a new understanding of a shared goal regarding what is best for a health mother and baby, the 'informed choice' needed on strategies to get there poses a challenge for both. Hilda sees that for the "*next generation*" there will be more questions as well as more understanding so that women can decide for themselves. With time and effort, familiarity with the midwife can increase, more questions can be asked, and their care-connection can be further established. Trust can, thus, be built further; a trust that is beyond that which allows 'yes' to everything the midwife suggests.

The next participant is another midwife, Violet. She shows a natural ability to build rapport with clients and reveals that understanding really is always 'on the way'.

7.8 Establishing a Care-Connection

Violet, as an LMC midwife, has cared for one I-Kiribati woman, Rata, who was in her third trimester. Violet describes and interprets her experience, alongside her own perspectives of understanding.

> *I did most of my antenatal appointments at Rata's cousin's home, where she was staying. I think women have more empowerment in their home through that whole experience. It's easier for them… if you go into their space rather than them coming into your space, which can be threatening… I do think doing home visits was part of why the family accepted me and my relationship with Rata changed and I got to know her. In our first conversation she was a little bit embarrassed about the house. But I said, "it's fine, I see all my women at home", and she said, "okay". I wasn't doing anything special to help build that trust, I would just sit on the floor usually, and chat. I'd hang out and be relaxed, just be myself… She was a quiet person… I do feel like there was a lot of me talking and a lot of her just nodding and agreeing, especially when it was just Rata and me. It was quite hard to draw her out but we were comfortable together, she connected with me. Rata's cousin would take over the talking a bit, even though Rata's English was actually totally fine. But she wasn't confident that her English was fine, so she'd let her cousin do the talking. Rata and the cousin would discuss things together and then one of them, often the cousin, would present it to me. Then, as time went on a bit more, it was her partner or her. We had lots of discussions, but I hadn't talked about car seats and so we got to hear postnatally that she had no car seat! Whoops! And I had no idea that they were going back up North...I heard when I came to do the discharge visit at the birth unit. (Violet)*

It is natural for Violet to chat, and normal to do home visits with her clients. She establishes a care-connection, a relationship, with Rata and her family. Over time she feels they come to "*accept*" and "*trust*" her; she feels she gets "*to know*" Rata, that they "*connected*". This feeling is shown by the fact that Rata can eventually have discussions with Violet without going through the cousin and is further evidenced by Violet's feeling a mood of being "*accepted*" and "*comfortable*" with Rata. However, Violet and Rata do not get to this point without effort. Violet enters Rata's 'space' by visiting at home. She speaks about having "*lots of discussions*" but feels she is the one who does most of the talking with little input from Rata. She speaks about taking time to talk, being timely, talking with the family as well as with Rata. By all of these means it appears she builds a trust relationship from their care-connection. In doing so, she is 'leaping ahead', preparing the way for future care.

What does Rata make of the discussions she has with Violet? Does she understand all that Violet is saying? While Violet is positive about Rata's English skills, Rata is less confident, perhaps explaining why Violet perceives she is "*quiet*". However, the talk is not just one-sided. Rata takes her time with Violet to listen; her silence is not without

meaning, and it does not just mean ‘yes’, she agrees or that she understands. Is Rata’s “*quiet*” also from a recognition that these two women are not in a friendship or a family relationship but that there remains a hierarchy to be respected with an *I-Matang* health professional? Does Rata’s “*quiet*” reflect a lack of experience in relating to people from a different culture? Or is there a mixture of lack of confidence in English, unfamiliarity with the New Zealand maternity system, and respect for hierarchy which Rata herself may not even consciously acknowledge? Does Rata’s “*quiet*” reflect previous negative experiences with *I-Matang*? Perhaps not, given the mood of feeling “*comfortable*” that Violet reports. Maybe Rata decides just to agree with her midwife as she has a limited conception of the merits for different choices before her but trusts that at least they have a new, shared understanding in the goal of having the best outcome for mother and baby. Maybe Rata sees that chatting as rapport-building, relationship-building, the opportunity to take time together, respecting each other is more important than the details. Perhaps in this respect Rata and Violet share a new understanding on the importance of relationship before tasks of care begin.

Despite the time taken for discussions, there are communication gaps and Violet is left questioning herself; what else could she have asked or how else could she have asked it? There are things unsaid and things which she is not told. Surprises come, perhaps indicating the right question has indeed not been asked, rather than a deliberate withholding of information. Rata may not know about the legal aspect of needing a car seat for a newborn in New Zealand, there being no such requirement in Kiribati. She may not think that a midwife needs to know what her plans are after discharge. In Kiribati there is usually no routine follow-up care after birth and so she expects none in New Zealand. On finding out these things, on finding a new plan is needed, Violet needs to ‘leap in’ and ask for a car seat, ‘leap in’ and make last minute arrangements for ongoing postnatal care. One wonders if, or suspects, that Violet’s antenatal care has ‘leapt ahead’ and facilitated Rata’s birth journey. Yet, sometimes care incorrectly assumes that understanding is complete, assumes the existence of a fused horizon or a new shared understanding between midwife and client.

Violet shows that there are many things a midwife can do to establish and build a positive care-connection with a client, relational as well as practical. However, even when applying all of these strategies there is potential for poor communication and lack of understanding. With this in mind, it is important for midwives to remember that understanding is always ‘on the way’.

In the next section, Merieti’s story brings out similar thoughts on what facilitates the establishment of a care-connection and, more, what builds trust.

7.9 A Care-Connection at Home

Merieti birthed two babies in Kiribati and her third in New Zealand. Here she speaks about her relationship with her New Zealand midwife.

> *When I met my midwife for the first time, I was a little bit shy but later on when we had chatted, we worked together as a team. She would come sometimes and visit at my home… She would ask, are you alright? But when my appointment came, I would always go to her at the clinic. But I think for me it is a good way. I connected more with the midwife and didn't feel shy to tell her something… Yes, her visiting at my home, for me it helped to feel more open and more comfortable to share. When I know her more, I can talk to her about things hard to say, because I'm open and she's the one that can help me with it. Yes, but just myself and my midwife… In your house, in your place, you feel more comfortable. It's just like a friend or another family member coming to visit you, and you can talk!... They are open to tell you things…*
>
> *When we went to the midwife office… it's a bit different… there could be other workers in there… more people you don't know... We always close the door but sometimes not, because I always went there with my toddler, and she was always running round… Yeah, because you know in the new environment that's not your home, I worried sometimes for me, that when I went to the office, it's not private… and when you go there you rush talking. You don't know if the midwife has other work, so when you're home you can relax more… Seeing a midwife in your home helps, and not rushing helps. But for me, the appointment visit, the one in clinic, is very important to go to, because there's stuff in there, and they can do a lot, and catch up for things, I don't know what. (Merieti)*

Merieti describes a mood of being shy changing to a mood of being "*open*" and "*comfortable*" as a result of the midwife's home visits. For Merieti a significant change is shown by her saying "*but later on… we worked together as a team*". Home visits afford client and midwife privacy, creating the possibility of chatting freely, openly, and not "*rushing*". Merieti observes that the midwife, too, is more open to talk in the home environment; "*they are open to tell you things*". However, it is not just the midwife; Merieti, too, makes an effort and takes initiative. Once she knows her midwife more, she makes a conscious decision to talk with her even "*about things hard to say*, *because I'm open*". There is a commitment to dialogue on both sides, a shared commitment to establish the care-connection resulting in a new understanding, a fusion of horizons.

Merieti sees the office appointment as an unfamiliar 'space', a stark contrast to the home environment which is not conducive to talking freely or maintaining privacy of person or conversation. Here, Merieti's midwife is distracted, sometimes rushed. In the office it is harder to establish their client-midwife care-connection and build trust. I

wonder if the midwife recognises how different their communication is when they are in the office compared to home. Does the midwife take for granted the comfort her own 'space' affords her in the office appointment, and is she aware of the tensions experienced by Merieti about her privacy there? Merieti knows that the office visit is important; the midwife can "*do"* things there, and maybe because of their relationship, she trusts these things are needed. It is possible she values the establishment of their relationship more than knowing the exact details of what her midwife does.

Merieti appears to have a respect for her midwife's knowledge and skills; knowing she "*can ask"* questions. However, it is clear Merieti does not expect her midwife to just do a "*job*", unlike Grace and Hilda's perception of their I-Kiribati clients as seen in their stories, also in this chapter. Merieti sees her relationship with the midwife as a normal relationship; that of a "*friend*", "*family member*", or as a "*team*". Such a difference in experiences emphasise that "*one size does not fit all*", as Grace and Maria have also observed.

I-Kiribati clients their own experiences, and for each person different things, enablers, exist for establishing a care-connection with their midwife. For some, like Merieti, the home environment provides the enablers of privacy and time which bring a mood of openness between her and her midwife and enable communication. Key to this care-connection is a midwife who is prepared to step outside her own familiar 'space' and reach out to refashion the physical and relational environment in which they meet for the client's benefit.

This story of the midwife and Merieti is about what helps to establish their care-connection and build trust between them. The next story is from Tantan and Tiimwa, who tell their story of care from family, based on a pre-existing care-connection.

7.10 The Family Care-Connection

Tantan, father and husband, tells the story of his wife Tiimwa's second birth, her first in New Zealand, and the importance in this story of the woman they call Grandmother. Tiimwa is present as he speaks.

> *We had a grandmother who stayed with us, who told us what we should do for the midwife and for the appointments and things. She had had children in New Zealand herself. We felt good about meeting the midwife. I went with her each time to the midwife. Grandmum came too.*
>
> *When having the birth, Tiimwa had a problem with low energy… Tiimwa needed help, because baby's head was too big… It was hard to push the baby out, and she needed the cut. They wanted to do a caesarean, but Grandmother forced them to let Tiimwa push the baby*

> *out. Yeah, everything was done with signing consent, and after they took her upstairs to the operating theatre, she pushed baby out… Grandmother went to the theatre, I didn't go. I just gave them advice to push the baby out…Tiimwa was happy to have a caesarean, because she said she no energy left to push a baby out, but the Grandmother forced her to push the baby out. She doesn't like the caesarean. Tiimwa was just happy to finish. The doctor checked the baby, and he asked her to push the baby out, but they needed the suction. (Tantan)*

Tiimwa is no stranger to birth, but this New Zealand experience is new to her and her husband, Tantan. They are 'thrown' into a new country and are surrounded by a foreign language and culture for their pregnancy and birth. They have a pre-existing relationship, a care-connection with Grandmother, and she is with them throughout their childbirth story. Grandmother is familiar, she is part of why they "*felt good at meeting the midwife"*, and a reason for them to feel 'at-home'. She is the one who provides true 'continuity of care', gives them confidence to establish a care-connection with their midwife. Grandmother is advocate, go-between, sometime spokeswoman, source of information; and is herself part of the midwife care-connection. She is alongside Tantan and Tiimwa. In being all these things Grandmother, knowingly or unknowingly, 'leaps ahead' in her care by establishing their care-connection together, mitigating the uncertainties and tensions this couple face at such a time. I wonder if Tiimwa and Tantan's midwife recognises Grandmother's role in this couple's childbirth journey?

Not surprisingly, Grandmother plays a significant part in the labour and birth, given that she *"forced them to let Tiimwa push the baby out".* There is no image here of Grandmother being a mild-mannered individual translating what is advised; rather, a strong woman, equal to telling the medical professionals involved what should happen for the sake of Tiimwa and her new baby. Grandmother also *"forces"* Tiimwa to push. Any midwife will know that pushing cannot happen unless the person in labour chooses to push themselves. It might be more accurate to say that Grandmother succeeds in giving Tiimwa, now very tired, sufficient motivation to do the pushing needed to get the baby to the point of birth; Tiimwa pushes her baby out with only *"suction"*, not caesarean section, for assistance.

Tantan and Tiinwa's pre-existing care-connection with Grandmother gives opportunity for their perspectives of understanding to meet. It would seem that Tiimwa's and their baby's wellbeing is Grandmother's goal, as it is theirs, and on this they share a new understanding, a fusion of horizons. Tantan implies they trust Grandmother to know what is best, what is 'right', to reach their shared goal. The hospital staff are perhaps challenged as to how best to achieve the goal of a healthy mother and baby. Do staff

immediately see and respect Grandmother's care-connection with Tiimwa or do they worry that Grandmother does not regard their expertise and advice highly enough? Are they wishing Grandmother to be gone so they can 'do' their job? Or are they silently cheering for this elder of the family who has such certainty of what is right, what is possible, and with an enviable ability to motivate a very tired mother in her labour efforts? The staff's perspectives of understanding meet those of this family and a new understanding, a fusion of horizons, is created through the necessarily rapid dialogue in the operating theatre. In reaching such agreement, positive care is made possible and acceptable, whether it be a 'leaping in' or a 'leaping ahead'.

In Tiimwa's labour, Grandmother is 'leaping in' in her care, dominating, giving her no choice but to push, making her dependent on her instructions. In another sense, Grandmother is 'leaping ahead' in her care by telling the staff and Tiimwa what is possible, merely facilitating Tiimwa to be free to push baby out herself. The care-connection and the fusion of horizons they share mean that such care is accepted. So too with the hospital staff who share the same goal of care. They 'leap ahead' in their care by holding back, giving freedom to Tiimwa and Grandmother to continue pushing and trying for a vaginal birth, rather than 'leap in' and demand to do a caesarean immediately. I wonder how different Tiimwa and Tantan's experience of care might have been with no Grandmother?

Family members can play a vital role in providing care alongside health professionals. They can give midwives clues as to how to establish care-connections which are the basis for perspectives of understanding to meet and create a new understanding, a fusion of horizons. Family members have potential to give the ultimate in continuity of care based on their pre-existing care-connections, established over time. While not all will have the knowledge and experience of this 'Grandmother', they are likely to share the client's goal of a healthy mother and baby, a vital starting point for appropriate and acceptable care. Midwives can learn much from family members who are 'present' for their family member in the childbirth journey.

The following section shows Vai relieved of her "*burden*" as a result of positive care.

7.11 Returning to a Care-Connection

Hilda is Vai's midwife for the second time. Here, she relates a follow-up to Vai's story seen in the previous chapter on Silence.

> *I made a gynaecology clinic appointment for her postnatally, and she did have a fistula… I think what happened was that she was too shy to say anything to me in that first pregnancy, because she took a long*

> *time to tell me what the problem was in her next pregnancy… I think the reason she told me was that it was just the next time, and she'd got braver, … she had to… get brave, to actually bring the subject up… So, she'd kept all that to herself. It was quite a big … burden for her to come out with… She had a repair, and it was really quite complicated. I saw her in the town, and she was telling me, so she was quite openly communicating about it… So, she'd kept all that to herself. (Hilda)*

Vai renews the care-connection between herself and Hilda, her midwife. To return to the same midwife may indicate some degree of trust has already been built. Hilda finds out how shy her client really has been when she cares for her this second time. Vai overcomes her silence and shyness, becomes "*brave*", and reveals to Hilda that she has a problem with a fistula; not just telling her, but telling her strongly.

From shyness to strength represents a big change in Vai. Vai appears to have come to Hilda this second time with new perspectives of understanding. Hilda's experience suggests so. While in the past Vai had no knowledge of possibilities, perhaps now she knows or suspects that something can be done about her fistula. Perhaps her connection with her midwife means she can venture a question about this, having learned that questioning is acceptable in New Zealand culture. An increase in familiarity or trust, or both, with her midwife, might give her the courage to entrust personal information to Hilda. Perhaps she trusts this time that the midwife will be accepting of her limited English skills and will listen. There is something in Vai which changes in order to seek relief from the tension and distress, the 'unease' or anxiety caused by her fistula. Vai should take credit for seeking help; "*brave*" describes it well.

In caring for Vai for the second time, Hilda has a pre-understanding of nothing being wrong. She does not know what she does not know. She is unaware that Vai has a serious problem, so cannot even ask about it. One can only surmise from the little that Hilda says that her own perspective of understanding is one of trying to understand Vai and her needs in order to give positive care. Something changes with time and talk, and, for her part, Vai is accepting of her midwife. There is some degree of understanding created between them, a new understanding. Perhaps this familiar care-connection makes Vai feel comfortable to open up and break her silence to disclose her problem. This new understanding includes a shared commitment to find appropriate care for Vai's problem, and Hilda is able to 'leap ahead' to free Vai to access care from the gynaecologist. On the way, there are aspects in which Hilda will need to 'leap in' and tell Vai what to do; Hilda being the one with links and information. It is Vai, however, who must go through the repair surgery and recover with two small children and an older special needs child. Ultimately, Vai is freed, through her courage and Hilda's care, to have the years of tension over her fistula symptoms relieved.

For Hilda and Vai the care-connection is established and trust is further built as new understandings grow between them. Vai's story shows that the results emanating from such a care-connection may not be immediate but, with time, they can be far-reaching. Such care-connections are thus dynamic and can be further established; by talking to each other, listening to each other, becoming familiar, by the experience of ongoing care and outcomes being positive. In the end, a care-connection such as this has potential to help I-Kiribati women to find their voices.

Vai's story leads to a discussion on all of the stories in this chapter with regard to the research question. "What is the experience for migrant I-Kiribati women of childbirth in New Zealand?" has been told by participants. There are tensions and there is silence, some silence needing to be broken and some silence needing to be understood. The stories in this chapter lead us to the care-connection, something which helps to mitigate the tensions and the silence for I-Kiribati women in their experience of childbirth.

7.12 Discussion

Amidst the tensions and silences of the first two findings chapters, some things show themselves to be important to I-Kiribati participants in the context of their childbirth care-connections; to know their midwife, to be known as individuals, to be connected, to be respected, to have dignity preserved, to access good care (both New Zealand and traditional I-Kiribati care), and for them and their babies to be safe. A call is made to midwives to accept and to respect, to not make assumptions, and to work on building rapport with their clients. What then can help to establish care-connections further and to build trust in the relationship to bring new understandings and facilitate positive care?

First, it is important to clarify what happens from having a care-connection, as it establishes, through to the building of trust. Solomon and Flores (2001) speak of trust as a verb, stating "Trust is dynamic. It is part of the vitality, not the inert foundation, of relationships. It involves personal responsibility, commitment, and change" (p. 13). It follows that while the care-connection is there, whatever is or is not done with it, further establishment of it, as with trust, is a dynamic process. It is only where there is such movement that both sides of the care-connection, midwife and client, two perspectives of understanding, can interact. This interaction has potential for a fusion of horizons; in other words, the sharing of a new understanding. Such is the recipe for positive care. As we have seen, at the most primordial level, Heidegger (1927/1962) says that Dasein is care. Remembering this relationship can be, or become, positive or negative or possibly indifferent.

All I-Kiribati and midwives do have care-connections. These care-connections are dynamic, always in process. As Gadamer says of understanding, they continue to be 'on the way' to being established. The care-connection at its basic level has similarities to 'the relational space between' as mentioned in the previous chapter (Reynolds, 2019; Wendt, 1996). There is no vacuum between Daseins; even when nothing is said, what is done or shown has an understanding behind it. The participants show that the care-connection can be between client and midwife, client and family member, client and *te tia tobi*, client and another health professional, or, in fact, between any two people. The care-connection can be recognised by a look, an observation, a voice, or by an expectation of what is. It can be established with dialogue and action, the proof of its veracity.

Dasein, both midwife and client, come together in their care-connection in a particular mood. This mood reflects their pre-understandings and their perspectives of understanding. A midwife's perspective of understanding may be that their I-Kiribati clients see her as being there just to do a "*job*", while I-Kiribati participants show there is a continuum of expectations of the care-connection. While some might expect just a "*job*" to be done, others seek a deeper connection or, even without analysing it, expect to establish a care-connection and access both practical and relational care.

Time is a factor for establishing the care-connection. Subsequent pregnancies can renew already established care-connections or bring a reminder of previous positive care-connections which can be projected to this new one. The obverse may also happen. Dialogue and getting to know each other over time helps this process and builds trust; trust to be understood, trust to be listened to, trust to be believed. The past feeds into the future, as communication is made free to flow. New understandings are thus made possible. It is on the basis of understanding, and on the basis of Dasein making themselves "present" in the here and now (Inwood, 1997, p. 82), that positive care is possible. The midwives demonstrate being 'present' in their stories, making an effort and making time; to let clients talk, to listen, to chat or to put themselves in the 'space' familiar not to themselves but to their clients by visiting at home.

While speaking about 'care-connections', 'building trust', perspectives of understanding, fusion of horizons (new understanding), and care, it must be remembered that running through all of these is a continuum of understanding that is not static. Each continues to be 'on the way'. I-Kiribati participants meet others, such as midwives, and each have their own perspectives of understanding. It is in the process of dialogue (and sometimes this dialogue is the reading of each other's actions) which brings this new understanding. This new understanding may be at the basic, albeit

important, level of a shared goal of a safe outcome for mother and baby. In such a care-connection the client may not always understand but they trust enough to accede to the midwife's suggestions. It does appear that some I-Kiribati participants agree because they trust the person with whom they have a care-connection. This could be trust taking the place of informed choice or understanding, but it could be obedience in the face of perceived authority. Sometimes the midwife will not know which it is.

Thus, understanding, in particular new, shared understanding, makes possibilities for positive care, both 'leaping in' and 'leaping ahead'. A midwife may show positive care by 'leaping ahead'; that is, she puts energy into fostering the care-connection and building trust. Perhaps later she will have to 'leap in' but for now she can step back so her client can step forward and communicate more easily with her. 'Leaping ahead', opening up possibilities for care, also happens when the midwives in participants' stories undertake home visits. Midwives 'leap in' when clients do not understand but do trust in their midwife, and decisions need to be made. It is possible this also reflects some clients working out what choice the midwife prefers, as they seek to do the 'right' thing. When a client shares with the midwife the goal of a safe outcome for herself and her baby, such intervention is welcomed.

Positive care is important to I-Kiribati participants and to the midwife participants who share their stories. Sulu describes the outcome as I-Kiribati clients feeling "*cared for"* and "*safe"*, but how are these moods fostered? Establishing care-connections and building trust is difficult when health professionals are under pressure to 'do' rather than 'be'; busy caseloads dictate a focus on the practical, the 'doing'. The midwife participants show they put time and energy into their care-connections to build trust in very practical ways. Some do home visits, some schedule more time, more explanations. For some midwives doing the practical side of the job is thought to be most important to their I-Kiribati clients, and that trust is built within the care-connection from midwifery skills and the positive practical outcomes seen. However, the practical job is not the only important aspect of care for these I-Kiribati participants.

More than practicalities, the I-Kiribati participants noted numerous things they value in their care. A comforting care-connection that brings hope and encouragement, feeling known and that someone is there for her, the comfort and reassurance of familiar Pacific voices, the value of talking, taking time and not rushing. These are what the I-Kiribati participants understand to be important in establishing the care-connection, and many of these are echoed by the midwife participants. However, in returning to the Experience of Tensions chapter, there is a caution for midwives; Marewe's wish that her midwife did not "*assume*" she was okay is a reminder to midwives to continue to try

to establish each care-connection and build trust, remembering, as several participants comment, it is “*not one size fits all*”.

7.13 Conclusion

Migrant I-Kiribati women experience many challenges in their experience of childbirth in New Zealand. Among other things, they ask for understanding, respect, to be treated as individuals, for time to talk, and time to get to know and be known by their midwives. Home visits and continuity of care is appreciated, and the care-connections thus established bring familiarity and build trust. Midwives are in a position to ask, to try to understand, and to actively promote care-connections and build trust relationships with I-Kiribati, and to give positive care.

Chapter 8: Discussion

> "Enlarged thinking" or… "double vision" … we enlarge our thinking by letting the voices and perspectives of others … resonate within ourselves, by allowing them to help us see them, as well as ourselves, from their perspective, and if needed, readjust our perspectives as we take into account their perspectives. (Volf, 1996, p. 213)

8.1 Introduction

The research question of this doctoral study was "what is the experience for migrant I-Kiribati women of childbirth in New Zealand?" The aim was to uncover meaning in I-Kiribati women's experience of pregnancy, birth, and the postnatal period to enable midwives and other health professionals to better understand the challenges I-Kiribati face as migrants, leading to better care. The findings show that the experience of childbirth for migrant I-Kiribati women in New Zealand can be one of tensions; that at times they experience being silent or being shy, and that relationships, care-connections, are important. Findings also support the presence of an I-Kiribati holistic view of health and wellbeing. In the light of these findings, the care-connection between migrant I-Kiribati women and their midwives has potential to make a difference to their childbirth journey.

What follows is a synthesis of the research findings. It incorporates literature which further adds to the discussion, recognising that there is no research specifically on the subject of migrant I-Kiribati women's experience of childbirth in New Zealand. Preunderstandings are revisited, the 'thinking spaces' from the Literature Review chapter are addressed, and the contribution of this research to the body of knowledge is highlighted. Limitations are explored and recommendations listed. This discussion concludes with a summary of the key messages emerging from the voices of migrant I-Kiribati women breaking the silence on their childbirth experience in New Zealand.

8.2 Bringing the Experience(s) Together

8.2.1 Experiences are Within the Context of Family Relationships

The phenomenon in question in this study is 'the experience' of migrant I-Kiribati women, of childbirth in New Zealand. It shows that migrant I-Kiribati women arrive in New Zealand with a network of relationships, their care-connections, the threads of which run through all their stories. While the predominant relationship shown is relationship with family, they 'bring with' them other relationships: to their I-Kiribati community, their history, their cultural ways and traditions, the land from which they

come; to the stories they have heard about New Zealand from others, their own experience, and to all that has gone before. That such widespread relationships exist, highlights the holistic nature of the I-Kiribati worldview of health and wellbeing (Cleverley, 2023; Namoori-Sinclair, 2020; Schutz, 2022). That a focus on family relationships exists, suggests that speaking about migrant I-Kiribati women in isolation misses the full picture and focuses on the 'part' while ignoring the 'whole'. While participants are individuals and remind us that one size does not fit all, their experience is not primarily an individual experience. It is about the individual and their family together. This has implications for midwifery care which shall be discussed later.

8.2.2 Experiences are Informed by a Holistic View of Health and Wellbeing

Relationships are a theme in all the participants' stories. So too is the notion that migrant I-Kiribati women have a context; indeed more, a holistic worldview, and that it is an important part of their experience. Heidegger's description of the holistic worldview of human beings, or Dasein, can assist understanding. Migrant I-Kiribati women are 'in the world', they are 'with others' and they have care-connections with others. Therefore relationships, whether positive, negative or indifferent, are an integral part of their makeup, their being. In them, body, mind, spirit, culture, place and history, the past and the present are linked, leading to the future, and are gathered together as a whole (Heidegger, 1927/1962).

While each person is situated holistically, the relationships between the 'parts', letting the 'whole' be seen, are not always visible to the outsider. Those not from a culture with a tradition of a holistic worldview of health and wellbeing may not easily recognise its existence in others. While many I-Kiribati themselves may not consciously think about having a holistic world view, the I-Kiribati participants telling their stories show there is more than just surface words and actions. There are relationships, beliefs, and practicalities in the background influencing what is seen on the surface. For example, an *I-Matang* midwife may see an I-Kiribati woman silently labouring and think she is 'coping well'. This may be true on one level; while meantime, the woman remembers admonishments from her mother to silently save her strength for pushing baby out, being true to her traditions. However, on another level, this 'coping well' may not be the woman's individual preference, merely her choice not to go against community tradition, 'that which is done'. Alternatively, it may be that she is too 'shy' to publicly express what she feels in an unfamiliar environment, as Tara alluded to in her first labour experience in New Zealand. It is clear that without an awareness of there being

a holistic worldview or context, assumptions about meaning can be made on the basis of what is seen on the surface, assumptions which may be incorrect.

The participants' stories are made up of many interwoven 'parts' of their lives which were important for them to talk about. They show that if the balance of 'parts' is not present, if one part of their life is not functioning well or faces a challenge, tensions can develop. Health professionals, including midwives, are not always aware of the complexity of the 'parts' comprising the 'whole' person before them. Some may not recognise that they, themselves, are within a context, nor see the effect it can have on their own lives. Whether or not a holistic worldview is recognised by the person themselves or by others, the balance of health and wellbeing of a migrant I-Kiribati woman is challenged when she comes to the unfamiliarity of New Zealand.

8.2.3 Experiences Include Unfamiliarity, and Feeling Unsafe or 'Not at Home'

For most I-Kiribati women, New Zealand encompasses many unfamiliar 'parts': culture and language, systems and people, and different ways of 'doing life' in their new country. All the 'parts' that make up their lives are potentially challenged, testing them to maintain the 'whole-ness' of their health and wellbeing. In Heideggerian terms, the effect of being 'thrown' into an unfamiliar world can bring a feeling of not being in control and give a sense of unfamiliarity, anxiety, unease, uncertainty, of feeling unsafe, a mood of being 'not at home' (Heidegger, 1927/1962). Such feelings are exacerbated if someone is facing their first pregnancy with no experience of caring for an infant; all is unfamiliar. Participants speak of much that describes the sense of being 'not at home' although, unsurprisingly, they do not use those exact words. I-Kiribati participants show that this sense of being 'not at home' can come from challenges and changes to relationships, from not being understood, not understanding, unmet expectations, feeling physically or culturally unsafe, or even from fears of any of these things occurring.

What is noticeable is the result of feelings of unfamiliarity and 'not being at home', even if such feelings are not expressed. For I-Kiribati participants in this study, often such feelings are described indirectly and, at the time, may not have been told, not verbalised, indicating a silence or shyness about sharing a mood of being 'not at home'. Questions are sometimes kept inside, or information not shared as a result of feeling 'not at home.' That help might not be sought at a crucial time clinically, or that it may be assumed that all is well when it is not, must cause concern about the safety implications for clinical care in such a situation. However, the participants continue their journeys, relying on family relationships in the process, doing what is needed to

progress on their way towards being ‘at home’. For them, it is not usually an individual endeavour; it is the thread of relationships with family, partners, parents and others, and sometimes midwives, which assist them on this journey. It is these relationships which are part of their context, with which they face change and find out about the New Zealand health system. As they carry out traditions, it is from these relationships from which they receive cultural knowledge and support (or not).

8.2.4 Experiences Show a Journey Towards Feeling Safe and ‘at Home’

Heidegger (1927/1962) would describe feeling ‘at home’ as a normal way to be or feel, as a sense of ‘everyday-ness’, something that all human beings strive for It is as though all are seeking a balance. The need for balance between the components of I-Kiribati health and wellbeing was described by Schutz (2022) and is part of the holistic worldview. For I-Kiribati participants this journey to feeling ‘at home’ is one which is always in play. It is always ‘on the way’ and in the company of family relationships.

I-Kiribati participants describe the result of having a sense of being ‘at home’. Each time participants speak of being understood or listened to, or feeling comfort in a voice, valuing a relationship, expectations being met, information being understood or feeling safe in their care, they indicate a sense of being ‘at home’. Participants show themselves to put effort towards feeling ‘at home’. They speak of taking time and making an effort to find care, find out information, develop relationships; that is, to establish and build care-connections, building trust and, ultimately, to find positive care. This is a dynamic journey, a negotiation of space towards feeling ‘safe’ and ‘at home’.

For some I-Kiribati women the journey may not be straight forward, such as those who may not have volunteered to be interviewed for this study because they lacked confidence in themselves or in their English language skills. It may be that they find this journey much harder than expected, or harder than others find it. For most there is added strength and resources from being part of the ‘whole’ which includes their care-connection to family and community. The participants know what it takes to continue on that journey and significantly, they decide for themselves if they feel enough familiarity, enough ‘at home’ within their care-connections, to break their silences when they need to and speak up. Such a decision cannot be taken by someone else. From what participants have said, it is made easier with family support and if they have a sense of being ‘safe’ and ‘at home’,

Movement along this dynamic continuum draws from their past and anticipates their future as they journey from feeling ‘not at home’ to feeling ‘at home’, to the here and

now of what matters most in their childbirth experience. This journey may begin to be understood further, by remembering that issues raised by I-Kiribati participants exist in the context of care-connections, relationships, and in the presence of a holistic worldview.

8.2.5 Experiences of Relationships With Family and Community

Migrant I-Kiribati women 'bring with' them strengths to their new country including pre-existing relationships or care-connections with their contexts, wider families, parents and partners, and others in their communities. Some relationships are preexisting but some are new, such as the family care-connections where sisters and aunties and grandmothers take on mothers' roles, the care-connection with a midwife who is like a friend, or the care-connection found in in the familiar sound of a Pacific voice. It is clear that there is more than just the midwife whose relationship is significant in the experience of migrant I-Kiribati women in childbirth. All are important care-connections in which trust can be built and bring the possibility of positive care but, in the absence of such support, the experience for migrant I-Kiribati women can be negative.

8.2.6 Experiences of the New Zealand Health System

Preexisting Care-Connections

Migrant I-Kiribati women participants are generally positive about receiving maternity care in New Zealand. Part of their journey towards feeling 'at home' is helped by the preexisting relationship or care-connection they have with the New Zealand health system. This was shown by several participants who spoke of feeling "*lucky"* to be birthing in New Zealand. For those participants it appeared to help give them a sense of being 'at home', at least in this part of their lives. The stories in which this is mentioned suggest that feeling '*lucky'* to have maternity care in New Zealand is related to feeling 'safe', in a clinical sense, compared to maternity care in Kiribati.

Traditional (I-Kiribati) Healthcare alongside Western Healthcare

I-Kiribati share characteristics in common with other Pacific Islanders. One is that there is an importance of tradition and culture practiced in family and in the wider community (Nabobo-Baba, 2006; Namoori-Sinclair, 2020; Schutz, 2022). This includes traditional medicines and healthcare, which may sometimes be at odds with New Zealand healthcare policies. Traditional medicines and healthcare are mentioned in I-Kiribati participants' stories, but it appears that they are not much discussed with midwives, if at all. Similarly, Schutz (2022) found that such practices were not always shared with health professionals. She called for more openness towards dialogue between traditional and western health sectors. This would be another way to give recognition to

I-Kiribati holistic beliefs about health and wellbeing, and to reveal more of this holistic worldview to those working in New Zealand's western healthcare system. 'Familiarity' on both sides will further establish care-connections, whether at institutional or individual level, and build trust for positive care. For this to happen, I-Kiribati participants who do talk of this issue ask for health professionals, midwives, to trust them and to trust that they have a common goal of a healthy mother and baby.

Communicating and Understanding with a White Face

All my participants spoke English so interpretation in this research study was not an issue. However, while English literacy was not a problem, a lack of health system literacy could sometimes create a further sense of unfamiliarity for I-Kiribati participants. Without family to guide and support finding maternity care, more participants would have been disadvantaged. Any struggles with English literacy would have made this an even bigger challenge. With or without English language skills, asking for information or clarification of what one must do can be further limited by a culture of shyness, which some I-Kiribati participants freely own to possessing.

The New Zealand maternity care system may be unknown; thus, 'unfamiliar'. The I-Kiribati women might be unknown and 'unfamiliar' to midwives, as heard in participants' stories where needs are not understood or 'how they are' is assumed. Additionally, the 'face' of this system remains non-Pacific, which adds to such unfamiliarity. While a Pacific midwife does not guarantee positive care in every sphere, as Marewe found, there is potential for the familiarity of a Pacific face or voice to bring comfort, as Maria experienced in her emergency caesarean, to open the way to feeling 'at home'. There is progress nationally with numbers of Pacific midwives increasing, as described in the Introduction chapter, but that is not the 'whole' answer. There remains potential for all health professionals to invest in understanding, and in becoming culturally safe.

Individual versus Community Responsibility

There is an expectation which predominates in the New Zealand health system, that individuals are responsible for their own health outcomes (Namoori-Sinclair, 2020). As Dixon and Guilliland (2019) observed, "neoliberal policies of past governments have resulted in holding the individual responsible for outcomes out of their control" (p. 48). If one sees that some people, such as I-Kiribati, are from a context in which there is a community responsibility for people's health and wellbeing (Namoori-Sinclair, 2020), one can see that there is potential for misunderstanding between health professionals and those needing their care. While participants did not explicitly bring up the subject of community responsibility for health (maternity) care, it is revealed by the importance of family and community relationships shown in participants' stories. An example is that of

Roi seeking a midwife. Finding a midwife is an individual's responsibility in New Zealand but, in Roi's story, she deals with the task through her 'community's' response and is successful. Alternatively, community responsibility for health and wellbeing should not be assumed, as seen in one of Marewe's stories, where her midwife did just that. A lack of expected support from family or community brings the person again into the realm of unfamiliarity and feeling 'not at home'. Recognition of such gaps can be difficult for an outsider to the culture or, in Marewe's case, even for someone from a similar culture. Understanding is needed that individuals have contexts which are not all the same, and which can change over time.

Informed Choice

Another expectation, indeed, a right of individuals utilising the New Zealand health system is that of 'informed choice' (Health & Disability Commisioner, n.d.), and midwives also expect this of clients. 'Informed choice' is a subject brought up by midwife participants; however, it was not mentioned by I-Kiribati participants. Stories suggest that 'informed choice' did not always exist for them, despite saying indirectly that they did have preferences for how they would have wanted their care to proceed.

Some of the midwife participants say that for some women, trust in the midwife is enough for a decision to be made. On one level, one could think this is stating the obvious, as 'don't we all make decisions on the basis of trust?' Trust that the information or probabilities we have been given is correct, that the people we are hearing are trustworthy, that we can trust our own capacity to weigh up what we hear and take responsibility to decide for ourselves? But the midwives also do not think this is an example of 'informed choice', as the women deciding do not have full understanding. Again, how much understanding is enough? There are different levels of understanding for each person depending on their knowledge and experience which feeds into the context of their history, their present circumstances, and their future. If 'informed choice' is to be achieved, who should say if the client is 'informed enough' before she makes her choice and trusts herself that she has made the 'right' choice. This leads me to see that both 'informed choice' and trust are more complex than is immediately obvious.

The complexity of 'informed choice' begins with the challenge, for clients, of communicating with people one does not know and whose ways one does not know. What further complicates 'informed choice' is that, while trust in the midwife giving care might be enough to make a decision, on what basis do women make their decisions, however much they understand about the issue before them? Among I-Kiribati there is respect for authority which in the health care setting can show itself as agreeing with

what the health professional suggests (Namoori-Sinclair, 2020). The reason to choose a particular option may be a deferment to the ‘authority’ of a midwife who is well-known or whose reputation is respected in the community. Alternatively, a choice may be made because information has been difficult to find or hard to understand and something must be chosen; therefore, the default of ‘what most people do’ is chosen. One I-Kiribati participant noted that some things may not be an individual decision but that of family. Perhaps some will decide on the basis of what family recommend and so maintain their cultural ties, while some may decide according to what they previously did themselves. Then again, it is possible that some may choose what the midwife recommends because they trust the midwife and believe that they have a mutual goal, that of the mother and baby being safe and healthy.

It may be that the discussion of ‘informed choice’ should be centred in cultural safety, which can only be gauged to exist by the recipient of care, the client. As trust is dynamic (Solomon & Flores, 2001), perhaps so too is cultural safety in the context of ‘informed choice’; one is never fully ‘there’.

8.2.7 Experiences of Midwives and the Woman-Midwife Relationship

The Woman-Midwife Relationship is a Journey

While some I-Kiribati participants express that they feel ‘safe’ and thus, to some extent, ‘at home’ with the wider New Zealand health system even before their arrival, in reference to midwives the participants’ stories are different. A mood of feeling ‘at home’ with midwives is not automatically or immediately present. I-Kiribati participants show a progression in their care-connection with their midwife, beginning with seeking a midwife, through finding a midwife, to knowing and being cared for by a midwife. In the beginning the I-Kiribati participant experiences the midwife as unfamiliar and in the anticipation of meeting, they can sometimes feel unsafe. For some I-Kiribati participants this feeling persists, and they are those who expressed concerns. If what follows is time and dialogue together with the midwife, the care-connection is further established, trust is built, and positive care is received and perceived. This appears to be the case for most of the I-Kiribati participants.

Everyone has a Context

Migrant I-Kiribati participants show they have a wider view of life than just a pregnancy and the arrival of a new baby. For midwives, it is this ‘part’ of an I-Kiribati client’s life in which they are involved. Just as migrant I-Kiribati women can feel ‘thrown’ when faced with someone they do not immediately understand linguistically or culturally, midwives can also experience a feeling of ‘thrownness’ in caring for I-Kiribati families. The sense

of ‘unfamiliarity’ and ‘not at home’ is not restricted to migrant I-Kiribati women. While midwife participants did not phrase it as such, there was a recognition that there is more to understand about their I-Kiribati clients. It may be that sometimes midwives are not aware of, or struggle to understand, the ‘whole picture’, the holistic nature, of I-Kiribati clients’ lives. It may not be obvious to the midwife that an I-Kiribati client-midwife relationship is not just two individuals establishing their care-connection but that a network of other relationships is at play. Such recognition is made more difficult if midwives are not aware that they, themselves, are situated in a context from which comes their own preunderstandings and influences everything they do and say.

Knowing one’s own context (tradition, culture, history, relationships, care-connections) equips midwives to understand that the ‘other’ is similarly complex in their makeup. Reflection on these things is a vital part of cultural safety for midwives (New Zealand Midwifery Council, 2012; Ramsden, 2002). It describes the beginnings of cultural safety and, as such, must play a part in clinical safety (Perinatal and Maternal Mortality Review Committee, 2022). I wonder if the new Midwifery Scope of Practice with its focus on the whānau and the client’s wider context, as defined by the client, will help understanding that midwife and client are both situated in a context (New Zealand Midwifery Council, 2024).

Relationship Not Checklist

Midwives often asked me while I was undertaking this research, “what do I need to know to care for I-Kiribati?” It seemed to me that they wanted a checklist on what they should know about migrant I-Kiribati women experiencing childbirth, in order to facilitate positive maternity care. A checklist would limit one’s understanding to surface details and a ‘one size fits all’ mode, something which both I-Kiribati and midwife participants in this study dispute. It would also risk neglecting individual need in the process of homogenising characteristics of those receiving care.

Rather than facts to know, I-Kiribati participants’ stories lead me to see that perhaps the question for midwives to ask should rather be “How do I care for I-Kiribati?” Although not as significant as relationships with family, participants show that they have relationships with their midwives in their time of childbirth. If they mention their midwife in their childbirth story most phrase their care-connection in terms of relationship. From what I-Kiribati participants say, there is no list of facts to learn; rather, a description of a dynamic journey, as already suggested, one of establishing a care-connection and building a relationship of trust. The answer to “what to know?” and “how to care?” is then clear; it is about relationships.

Understanding versus Doing

I-Kiribati participants do not see a midwife's role as just as there to do a job, as assumed by some midwife participants. Most show they value practical checks as well as their care-connections with their midwives, and that understanding is important in this relationship, their care-connection. I-Kiribati participants' stories show them experiencing tensions in their childbirth journeys which may not be obvious or understandable to the midwives caring for them, who might only hear silence. However, participants' stories emphasise that a lack of audible questions does not mean the absence of questions, and that verbal agreement does not always mean full understanding or complete agreement, as found by Uauang's midwife, Violet. Silence has meaning which may be about dissent, misunderstanding, confusion, or even something else. There is more to understand.

Midwives may be aware there are tensions for migrant I-Kiribati women and may be tempted to try to 'fix', 'control', or 'deal with' it in practical ways, especially if they are busy and have time constraints. In doing so there is a risk that there is a loss of focus on understanding and building the relationship. Admirable and appropriate as it may be to 'do' things, this can be a 'leaping in' which ignores that the strengths required for migration are still there, within both the individual and the community. Such strengths can be revealed through dialogue in the context of the care-connection with the midwife. 'Leaping in' may also deny the client possibilities of succeeding in 'doing' it themselves in the here and now, and of sharing such experience or knowledge with others in the future.

'Leaping ahead' involves a midwife trusting that they share the same goal of care as the client and their family, trust which is built on their care-connection. 'Leaping ahead' also suggests inclusion of family and community. Such inclusion begins with asking about and recognising their presence and ongoing influence and including, fostering and facilitating their support for the client's wider health and wellbeing. The woman-midwife relationship has potential to build trust in pre-existing and new care-connections in order for migrant I-Kiribati women to access positive maternity care. Such positive care works well; both 'leaping ahead', maximising the client and family's potential to do it themselves; and 'leaping in', such as is most often needed in emergencies.

8.2.8 What do Migrant I-Kiribati Women Ask of Midwives?

The short answer to this question is that one is unlikely to hear any demands from many migrant I-Kiribati women given the existence of cultural shyness (*te mama*), at least not directly or on first meeting. The participants' stories, however, tell what did

and did not help them progress in their childbirth journeys, speaking indirectly and directly to this question. What follows is based on my interpretations of what I-Kiribati participants want from their midwives and health professionals.

I-Kiribati participants ask indirectly to be understood, to recognise that they have pre-existing care-connections and, like midwives, are part of a context. Recognising and facilitating the involvement of pre-existing care-connections, as staff did for Tantan and Timwa's grandmother, gives the possibility of positive care, both short and long-term. There is no checklist for the midwife concerned as to how to do this but, as those caring for Tantan and Timwa showed, it can be worked out. What is available are relationships or care-connections with the person giving birth and their family, and from these come the possibility of the midwife dialoguing with them and listening to them, recognising their common goal of care, and trusting those such as Grandmother, to give positive care.

I-Kiribati participants highlight experiences of positive care which is both practical and relational. These include midwives choosing to cross into unfamiliar spaces to meet with them as in home visits; midwives taking time and effort to build rapport, to listen, talk, give information; to not rush; to maintain privacy; to understand the silences, and to hear when the silences are broken. Midwives also allude to the importance for midwives to understand that not all clients are familiar with 'informed choice'. Other experiences in I-Kiribati participants' stories focus on attitude such as proffering respect, preserving dignity, having an attitude of being 'present'; accepting them and treating them as individuals within their *utu* or *kaainga*, their I-Kiribati community; and not assuming how things are for them. All these things I-Kiribati participants ask for, and show from their experience, facilitate the establishment of care-connection and build trust, creating an platform or environment for positive care.

8.3 The Fate of Researcher Pre-understandings and 'Thinking Spaces'

The research question comes from my heritage and my worldview, my pre-understandings. In the course of this research, I was learning all the time. I had assumed that women would be comfortable with sharing their stories and I believe this was so. There were a number of cultural assumptions I made about I-Kiribati which I noted to be different between individuals. Migrants' lives and actions may be dictated by their social situations, such as living in community. This was shown by the paradoxes in a story such as Marewe who would have loved to have a community of I-Kiribati around her but did not, and Maria's story, where she struggled with the

closeness and extent of her community while remaining staunchly committed to them. The tensions experienced are indeed individual.

While I had thought that I-Kiribati women would want to conform to what is done in New Zealand, to try to do what was ‘right’ locally, I again found it was very individual. While some might conform, it was clear that women who chose to would keep to the ‘I-Kiribati way’, but their midwives may not know. To a large extent my preunderstandings, as seen in the Introduction chapter, were practical things. Even after my Kiribati trip, my preunderstanding that everything would be different and unfamiliar for migrant I-Kiribati women was related to practicalities they would face. What emerged were stories clearly based around the presence and absence of relationships in a wider context than just practical issues. Yes, everything was different and unfamiliar, but it went deeper than just being in a new location and culture, deeper than practicalities. Some preunderstandings were revealed only when I reflected on what surprised me in reading participants’ stories. For example, I felt surprise at Tara’s evident fear of meeting her first New Zealand midwife, and still wonder both at the enormity of the unfamiliarity she faced and what she might have heard from others about unconscious bias or racism in New Zealand healthcare. I wondered too if any of my I-Kiribati clients had ever had similar experiences which I had not heard about.

The cultural shyness which I have observed, and some I-Kiribati researchers have noted, was spoken of by both I-Kiribati participants and midwives. My unspoken pre-understanding that this research question is midwife focused was not correct; participants’ stories are indeed their stories, which focused on relationships but not always on those with midwives. Midwives are just a part of the whole context of life for migrant I-Kiribati women experiencing childbirth in New Zealand.

With learning came new understandings, and my own practice began some small changes. The following are examples:

- I began to ask at booking appointments or first meeting clients or clients of colleagues, “What do you want me to call you?”, and document it in clients’ notes.
- I began to document what the expected greeting in clients’ mother tongue would be and try to remember to greet them with it each time we met, with varying degrees of success and no small amount of laughter.
- I went from “do you have any questions for me?” to “what questions do you have for me today?” at the end of a consultation.

Further questions arising from my preunderstandings were raised in the ‘thinking spaces’ noted in the Literature Review. As the stories of the experiences of I-Kiribati participants showed, many of these questions were addressed in the Findings chapters. For example, I wondered what the experience would be for an I-Kiribati woman in meeting a midwife for the first time. Tara’s experience of anxiety and tension is shown in the anticipation of her first meeting with the midwife, even though she herself is very articulate in English language. Although she does not name it as such, this same example shows that Tara has concerns which could translate to a fear of racism or discrimination. This answers another ‘thinking space’, while at the same time provoking other questions about what Tara had heard or experienced previously which made her feel that way.

It is clear that not all questions from the ‘thinking spaces’ are answered by this research. Some questions were unanswered because the topics were not brought up by participants, such as translation or the experience of not attending clinic appointments. Still other questions remain, some of which stand out to be researched and will be seen in the recommendations section.

8.4 Other Literature

This research is unique in its focus on migrant I-Kiribati women and their experience of childbirth in New Zealand. It lends support to research showing the holistic nature of the I-Kiribati worldview of health and wellbeing (Cleverley, 2023; Ministry of Social Development, 2015; Namoori-Sinclair, 2020; Schutz, 2022; Thompson, 2016). “*Te mauri* (wellbeing) encompasses a comprehensive and holistic health belief system that incorporates elements of cultural, mental, physical, social, spiritual and environmental aspects of health” (Schutz, 2022, p. 212). Schutz proposed *Te Kuan* Model of *Te Mauri* which illustrates, pictorially, all the aforementioned components contained in an I-Kiribati fishing net. Such a net must be balanced by weights, illustrating the need for a balancing of its components in order for health and wellbeing to be a reality. Tensions shown in I-Kiribati participants’ stories reveal that such a balance is clearly a challenge as they face an unfamiliar environment. What I-Kiribati participants in my study add to this model of wellbeing is the temporal element. Participants show clear connections with the past, in terms of people and place, which are presented as influencing the here and now. They also speak of, and demonstrate, clear hopes for the future. Past, present, and future all influence their wellbeing.

Thompson’s (2016) research showed the holistic nature of I-Kiribati migration experience in New Zealand and acknowledged the temporal aspect of their settlement journeys. Their interlinking areas of life aim for the goal of “settlement satisfaction” over

time, which results in a “sense of belonging in New Zealand” (p. 236). This corresponds to the feeling ‘at home’ as shown by I-Kiribati participants in my study, who make it clear that feeling ‘at home’ is not a one-time achievement of a goal, nor is it one ‘thing’. Similarly, I-Kiribati values and culture change and vary between people. “Not all I-Kiribati and researchers agree on what the core values or characteristics of Kiribati culture are… it is important to recognise that what constitutes Kiribati culture is not static” (Ministry of Social Development, 2015, p. 8). That there is no one homogeneous group can be understood from the varied stories of I-Kiribati participants, who also say one size does not fit all.

Other Pacific cultures share the holistic view of wellbeing as a foundational principle (Havea, 2024; Teariki & Leau, 2023). Teariki and Leau (2023) found that “‘Family’ is described as lying at the centre” (p. 8), and that relationships are a vital aspect to this worldview. Pacific women voiced that “the strength of being part of a collective contributes to wellbeing” (PACIFICA Incorporated, 2023, p. 30). The centrality of family in I-Kiribati participants’ lives is seen in their stories and given the holistic worldview, this relationship cannot be separated from the rest of their context, health, and wellbeing, and their childbirth experience.

I-Kiribati participants in this study spoke about their care-connections with their midwife in terms of a relationship, which concurs with other New Zealand research. Participants in Freeman et al.’s (2004) study, 41% of whom were Māori or Pacific women, used relationship terms such as “personal attributes” or “the importance of feeling comfortable” (p. 10) to talk about their midwives. In Knox’s (2021) study, half of whom were Pacific women, relationships were important; “relational richness with maternity health professionals was revealed as a critical enabler of wellbeing in maternity contexts” (p. 131). Griffiths (2019) found that for her participants, all of whom were Māori or Pacific women, “building an effective relationship with their midwife” was important in their ongoing engagement with pregnancy care, and that their building of these relationships developed trust (p. 200). Women’s feedback is routinely sought from midwives’ clients in New Zealand and supports the literature above. Dixon et al. (2023) found that for clients receiving continuity of care from midwives, the building of a positive relationship took “the establishment and maintenance of trust, honouring decisions and empowerment” (p. 1), and resulted in positive care. The converse was also true. Daellenbach et al. (2024) used the same dataset but looked at clients receiving episodic care from hospital midwives. They found the aspects of care which built relationships to be “building trust quickly, respecting decision-making, fostering maternal confidence” (p. 1), and that a positive care relationship shaped positive satisfaction with maternity care for clients and their whānau. Both studies are

supported by I-Kiribati participants' stories. While they did not overtly mention empowerment and decision-making, empowerment as a result of their midwife relationship or care-connection was implied, and participants spoke of having trust in, and valuing, respect from their midwives.

I-Kiribati and midwife participants in the current study both demonstrated and spoke of the effort needed to establish and build their relationship, their care-connection, for positive care to exist. McPherson (2020) advocated for health professionals to find out about a Pacific person's culture in order to care for them well. Cleverley (2023) agreed, saying health professionals will then gain "some understanding of their client's cultural background" and become "sensitive to their client's cultural beliefs, values and needs" (p. 31). Just as understanding is always 'on the way', the woman-midwife relationship or care-connection is never static. As Teariki and Leau (2023) stated, "relationships do not simply just exist. Rather, they need to be nurtured and protected for the benefit of the holistic system" (p. 8). These are echoes of what I-Kiribati women asked of midwives; to listen, to respect, and to take time to get to know and understand them. This is how midwives have potential to make a difference and how they can build positive care for health and wellbeing.

8.5 A Contribution to Current Understanding

What this research adds to the field of research about maternity care in New Zealand is the voices of I-Kiribati women; it is an in-depth view of the experience of a small number of the I-Kiribati diaspora in New Zealand, whose voices are rarely heard. Participants' stories go much deeper than statistics could show, bringing increased understanding about the lived experience of migrant I-Kiribati women.

An I-Kiribati holistic view of health and wellbeing, as already described, is supported in the current study. The research shows that midwives and other health professionals have more to understand about their clients of 'other' cultures to themselves; in particular, that their clients exist in a context. To the midwife or health professional they are the 'embedded other'; embedded in their context, their network of relationships or care-connections. The writings of Heidegger (1927/1962) on Dasein can assist midwives, particularly those from western cultures, to understand more about the holistic nature of human beings.

8.6 Limitations of This Research

Thinking reflexively continues and although there will be more limitations elucidated over time, I 'bring-with' me the positive attribute of having cared for around 70 I-Kiribati families through childbirth in the last 17 years, and so have begun on the path of

understanding about I-Kiribati and I-Kiribati culture. With this understanding comes recognition that familiarity can give way, at times, to assuming the meaning of conversations.

As a researcher from outside the I-Kiribati culture I 'bring-with' me pre-understandings from a different culture, both ethnically and professionally, to my interaction with the I-Kiribati participants. These pre-understandings colour how the interviews have been conducted, and it may be that as 'midwife' the conversations would have been different than if participants had seen my qualification to be that of 'researcher', for example, or from another profession.

Being an outsider, I may not have understood well, and I may not have been given some information because I am an outsider. For example, I-Kiribati spirituality is an important part of the holistic worldview but, apart from a recognition of belief in God, there was little divulged in women's stories about their spiritual element of life.

The majority of research with I-Kiribati in New Zealand, including this study, is with well-educated participants, mostly schooled to tertiary level. While such research remains valid, there may be other voices and stories, different issues, not heard as a result.

This study has a small number of participants and while this allows participants to be viewed at some depth, the range of views and stories could be wider. However, the value of such depth cannot be underestimated, and what the existing range of participants' experiences reinforces is that, despite similarities culturally and experientially, "*one size does not fit all*".

8.7 Recommendations

Practice

Practice recommendations begin with the premise that most midwives want the best for their clients and want to understand, as shown by the midwife participants' stories. Practice points major on midwives purely because I myself am a midwife, but such practice is applicable to other health professionals.

- Midwives are in a position to ask about, and recognise, I-Kiribati clients' care-connections; that is, their context. They can recognise and acknowledge these care-connections, include, foster, and facilitate them to support their client; with the aim of ongoing positive care. This is, in fact, relevant to any client from a culture other than the midwife's own.

- Midwives can hear what I-Kiribati participants have said and, like them, see the women-midwife care-connection as a relationship.
- Midwives can try to understand while not assuming that they already do so.
- Midwives can ask I-Kiribati clients about their culture (Cleverley, 2023) to further understand the I-Kiribati holistic worldview of health and wellbeing, while recognising that each person is an individual and that each person's contexts are not the same.
- Midwives can have the attitude of being 'present', regardless of the time available, and so give more than practical care.
- Midwives can take what time they are able to; dialogue, let clients talk, listen, develop rapport, explain, put themselves into an 'unfamiliar' space such as a home visit in order to get to know their clients.
- Midwives can create an environment for establishing care-connections and building trust, an environment conducive to questions being asked and clients can break their silence if they choose.

Service and Community

Service and community recommendations are combined because they both bring components to service planning which are vital for care to be appropriate and culturally safe.

- Service planners can give opportunities for dialogue between key I-Kiribati leaders, I-Kiribati traditional health practitioners and professionals of the western health sector (Schutz, 2022), with the aim of western health professionals gaining understanding of the I-Kiribati holistic worldview of health and wellbeing and applying it to both service planning and professional practice.
- Service planners have a responsibility to support all health professionals to invest time in understanding 'becoming a culturally safe professional'; that is, allocating paid time for training and time for practicing cultural safety as part of normal work responsibilities, particularly where practitioners are working with clients from different cultures to their own.
- A service planner or community organisation can establish a working group of health professionals and I-Kiribati non-professional advisors with an aim to find ways to ensure I-Kiribati and other small diverse groups of childbearing women are accessing services and have information they need to both navigate maternity care and meet their holistic needs. This group could establish an I-Kiribati information hub for maternity care (or indeed for health care in general) in locations where the number of I-Kiribati are significant. This 'information hub' could be a person, in the form of a 'maternity advocate', who walks alongside

and advocates for those needing support to find appropriate care. At the most basic level, this person would be an I-Kiribati, someone with some training about what is offered and where, who also knows how to access interpreter support. Ideally, they would be linked with the local I-Kiribati community and develop links to primary or secondary birth units where they 'know and are known'. The 'maternity advocate' could also link with those who employ significant numbers of I-Kiribati to spread this information and/or publicise their work. Such a 'maternity advocate' would be a resource for the families who are already informally filling this role (Namoori-Sinclair, 2020). Key to this role is a goal to 'reproduce' this person both in the I-Kiribati community and in other small diverse communities. Various models exist from which ideas could be taken; for example, maternity support workers at Whangarei Hospital (S. Bree, personal communication, April, 2024), or Amma Birth Companions (2021).

- An alternative to a person being the 'information hub' may be an 'information hub' in the form of a written booklet translated into I-Kiribati language, or an I-Kiribati website. The focus would be maternity care, what is possible and where to get care and further information; but other aspects of wellbeing could be addressed in a holistic manner.

Education

In writing these recommendations I recognise that understanding will always be 'on the way', and further education or training will assist in this process. There is, too, a need for those who are learning to be valued rather than problematised, in the same way they are expected to value the different cultures to which they are exposed. This emphasises that it is not just about behaviour change (Knox, 2021).

- Student midwives and post registration midwifery education need to go deeper in addressing how to practice in a culturally safe manner; self-reflection regarding worldviews, how to find out about and understand alternative worldviews; what is a holistic worldview, how to communicate with clients from cultures not your own, and how to balance treating people as individuals as well as part of a community. The possibilities are endless but it is vital that there is recognition that midwives themselves come from a context which shapes them, and recognition that the predominant understanding of culture, as well as the maternity care system in New Zealand, is western-centric, in which many migrants do not feel 'at home'.
- Include in such programmes the subject of caring for the 'embedded other''; asking about care-connections, the context; recognising context and different worldviews, acknowledging context, including, fostering, facilitating context -

and so enabling the person's network of care-connections to be supportive in the long term.

- More Pacific midwives, including I-Kiribati, are needed. Although not all women want a midwife of their own ethnicity (Griffiths, 2019), more Pacific midwives will increase the body of understanding in midwifery in New Zealand about Pacific peoples, which has potential to increase cultural safety for Pacific women experiencing childbirth. There is a need for funding scholarships to be more accessible for Pacific student midwives of the smaller diverse groups. Support by Pacific midwives alongside the finance will be a vital part of enabling these students to thrive.
- A community organisation or collective has potential to run a course for new migrant I-Kiribati people, as suggested by Namoori-Sinclair (2020); "culturally appropriate training is needed to support… women to be empowered to ask questions and seek help, and not to be *mama* for fear of making mistakes as English is their second language" (p. 167).

Research

Recommendations for research would do well to note recommendations from Pacific researchers; for example, conducting research that is "by Pacific, for Pacific" (PACIFICA Incorporated, 2023, p. 38). In this research, as in a number of other studies with I-Kiribati and Pacific people, the majority (two thirds in this study) had tertiary qualifications or had planned tertiary studies. There is a "need to capture views of Pacific women with lower income and educational achievement" (PACIFICA Incorporated, 2023, p. 39). This may include those for whom both English and the New Zealand maternity system are other languages. There is also a need in Pacific research to capture the experiences of the second and third generations, who are increasing in number and who may be more evident among maternity clients in the future.

- Salutogenic research on what is working in client/whānau-midwife relationships in New Zealand; that is, how do midwives encompass family and other care-connections in caring for their clients.
- Interpretive research, client rather than professional focused, on what constitutes holistic midwifery care in New Zealand.
- Action research on teaching holistic care.
- What does holistic research look like? What roles will the care-connections and context, of both researcher and 'the researched' play in such research?
- What is the meaning of informed choice to those who are new to the experience?

- Appreciative inquiry research on what helps women/girls to sign up for midwifery education and what enables them to continue through to the end of the programme.
- Action research and evaluation of ‘maternity advocates’ working with migrants and other diverse groups.
- What is the connection between cultural safety and clinical safety in maternity care? (Perinatal and Maternal Mortality Review Committee, 2022).
- How can New Zealand College of Midwives gauge satisfaction with midwifery care by the significant group of clients who do not complete the current online consumer satisfaction survey? For example, busy mothers for whom English is a second language or who feel constrained by cultural shyness to speak their mind.
- Quantitative analysis of health and perinatal outcome statistics for the smaller Pacific ethnic groups, such as I-Kiribati, in order to bring focus to what is needed in their maternity care so that budgeting can target deficits.

8.8 The Closing and the Beginning

This thesis shows there is much to celebrate in participants’ stories, particularly the strong migrant I-Kiribati women and caring midwives. It is my hope that this thesis is a beginning of new understanding, and an inspiration for further questions to take understanding ‘on its way’ (Gadamer, 1975/2013).

I-Kiribati come to New Zealand with all that has gone before, history, cultural ways and traditions, and experience. Each has their here and now; their ‘what matters most at this time and in this place’. They do not immediately feel ‘at home’ in New Zealand nor in its model of midwifery care. At times their experience is that of feeling ‘thrown’ into an unfamiliar world, and of not necessarily feeling in control. With the balance of holistic wellbeing disturbed, unfamiliarity, anxiety, and tensions, can all combine to make them feel ‘not at home’.

The experience of silence was also noted by participants. There is never an empty silence. Silence holds meaning which may be about cultural shyness, respect, strength, or tradition, but it cannot be assumed to mean consent. Participants show that some silence needs to be understood, while other silence waits to be broken at a time of the client’s choosing. Silence is a complex phenomenon, but it is also common, and these stories may resonate with cultures other than I-Kiribati.

Findings in this study support the presence of an I-Kiribati holistic view of health and wellbeing; migrant I-Kiribati women experience childbirth in the context of relationships,

particularly those with family. This supports the premise that care-connections exist between all people, negative, positive, or indifferent (Heidegger, 1927/1962), and there is always a ‘relational space between’ them (Nabobo-Baba, 2006; Wendt, 1996).

Midwives can ask women about their wider care-connections, their context, and which ones are important to them. These care-connections can then be recognised, acknowledged, included, fostered, and facilitated to enable women to receive the holistic care and support they need to feel ‘safe’ and ‘at home’ on their childbirth journey.

In the light of the findings in this thesis, the migrant I-Kiribati women’s relationships, their care-connection with midwives, have the potential to make a difference to their childbirth journey. Building these relationships creates an environment of trust and a possibility of positive care, meaning silence can be broken and tensions are able to be voiced and/or understood by midwives. In such an environment, I-Kiribati women and their families are more likely to feel ‘at home’ in such a way that they journey through childbirth feeling ‘safe’, understood for who they are and what they bring.

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Appendices

Appendix A Poem on Post-Kiribati Visit Interview Reflections, 2019

On what I imagined a Kiribati migrant woman's first experience of childbirth might be like in NZ:

All is change, it's not the same
as back at home,
so many rules that no-one tells
in this new land;

She meets the midwife, what is that?
the Kiwi accent's hard to catch;
Thinking, "too much choice, confusing me,
I'm only having a baby!";

Offered classes for third trimester,
shy to speak and why she ought to go eludes her;
Many questions, keeps them hidden,
but talk to mother, sister, aunt...
when internet and data package meet;

Many visits, something wrong?
making pregnancy last so long;
Sometimes late to appointment time,
don't they know - family's first she can't offend?;

And where to birth? well where would you?
cousin gave birth there, survived, so she will too;
The labour came and went in pain,
thought she'd die, hope to never do it again;

Husband came and saw the birth,
no one else to see my work, except the staff;
Baby birthed and safe, alive!
seen in Kiribati on messenger from its first cry;

Birthed and in a quiet room alone,
not like home, where she'd get help to get things done;
Baby nurtured kept inside,
rarely wrapped but always close to mother's side;

It is her fate this job has come,
this gift of motherhood bestowed from the Divine;

All is change, it's not the same
as back at home,
so many rules that no-one tells
In this new land.

Appendix B Literature Review Research Articles

International research with migrants

Study & study aim	Location & methodology	Participants & data collection	Key findings
Balaam et al. 2013 Migrant women's perceptions of their needs & experiences related to pregnancy & childbirth	European countries Qualitative systematic review, analysed via thematic synthesis	Participant range in studies from 4 to 80 migrant women from Africa, Asia, Middle East, & Europe. 16 articles (1996 to 2010); all individual interviews + 1 focus group	Immigrant women wanted from their maternity care good communication; to understand how the care system works; to have carers who treat them with respect, kindness, & in a non-discriminatory way; and to have a safe pregnancy & birth. Concludes: migrant women, when pregnant & giving birth, are in a vulnerable situation. To improve their situation there is need to strengthen continuity of care & provide a "caring relationship to help them find meaning in the new country" (p. 1927). **Critique:** There is a diverse range of women categorised as 'migrant', a homogenous term. **Relevance:** The ethnicities of all these women may come with very different backgrounds and values to *I-Kiribati* women.
Benza & Liamputtong 2017 Enquires into the meanings & experiences of motherhood from the perspective of migrant Zimbabwean women	Melbourne, Australia Qualitative study	15 Zimbabwean women who had had children in Zimbabwe & Australia In-depth interviews, photo elicitation, & drawing	Motherhood is significant and provides pleasure & joy, but for some it is burdensome in their new country and all say it is not easy. Zimbabwean cultural expectations of mothers exist, and some keep quiet about difficulties for fear of being labelled a 'bad mother'. Challenged by lack of knowledge about health & social care systems in new country. Often treated without respect, and racial stereotyping or labelling was of major concern. Although motherhood had a positive side for these women, negative experiences with health care (as above) meant they felt "overwhelmed about becoming a mother in (Australia)" (p. 76). Suggests: to improve health & social care for migrant women & their children, health care providers should try to understand how they perceive & experience motherhood & their mothering role. **Critique:** a strong qualitative study that brought forth meaning-rich analysis. **Relevance:** African culture may bring different experiences of being a migrant but the Australian birthing experience may have similarities to New Zealand, although without the continuity of care model.

Study & study aim	Location & methodology	Participants & data collection	Key findings
Bollini et al. 2009 Pregnancy outcome of migrant women compared to women of host countries	12 countries in Europe Systematic review	65 epidemiological studies in European countries (1966 to 2004) (1,632,401 migrant women out of total 18,322,978)	Immigrant women showed poorer outcomes: 43% higher risk of low birth weight, 24% high risk of preterm birth, 50% higher risk of perinatal mortality, 61% higher risk of congenital malformations. Significant reduction in risk of the above (compared to host country women) in countries with strong integration policy, even after adjustment for age & parity. Possible reasons for improvement are immigrant participation, decreased stress, & decreased discrimination. **Critique:** No experiences documented. **Relevance:** This comprehensive international study provides context on migrants' perinatal outcomes.
Crowther & Lau 2019 Explores experiences of communication & language concerns for migrant Polish women when accessing UK maternity services	Scotland Qualitative descriptive; salutogenic conceptual framework for analysis	9 migrant Polish women with recent experience of Scottish maternity services & limited understanding of English In-depth individual semi-structured interviews	1/ Communicating & understanding: participants had feelings of vulnerability about language proficiency, interpretation services were inconsistent, and the quality & type of information provided was crucial to them. 2/ Relationships matter: both in continuity of care with providers & with family. Both bring meaning to participants' experiences. Responsive communication made them feel safe, respected, & understood. 3/ Values & expectations: coming from a biomedical model of maternity care to a psychosocial model challenged expectations; e.g., scans, some had unmet expectations. Women adapted through internal strengths & valuing differences such as free care & having choices. This shows: 'the significance of quality communication, relationship & culturally sensitive practices as ways of mitigating feelings of vulnerability in the host country" (p.30). **Critique**: Two main points arise; this was carried out with one ethnic group in one UK city so findings may not be generalisable. Characteristics of interviewers were not clear; some used a translator and others did not, both aspects can bring interviewer or translator influence to bear on what was or was not discussed. **Relevance:** These themes resonate with those found in other research with migrant women internationally and in New Zealand.

Study & study aim	Location & methodology	Participants & data collection	Key findings
Goodwin, Hunter & Jones 2017 The midwife-woman relationship in a South Wales community: experiences of midwives and migrant Pakistani women in early pregnancy	South Wales Focused ethnography	9 migrant Pakistani women & 11 practicing midwives Semi-structured interviews & observation	The midwife-woman relationship was important for participants' care experiences, but women & midwives saw factors influencing this relationship differently. These factors were family relationships, culture & religion (tension with western medicine), differing health-care systems (differing expectations brings tension), authoritative knowledge (difference disrupted relationship), & communication of information (e.g., family speaking for woman seen as caring by women but as a barrier by midwives). Midwife-woman relationship seen differently: midwives saw a poor relationship resulted from misunderstanding or not adapting to the health care system or misunderstanding the nature of this relationship. Women saw family relationships as central & expected services to adapt to their needs. Shows: the need to recognise & manage differing expectations of maternity care. **Critique**: This research focussed on Pakistani women who come from a very different culture and migration background to most of New Zealand's migrant and are in a very different maternity care system than the midwifery model seen in New Zealand. Assumptions were perhaps sometimes made about the culture by researchers, such as assuming that months 1 to 3 of "becoming immersed in the culture" (p. 349) could be achieved by, in the main, attending public gatherings, which is the male space in Pakistani culture. **Relevance:** Women's voice was heard about their expectations of maternity care in a Western country.
Henderson et al. 2018 To describe & compare maternity experiences according to recency of migration & compared to UK-born women, taking	England Cross-sectional national survey (carried out in 2010)	Random sampling. 5332 postpartum women responded (54% response-rate). Grouped into UK-born (78.8%), Accession countries (those who joined the EU since 2003), & rest of the world	All migrants less likely to begin antenatal care by 10 weeks gestation & rates of pregnancy complications less than UK-born women. Recent migrants from Accession countries had more antenatal checks & more likely to have a normal birth than UK-born women. Recent migrants from rest of the world were more likely to have a caesarean and preterm birth. This group, while having fewer complications than UK-born women, perceived it to be a more negative experience; perhaps related to expectations. In response to questions about understanding & being treated with respect & kindness, "overall satisfaction with care was lower in all migrant groups at each stage, especially during labour & birth, compared with UK-born women" (p. 89). "Those from Accession countries were significantly

Study & study aim	Location & methodology	Participants & data collection	Key findings
region of origin into account		Also, 0-3 years or 4 or more years since arrival Questionnaires via interview or via interpreter	less likely to feel that they were spoken to so they could understand & treated with kindness & respect" (p. 87). Shows: the importance of health professionals discussing differences between women's home countries & the UK to inform women's expectations of care about what options they have. **Critique**: 'Rest of the world' migrants were a heterogeneous group so little about this group is likely to be transferable; however, data on other groups is of use. The participants self-selected to respond, and so characteristics of non-responders in each group could not be determined and may have revealed different data. Also, the large number of participants creates a need to homogenise data and individuals' data and outliers' voices are less likely to be heard. **Relevance:** Migrant women's voices are heard in reply to set questions potentially providing some consistency in data collection.
Heslehurst et al. 2018 Review of perinatal outcomes, access to perinatal health care, & experiences for migrant women, including asylum seekers & refugees	Worldwide Systematic review Quantitative = 14, Qualitative = 9, Mixed methods = 6	29 systematic reviews (2009 to 2017, including studies 1956 to 2016) 1 study with women of asylum seeker status 27 studies with women migrants, including asylum seekers & refugees; plus 1 review including marginalised groups Various	"Perinatal outcomes were predominantly worse among migrant women, particularly mental health, maternal mortality, preterm birth and congenital anomalies" (p. 1). "Access and use of care was obstructed by structural, organisational, social, personal and cultural barriers" (p. 1). "Migrant women's experiences of care included negative communication, discrimination, poor relationships with health professionals, cultural clashes and negative experiences of clinical intervention" (p. 1). Concluded that "Improvements in the provision of perinatal healthcare could reduce inequalities in adverse outcomes and improve women's experiences of care. Strategies to overcome barriers to accessing care require immediate attention" (p. 1). **Critique**: 28 out of the 29 systematic reviews included did not differentiate between migrant, asylum seeker, and refugee, which are very different groups; thus not allowing interventions based on findings to be focused on specific groups. Some data on perinatal outcomes and risk factors are limited and some definitions are inconsistent between studies. **Relevance:** The measurement of perinatal outcomes is consistent enough to highlight a problem with perinatal outcomes, and points to further research being needed to determine strategy.

Study & study aim	Location & methodology	Participants & data collection	Key findings
Newall et al. 2012 Maternity needs & experiences of migrant women & professionals	West Midlands, England Qualitative study	82 migrant women from 28 countries who had used maternity services in the UK 18 maternity professionals Desktop study to establish size of migrant population Face to face interviews In-depth case studies (n=13)	Differences in access to services & continuity of service to host country population. Women said continuity of care was limited by impact of poverty, problems getting transport, & controlling relationships. Half of women said needs at birth related to language, pain relief, and religion/culture not met; feeling "ignored, unable to communicate and not in control of their labour" (p. 21). Many women felt a lack of communication & understanding about what the purpose of the home visit, so thought it was just for the baby. Use of family for chaperone or for interpreting meant that some women did not feel they could disclose problems (e.g., abuse). Suggested: "Many of the problems faced when seeking to use the maternity system relate to migration status, … poverty & poor language skills" (p. 22) & these are outside of maternity care professionals' scope of practice. However, they recommended training of staff for cultural competency, & rights & entitlements for migrants as well as systemic changes. **Critique**: This study focuses on one urban area in one country. Suspected differences in those with different migrant status but needs more research to show details and to suggest best practice in meeting migrant women's needs. **Relevance:** Recognises superdiversity of the population and variation within ethnic groups. Methods of data collection were comprehensive to glean data for a wide understanding.
Ouanhnon et al. 2023 Explore migrant women's experience of gynaecological care (including pregnancy)	Toulouse, France Qualitative study; grounded theory analysis	Convenience then purposive to maximise diversity. Included Romanian, Syrian, Sudanese, Bulgarian, Kosovan, & Albanian migrants	Some experienced active or passive discrimination or paternalism. Many saw the importance of both competence & "human qualities" in a good health provider & on having a trust relationship with them. The uncertainty of their lives means they find it difficult to prioritise health care. Unfamiliarity with how the health systems worked & lack of language skills were barriers to understanding how to access health care.

Study & study aim	Location & methodology	Participants & data collection	Key findings
		Semi-structured interviews	Women respected the system, but some felt it to be over medicalised, rigid, & required visits too frequently. Suggested: health professionals increase their understanding of barriers migrant women face, highlighting self-reflection to fight discrimination & paternalism, being flexible with care, asking what women already know & their cultural needs, taking opportunities for care when they present, & plan care with them. **Critique**: Interviews were undertaken but the French-English translation is basic and could benefit from back-translation and rewriting. The presence of a professional interpreter as backup in all but one of the interviews may have limited the openness of the participants if they were on their own with the researcher and interpreter. **Relevance:** The voices of a diverse group of migrant women and their experience accessing gynaecological care including pregnancy care is heard.
Small et al. 2014 To compare immigrants & non-immigrant women's experience of maternity care	Australia, Canada, Sweden, UK, & USA Systematic comparative review	55,495 women in 12 population-based studies 2498 women in 22 immigrant specific studies 12 studies from the 5 countries (1989 to 2013) Immigrant specific studies (1990 to 2012)	Immigrant & non-immigrant women appeared to want similar things from their maternity care; "safe, high quality, individualised care… adequate information & support" (p. 1) but immigrant women gave poorer ratings of their care. Immigrant women faced challenges which negatively affected their experience of care; communication difficulties, lack of familiarity with care provision, experiencing discrimination, and poorer quality care than non-immigrant women. Health systems are challenged to improve communication, increase women's understanding of care provision, & to reduce discrimination in order to reduce barriers to maternity care for immigrant women. **Critique**: For 31,887 out of 55,495 total participants (57%) documented in this review, it was unknown if they were immigrants which may limit what can be taken from results. There is a risk of homogenizing the responses of participants due to the large number in the study. **Relevance:** Some information specific to immigrant women could be differentiated, and so their voice was heard.

Study & study aim	Location & methodology	Participants & data collection	Key findings
Thomson et al. 2022 To explore minoritised ethnic women's experiences of maternity services, including maternity care & mental health support	North West England Mixed methods & analysed using an equity lens	18+ years from self-reported minoritised ethnic backgrounds, birthed within previous 2 years, & received maternity care in the locality Online survey, interviews, community consultations (in English) (n=104) 17.6% not born in UK	While 53.8% never felt maternity staff were less caring or positive to them than to other women, 34% felt they were treated differently, many because of their ethnic background. Women described experiences or discrimination, racism, marginalisation – this can help to explain high levels of dissatisfaction, reticence in seeking help, & poor mental health. 20-30% felt their religious & cultural needs were neither understood nor supported. Incorrect assumptions about them. Some observed the difficult situation for others who did not speak English well – experiencing rudeness or poor understanding. Key recommendations = cultural safety training for health care staff; develop resources with service-users; recording systems to better detail self-disclosed ethnicity; facilities & support that are aligned with religious & cultural needs. **Critique**: While not specifically focussed on migrants, the fact that a percentage had English as a second language shows that migrants are represented among these participants (17.6%). The collection of data was largely through online questionnaires and as such includes only those who are computer literate and have motivation, confidence, and time to respond; the characteristics of those who did not respond remain unknown. **Relevance:** The experience of some women migrants is heard, and may resonate with other participants in the study.

Research with migrants in New Zealand

Study & study aim	Location & methodology	Participants & data collection	Key findings
Adelowo 2012 How do African women construct their experience of immigration to New Zealand, & what does the reveal about their well-being?	New Zealand Qualitative – a narrative study	15 immigrant women from South & West Africa who had been in New Zealand 1-5 years Individual interviews	Main reason for migrating was career development. Most significant stressor missing home & resultant loss. Most significant coping strategy was communalism. Their stories also reflect strengths & resourcefulness of participants in the face of challenges, which include racism. **Critique:** Participants are from a variety of African nations, representing different ethnic backgrounds. **Relevance:** Women migrant voices about their lives in New Zealand are clearly documented and bring out areas of questioning for I-Kiribati migrant research, although they do not mention childbirth.
***Burnett & Boyd 2019**	New Zealand Qualitative - *taona tabon inaim* methodology guided interactions between researcher & participants Discourse analysis	5 I-Kiribati born or raised in New Zealand tertiary students 7 semi-structured interviews	'Identity dancing'occurred as participants moved between *I-Kiribati* and New Zealand cultures. The term Pasifika can serve to marginalise I-Kiribati identities, & there is a concern that they can be subsumed in a pan-Pacific definition. Community was very important in establishing and maintaining identities within this minority group. **Critique:** Most participants were not migrant I-Kiribati, which can bring different challenges and understandings to that of migrants, so may not be so relevant to my own research. **Relevance:** The issues raised about identity are important also for Kiribati-born migrants.
***Cleverley 2023** To explore I-Kiribati meanings of well-being &	New Zealand	5 I-Kiribati professionals working in health,	Participants said well-being not about physical well-being but is holistic involves social domain, spirituality, culture, family, community & the home; none of which exists alone. Themes influencing well-being were; **family** is both nuclear & extended (support, quality time, love & nurture for children; financial stability; & respect is the core);

Study & study aim	Location & methodology	Participants & data collection	Key findings
how these understandings contribute to creating more culturally appropriate social services	Qualitative study with thematic analysis	education, & public sector Semi-structured interviews	**culture** (maintaining practices, values, beliefs, language); **community** (to problem solve, enhance well-being, to celebrate & maintain customs). Participants thought language was a barrier to accessing health care & a big issue was that they are taught to exhibit shyness & not be up front but to wait to be helped. It is also not their way to ask help of those they do not know - said this is the main issue preventing them seeking social services support. They thought some were unwilling to adapt & to learn the New Zealand system – they all felt it hard to adjust to the culture & way of life when they first migrated. Laughing is seen as mocking – something service providers need to know. Factors preventing access to social services include language barriers, acculturation issues, & lack of cultural knowledge & understanding with health & social services. Service providers need to expand their understanding of the I-Kiribati culture through more collaboration with I-Kiribati communities. Service providers can help new arrivals link into established I-Kiribati communities. **Critique**: Participants were a small number and a group of I-Kiribati professionals talking about I-Kiribati. As such, this is indirect information. Also, not all cultures of I-Kiribati people in New Zealand will be represented. **Relevance:** This group of professionals are knowledgeable key informants and are better placed than most in New Zealand to give in-depth insight on their culture and kinfolk and I-Kiribati meaning of well-being.
Doering et al. 2015 Explores how some immigrant Japanese women experienced	One urban centre in New Zealand Qualitative descriptive study,	13 Japanese women who had given birth within the last 3 years	Reported comparisons between care in Japan & care in New Zealand: in Japan, more scans & blood tests & weight checks; in New Zealand, more supplements & diet advice & generally too relaxed.

Study & study aim	Location & methodology	Participants & data collection	Key findings
pregnancy, labour, & birth care in New Zealand	then thematic analysis	Individual interviews (9) & Focus group (1)	Many not satisfied & struggled with the lack of scans but did not receive or ask for detailed explanations for the 'lack' of scanning; there was no discussion of the differences of maternity care expectations. Women sought information from Japanese books/material but not from the English material they were given; none had problems with English normally but struggled in pregnancy with the different medical language. A few had particular difficulties with English while in labour. Unmet expectations caused anxiety & were made worse by language difficulties. Enjoyed New Zealand care but "something was missing at times" (p. 6). While in Japan, women after birth are advised to take a long rest; women in New Zealand are encouraged to mobilise quickly. Cultural hot/cold traditions were hard for the participants to maintain in New Zealand. Participants didn't easily ask questions, expecting caregivers to work out preferences without being stated – as they might in Japan, where society is homogenous. Participants seemed to focus on what was expected (doing what was dutiful) and not "hurting the care provider's feelings" (p. 9), even if this meant their preferences were not met, as preserving this care relationship was more important to them. Suggests trusting relationship with midwife will help communication. Understanding cultural values will help Japanese women feel supported & make better informed decisions. **Critique**: Given that participants represent a small ethnic group and are from the same urban location, the chances are high that they know each other, which may influence the course of a focus group discussion. Participants' concerns are documented but limited information on the care given, or information given to counter concerns, leading me to think as a practitioner that their experience is unusual care.

Study & study aim	Location & methodology	Participants & data collection	Key findings
			Relevance: These Japanese women are migrants also, so their experience may have similarities to I-Kiribati women migrants.
DeSouza 2006 Explores the maternity experiences of migrant women from five different backgrounds	Greater Auckland Qualitative study with thematic analysis	4 Arab, 9 Korean, 9 Indian, 8 Chinese, & 10 European migrant women who had birthed in the previous 12 months 5 focus group interviews	Antenatal: Participants had to take responsibility to learn about the system & find information; Korean women noted a lack of information; women or their husbands had to take more responsibility in absence of family support; finding a midwife was a challenge – some specifically wanted someone who knew their language/culture or a female carer; antenatal classes gave support if language was not an issue. Satisfaction with antenatal care was linked to continuity of care, professional expertise, feeling nurtured, having regular contact, & knowledge of community resources. For labour & birth, some women felt they did not have enough knowledge to make informed choices, & would be told what to choose in their home countries; others received general encouragement but not enough information; others focussed on trusting the midwife; the idea of natural, non-medicalised birth was different to some but many were satisfied with it; some struggled with lack of continuity of care; women valued clinical competence, good communication, & having caring understanding midwives, some valued family support in labour while others did not. Postnatally, many women felt that the focus was on baby not the mother & that women were expected to get back to normal as soon as possible, in contrast to their perceived vulnerability & the special status of mothers; lack of information & lack of family support compounded this perception; lack of privacy & inability to get culturally appropriate foods in hospital were issues for some; loneliness & isolation was an issue for some, while others had a new self-reliance. Comments that the health system assumes that motherhood is a universal physiological experience; this means that migrant mothers can find culturally appropriate care difficult to access (e.g., certain foods or rest periods or expected interventions). **Critique**: Author's comment (and assumption) that the health system assumes motherhood to be one thing is very simplistic given that each midwife (who gives much of the maternity care) is an autonomous practitioner who decides for themselves how

Study & study aim	Location & methodology	Participants & data collection	Key findings
			to interpret the midwifery scope and standards for each client. Like the previous study, it is not clear what care was received. The focus group could, like the previous study, be a small group of women from one ethnic group who already know each other; thus giving a picture showing limited experiences. **Relevance:** The variety of participants gives a wide variety of responses and experiences, which may resonate with some I-Kiribati migrant women.
De Souza 2014 To critically analyse the power relations underpinning New Zealand maternity, through analysis of discourses used by Korean mothers	New Zealand Qualitative using discourse analysis	8 Korean mothers (birthed within the previous 12 months) Focus group in Korean language (undertaken in 2006)	The women saw biomedicine & medicalisation of childbirth as 'benevolent' & having a key role in making sure of theirs and baby's well-being (e.g., monitoring & surveillance in pregnancy & labour & birth is seen as 'empowering'). Expectations based on the medically oriented Korean maternity care system so New Zealand compared unfavourably. Experienced 'othering' by staff & by other mothers. Korean cultural traditions & beliefs focus on the woman & baby being vulnerable & in need of special care (e.g. resting & being cared for by others after birth, hot-cold traditions not respected). Advocates spaces for dialogue to resource staff to "adequately respond to difference & support the aspiration for empowering outcomes of all mothers" (p. 354). **Critique**: Assumes much about the New Zealand maternity model and the relationships between the midwives & clients. There are drawbacks of focus groups, who may know each other if they are from a small migrant group. Facilitators worked with the community so may not have had the same knowledge of how to allow participants' voices to all be heard. Is the difference shown from, as the author says, a fundamental difference in discourse, or is it just from the women in the focus group experiencing midwives who have not taken time to discuss the possibilities? That is, busy and unthinking midwives rather than ideologically led midwives? **Relevance:** Again, these women are migrants to New Zealand and have voiced their experiences, some of which may resonate with I-Kiribati in New Zealand.

Study & study aim	Location & methodology	Participants & data collection	Key findings
Gillard & Dyson 2011 I-Kiribati migration to New Zealand: experience, needs, aspirations	Auckland locations (Warkworth & South Auckland) Qualitative study	20 migrant I-Kiribati adults 2 semi structured interviews & 4 focus groups	Participants raised issues regarding housing (it is usual to live with another I-Kiribati family on first arriving in New Zealand), employment (in particular that training done in Kiribati is not recognised in New Zealand, so most will start at a basic level of employment), language (in particular the culture of being shy to speak in front of others because of upbringing & fear of being mocked for poor English). Global warming is an ongoing concern to participants & for some the difficulty of maintaining their culture in their host country (e.g., children who have grown up in New Zealand sometimes do not speak I-Kiribati language). **Critique**: This group was comprised of both men and women, of differing ages. Little was seen of migrant women's experience of childbirth per se but general migration challenges were heard. **Relevance:** This study serves as good background for migrant I-Kiribati women in New Zealand.
McAra-Couper et al. 2018 To ask Pasifika women about their choices for place of birth within the District Health Board	Counties Manukau District Health Board, Auckland Qualitative descriptive, utilising thematic analysis & hermeneutic interpretation	6 low risk Pacific women who would be eligible for birth in a primary care birth unit, who had had their babies in the previous 12 months, 4 of whom were New Zealand born Semi-structured interviews	Researchers assumed that Pacific women would prefer to birth at a primary birth unit. Participants said the hospital was close by, familiar, safer, & that is where they preferred to birth, This decision was influenced by their community & possibly their midwife. Participants had little understanding of why they would want to birth at a primary birth unit, while some had had negative experiences there (e.g., feeling alone, not comfortable eating in the lounge with others, finding too many rules). The women's choices were not so much about knowing or not knowing the choices offered; rather, more a rational balancing of the evidence. Authors recommended consultation with Pasifika women prior to design or changes to birth units to ensure facilities match their needs, & for midwives to take time to listen to the opinions & stories of those for whom they care, especially those of other cultures to their own.

Study & study aim	Location & methodology	Participants & data collection	Key findings
			The challenge is to find ways of working with Pasifika communities to maintain their high rates of normal birth while giving a real choice; this would be primary units "attuned to their needs" (p. 20). **Critique**: In this study only 2 participants were migrant Pacific women and may or may not have been I-Kiribati. Their community decision making may or may not be relevant to that of I-Kiribati women. What was 'not said' about primary units being 'attuned to their needs' would have been useful to pursue further for future planning, but it may have rested outside the aim and time available for this research study. **Relevance:** There is a clear voice of Pacific women which may resonate with I-Kiribati women in terms of reasons for choice of birthplace and how decisions are made.
McPherson 2020 Pacific women's experience of navigating colposcopy services in New Zealand	Auckland Concurrent transformative mixed methods approach utilising Talanoa	9 Pacific women (Cook Islands Māori, Samoan, Tongan) Some New Zealand-born, some migrants Individual interviews	3 themes: 1/ Pacific women's experiences were influenced by cultural beliefs & values (e.g., around sexuality, ways of communicating, the importance of family, & the place of traditional beliefs & prayer). 2/ Participants' experience of making sense of abnormality, & the challenges of understanding & what helped. 3/ The participants' views of factors to improve service delivery (e.g., communication & practical help). **Critique**: While participants were Pacific peoples, it is not clear if any were migrants. The subject was not about childbirth but about health care. **Relevance:** The study is about Pacific women's experience accessing health care so there may be similarities with I-Kiribati experience.
***Namoori-Sinclair 2020** Examines the health & well-being experiences of Pacific Access	Auckland, Hamilton, Wellington Qualitative study utilising *Te maroro*	30 migrant I-Kiribati women who had come to New Zealand under the PAC policy	PAC policy is based on neoliberal thought which favours self-responsibility & individualism; traditional I-Kiribati 'maneaba' governmentality focuses on community – so women interpreted the New Zealand system as lacking support/not helpful. Author recommended a hybrid between the two to aid PAC migrants. Finding jobs was stressful, especially if they kept the I-Kiribati culture of shyness (e.g., asking for a raise/help).

Study & study aim	Location & methodology	Participants & data collection	Key findings
Category (PAC) migrant I-Kiribati women, including how policy impacts them	and thematic analysis	Individual interview (*Te maroro*)	I-Kiribati families in New Zealand have had to give support to PAC migrants as they have had none from the state (e.g., housing, job-finding, healthcare & other services). Some childbirth experiences noted by participants (e.g., stillbirth) – participant blamed the midwife for not giving enough information & being unhelpful, but who did not show cultural understanding of I-Kiribati culture such as the whole community having responsibility for the health needs of the individual. Knowing English does not equal health literacy. Examples: • Not eligible for free maternity care (afraid of cost & not sure of the system) so sought care when residency came through in 7th month of pregnancy on the encouragement of relatives. • A participant charged for care during a miscarriage which she could not afford. • Children not sent to see doctor when sick, or sent late, as not eligible for free care. • Stress of arriving in an individualistic society with no family support. Proposes a neo-*maneaba* health & well-being model. **Critique**: While all participants were migrants, not all had childbirth experience in New Zealand, and the focus of this research was not on childbirth. **Relevance:** Women's health and well-being, and the descriptions of the I-Kiribati culture are all highly relevant to the experience for I-Kiribati women of childbirth in New Zealand. That the author is I-Kiribati strengthens the veracity of the observations noted in this thesis.
***Schutz 2022** To explore the health beliefs & practices of Kiribati migrants	New Zealand-wide Qualitative using a *te kora*, an I-Kiribati framework and thematic analysis	30 I-Kiribati 1st generation migrants to New Zealand, 18 years or over, who had accessed the New Zealand health system	Many participants struggled to manage illness in a timely manner & lacked understanding of western health practices. I-Kiribati practice their traditional health beliefs & values in New Zealand, but also navigate between western, Māori, & other-Pacific health practices. Participants reported having massages in pregnancy from family or a traditional healer (for pain, changing fetal position), and traditional cares after birth to speed recovery &

Study & study aim	Location & methodology	Participants & data collection	Key findings
		Individuals interviewed (a discussion or *maroro*), some with support people present	establish breastmilk. Fears of unnecessary hospital intervention were noted (e.g., Caesarean or episiotomy), as was the importance of mothers supporting their daughters in pregnancy & at birth. Keeping baby inside & baby things separate would prevent illness, & family support would prevent psychological illness on the part of the mother. Language & health literacy appeared not to be major issues for participants. If appropriate, reassurance & explanations of procedures were given. Offers a research model with I-Kiribati of *te kora*. Proposes a model of I-Kiribati health & well-being (*Te kuan* model of *te mauri*), which describes how I-Kiribati perceive health & how they navigate between health practices to manage their health in New Zealand. This is a starting point for supporting traditional I-Kiribati practices. **Critique**: Males and females were interviewed which gives wider information but is less specifically about women. The author's own critique notes potential loss in clarity in the process of translation from I-Kiribati language to English. Sensitive subjects may not have been spoken of so fully by participants. Findings may have been influenced by the researcher being known as a 'nurse' and, therefore, a person with 'power' not possessed by the participants. **Relevance:** In the I-Kiribati, author proposes a holistic model of health & well-being, understanding of participants' stories is increased.
***Teariki 2017** Examines the role of housing as an influencer of the settlement health of I-Kiribati migrants	*Article from the thesis listed under Thomson (2016) as below*	I-Kiribati migrants	Housing is a significant influence on I-Kiribati settlement. Adults bear the mental cost of poor or limited housing, including social isolation; often sleeping in one room as a family to keep warm during the early days following migration. Children bear the cost of poor housing physically. Shows a link between ill-health and overcrowding. Familiarity influences where I-Kiribati chose to live.

Study & study aim	Location & methodology	Participants & data collection	Key findings
			Advocates minimum standards for rentals.
***Thompson 2016** Explores the settlement experiences of I-Kiribati migrants living in New Zealand	Wider area of Wellington & Kapiti Qualitative study, using constructivist grounded theory	14 I-Kiribati adult family representatives (8 women; 6 men who had been in New Zealand less than 10 years In-depth individual interviews, sometimes accompanied by other family members	Settlement is complex. Support from family & friends was key to establishing their settlement base in New Zealand. Labour market mobility had the most effect on participants' experiences; language proficiency was especially important determinant for women. Participants wished their children to retain I-Kiribati culture & tensions arose that they did not seek connections with New Zealanders as much as their children wanted. Retaining culture & language assisted sense of belonging in New Zealand. Participants' health could be negatively affected by effects of migration (or was it that they were diagnosed in New Zealand? or was it that Tarawa population relies increasingly on imported refined foods?), but most said they & their children were healthier in New Zealand with better air, more fresh fruit and vegetables, & better health services. **Critique**: interviews in one city may bring up issues particular to that area. It is not clear what language interviews were conducted in. **Relevance:** The study is about migrant I-Kiribati. The research is both insider and outsider; the insider researcher will have more understanding and insight, while the outsider researcher may make it easier for participants to be open about difficulties they have had. While not about childbirth, health and well-being are connected.

*I-Kiribati author

Research about Women's experience of maternity care

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
Almorbaty et al. 2022 Factors related to development of supportive relationships between women and midwives	USA, UK, Sweden, Japan, East Africa, Australia, New Zealand Integrative review – qualitative except for 1 mixed method publication	14 publications. 273 childbearing women or mothers, 450 midwives, & 78 maternity nurses (n=762)	Successful relationships require communication, trust, respect, partnership, & shared decision-making. Supportive relationships improve women's satisfaction and birth outcomes. Continuity of care is a 'crucial' enabling factor. **Critique:** Only one study from New Zealand. Ethnicity and migrant status not defined. **Relevance:** Women's voice heard, but numerous models of midwifery and maternity care different to New Zealand represented.
Bradfield et al. 2018 What is known and publish about being 'with women'	Western Europe, USA, New Zealand, Australia Integrative review - mixed method	32 publications. Women & midwives	Important themes of what influenced being 'with women' were: 1/Philosophy – of midwives and philosophy of care; 2/Relationship – with women, with their partners (context); 3/Practice – midwives' presence, care across the continuum, practice that empowers. Feeling in control was important to participants. **Critique:** Only three studies from New Zealand. Numbers not clear. Ethnicity and migrant status not defined. **Relevance:** Women's voice heard, but numerous models of midwifery care different to New Zealand represented.
Bridle 2021 Understand the experiences of midwives using language support services	UK Qualitative – analysed using thematic analysis	12 midwives Semi-structured interviews	Key themes found regarding navigating care without language: "Continuity as key", Facilitating tools", "Networks of support", & "Innovative planning". Midwives were clearly keen to support women with language barriers, but the system made this difficult (e.g., lack of interpreters or lack of accessibility for the women causing some to "fall through the net"). "Continuity of carer appears to be a protective factor due to the flexibility, relationship and continuum of support" (p. 359). **Critique:** This study does not give voice to women who experience language barriers but to the midwives' interpretations of their experience. Such women may or may not give the same interpretations.

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
			Relevance: While this study was done in the UK and in the context of a different model of care to New Zealand, it does focus on migrants.
Dawson et al. 2021 Examine whether there is discernible inequity in reported maternal satisfaction of care during pregnancy, birth, and after	New Zealand Quantitative – secondary analysis of survey using structural equation modelling	3,801 self-selected women who had received maternity care from the 2014 Ministry of Health maternal satisfaction survey Structured questionnaires	Overall satisfaction with the system, satisfied or very satisfied, was 77%. First time mothers more likely to be dissatisfied and, to a lesser extent, younger mothers. Remote rural women were dissatisfied with information provided and cultural care. Women in areas of high deprivation were less satisfied with information provided and physical access. Cost was a factor for some groups for some aspects of care. **Critique:** Response rate was low (especially among Māori & Pacific women), at 29.2% (margin of error 1.5%), so did not reflect New Zealand's birthing population. Respondents were self-selected & it is unclear what are the characteristics (or potential response) from those who did not respond. Postal survey may not suit some potential respondents. The cost analysis shows a lack of understanding by those who set the questions about the maternity system, given that first time mothers tend to be the majority taking up antenatal classes & these are funded by the Ministry of Health. **Relevance:** Responses were from women themselves; however, specific reasons for responses were limited.
Dixon et al. 2023 Explore women's experiences of continuity of midwifery care	New Zealand Mixed method. Analysed using descriptive statistics & free text thematic analysis	Feedback forms about midwifery care routinely collected in 2019 from 7,729 women	Positive relationship building (& therefore valuing of the women) came from establishing & maintaining trust, honouring women's decisions, & empowerment of women. Negative relationships made women not feel valued & showed lack of trust, a failure to honour women's decisions, & feeling disempowered. **Critique:** Although consumer feedback may not arrive in the year of birth, the feedback forms comprised 13% of the births that year, so not generalisable. Bias may occur as it is the midwife who asks for feedback. Views may not reflect the characteristics of the midwife-woman relationships of those who did not send feedback (e.g., those who do not feel strongly, or those for whom English is limited). **Relevance:** Study is set in the New Zealand midwifery care model & reports some women's voices.

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
Farry 2015 Examine the effect of place of birth on five perinatal outcomes	South Auckland, New Zealand Quantitative – retrospective cohort using an accuracy assessment of database & binary regression analysis	4,207 well women with singleton, cephalic pregnancies who went into spontaneous labour	Intending to birth at tertiary hospital compared to a primary unit, low risk women 4x more likely to have a Caesarean section, 1.5x more likely to have a postpartum haemorrhage, 5x more likely to be admitted to operating theatre, high dependency unit, or intensive care unit; & their babies 3x more likely to have low apgar (<7 @ 5 minutes) & 2x more likely to be admitted to the neonatal unit (see p. 118). The 'why' is hypothesided, but not concluded. "different models of midwifery care (continuity vs fragmented) did not have a significant impact on outcomes…the place where midwives care for women has the potential to significantly improve the 5 measured outcomes" (p. 118). **Critique:** The study could not control for the unknown factors as to why women choose where they birth. These factors may or may not be important influencers of outcomes. Augmentation of labour (including artificial rupture of membranes) & episiotomy were not captured in the research; controlling for these features may have influenced findings. Potential confounders may not have been as significant as thought, as the logistic regression models were not a great fit & other confounder may have been more significant. Among the participants, not representative of national ethnic groups, as sample comprised less New Zealand Europeans & more Pacific & Asian people. **Relevance:** Does not refer to women's experience but does look into statistics for low-risk women in the two models of midwifery care—continuity and fragmented.
Freeman 2003 Examine whether equal power is essential to the perceptions of partnership in midwifery practice & propose an alternative model of how	Hospital & homebirth settings in Auckland, New Zealand	Study One: 41 independent & hospital-based midwives & 11 nulliparous women with low obstetric risk for whom labour care was provided Study Two: 30 midwives & 27 women for	The majority of midwives and women felt they had achieved a midwife-woman partnership. Little emphasis was placed on needing equality in decision-making. The largest number of midwives "described partnership as working together with the woman towards a common aim" (p. 8). Others described "sharing information" or "joint decision-making" (p. 8). A few midwives said partnership was "not achievable because equality is not possible in practice" (p. 8), saying midwives come to the relationship with more experience and knowledge than their clients & they could influence how information was conveyed. Midwives and women have different roles and culture could influence how joint decision making is perceived. Most women described partnership in relational terms, and some spoke of importance of partner involvement in the partnership or teamwork, and others of joint decision making.

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
power might best be shared		whom the midwives provided labour care Interviews, questionnaires, & thinking aloud tape recordings	Further analysis suggested a model to show decision-making in the midwife-woman relationship as a "shared endeavour" (p. 11). Low risk decisions are made by women (e.g., positions in labour or pain relief strategies). High risk decisions were made by the midwife (e.g., labour management for slow progress, for foetal monitoring, or epidural management). Medium risk decisions were made jointly. Most women said they achieved a partnership with their midwives. Those midwives who felt partnership was not achievable, because they were not equal, were mostly experienced independent midwives. **Critique:** Sampling was not clear, with abstract different to body of paper. The model proposed has potential but may require a homogenous group of women & midwives for it to be applicable. **Relevance:** The voice of women was heard in this research and may include migrant or Pacific women.
Griffiths 2019 How do women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives?	Area of high socioeconomic deprivation in North Island cities, New Zealand Qualitative – constructivist grounded theory	11 women (6 Māori, 5 Pacific) 10 midwives (2 Māori, 7 New Zealand European, 1 European other) Semi-structured interviews	Accessing a midwife was complex – some found it easy, some difficult. Describes New Zealand as a "one size fits all" (p. 27) maternity system. Women in these areas have complex needs in changing conditions, so prioritisation of needs may mean missing midwifery care. 'Building effective relationships' between midwives and women helped them to work together to meet the woman's care needs. Along with continuity of care, women relied on the midwife for support and advocacy to negotiate a way through the maternity care system. If complications arose, there was sometimes a tension between the continuous pregnancy journey and continuity of midwifery care and the fragmented care of different cadres of health professional. **Critique:** While the author wonders if knowing the women's ages would give more information, I do not think so, as the area of focus is how women access & engage with midwives; to include all contextual demographic data may have taken away from these key areas (e.g., age, whether New Zealand born, financial situation among other things). **Relevance:** Although not clear if participants were migrants, a quarter were Pacific women, who may or may not have similar experiences to that of I-Kiribati migrant women in my study.

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
Howarth et al. 2011 Obtain an in-depth insight into the birth experience of first time New Zealand mothers	New Zealand Qualitative phenomenology, using thematic analysis	10 primiparous women between 11 days &16 weeks of giving birth Semi-structured interviews.	Relationship issues are important – with the midwife, with the partner who was the primary provider of continuous support, and support from friends and family. Acknowledgement by the midwife of the importance of each brings increased birth satisfaction. **Critique:** Participants' ethnicity or migration status not defined. **Relevance:** Women's voice is heard regarding their experience of New Zealand midwives, which may or may not be similar to migrant I-Kiribati women.
James (2021) Uncover understandings of the professional relationship between case loading midwives and the women for whom they care	North Island, New Zealand Hermeneutic phenomenology	9 case loading midwives & 8 women clients Semi structured interviews	Women came with expectations arising from previous experience. The 'right' midwife was responsive and had relational skills. They trusted their midwife to keep them safe & to be professional. Trust underpins effective relationships, is complex, and needs ongoing input. **Critique:** Women were self-selected; those for whom the midwife-woman relationship was negative, or had alternative views of midwifery, may not have volunteered to be interviewed by a midwife. There may also be different responses from different cultures. **Relevance:** The midwife as well as the women's views were heard & women were from a wide range of geographical areas and backgrounds.
Krisjanous & Maude 2022 Explore the phenomenon of customer value co-creation within a partnership model of healthcare and	New Zealand Subjective person introspection (SPI) approach, analysed in light of social practice theory	3 midwives Reflection and discussion	The Midwifery Partnership Model (MPM) in New Zealand facilitates customer value co-creation, but the partnership model "may need broadening" to add value. "Not all customers can or will choose to engage to the same extent in partnership" (p. 235). For example, the vulnerable, the young, migrants, Therefore, MPM does not cater for women who have different 'practice styles' to the majority. **Critique:** Reflection by midwife experts but a limited number. No women's voice. Premise of normal birth being the norm. **Relevance:** Analysis of partnership by those who have worked many years in MPM. May be relevant to I-Kiribati.

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
classify the nature of activities oriented to customer value co-creation			
MacDonald 2018 A history and a critique of the concept of informed choice in midwifery	Ontario, Canada Qualitative ethnographic study	1990s: Interviews with midwives, midwifery clients and colleagues (physicians & nurses). 2014-15: Participant observation. In-depth semi structured interviews with midwives, clients, consumer representatives (n=15)	Informed choice in midwifery began as a social movement; personal responsibility for health brings strength & autonomy. Critique of health providers & institutions. CHOICE. Passive to active consumers. Supported by consumer activism & lay expertise. Now clients not patients. Midwives practised informed and shared decision-making, & women-centred care. Late 1970's it became the partnership model of midwifery care. Informed choice implicit, not explicit. Clientele looked not just for choice but the package it was facilitated by; time, home visits, continuity of caregiver, postpartum care and support, for it to be more personal than technical and to have more control (see p. 283). Defining informed choice & identifying it as fundamental to the practice of midwifery was a "critical step in the making of midwifery as a profession" (p. 284). Three pillars of their midwifery care became informed choice, choice of birthplace, and continuity of care. Points out that informed choice is seen in a relational context; one could not offer care without choice, nor choice without care. While some clients see choice as political, some also see it as a commodity. **Critique:** It is clear this study is carried out by someone who has strong views but the reporting is based on the voices of participants. Method of selection for the historic or the recent data collection not clearly outlined; however, significant data are quoted from both midwives and clients. **Relevance:** The key individuals, midwives and women, predominate among the participants. Although the New Zealand midwifery model is different to that of Ontario, there are similarities in the historical changes, giving rise to thought.
Noseworthy 2013 Explore decision-making	New Zealand & Ontario, Canada Qualitative - Original research design,	14 childbearing women, 5 support person, & 18 midwives	"Decision-making in the woman/family-midwife partnership is relational in nature, influenced by the social networks and the historical, social, political, and economic contexts and locations in which they are embedded" (p. 186). Develops a decision-making model. **Critique:** This study spreads over two countries & therefore two different (albeit similar) models of midwifery care. An element for critique is that this is an original research design (see p. 84), as yet untried elsewhere, but it does place participants at the centre. The midwife & women/family are

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
in the woman-midwife dyad	a 'relational methodology'	Audiotapes of third stage of labour Interviews	both involved in the research, which may censor what is said by the woman, in case the known midwife gets to hear what she discloses. **Relevance:** While some participants are not in New Zealand, & it is not clear whether or not there are migrants among the New Zealand participants, the experience of the midwife-woman/family relationship may be relevant.
Priday & McAra-Couper 2016 Provide information, evidence & analysis on an integrated lead maternity care model for a midwifery practice in a high deprivation community	South Auckland, New Zealand Mixed-methods, using descriptive statistical analysis & content/thematic analysis	Quantitative = statistical outcomes for midwife participants for 2010, as well as National Ministry of Health, District Health Board and Midwifery and Maternity Provider's Organisation (MMPO) statistics Semi structured interviews with 9 midwives in one midwifery practice	Barriers to care and poor perinatal outcomes appear to be mitigated by the continuity of care and integrated services of a midwifery practice embedded in a Family Health Practice (FHP), leading to numerous recommendations beginning with "Lead Maternity Care, Continuity of Care to be made available to all pregnant women" (p. 89). Features of the findings included there were positive relationships between midwives and clients, there was early access and engagement with midwifery care, access to care assisted by interprofessional relationships, "MW care… is socially and culturally accepted by the community it serves" (p. 90), all positively impacting on others in the extended families accessing future care. **Critique:** While the statistics are present and positive about women receiving maternity care from this midwifery practice integrated into an FHP, the women's voice is not heard. If it were, deeper analysis could possibly show some surprises in what works and why in this situation. **Relevance:** Although this study shows the midwives' interpretations, the conclusions are valid for this community which includes 62.2% Pacific women, of whom some will have been migrants.
Pullon et al. 2014 To investigate feasibility of using focus	Wellington, New Zealand	Women who had received maternity care in New Zealand: 3 Samoan, 6 Cambodian, & 2	Positive endorsement of the model of care, including collaborative nature between professionals, but mixed response about the 'team approach' they experienced; appreciation of good communication. Negative perceptions of written surveys & a preference for oral feedback.

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
groups & interviews to gauge consumer satisfaction of maternity care by high needs women	Qualitative with thematic analysis (Pilot study)	New Zealand European (n=11) Focus groups & Interviews with set questions	**Critique:** Focus groups conducted by facilitators while it is not clear who did the individual interviews. Some interpretation was necessary; levels of interpretation likely to have occurred between what the women said and what the researchers heard. **Relevance:** Although the purpose of this study is to pilot a research process, migrant women's voice is heard to some degree.
Sandall et al. 2016 Midwife-led care compared with other models of care for childbearing women and their infants	Australia, Canada, Ireland, UK Cochrane intervention review	15 trials involving 17,674 women Review	Primary outcomes showed: Women in midwifery-led continuity models of care less likely to experience regional analgesia, instrumental vaginal birth, preterm birth <37/40, fetal loss before & after 24/40, & less neonatal death. They were more likely to experience spontaneous vaginal birth. No difference for Caesarean births or intact perineums. Secondary outcomes for these women showed: less likely to experience amniotomy, episiotomy, fetal loss <24/40 & neonatal death, but more likely to have a longer mean labour length, to be attended by a known midwife. No difference for numerous other outcomes. Majority of studies reported midwifery-led continuity of care models showed higher rates of maternal satisfaction & a cost-saving effect compared to other care models (these two aspects reported narratively). **Critique:** Does not include women with existing serious pregnancy or health complications, so it cannot be assumed these findings would be the same. Positively, all primary outcomes were of 'high' grade evidence. **Relevance:** Review does not include the New Zealand midwifery care model, although continuity of care is a common factor and it is possible that findings in New Zealand would be similar. All women are grouped together, with no differentiation between women who are migrants or of a different ethnic group and others.
Sharma et al. 2023 To analyse structure (ethnic	New Zealand Qualitative – using thematic	13 maternity health practitioners	Issues raised included significant barriers with language and communication, stereotyping by professionals, ethnic women having constraints due to cultural and family expectations, a lack of knowledge about reproductive health, and an over- or under-reading of culture, partly a result from

Author(s) & study aim	Location & methodology	Participants & data collection	Key findings
minorities & migrant inequalities) and cultural (responsiveness to ethno-cultural practices	analysis framework	Semi-structured in-depth interviews	the professional's own ethnic background; so while professionals could be more 'sensitive to' women, they 'also marginalised' women. These things shaped most maternity care practices. **Critique:** Participants were mostly from hospitals & only included 4 midwives, others being gynaecologists, obstetricians, and fertility specialists; so mostly doctors. Responses also focussed on Indian women. **Relevance:** Despite not being the women's voice, and only a third of participants were midwives, this study provides context.
Wakelin et al. 2022 Describe midwife's experience of using communication technology with pregnant women/people	New Zealand Mixed methods; quantitative via descriptive statistics, qualitative via thematic analysis	104 lead maternity carer midwives Online survey, recruited via closed midwifery Facebook sites	Communication technology supported and enhanced women's relationships with midwives. Texting enhanced documentation of care & efficiency. Concerns raised about managing women's expectations including texts for urgent issues. **Critique:** Sampling selective of a particular group of midwives (lead maternity carers and those lead maternity carers who use Facebook) & a self-selected group from within that group, so difficult to generalise, even in the New Zealand setting. Only the midwives' view is reported. Women's voice not heard to confirm or deny the midwives' opinions. **Relevance:** Interesting but not relevant at this time.

Appendix C Auckland University of Technology Ethics Committee (AUTEC)

Original Ethical approval letter

Appendix C: Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

19 August 2019

Liz Smythe
Faculty of Health and Environmental Sciences

Dear Liz

Ethics Application: 19/265 Kiribati migrant women's experience of childbirth in New Zealand

Thank you for submitting your application for ethical review. I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 12 August 2019, subject to the following conditions:

1. Clarification of how snowballing is being used. AUTEC 's preference is for the intermediary or other participant to be supplied with an advertisement to be passed onto potential participants, who can contact the researcher directly if they are interested. If the current process as described is followed, then clarification is needed about how the researcher will be assured that the intermediary or other participants has permission to pass on contact details;
2. Inclusion of the AUT logo on all the public facing documents;
3. Confirmation that the Consent Form will be sent out with the Information Sheet.

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

I look forward to hearing from you,

Yours sincerely

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: kycl@xtra.co.nz; sandra.thaggard@aut.ac.nz

Amended Ethical approval letter

c)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

16 April 2020

Liz Smythe
Faculty of Health and Environmental Sciences

Dear Liz

Re: Ethics Application: **19/265 Kiribati migrant women's experience of childbirth in New Zealand**

Thank you for sending through your responses to the conditions for the amendment to your ethics application.

The amendment to the data collection and recruitment protocols approved

Non-Standard Conditions of Approval

1. Amendment of the Information Sheet as follows:
   a. Clearly address their intended audience. For example, both second person and 3rd person pronouns are being used;
   b. Update the Executive Secretary to Dr Carina Meares on all the Information Sheets.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

I remind you of the **Standard Conditions of Approval**.

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: kycl@xtra.co.nz; sandra.thaggard@aut.ac.nz

Appendix D Tools

Introduction Letter for I-Kiribati Intermediaries

Note for those who are willing to find participants for this research:

This is something you could email directly to people you know, or read out to them if you are talking to them.

I look forward to hearing back from you.

Korabwa!

Date:.....

Mauri.....

I am writing to you for Kathy Carter-Lee, Midwife.

Kathy wants to interview/talk to some Kiribati women. She is studying "What is the experience of childbirth for migrant Kiribati women in New Zealand?" and she wants to talk to some Kiribati women one to one and write their stories. (Kathy is not allowed to interview women who have been her clients, as she knows a lot about their stories already.)

So if you have had a baby in NZ in the last 2 years OR if you had a baby in Kiribati and have been close to another Kiribati woman who has had a baby in NZ in the last 2 years, Kathy is keen to talk to you about your experiences.

Kathy will mostly interview Kiribati women for this study, and she will interview a few midwives. Kathy is doing this because she wants to understand more about Kiribati women to help her work as a midwife and to help other midwives and health professionals understand more and to improve the care they give. She is also studying for a research degree (DHSc) and this means she has to write a thesis after she has completed the interviews. Kathy plans to write out the stories women tell her for them to keep, and at the end she will write a plain English summary of the whole research and return it to them also. The younger generation of Kiribati mothers may also be encouraged by reading the other women's stories.

If you think you might be interested in being interviewed or just want to find out more first, please email me or tell me so that I can give your name and email or phone number to Kathy.

Tekeraoi

From

.....

Introduction Letter for Midwife Intermediaries

Date:.....

Dear Colleague,

I am writing to you on behalf of Kathy Carter-Lee, LMC MW with Rodney Coast Midwives in North Rodney, who is also studying for a professional doctorate with a MW emphasis.

Kathy is wanting to talk to some LMC Midwives who have cared for Kiribati women clients in the last year or so. She is going to study the question "What is the experience of childbirth for migrant Kiribati women in New Zealand?"

Kathy will interview both midwives and Kiribati women for this study. Her reason for doing this is partly to fulfil the thesis requirements of a research degree (DHSc), but the reason she has chosen this subject is a desire to increase understanding about these women. It is hoped that this study will impact Kathy's own practice and give further insight to midwives and other health professionals about the migrant women, particularly from Kiribati, with whom we have increasing contact. The study will also help to inform the younger generation of Kiribati women.

If you think you might be interested in being interviewed or just want to find out more first, please let me know so that I can pass on your name and contact details to Kathy.

Warm regards

From

.....

Phone:

Email:

Kathy's Phone: 021425115

Kathy's Email: kycl@xtra.co.nz

Invitation Letter

Kathy Carter-Lee
DHSc Student
Midwife in
North Rodney & South Kaipara
NZRN (Comp), RM, MScMCH

Email: kycl@xtra.co.nz
Mobile: 021425115
Home Phone: 09 4256749
Address: P.O. Box 296,
Warkworth. 0941.

Date:

Dear.....

Mauri.

This letter is an invitation to take part in a study. I hear that you may be interested in this study. It is about the experience of childbirth for Kiribati women in New Zealand. I am doing this study for a DHSc thesis, through AUT University.

With this letter comes an information sheet about this study and a consent form. The information sheet explains what the purpose of the study is, what will happen in the study, and what your part will be in the study. The consent form is for you to sign when we meet. The consent form is to say that you take part in the study because you want to, and not because you think you have to.

If you would like to take part in the study, please call me or email me to let me know. We can then make plans to meet. You can also text me and I will call you back. If I do not hear from you within three weeks I will assume that you do not want to take part in the study, and I will not contact you again.

If you have any questions I am happy for you to call or email me.

Tekeraoi

Best Regards

From

Kathy Carter-Lee

Participant Information Sheet (I-Kiribati Women)

Date Information Sheet Produced: 29 JULY 2019

Project Title - Kiribati women's experience of childbirth in New Zealand.

An Invitation

My name is Kathy Carter-Lee. I have been a midwife for 35 years. I have worked in the Warkworth area for 12 years. Many of the women I have cared for are Kiribati women. As you are a woman from Kiribati, I wish to find out more about your experience of childbirth in New Zealand. I want to hear your stories.

You are invited to take part in an interview to talk about your own experience. It is your choice. It is fine to say "No".

What is the purpose of this research?

I hope that the findings of this research will help midwives and others working in the NZ health system to understand Kiribati women better. This should help to improve I-Kiribati well-being, especially in relation to childbirth. The findings of this research will be summarised in a plain English document. This will be given to you and your community. The findings of this research also may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

Several Kiribati women I know have said that they will ask other women if they are willing to be interviewed. I am interested to interview

- Kiribati women who have had a baby in NZ.
- Kiribati women who have had one or more babies in Kiribati **and** have had one or more babies in NZ or know another Kiribati woman who has had a baby in NZ.
- When I have finished the interview, I will ask you if you know of anyone else who may be interested in being interviewed. If you find someone who is interested, it would be good it you could give me their phone number so I can send this information sheet and arrange to meet them.

If you have had 'me' as your midwife, then I am unable to include you in the research. This is so it is not uncomfortable for you if there may be some things about my practice that you did not like.

How do I agree to participate in this research?

Your participation in this research (study) is voluntary (it is your choice). You can phone me or send me a message via email or text. I would arrange to meet you and talk through what it means to be part of this research. If you are still willing to be interviewed, I would then ask you to sign a consent form. You are able to stop taking part in the study at any time. If you choose to stop taking part in the study, you can choose for your interview to be removed or to allow it to continue to be used. However, after the findings have been produced, removing your interview may not be possible.

What will happen in this research?

First, I would arrange to meet with you at a place that works for you. It may be at your home, or at a community centre, or at one of the AUT rooms. We will begin with introductions and have refreshments which I will bring. Once you have understood what is involved and agree to participate, you will be asked to sign a consent form. The interview may follow or may take place at a second meeting. The interviews will be recorded on a small recording device so that it can be written down at a later time. The whole thing will probably take about one and a half hours. Later, you will be sent a copy of the stories that have been taken from the transcript of your interview. At this stage you can delete or change anything you said.

What are the discomforts and risks?

You may be reminded of difficult or sad times. The interview also takes time, so this means there can be some inconvenience for you if you are busy with family or work.

How will these discomforts and risks be alleviated?

If you have taken part in an interview and been reminded of difficult or sad times you may want to talk to someone who is not one of your friends or not one of your family. This can be a counsellor at AUT (see below), a counsellor through the Warkworth Women's Centre (09-4257261), or a social worker/counsellor in Warkworth (Rosanna - 0212167244). Other supports contacts can be found by asking me (Kathy - 021425115.)

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- *drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992*
- *let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet*

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

The interview you take part in will help me to understand and write about Kiribati women's experience of childbirth in NZ. This will become my research thesis. I will submit this thesis for a Doctorate qualification at Auckland University of Technology (AUT).

After you have had an interview, I will send you a copy of the summary of your own story to keep for yourself and for your family. At the end of the study, you will receive a plain English summary of the findings of the research.

I hope this research will increase midwives and other health workers understanding of Kiribati women. I hope also that this will have a good effect on health care policies to improve wellbeing of Pacific island mothers and babies.

How will my privacy be protected?

I will make sure that no one else but me will know who told which stories. I will do this by doing interviews with Kiribati women from different areas of NZ, and by replacing true names in the story with made-up names. The interviews will be transcribed (written down) by a professional person who agrees to keep the interviews confidential (private). You will not have your name shown on your interview. Instead we will decide together what name to refer to you by, or if you wish, I will choose a name for you.

What are the costs of participating in this research?

The main cost of participating in this research will be the time for the interview. This time will probably be about 1.5 hours plus a small amount of time before the interview to read and discuss the information sheet and consent form. Sometime after the interview a story will be returned to you and it will take more time to read this, and to call or email me if there are any questions or corrections you have about the story.

What opportunity do I have to consider this invitation?

Please contact me at any time if you have questions about the information sheet. Please contact me also if you are ready to make a time for an interview. When you contact me, I will plan an appointment for the next month ahead or later. This is so that you have time to think about the information I have given you, and so that I can plan ahead. There may come a time when I have enough interviews and am not able to include more women in the study.

Will I receive feedback on the results of this research?

If you do an interview, I will return to you the summary of your story to keep at a later time. I will also write a summary of the results of this study in plain English and send it to you at the end of the study.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Liz Smythe, liz.smythe@aut.ac.nz, or phone 021351005.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Dr Carina Meares, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Kathy Carter-Lee, P.O.Box 296, Warkworth. 0941. Phone 021425115.

Project Supervisor Contact Details: Liz Smythe 021351005 liz.smythe@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *29th August 2019*, AUTEC Reference number 19/265.

Participant Information Sheet (I-Kiribati Men)

Date Information Sheet Produced: 29 JULY 2019

Project Title

Kiribati women's experience of childbirth in New Zealand.

An Invitation

My name is Kathy Carter-Lee. I have been a midwife for 35 years. I have worked in the Warkworth area for 12 years. Many of the women I have cared for are Kiribati women. As your partner is a woman from Kiribati I wish to ask about your stories of her experience of childbirth in New Zealand.

You are invited to take part in an interview to talk about your own experience. It is your choice. It is fine to say "No".

What is the purpose of this research?

I hope that the findings of this research will help midwives and others working in the NZ health system to understand Kiribati women better. This should help to improve I-Kiribati well-being, especially in relation to childbirth. The findings of this research will be summarised in a plain English document. This will be given to you and your community. The findings of this research also may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You are known by the intermediary person from the Kiribati community who is assisting me in recruitment. You have been identified as being:

- A partner of a Kiribati woman who has had a baby in NZ.

When I have finished the interview, I will ask you if you know of anyone else who may be interested in being interviewed. If you find someone who is interested, it would be good it you could give me their phone number so I can send this information sheet and arrange to meet them.

If your partner has had 'me' as your midwife, then I am unable to include you in the research. That is so it is not uncomfortable for your partner if there is anything about my practice that she did not like.

How do I agree to participate in this research?

Your participation in this research (study) is voluntary (it is your choice). You can phone me or send me a message via email or text. I would arrange to meet you and talk through what it means to be part of this research. If you are still willing to be interviewed, I would then ask you to sign the consent form. You are able to stop taking part in the study at any time. If you choose to stop taking part in the study, you can choose for your interview to be removed or to allow it to continue to be used. However, after the findings have been produced, removing your interview may not be possible.

What will happen in this research?

First, I would arrange to meet with you at a place that works for you. It may be at a community centre, or at one of the AUT rooms. We will begin with introductions and have refreshments which I will bring. Once you have understood what is involved and agree to participate, you will be asked to sign a consent form. The interview may follow or may take place at a second meeting. The interviews will be recorded on a small recording device so that it can be written down at a later time. The whole thing will probably take about one and a half hours. Later, you will be sent a copy of the stories that have been taken from the transcript of your interview. At this stage you can delete or change anything you said.

What are the discomforts and risks?

You may be reminded of difficult or sad times. The interview also takes time, so this means there can be some inconvenience for you if you are busy with family or work.

How will these discomforts and risks be alleviated?

If you have taken part in an interview and been reminded of difficult or sad times you may want to talk to someone who is not one of your friends or not one of your family. This can be a counsellor at AUT (see below), a counsellor through the Warkworth Women's Centre (09-4257261), or a social worker/counsellor in Warkworth (Rosanna - 0212167244). Other supports contacts can be found by asking me (Kathy - 021425115.)

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for you if you become a participant. These sessions are only available for issues that have arisen directly as a result of

participation in the research and are not for other general counselling needs. To access these services, you will need to:

- *drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992*
- *let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet*

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

The interview you take part in will help me to understand and write about Kiribati women's experience of childbirth in NZ. This will become my research thesis. I will submit this thesis for a Doctorate qualification at Auckland University of Technology (AUT).

After you have had an interview, I will send you a copy of the summary of your own story to keep for yourself and for your family. At the end of the study, you will receive a plain English summary of the findings of the research.

I hope this research will increase midwives and other health workers understanding of Kiribati women. I hope also that this will have a good effect on health care policies to improve wellbeing of Pacific island mothers and babies.

How will my privacy be protected?

I will make sure that no one else but me will know who told which stories. I will do this by doing interviews with Kiribati women from different areas of NZ, and by replacing true names in the story with made-up names. The interviews will be transcribed (written down) by a professional person who agrees to keep the interviews confidential (private). You will not have your names shown on your interview. Instead we will decide together what name to refer to you by, or if you wish, I will choose a name for you.

What are the costs of participating in this research?

The main cost of participating in this research will be the time for the interview. This time will probably be about 1.5 hours plus a small amount of time before the interview to read and discuss the information sheet and consent form. Sometime after the interview a story will be returned to you and it will take more time to read this, and to call or email me if there are any questions or corrections you have about the story.

What opportunity do I have to consider this invitation?

Please contact me at any time if you have questions about the information sheet. Please contact me also if you are ready to make a time for an interview. When you contact me, I will plan an appointment for the next month ahead or later. This is so that you have time to think about the information I have given you, and so that I can plan ahead. There may come a time when I have enough interviews and am not able to include more participants in the study.

Will I receive feedback on the results of this research?

If you do an interview, I will return to you the summary of your story to keep at a later time. I will also write a summary of the results of this study in plain English and send it to you at the end of the study.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Liz Smythe, liz.smythe@aut.ac.nz, or phone 021351005.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Carina Meares, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Kathy Carter-Lee, P.O.Box 296, Warkworth. 0941. Phone 021425115.

Project Supervisor Contact Details:

Liz Smythe 021351005 liz.smythe@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *29th August, 2029*, AUTEC Reference number *19/265*.

Participant Information Sheet (Midwives)

Date Information Sheet Produced: 29 JULY 2019

Project Title: Kiribati women's experience of childbirth in New Zealand.

An Invitation:

My name is Kathy Carter-Lee. I have been a midwife for 35 years. I have worked in the Warkworth area for 12 years. Many of the women I have cared for are Kiribati women. I wish to find out more about childbirth in New Zealand for Kiribati women and to hear their stories.

You are invited to take part in an interview to talk about your own experience caring for Kiribati women. It is up to you if you wish to take part or not. There are no problems for you, whichever you decide.

What is the purpose of this research?

The Kiribati community is included in Pacific Island statistics in NZ. It is known that Pacific Islanders can have poorer health than other groups in NZ. There are not a lot of statistics about Kiribati people in NZ, and nothing is written about their childbirth experience. I wish to understand more by researching their stories.

I hope that the findings of this research will help midwives and others working in the NZ health system to understand Kiribati women better. This should help to improve I-Kiribati well-being, especially in relation to childbirth. The findings of this research will be summarised in a plain English document. This will be given to participants and their communities. The findings of this research also may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

Several Kiribati women and midwives I know have said that they will ask midwives or Kiribati women, if they are willing to be interviewed. (In the case of Kiribati women, them or their husbands or partners.) I am interested to interview the following people:

- Lead Maternity Carer (LMC) Midwives who have cared for at least one Kiribati women in the last five years.
- Kiribati women who have had a baby in NZ.
- Husbands or partners of migrant Kiribati women who have had a baby in NZ.
- Kiribati women who have had one or more babies in Kiribati **and** have had one or more babies in NZ or know another Kiribati woman who has had a baby in NZ.

When I have finished the interview, I will ask you if you know of anyone else who may be interested in being interviewed. If you find someone who is interested, let me know, and I will arrange to give you an invitation letter with more information to give to them. They will then contact me if they are still interested to take part.

In this research I will not plan to do interviews with Kiribati women who have been my clients in the past, or with their husbands/partners, but they may know of others who will be interested.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice). If you choose to take part or not, there will be no advantage or disadvantage to you. If you are willing to be interviewed, I would then ask you to sign a consent form. You are however, able to stop taking part in the study at any time. If you choose to stop taking part in the study, you can choose for your interview to be removed or to allow it to continue to be used. However, once the findings have been produced, removing your interview may not be possible.

What will happen in this research?

For this study I will arrange a meeting with you if you agree to take part in an interview. The place for the interview will be up to you. It may be at your home, or at a fast-food place, a community centre, or at one of the AUT rooms. At the interviews, we will begin with introductions and have refreshments which I will bring. At this time you would sign a consent form to say you agree to the interview. The interviews will be recorded on a recording device so that it can be written down at a later time. The whole thing will probably take about one and a half hours.

What are the discomforts and risks?

Taking part in this interview will be interesting for me and for the women and midwives taking part, but you may be reminded of difficult times or sadnesses in the past or in the present time. The interview also takes time, so this means there can be some inconvenience if you are busy with family or work. As a midwife, I will ask that request someone else to be oncall for you in the 1.5 hours the interview process could take.

How will these discomforts and risks be alleviated?

If you have taken part in an interview and been reminded of difficult times or sadnesses, you may want to talk to someone who is not one of your friends or not one of your family. This can be a counsellor at AUT (see below), a counsellor at Warkworth Women's Centre (09-4257261), or a social worker/counsellor in Warkworth (Rosanna - 0212167244). Other supports contacts can be found by asking me, the researcher (Kathy - 021425115.)

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- *drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992*
- *let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet*

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

The interview you take part in will help me to understand and write about Kiribati women's experience of childbirth in NZ. This will become my research thesis. I will submit this thesis for a Doctorate qualification at Auckland University of Technology (AUT).

After you have had an interview, I will send you a copy of the summary of your own story to keep for yourself and for your family. At the end of the study, you will receive a plain English summary of the findings of the research.

I hope this research will increase midwives and other health workers understanding of Kiribati women. I hope also that this will have a good effect on health care policies to improve wellbeing of Pacific island mothers and babies.

How will my privacy be protected?

I will make sure that no one else but me will know who told which stories. I will do this by doing interviews with women and midwives from different areas of NZ and replacing true names in the story with made-up names. The interviews will be transcribed by a professional person who agrees to keep the interviews confidential. You will not have your name shown your interview. Instead, we will decide together what name to refer to you by, or if you wish, I will choose a name for you.

What are the costs of participating in this research?

The main cost of participating in this research will be the time for the interview. This time will probably be about 1.5 hours plus a small amount of time before the interview to read the information sheet and consent form. Sometime after the interview a story will be returned to you. and it will take more time to read this, and to call or email me if there are any questions or corrections you have about the story.

What opportunity do I have to consider this invitation?

Please contact me at any time if you have questions about the information sheet. Please contact me also if you are ready to make a time for an interview. When you contact me, I will plan an appointment for the next month ahead or later. This is so that you have time to think about the information I have given you, and so that I can plan ahead.

Will I receive feedback on the results of this research?

If you do an interview, I will return to you the summary of your story to keep at a later time. I will also write a summary of the results of this study in plain English and send it to you at the end of the study.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the **Project Supervisor**,

Dr Liz Smythe, liz.smythe@aut.ac.nz, or phone 09-568370.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Dr Carina Meares, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows: **Researcher:** Kathy Carter-Lee, P.O.Box 296, Warkworth. 0941. Phone 021425115.

Approved by the Auckland University of Technology Ethics Committee on *29th August 2019* AUTEC Reference number *19/265*

Consent form

Project title: ***Kiribati migrant women's experience of childbirth in New Zealand***

Project Supervisor: ***Dr Liz Smythe***

Researcher: ***Kathy Carter-Lee***

- ○ I have read and understood the information provided about this research project in the Information Sheet (dated 25 July 2019.)
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that the interview will be audio-taped and that it will be transcribed or written down. I understand that notes may also be taken during the interviews.
- ○ I understand that it is my choice to take part in this study, and that there will be no problem for me if I decide not to take part in it any more.
- ○ I understand that if I stop being part of the study then I can choose for my interview to be removed or to allow it to continue to be used. I know that once the findings have been produced, removing my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a plain English summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 29th August, 2019. AUTEC Reference number 19/265

Note: The Participant should retain a copy of this form.

Indicative Questions for Interviews

Indicative questions for Kiribati women who have birthed in New Zealand within the last two years:

"Tell me your story about your pregnancy/birth – from the beginning"

"Tell me about having your baby in New Zealand"

"What do you mean by...?"

"Tell me about a good visit with your midwife"

"Tell me your story of what happened after baby was born"

Indicative questions for Kiribati older women, who have birthed in Kiribati and have also witnessed childbirth in NZ:

"Tell me about your birth(s) in Kiribati"

"Tell me how it seems to be different in New Zealand?"

Indicative questions for LMC midwives who have cared for a Kiribati client in the last year:

"Tell me about a Kiribati woman/family you looked after that stands out in your mind"

"What did you learn from this experience?"

"What were the challenges?"

Appendix E Transcriptionist confidentiality agreement

Project title: Kiribati women's experience of childbirth in New Zealand

Project Supervisor: ***Dr Liz Smythe and Dr Sandy Thaggard***

Researcher: ***Kathy Carter-Lee***

√ I understand that all the material I will be asked to transcribe is confidential.

√ I understand that the contents of the tapes or recordings can only be discussed with the researchers.

√ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: 

Transcriber's name: Shoba Nayar

Transcriber's Contact Details (if appropriate):

...email: snayar19@gmail.com

Date: 19th October 2019

Project Supervisor's Contact Details (if appropriate):

.....Liz Smythe.....

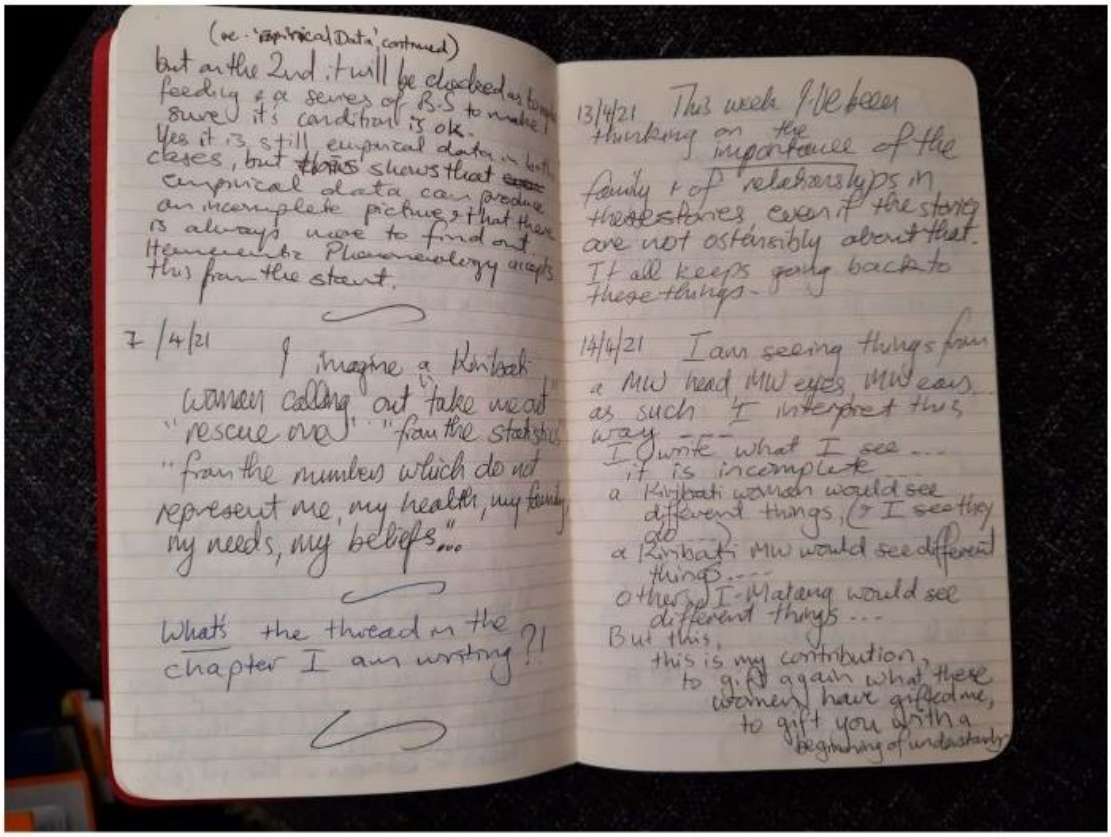
.....liz.smythe@aut.ac.nz.....

Approved by the Auckland University of Technology Ethics Committee on 29th August 2019. AUTEC Reference number 19/265.

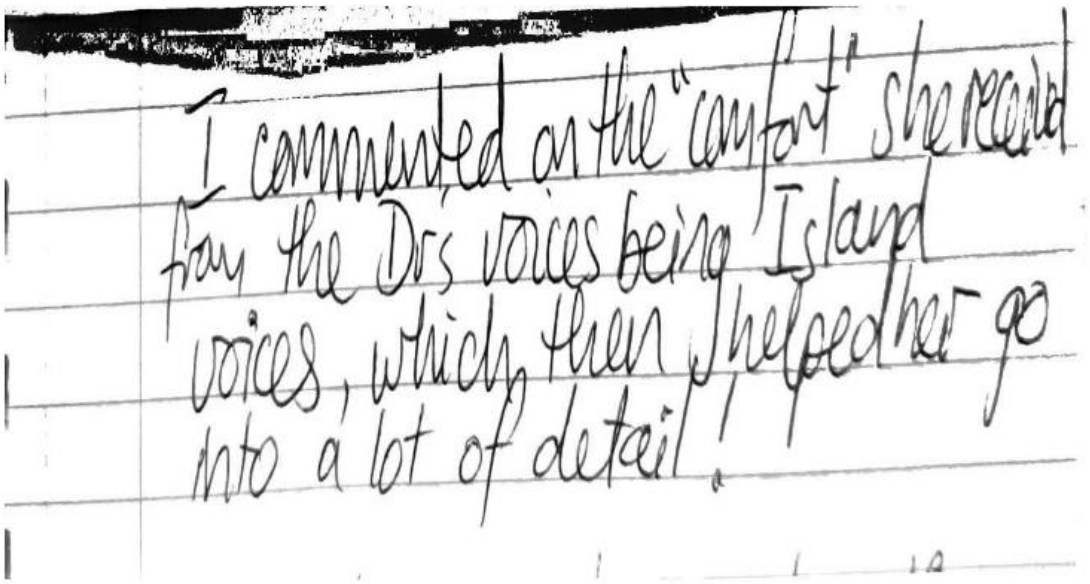
Note: The Transcriber should retain a copy of this form

Appendix F Analysis

Journals of Learning and Excerpt



Excerpt from field journal


I commented on the "comfort" she received from the Drs voices being Island voices, which then helped her go into a lot of detail.

Example of 'transcript', to full story to crafted story with initial reflections

Excerpt from Raw Transcript…

[from Interview with Roi, a Kiribati woman: [Roi flew to New Zealand when she was pregnant. She stayed with her sister and subsequently gave birth in New Zealand]

Interviewer: Thanks so much for agreeing to

Roi: No worries

Interviewer: To do this interview and we've talked a little bit about um what I'm hoping to do but um I guess in a, it's going to be important for me to listen a lot and for you to talk a lot if you don't mind ah but I just wonder if you could perhaps start by telling me your first experience um of finding you were pregnant in New Zealand? And I'm thinking, thinking about childbirth but I'm thinking as a midwife you can't separate the pregnancy from the childbirth and then you can't separate the childbirth from the um six weeks after that time.

Roi: True.

Interviewer: Tell me, what's your story?

Roi: So um I found out I was pregnant in Kiribati actually so yeah so um we were in Kiribati ….they flew me here and um my sister was here, so I was living with her and I was …pregnant when I got, arrived in New Zealand yeah so um. The hardest

To, to [name of NZ city]

No Auckland….Yeah so the hardest part of it was finding a midwife because it was like, um it was late, they say it was late yeah it was, you know they can't get information when I first got my pregnancy yeah. So, it was very hard we've, we, we I called around 3 or 4 midwives and you know, they, they um, apologised and say they couldn't you know because we were so late. And then

What did you do?

Um. My aunty, she recommended someone for us. And um she was um a Pacific midwife. Yeah so we called her and she was like oh I'll get someone to um, to find someone for you.

Oh great.

Yeah and then she, she saw us, well she made, we had a meeting with her, for the first time and then somehow I think she felt sorry for us because we were all like oh we don't know what to do because it was our first time yeah here. And then yeah she took over. She, she became our, our my midwife. Yeah so she was with me the whole way and, the difference between her and Kiribati is that they do like home visits yeah where in Kiribati you have to, visit the clinic yeah. Because, too many women, too many, to um, not too many staffs yeah. So yeah. So they came

So she came to your house?

Yeah.

For, for all of the pre birth visits

Yeah pre birth. But you know she, did our um, scan yeah so we went to the, x-ray thing, the scan yeah

Radiology

Yeah radiology yeah we had a scan there. Yeah so, it's kind of different and I think, here is, they take care of their clients more, as well.

How do you mean?

Like. Like they take care of us more like, they make sure they call us every now and then. They make sure that we're okay and we don't need like, there's nothing wrong and all that. Where in Kiribati, it's very different. Like, it's, if you have a problem you go straight to the hospital, not to the midwife. Yeah so you're not assigned to a midwife differently, you're assigned to the hospital. Like they just record it and then send it over to the hos, the main hospital.

How else did your midwife make you feel like you were cared for?

Um. In many ways! Yeah. I think it's very different here with Kiribati because yeah they're very nice like they're very what do you say? What do you call them? They attend, attend to your needs and all that yeah. They, they give you this um, things you should eat and all yeah. They give you this pamphlet yeah about things you should eat and things you shouldn't do and if like, many um pre signs, the signs yeah oh danger signs before birth, yeah. So you, actually know what's, what to do before anything bad happens. Yeah.

Excerpt from the "Full Story"…

The hardest part of it was finding a midwife because it was late. They said it was late. They didn't know about me from when I was first pregnant. So, it was very hard. We called around 3 or 4 midwives and they apologised and said they couldn't take us because we were so late. My aunty, she recommended someone for us, a Pacific midwife. So, we called her, and she was like, "Oh I'll find someone for you." Then we had a meeting with her for the first time and somehow, I think she felt sorry for us because we were all like, "oh we don't know what to do", because it was our first time here. And then she took over, and she became our, my midwife. She was with me the whole way. She sent me for a scan and did home visits pre-birth.

The difference between here and Kiribati is that they do home visits, whereas in Kiribati you have to visit the clinic. I think because there are too many women, and not too many staff. It's kind of different here as well, they take care of their clients more. They make sure they call us every now and then. They make sure that we're okay and we don't need anything, and that there's nothing wrong and all that. Whereas in Kiribati, it's very different. If you have a problem you go straight to the hospital, not to the midwife. You're not assigned to a midwife, you're assigned to the hospital. The midwife made me feel cared for in many ways! Yes, I think it's very different here compared to Kiribati because here they're very nice. They attend to your needs and all that. They give you this pamphlet about things you should eat

and things you shouldn't do and danger signs before birth. So you actually know what to do before anything bad happens.

A "Crafted Story" entitled, 'Finding a midwife'…

[From Roi's Transcript and Full Story]

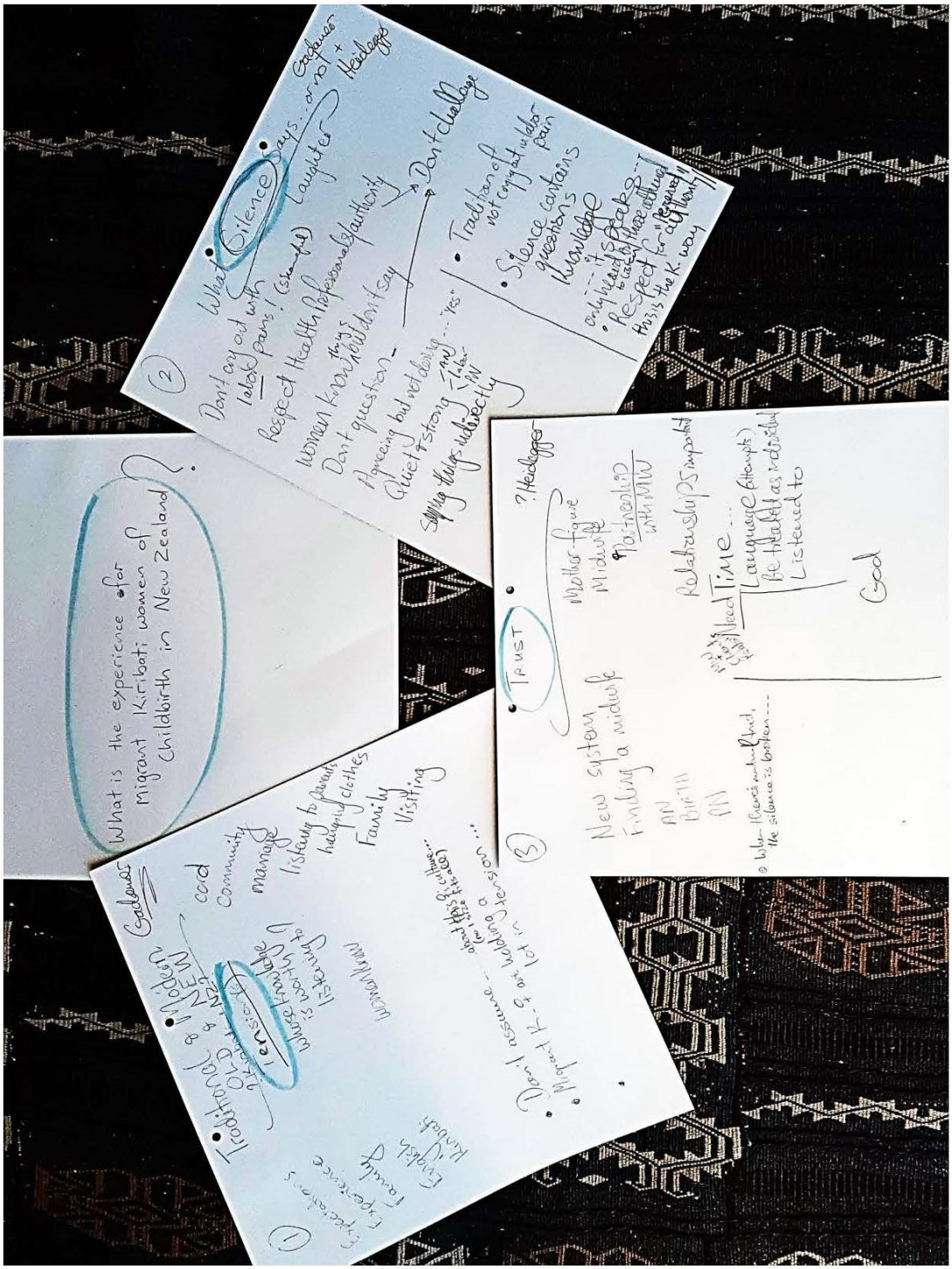
I found out I was pregnant in Kiribati. I flew here to New Zealand when I was pregnant, and I lived with my sister.

The hardest part of it was finding a midwife because it was late. They didn't know about me from when I was first pregnant. So, it was very hard. We called around 3 or 4 midwives and they apologised and said they couldn't take us because we were so late. My aunty, she recommended someone for us, a Pacific midwife. So, we called her, and she was like, "Oh I'll find someone for you." Then we had a meeting with her for the first time and somehow, I think she felt sorry for us because we were all like, "oh we don't know what to do", because it was our first time here. And then she took over, and she became our, my midwife. She was with me the whole way. She sent me for a scan and did home visits pre-birth.

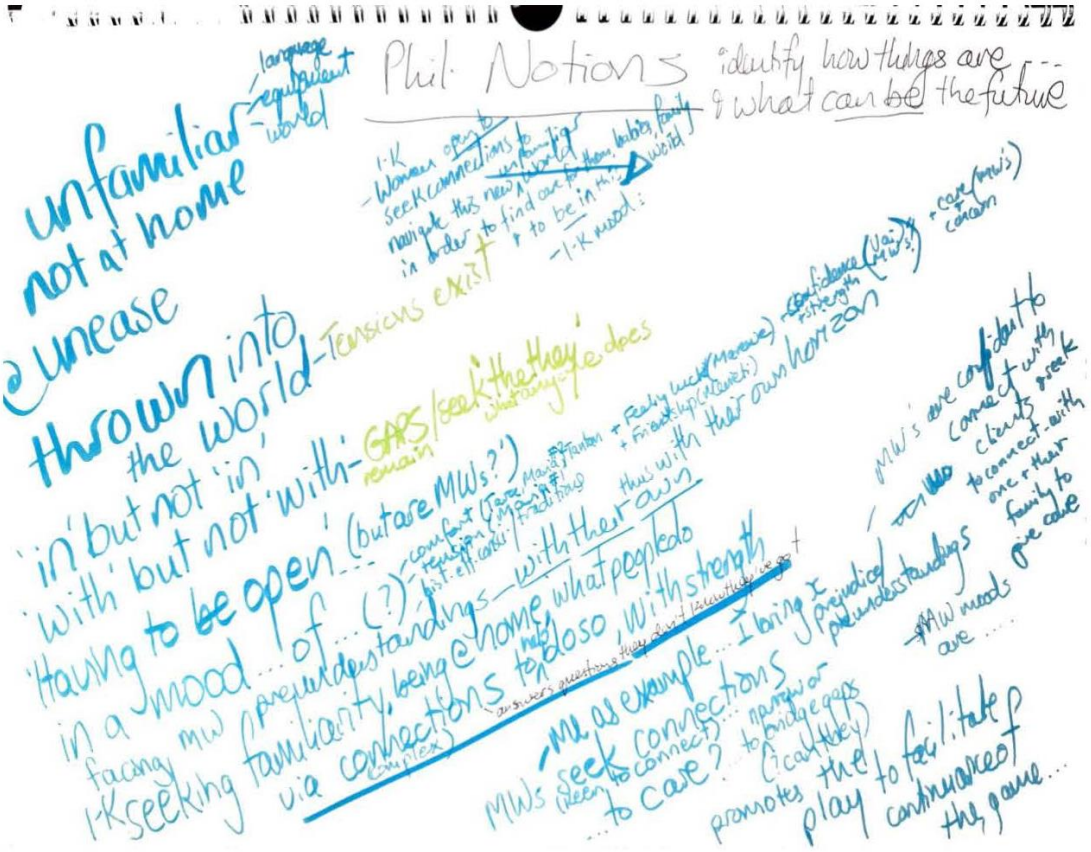
Reflection on Roi's "Crafted Story"…

Roi has gone to some lengths to make the move to NZ for the birth of her first baby. She has left husband and parents for the sister's student house, left the familiarity of Kiribati for the unknown diet and climate of NZ, left the familiar language and health system for the good of her baby and the family. The way is then blocked. Expectations of receiving care are not met. She is "late". Having planned and prepared and been organised to get to NZ in good time for the birth, she is "late" according to the NZ system. It must have been a shock, as later in the interview, she repeated her comment that finding a midwife was the hardest thing for her and expected that other women like her would find it the biggest challenge too. There were midwives, nice midwives, 3 or 4 of them even, but no midwives available to care for Roi. And then, connections are found. Aunty knows someone who is a midwife. She is a Pacific midwife. This midwife promises to help. There is a meeting, and Roi is connected to midwifery care. She and her sister, and their pregnancy, have been successfully taken over into the care of this midwife. They now belonged to a midwife, they had a midwife who was "theirs", who was with them "the whole way". In fact, Roi was never "late", she still just needed to make her connections. And, as she would have said herself, she/they did it "the island way."

Working out three themes



Example of jottings for direction from 3rd findings chapter



Appendix G Documentation of feedback session

Held at Mahurangi Presbyterian Church Hall, attended by 15 I-Kiribati women and led by Kathy Carter-Lee, May 2023.

What is the experience for Migrant Kiribati women of childbirth in New Zealand?

What do you think about these stories?

Marewe's story:

Three things:

1. What do you think of what Kathy said about the story?

It's the woman's first baby, most do know what to expect. Very sad story, the midwife is supposed to know that we are not from NZ, so the midwife should do some research on the country that we come from, sometimes not comfortable at giving birth at hospital, comfortable with our husbands.

2. What do you think is happening in the story?

- Common in first experience to not be prepared until the baby arrives.
- There is a communication breakdown on both sides. M didn't communicate well and ask questions and the Midwife didn't understand.
- You don't prepare stuff until the baby comes and that is tradition.

3. What was your own experience of the story?

- My own experience. We don't do baby showers and don't prepare until the baby arrives
- First experience. Didn't know what a midwife was – thought it was a middle wife for her husband.
- Midwife provided what she needed and her baby needed. Provided finances for rent and baby. Do not be shy to speak out and ask many questions of the midwife. Is it a hard thing to do? To ask questions? Yes.

Tara's story:

1. What do you think of what Kathy said about the story?

- Privacy and dignity is strong. Want to be understood then they will share the problems. Very hard for them to call the midwife if they don't feel close. Very comfortable and open to a person who speaks their language. So need an interpreter. They will just say they are fine even though they are not understood.
- There is a difference between pregnancy and childbirth in NZ than in Kiribati. e.g. Smear tests are not compulsory. The power differential between them and the Midwife – They are Kiribati, and the midwife is a Pelangi. Worried about what your midwife thinks about your womanly parts. Woman's private parts are our dignity. Worried we might feel judged about our female parts.
- Privacy is important.
- True that you might be afraid of being misunderstood. But would like a Kiribati Midwife. Communication is important so having a translator is important.

- Sometimes have concerns that they can't communicate well. Maybe a mixture of English language and understanding (BOTH!)
- "Tara is worried the MW will be racist to her. There's always an idea that we are below I-Matang."

2. What do you think is happening in the story?

- A lot of overthinking. She feels stuck. Had to go with the options that were given to her.
- " In Kiribati she didn't have a lot of worries – now in NZ she has a lot of worries – her family is there, she's comfortable with the nurse (probably related), and she can speak her own language.

3. What was your own experience of the story?

- Told she needed at test for DS. She wasn't told about the risk from the Midwife. She was told by the specialist (once she went there.)
- Supported by her husband every step of the way. Blessed to have Kathy as a midwife because you understood.
- Every woman is different and every child pregnancy is different.

We need to train some Kiribati midwives – I can train, take people on visits

Language – English as a second language makes things difficult. It is hard to get a translator. Kathy – If we don't ask then we don't get.

_Marewe (further notes)

No contradiction to what I said, as expected, but they thought that Marewe's issues were related to it being her first baby & that I-Kiribati don't prepare things beforehand, in case something happens (don't do baby showers)...The side comment was that every Kiribati woman has a family network...

Another group brought out that it was a situation of 'communication breakdown' but that it was from both sides that communication was poor. (For me as MW I was 'blaming' the MW). There was a lack of understanding by the MW & a shyness on Marewe's part to ask

MW supposed to know we are from overseas – should research about us – we don't know how NZ system works.

Communication imbalanced "Marewe didn't communicate more with her MW & The MW didn't ask more questions to Marewe"

(With my 1st pregnancy in NZ) "I didn't know I needed a MW. Is it a 'middle wife'?..."

"Don't be shy to speak out and ask many questions."

Common not to prepare things for baby until baby arrives – traditional.

" From our understanding in Kiribati they know what to expect from their own experience looking after other baby/ siblings"

Tara (further notes)

Yes need more Kiribati MWs

Language barrier means "it is not easy for us", "Challenging because we cannot say what we REALLY think when communicating." That is, its easier to ask questions or to say what you think when you are with someone who speaks your mother tongue.

When I commented that Tara was right, she had no choice, a true choice would be to have an Island midwife...there was agreement – everyone thought this was a good idea!

Always ask for a Kiribati translator (what K says).

..."Afraid you wont understand what the MW is saying. That is why they prefer a Kiribati MW because then they can converse freely."

"Building a relationship is important & communication is key". K MW or translator. Sometimes cannot communicate concerns and sometimes the "relationship isn't that strong here and..."

Sometimes need more information to make decisions.

"Sometimes they've come across racist MWs, but they know people are different."

Ongoing conversations

Someone spoke of seeing their cousin in reception at the medical centre & then being able to facilitate their client's visit. The client she was supporting then knew the cousin and could attend on their own as they had a connection, someone to explain things, someone to show you where to go.

Privacy & dignity were big issues. One person was shocked to find that there were male midwives. Another could not talk to a male doctor until she had a female chaperone and then only talking through the chaperone to the Dr.

Most, probably took "childbirth" to mean "labour & birth".