New Zealand Resident Sāmoan Health and Illness Beliefs About Chronic Pain and Healthcare Management: A Qualitative Descriptive Study

A thesis submitted to Auckland University of Technology in partial fulfilment of the requirements for the degree of Master of Health Science

School of Clinical Sciences

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2021

Abstract

Chronic pain carries considerable impact on individuals, families, and communities in Aotearoa/New Zealand (A/NZ), almost one in five adults experience chronic pain (Ministry of Health, 2019). Chronic pain is a multidimensional experience, with cultural attitudes and beliefs known to powerfully influence the experience, behaviour and management of pain (Pillay, et al. 2015). Ethnic disparities in access to chronic pain services exist in A/NZ (Lewis & Upsdell, 2018), as well as in the efficacy of treatment (Lewis et al, 2021). Counties Manukau is home to the majority of the New Zealand based Sāmoan population. Unique Sāmoan beliefs have been found to influence not only the experience of pain, but also their health interactions and treatment seeking (Mauili et al, 2013). This study aimed to investigate Sāmoan health perceptions and beliefs in relation to pain and how they seek help.

Methods: This qualitative descriptive study drew on Pasifika research methodologies including tālanoa/face-to-face conversation and teu le va/nurturing of the relational space. Nine key informants from the Sāmoan community were identified, and eight tālanoa were conducted. A Sāmoan researcher was recruited to consult and inform on cultural nuances and practices, adding to the cultural integrity of the research. Data were analysed thematically using the Braun and Clarke (2020) six phase process.

Results: Data were constructed into three main themes: stoicism, strength in connectivity and unbridged worlds. Stoicism describes the predominant belief that persistent or chronic pain should be endured without display or complaint. Strength in connectivity describes the inherent pain coping strategies that are integrated in Sāmoan communities. Unbridged worlds describes the disconnect Sāmoan people feel when accessing and interacting with healthcare services.

Conclusion: A/NZ Sāmoan people hold holistic beliefs and perceptions about pain. Pain is attributed to multiple causes, including spiritual, relational, and biological. Contemporary healthcare services are reserved for severe pain from biological causes with the expectation of fast, effective pain relief. This can present conflict with services which focus on pain prevention or management of pain impairments. Chronic pain is more often endured, with help from within the āiga/family and community by use of social gatherings that include, story-telling, laughter, and prayer and, by seeking traditional healing practices like fofō/traditional Sāmoan healer. Findings point to the Sāmoan community facing significant difficulties in accessing pain services, including language and health literacy barriers, limited understanding of chronic pain, and limited knowledge of what services are available and how they can benefit patients. Recommendations for clinicians include a need to foster relationships with Sāmoan individuals and their āiga and greater cultural sensitivity and appreciation of the wider psychosocial context of pain, including spirituality of patients. Furthermore, healthcare services should consider how to adapt and expand to include more Pasifika personnel and to be more accessible and culturally relevant for A/NZ Sāmoan people.

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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 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."

Angela Upsdell

Acknowledgements

This thesis was not possible without my dear friend and colleague Jessee Fia'Ali'i. I am so grateful for the opportunity to work alongside you. Thank you for sharing your wisdom, knowledge and culture with me. I look forward to sharing in the ongoing mahi.

I am so thankful to all the informants that participated in the project. The ongoing friendship, conversations and laughter on the side of the football pitch, in the church foyers and in and around the Superclinic have been invaluable.

Dr Gwyn Lewis and Dr Gareth Terry, thank you for your amazing patience, care and inspiration in guiding me through this unfamiliar academic process.

The Counties Manukau Health Chronic Pain Service clinicians, past and present. I am grateful for the collective knowledge and wisdom that constantly challenges me to think more and be better.

Thank you, Dr Sarah Mooney for Wednesday morning coffee runs. Just 20-30 minutes each week has helped to keep me on track, primed and focused. I am so grateful for your mentorship and friendship.

Dr Fiona Language, thank you for paving the way in cross-cultural research for me. Your wisdom and guidance in this space has been invaluable. Your love for the Pacific is contagious, and courage for speaking up for children and the disadvantaged an inspiration. Your faithful friendship will always be cherished.

Dr John and Alex Upsdell, I stand on the shoulders of giants. Thank you for providing an expansive worldview that challenges me to think beyond the norm, the support to paddle my own canoe, and the example of humility required to care for others.

Thank you to Joseph Salaivao for being a gift to our family in the middle of this work and our chaotic home. May you know the peace that you “belong everywhere and nowhere” (Maya Angelou).

Lastly, to Gav, Ethan, Jaime-lee and Roman Spurdle. You are the loves of my life.

Sāmoan Glossary

The glossary in this section is set according to the Sāmoan alphabet. A, E, I, O, U, F, G, L, M, N, P, S, T, V, H, K, R

Āiga	Member of the nuclear and extended family
Alofa	Love, affection, charity
Atua	God or deity
Ava	Respect
Fa’a’aloalo	Humility
Fa’alavelave	Anything that interferes with normal life and calls for special activity. For example, weddings, births, building dedications, funerals.
Fa’ a Sāmoa	Sāmoan way of life
Fofō	Described as a generic word that means ‘to doctor’ ‘apply massage’ ‘give medical treatment’; ‘a person skilled in massage, masseur’ (Pratt, 2010).
Fonofale	A model of health and wellbeing that acknowledges and embraces Pacific perspectives.
Lotu	prayer/religion
Mafana	warmth
Ma’i fa’afusae’i	injury or illness caused by trauma
Ma’i manatu	Thinking sickness.

Malie	humour
Meaalofa	gift
Mo’oni	pure, real, authentic
Nu’u	village, community
Pālagi	Westerner or European
Pasifika	refers to a dynamic and diverse group of people who migrated from the Pacific Islands or who identify with the Pacific islands because of ancestry or heritage and now live in Aotearoa/New Zealand.
Pe’a	Traditional male tatua/tatoo of Sāmoa.
Tālanoa	Pacific research methodology informed by Tongan, Sāmoan and Fijian understandings of tālanoa (tala—to inform, tell relate, command, ask or apply; noa—ordinary, nothing in particular) (Vaioleti, 2016).
Tatau	Tatoo. Ta means ‘to strike’ and tau ‘to place upon’ or ‘to mark’.
Taulāsea	Someone who is skilled in the use of native medicines. A traditional healer, healing not only the physical, but also the psychological ailments with advice and ministrations (Macpherson & Macpherson, 1990).
Teu le va	Nurturing of the relational space.
Va	space that relates (Wendt, 1999).

Māori Glossary

Te Whare Tapa Whā	is a four-dimensional model developed by Mason Durie 1984 to provide a Māori perspective on health. The four dimensions are: taha tinana (physical wellbeing), taha wairua (spiritual wellbeing), taha whānau (family wellbeing.
Wairua	spirit, soul – spirit of a person which exists beyond death.
Whānau	extended family, family group, a familiar term to address to a number of people – the primary economic unit of traditional Māori society. In the modern context the term is used to include friends who may not have any kinship ties to other members.
Whakamā	to be ashamed, shy, bashful, or embarrassed.
Whakawhanaungatanga	the process of establishing links, making connections and relating well to others

Abbreviations

Aotearoa/New Zealand	A/NZ
Australian and New Zealand College of Anaesthetists Faculty of Pain Medicine	FPM
Culturally and linguistically diverse	CALD
Counties Manukau Health	CMH
District Health Board	DHB
General Practitioner	GP
International Classification of Diseases	ICD-11
Multidisciplinary team	MDT

Chapter 1. Introduction

1.1 Problem Statement

Chronic pain is one of the most prevalent long-term health conditions in Aotearoa/New Zealand (A/NZ). It is estimated to affect 20.2% of adult New Zealanders (Ministry of Health, 2019) and causes significant impact on individuals and society (Cohen, et al., 2021, Dominick et al., 2011). The burden of chronic pain is often difficult to measure, however, the economic and social costs of chronic pain are immense as those with chronic pain experience long-term difficulties with day to day functioning and are at risk of developing psychiatric disorders including depression and anxiety (Pridmore et al., 2001; Swain & Johnson, 2014). The Global Burden of Diseases study emphasises the high prominence of pain conditions and pain related diseases (Vos et al., 2017). Six of the top eight conditions causing both disability and loss of life in 2016 were pain related (Vos et al., 2017). These conditions included low back pain, arthritis, and migraine. The prevalence of chronic pain is rising both in A/NZ and globally, hence the importance of increasing awareness and research in this area. A report commissioned by the Australian and New Zealand College of Anaesthetists Faculty of Pain Medicine (FPM) estimates that, due to our aging population, the number of chronic pain sufferers will increase from 770,000 in 2016 to around 1.26 million by 2048 (Moore & Davies, 2018).

Pain does not affect populations equally. Significantly differences between ethnicities in reporting pain, attendance at pain services, and outcomes following pain treatment services have been found. In particular, the prevalence is lower in Pasifika and Asian chronic pain than other ethnicities (Ministry of Health, 2019), and are highly under-represented in attending district health board (DHB) chronic pain services (Lewis & Upsdell, 2018). While this may indicate a lower prevalence of chronic pain in these population groups, it may also mean that Pasifika and Asian people are not reporting pain as much as non-Pasifika or non-Asian. In addition, non-Europeans have poorer baseline pain related scores prior to pain service interventions; indicating greater burden, need, and psychological distress prior to entering pain services and inequality in pain treatment (Lewis & Upsdell, 2018; Lewis et al., 2021). These studies indicate that ethnic disparities exist in chronic pain prevalence, attendance or access to chronic pain services and effectiveness of treatment strategies. However, they do not provide an understanding of the meaning of pain and specific cultural views on pain management and help seeking for pain conditions.

It is estimated that by 2050, the diversity in the A/NZ population will be such that half of the population will be of non-European descent, with large increases particularly in the Asian and Pasifika populations in Auckland. The Pasifika population makes up 8.1% of New Zealanders and historically has resided primarily in urban areas, particularly Auckland. Indeed, Counties Manukau Health (CMH) has the highest proportion of Pasifika in A/NZ, with 21.1% (2018/2019 Ministry of Health). Statistics New Zealand estimates that Auckland's Pasifika population will increase by 50.5% from 252,400 in 2018 to 367,000 by 2038 (Auckland Council, 2018). Sāmoan people make up the largest part of this group, contributing 49% of the total Pasifika population (Statistics NZ, 2019) and it is estimated that almost half of the NZ Sāmoan population live in Counties Manukau (Counties Manukau Health, 2018).

This fast growing Pasifika population disproportionately experiences poorer health outcomes with the gap between Pasifika and non-Pasifika health status continuing to widen (Ministry of Health, 2020; Wright & Hornblow, 2008). The Pasifika population in A/NZ is also diverse – it represents 22 different cultures with unique language, traditions, and beliefs. While there are some similarities between these different cultures, there are also many differences. Culture is shown to significantly influence interpretation and expression of pain, as well as help-seeking behaviours and acceptance and preference of treatments for pain (Davidhizar & Giger, 2004; Meeus, 2018; Peacock & Patel, 2008). Currently, there are no known studies that investigate the unique beliefs and attitudes around pain and help-seeking behaviour in any of the Pasifika cultures. Given that Pasifika have low representation and face greater need when entering chronic pain services, it appears pertinent to investigate this perspective.

1.2 Study Objectives

The overarching objective of this study was to explore the health and illness beliefs about chronic pain of Sāmoan people in A/NZ, and how these beliefs affect the way they utilise healthcare. In this study I have chosen to focus on the pain and pain management beliefs of the Sāmoan community residing in CMH. The specific study objectives are:

- To understand the health and illness beliefs of Sāmoan people in A/NZ, and their views of pain including psychosocial stressors, impact on self and impact on family, using a culturally appropriate perspective of wellbeing.
- To explore beliefs in relation to pain management including exercise, medication use, and alternative medicines.

To answer the studies objectives key informants will be recruited from the Sāmoan community, to access experience and expert knowledge.

1.3 Study Implications

There is very limited literature exploring how different cultural lenses impact on the experience of chronic pain in A/NZ, including quantitative, qualitative and epidemiological research, making it difficult to build on previous studies. Of the limited literature exploring Pasifika health and illness beliefs, unique Pasifika perspectives are known to influence other aspects of health and healthcare access (Mauiliu et al., 2013). Engagement with clinicians and healthcare services is crucial to responding to the needs of the Sāmoan community. This engagement would help Sāmoan people better manage their pain and optimise their quality of life, while minimising costs to them and healthcare providers. This study will contribute by providing insight and guidance to clinicians with the aim of improving their ability to engage with Sāmoan people with chronic pain. Promoting culturally safe practice to clinicians, including understanding their unique beliefs around health and illness, is essential to enhancing service delivery of chronic pain management, particularly as clinician attitudes and behaviours influence patient engagement (Bright et al., 2017). This is especially pertinent to our current workforce where there are few Pasifika healthcare clinicians; Pasifika doctors make up only 1.8% of the current workforce (Medical Council of New Zealand, 2019).

Chapter 2. Literature Review

2.1 Structure and Literature Search Methods

This literature review presents current understanding about chronic pain and its impact on individuals before presenting national and international literature around the impact of cultural beliefs in chronic pain. Current chronic pain management in the A/NZ setting is then discussed before exploring the unique Pasifika health beliefs, disparities and barriers to access of care. Articles with a focus on A/NZ and Pasifika perspectives, indigenous populations, minority populations on health and health beliefs were prioritised.

Literature searches were conducted between July 2019 and March 2021. Journal articles were accessed using the following databases: PubMed, MEDLINE, EBSCO, JSTOR Google scholar and ProQuest. Keywords used in searches included, but were not limited to: Pacific, Pasifika, Polynesian, New Zealand, Sāmoan, chronic pain, ethnicity, culture. The terms ‘disparities’ and ‘differences’ were included later.

2.2. Setting the Scene

Pain by definition is “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage” (International Association for the Study of Pain, 2019). Chronic pain has been defined as pain that lasts or recurs for more than three months (Raja, et al., 2020). Chronic pain can occur in the absence of tissue damage, or pathophysiological cause, and even if there is tissue damage, the severity of pain is not always correlated (Taub et al., 1998). Chronic pain is often recognised as a symptom of a disease rather than a disease entity in itself, and it was only in May 2019 that the International Classification of Diseases (ICD-11) included the systematic representation of chronic pain diagnoses in their new edition (Mailis et al., 2020). These recent definitions of chronic pain have been based on a biopsychosocial model and attempt to recognise the accompanying distress and functional impairment that often comes with chronic pain, and its impact upon individuals, their families, and their communities (Ashburn & Staats, 1999; Cohen et al., 2021). This was introduced to help to reduce the stigma previously attached to chronic pain and facilitate the use of holistic treatment methods. Chronic pain is also expressed uniquely for each person with no single or typical presentation. While pain is one of the main reasons people seek medical care, the complexities and consequences of having chronic pain contribute to it being often poorly understood, recognised and managed in the community (St Sauver, et al, 2013).

The New Zealand Health Survey defines chronic pain as “pain that is present almost every day and has lasted, or is expected to last, more than six months” (Ministry of Health, 2019). According to the NZ Health Survey, the prevalence of chronic pain in adults is 20.2% with some differences found according to age, gender, ethnicity and socioeconomic status (Ministry of Health, 2019). Rates of chronic pain increase with age, with 35% of adults over 75 years affected and it is more prevalent in females than males. Asian adults are 30% less likely to report chronic pain than non-Asians, while Māori adults were 20% more likely to report chronic pain than non-Māori. The prevalence of chronic pain in Pasifika people increased significantly from 12% in 2006/2007 to 19.3% in 2019/2020 however is still lower than non-Pasifika. These data used level 1 ethnicity classifications (Statistics NZ, 2019), which means that the specific prevalence in the NZ Sāmoan community is unknown.

Examining international literature, there is evidence that the prevalence and impact of chronic pain appears to disproportionately affect already vulnerable populations. Chronic pain appears to be particularly prevalent in certain socio-demographic groups including; the older population, females, rural populations, and those with lower socio-economic status, poorer health status, or lower employment status (Dahlhamer et al., 2016; Mills et al., 2019; van Hecke et al., 2013). The burden of chronic pain also disproportionately affects culturally and linguistically diverse groups, including migrant, and refugee communities (Kellner et al., 2013; Kurita et al., 2012). Further studies indicate that ethnic minorities including indigenous minority communities, with chronic pain report higher pain levels, greater pain-related impairment and poorer psychological health status (Barnabe, et al. 2015; Craig, et al., 2020). This has been demonstrated here in A/NZ using data focusing on Māori and Pasifika populations attending chronic pain services, (Lewis & Upsdell, 2018) as well as internationally in migrant communities (Kellner et al., 2013; Meghani & Cho, 2009). Socioeconomic differences have also been found. New Zealanders living in low socioeconomic areas were 50% more likely to experience chronic pain (Ministry of Health, 2019). This is supported by international population studies also showing chronic pain to be inversely related to socio-economic factors (Maly & Vallerand, 2018; Poleshuck & Green, 2008).

The impact of chronic pain, including individual, social and economic costs, must also be remembered. Impairments associated with chronic pain include deficits in physical capacity, sleeping, concentrating and maintaining relationships (Shipton et al., 2013; Vos et al., 2012). Chronic pain not only restricts a person’s ability to perform daily tasks, it has been shown to interrupt their ability to fulfil family roles, and impacts family interactions (Dueñas et al., 2016). Furthermore, reduced physical ability and psychological deterioration not only can produce restrictions on leisure activities and social activities, but can cause dependency and reliance on family and friends (Ojeda et al., 2014). These factors all impact quality of life for not only the chronic pain sufferer, but also their closest supports.

The impact of pain in the workplace is also an important issue, as absenteeism, reduced productivity, early retirement and disability is more common in those experiencing chronic pain (Dueñas et al., 2016). A review of the impact of chronic pain in the workplace found that 26%-88% of participants across 35 studies reported that pain interfered with their employment status (Patel et al., 2012). The direct and indirect costs of chronic pain economically are difficult to accurately measure, but the FPM estimated, that the total cost of chronic pain in NZ in 2016 was $13 - $14.9 billion, and predicts this will continue to rise (Moore & Davies, 2018). This is more than the estimated costs for diabetes, dementia, smoking and musculoskeletal disorders in A/NZ (Moore & Davies, 2018).

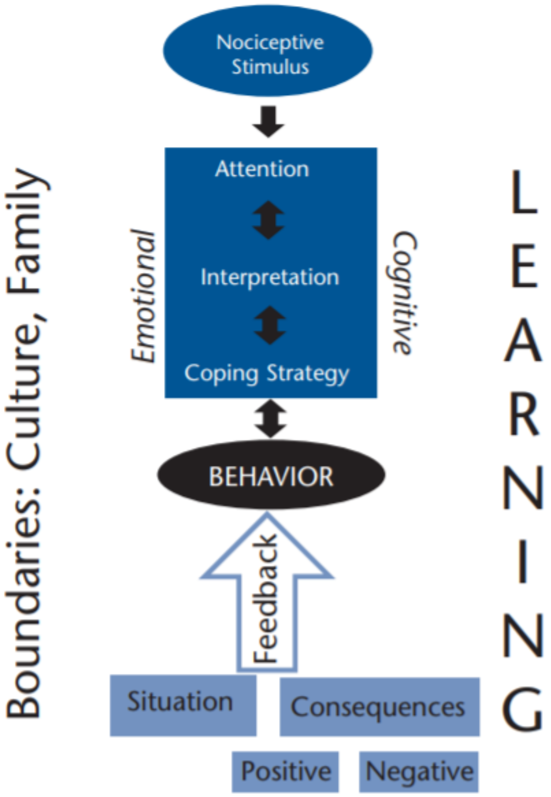
2.3 How Culture Influences Chronic Pain

Pain is a multidimensional experience that moves beyond physical sensation. The biopsychosocial view of pain is well recognised, with pain seen as a complex interaction of biological, psychological, and social factors (Gatchel et al., 2014). Included within these social factors is the powerful influence of cultural based attitudes, beliefs and values (Pillay et al., 2015). Research indicates that beliefs and values mediate emotional responses to pain, pain coping strategies, spiritual coping, hypervigilance and catastrophising, (Gatchel et al., 2014).

The pain perception model by Linton & Shaw, (2011) (Figure 1) is an attempt to show how the biopsychosocial processes fit and function together to influence the expression of pain.

Figure 1

Linton's model of pain perception from a psychological view (Linton & Shaw, 2011, p.701).



Linton's model illustrates the influence of psychological factors as a sequence of processes, starting with a nociceptive stimulus. This leads to cognitive and emotional processing, including appraisal and interpretation, which determines an individual's pain behaviour. Emotion is the more immediate reaction to pain and typically includes emotions such as fear, anger, and frustration. One of the most recognised responses is fear of pain, and evidence has shown fear avoidance beliefs and the fear of moving are associated with higher pain intensity, disability and lower quality of life scores (Luque-Suarez et al., 2019; Martinez-Calderon et al., 2019). Cognitions attach meaning to the emotional experience and this cognitive appraisal is often shaped by previous pain experiences. This can be seen in medication expectations. For example, a negative expectation can reverse the analgesic effect of an opioid (Bingel et al., 2011), whereas the expectation of pain relief is a known important component of placebo analgesia (Qiu et al., 2009).

These emotional and cognitive appraisals lead to pain behaviour or expression. Pain behaviour refers to the thinking or actions taken towards pain, and can have the goal of communicating pain to others or protecting the body from aggravation or further pain (Martel et al., 2010). Pain behaviour can result in more or less pain, reinforcing a behaviour to be taken with future pain episodes as shown in the feedback stage (Cordier & Diers, 2018). This behaviour can be helpful in establishing good pain coping strategies; however, some behaviours can also facilitate the development of long-term problems (Leeuw, M. et al, 2007). For example, using rest can be an effective acute pain management but is not appropriate for the management of chronic pain.

The Linton model also shows pain behaviour is influenced directly by environmental consequences and limited by cultural and social values. The cognitive and emotional appraisal of pain help to form pain beliefs and attitudes. Pain beliefs can be defined as "cognitions or thoughts related to the pain, including beliefs about the cause of pain, its meaning, or appropriate treatments for pain" (Linton & Shaw, 2011, p. 703). These beliefs may be held personally by an individual or shared culturally, or both, and may lead to positive or negative outcomes as the individual adjusts behaviour. It is understood that this adaptiveness varies with context, and considers cultural and social factors, with cultural differences found to be contributing to a difference in pain experience and perceived disability across clinical and experimental pain studies (Darlow et al., 2012; Meints et al., 2016; Pillay et al., 2015). For example, individuals need to consider the cultural appropriateness of seeking emotional support from others versus keeping their problems to themselves. In turn the racial, ethnic and cultural influences have a crucial impact on healthcare preferences, help seeking and acceptance of medical interventions (Meeus, 2018).

In a Western context, psychological based treatments are used in a chronic pain management setting to target these psychological processes. As shown, culture has a significant impact on illness beliefs, through contributing to meaning and interpretation of pain and consequently the behavioural response, and differences between ethnicities has been established (Meeus, 2018). A recent systematic review including 6,797 individuals with chronic pain suggested there are significant differences between countries in overall pain beliefs and behaviours (Sharma et al., 2020). While differences between ethnicities have been shown, few studies have investigated the effectiveness of a culturally responsive pain management programmes. An Australian study investigating the delivery of pain management care, specifically catering to different cultures with the understanding of their unique health and illness beliefs, has shown improved outcomes when compared to standard delivery (Brady et al., 2017). This evidence supports illness beliefs influence healthcare preferences, help seeking behaviour and the ability to engage with healthcare professionals. Thus, it is imperative that there is greater understanding of the unique health beliefs and cultural influences on those in the chronic pain population.

Alongside addressing maladaptive pain beliefs and behaviours, a key focus for health professionals is to promote self-care and self-management with an emphasis on empowering individuals to be active partners in their own management (Wells-Federman et al., 2002). Bandura, (1977 p.193), defined pain self-efficacy “as the belief in one’s ability to manage and complete a task, despite pain”. Greater pain self-efficacy has been shown across several studies to improve chronic pain outcomes, including lower disability levels, less pain, greater beliefs and adherence to physical activity and improved psychological status (Du et al., 2018; Jackson et al., 2014; Martinez-Calderon et al., 2019). Findings from Denison et al., (2004), indicate that pain-related beliefs (including self-efficacy and fear avoidance) are more important determinants of disability than pain intensity and pain duration.

2.4 Management of Chronic Pain

The use of interdisciplinary or multidisciplinary teams (MDT) of medical professionals has been promoted as best practice for delivering chronic pain services (Scascighini et al., 2008; Cohen, 2021). A team approach acknowledges the complex nature of chronic pain, allowing each professional to build on each other's skills and knowledge expertise, while reducing fragmentation of services and promoting better integration of care for the individual. A recent review concluded several characteristics of a well-functioning pain MDT team included sharing philosophy and office space to facilitate support and meaningful communication, collaboration and shared learning (Griffin & Hay-Smith, 2019). Aotearoa/New Zealand provides MDT chronic pain services through the public health service and private practices; however, the quality and the integration of the teams in the provision of their services is unknown. Counties Manukau Health has a part-time MDT chronic pain service which is primarily accessed by referrals from general practitioners (GP) and other medical specialists. This department serves those with chronic pain residing in the CMH catchment.

The International Association for the Study of Pain (IASP) provides guidelines for chronic pain teams on how services should function and the services they provide. However, these recommendations are based on a Western worldview predominantly informed by research in Western countries. Brady et al. (2016) reported that 90% of published randomised controlled trials investigating the efficacy of multi-disciplinary management for chronic pain were based in Western countries. A few trials in non-Western countries did show positive outcomes demonstrating the efficacy of the multidisciplinary team approach when the dominant ethnicity of practitioners and patients is non-Western, but findings were not as positive when studies involved ethnic minority populations or migrants (Brady et al., 2016).

Differing paradigms and world views will have implications on decision making for individuals with chronic pain. While most A/NZ MDTs endeavour to uphold a biopsychosocial model of care, where pain is recognised as an expression of interactions between biological, psychological, social and cultural factors it needs to be recognised that the Western biomedical paradigm still prevails (Quintner et al., 2008). Western cultures alongside others, have long held strong beliefs in the primacy of structural pathology being the major criteria for discovering disease (Engel, 1977; Scheermesser et al., 2012). This model leads to pain being understood solely as an expression of a disease process from a pathological cause, and healthcare professionals as the gatekeeper to a pain cure (Eccleston et al., 1997). There are strong calls for change, better understanding, and recognition of behavioural science, psychology, and its influence in health (Aldington & Eccleston, 2019). In response new ICD-11 definitions have been added to reflect this however, in clinical practice this is difficult. Many patients struggle to accept that psychological aspects can contribute to pain, and often expect pain-centred, passive treatments, for which there is little evidence for in the context of chronic pain (Scheermesser et al., 2012). The A/NZ health system is also based on a Western individualistic society, where there is a strong emphasis on the individual, their needs and their goals. This is in direct contrast to many cultures where a collectivist paradigm is held where the goals of a collective is held ahead of the individuals, and there is a strong attachment to the group (Triandis et al., 1988).

2.5 Disparities in Pain Management

International reports show ethnic minorities receive unequal care in relation to chronic pain. In the United States, pain is underestimated, under-investigated and undertreated across a large range of conditions, in ethnic minorities, when compared to their white American counterparts (Anderson et al., 2009; Campbell & Edwards, 2012; Green et al., 2003). Barriers to efficient, timely and appropriate pain management for ethnic minorities are multifactorial and include communication difficulties between patient and health provider, poor assessment of pain, and difficulty in health system navigation (Green et al., 2003). These factors contribute to poorer outcomes, increased morbidity and a greater burden of disease (Edwards et al., 2001). Furthermore, many non-white ethnicities experience unconscious bias and marginalisation, which can result in lower socioeconomic standing (Hall et al, 2015). Discrimination of those from low socioeconomic backgrounds has been found within the chronic pain setting, with healthcare professionals giving less agency and denial of competence to manage pain (Diniz et al., 2020). People from low socioeconomic backgrounds are presented as incompetent in using pain medication, and are viewed as less compliant with recommended treatments (Hollingshead et al., 2016).

In A/NZ, ethnic disparities in pain services also exist and while there is limited research into the suitability of pain management services for ethnic minorities, there is evidence of inequity of attendance at pain services and outcomes for ethnic minorities (Lewis et al., 2021). More recent data investigating outcomes from pain programmes indicate that non-European participants, particularly Māori and Pasifika, have poorer outcomes in psychological measures (mood and catastrophising) at end of treatment (Lewis et al., 2021). These studies give evidence that ethnic minorities carry a higher burden of pain and unmet need, as well as indicate that current pain management services may not be servicing our ethnically diverse communities equally.

Studies in A/NZ investigating differences in cultural beliefs and perceptions of pain are limited. Case studies on those in A/NZ with chronic pain expressed the importance of being understood in a holistic manner, with their spiritual, emotional, and mental state appreciated in their interactions with health professionals (New Zealand National Advisory Committee on Health and Disability, 2007). Furthermore, when this was not included in health interactions, Māori and Pasifika people experienced cultural alienation, while European New Zealanders felt their lives became more fragmented (New Zealand National Advisory Committee on Health and Disability, 2007). These themes are supported by Māori research which report clear differences in how Māori express and perceive pain. Māori have a holistic outlook on pain, particularly in relation to spirituality, and whānau (family) are particularly important health advocates (Magnusson & Fennell, 2011; McGruer et al., 2019).

2.6 Pasifika in NZ

> "In New Zealand, inequalities are not random: in all countries, socially disadvantaged and marginalised groups have poorer health, greater exposure to health hazards, and less access to high quality

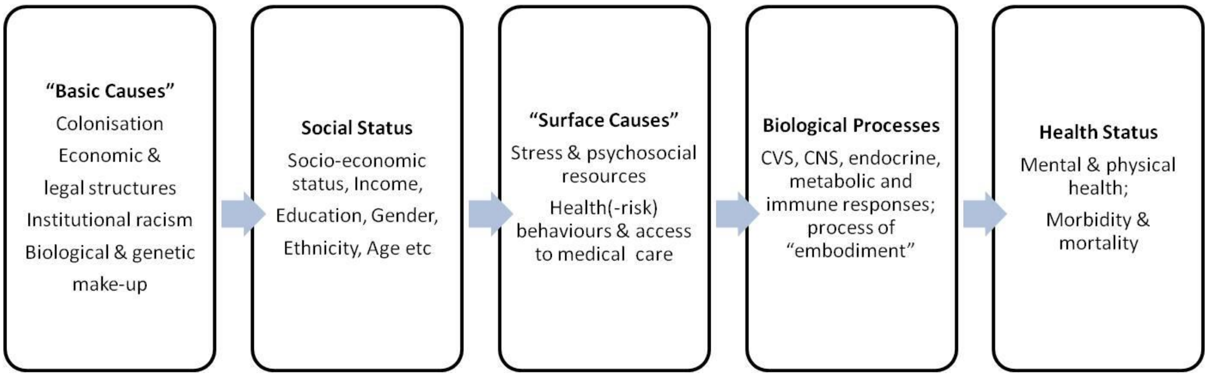
> health care than the more privileged.” (Speech at launch of Decades of Disparity III, delivered by Hon Pete Hodgson 8 May 2006).

Aotearoa/New Zealand has significant health inequities across different population groups, including Pasifika. Health equity is “the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically” (World Health Organization, 2010, p. 12). As such, health equity is about the distribution of health across the population, giving every individual in society an opportunity for good health, wellbeing and length of life (Sheridan et al., 2011). Health inequities refer to health differences that are “unjust and avoidable differences in health that stem from some form of discrimination or lack of access to certain resources”. Inequities, therefore, can be avoided or changed (Hosseinpoor et al., 2015).

Williams (1997) provides a framework to examine why inequities in healthcare exist. This framework, shown in Figure 2, can be used to understand the relationship between health, society and historical causes. This model will be used to examine the historical and contemporary drivers of health inequities which exist for Sāmoan people in A/NZ and show how wider determinants can impact on health.

Figure 2

Williams ‘Basic Causes’ Model (Williams, 1997, p.328)



The Williams Model demonstrates the importance of basic/structural drivers of ethnic inequities in health. Historical colonisation has been cited as having influenced health, equity, social change and even the existence of indigenous Pacific populations (Anderson et al., 2006; Moewaka Barnes & McCreanor, 2019). Migration is also known to be a significant determinant of health (Castañeda et al., 2015) and, while migrants may experience an improvement in material well-being, there is evidence that Sāmoan migrants may be at high risk for poor health (McGarvey & Seiden, 2010). Aotearoa/New Zealand and the Pacific Islands have had strong relationships dating back to the 1840s. Migration started in a small way in the early 1900s; however, the Sāmoan community in A/NZ grew into a population of considerable size and social influence in the 1950s to the 1970s. This was due particularly to employment opportunities such as the Western Sāmoan Quota Scheme, which facilitated employment due to increased labour needs and prosperous A/NZ economy (Wright & Hornblow, 2008). Many of the migrants entered on temporary working or visitor permits and often overstayed their expiry date. However, in the early 1970s, there was a deterioration of the A/NZ economy. Aotearoa/NZ changed their migration policy in response to an economic recession and ended immigration quotas for Sāmoan people (Hajat et al., 2010). Dawn raids followed and the government began forcefully deporting Sāmoan people despite the majority of overstayers at the time being European (Ongley & Pearson, 1995). This undervaluing, marginalisation, and discrimination of Pasifika can be attributed as one of the “Basis Causes” as seen in Williams', (1997) model, which has led to the progression of health implications. As Sāmoan social status declined, significant health implications followed from household overcrowding, poor working conditions and environments, and mental stress (Anae, 2020). Economic reforms in the 1980s contributed to high unemployment and benefit reforms in the 1990s further contributed to low socioeconomic status of many Pacific people (Blakely, et al., 2005). Many of these social and economic determinants remain significant today and are described by Williams’ model as “Surface Causes”.

It is understood today that the greatest influences on the health of Pasifika in A/NZ are socioeconomic and cultural factors (Sundborn et al., 2006). Education level, socioeconomic status, occupation and employment status, and living conditions, are significantly lower than other communities (Sundborn et al., 2006). Pasifika tend to be geographically clustered in low socioeconomic areas, often living in overcrowded households with extended families and are more likely to be renting (Ministry of Health, 2020). In 2018, 81% of Pasifika adults did not own their usual place of residence (Statistics NZ, 2019). Pasifika have the worst socio-economic status of any of the major ethnic populations in A/NZ, with over-representations among the unemployed, lower-skilled workers and low-income earners (Statistics NZ, 2019). Sāmoan incomes are low; in 2018, the average median personal annual income reported was $25,400, compared to the European average of $34,600. In 2013, 39% of Pacific people lived in housing defined as crowded, compared to 4% of Europeans (Ministry of Social Development, 2016a). Evidence suggests that it is not a lack of knowledge around healthy lifestyle that restricts Pasifika, but rather lack of economic resources to enable healthier choices in relation to exercise, diet, rest, and housing (Ryan, 2012).

Another “Surface Cause” recognised in Williams’ model is the access to healthcare. Barriers to accessing healthcare for Pasifika have been recognised and documented. Cost is recognised as a significant barrier to attending primary care, including the cost of transport, parking and medical fees and also for filling prescriptions (Ministry of Health, 2019; Crampton et al., 2000). Racial discrimination hinders Pasifika from receiving health treatment, with Pasifika almost twice as likely to receive any degree of discrimination compared to NZ Europeans (Harris, et al., 2012). This discrimination has significant negative impact on psychological health and well-being of Pasifika (Kapeli et al., 2020). Further Pasifika research shows dissatisfaction with ‘Western’ medicine, namely traditional public healthcare, due to long waiting times, short consultation times, availability of appointments and, at times, ineffective treatment (Bassett & Holt, 2002; Ludeke et al., 2012). Language, communication and health literacy barriers have also been reported to significantly impact Pasifika in accessing medical and mental health services (Corbett, 1999; Ministry of Health, 2020), and as well as unwelcoming reception and a lack of Pacific presence at healthcare workplaces (Ludeke et al., 2012).

Following the causal pathway from “Surface Causes” in the Williams model is “Biological Processes” leading to “Health Status”. This is where the persistent basic and surface causes along with social status manifest as diseases and chronic health conditions. These biological causes determine our health status, including physical function, mental health, quality of life, and mortality. Cardiovascular disease, diabetes, cerebrovascular disease, and cancer remain significantly higher in the Pacific population than the general population in A/NZ (Ministry of Health, 2020). Pasifika also have the highest rates of multimorbidity compared to other ethnic groups in A/NZ (Stanley et al., 2018).

Life expectancy for Pasifika remains lower than the total A/NZ population by approximately 3.5 years for females and 4.6 years for males (Statistics NZ, 2019). This lower life expectancy is attributed to higher rates of long-term conditions and multimorbidity, particularly at a younger age. Pacific adults also have disproportionate health risk factors, including obesity, smoking, alcohol use, and physical inactivity (Ministry of Health,2020). Mental health appears to also be a significant challenge, with evidence highlighting high rates of mental health disorders in Pasifika compared to the total population (Foliaki et al., 2006; Ministry of Health, 2020). There are particular concerns over high rates of youth suicide and suicidal ideation among this population (Teevale et al., 2016).

The Williams model helps us to focus beyond lifestyle choices and individual risk factors, and acknowledge the broader multi complex determinants of health for Pasifika. As explained by Curtis et al., (2010), the Williams model shows “what members of society suffer disparity, and how our social norms have come to accept these disparities.” (Curtis et al., 2010 p. 230). The linear design, however, fails to capture the complex and interconnected nature of processes at play within the

Pasifika community in A/NZ. For example, constant immigration and migration globally of Sāmoan people results in more complex links and changes between basic causes, social status and surface causes at an individual level.

2.7 Sāmoan Health Beliefs and Perspectives

Sāmoan people, like many other ethnic minorities in A/NZ, are recognised to have unique social, and cultural health perspectives (Mark & Lyons, 2010). Evidence shows that cultural worldviews significantly influence the way in which Pasifika perceive, access and use health services, and influence health outcomes from interventions (Ministry of Health, 2020). Therefore, understanding Sāmoan cultural perspectives is central to understanding individuals, āiga/family, and nu'u/village health.

Pacific people traditionally have "holistic views of health that incorporate beliefs and values relating to family, culture and spirituality" (Taufe'ulungaki, 2004). Fa'a Sāmoa /the Sāmoan way is the foundation on which Sāmoans build their identity, customs, moral and social values. Seiuli, (2013) defined fa'asāmoa as:

> "Firstly, fa'a Sāmoa provides a firm foundation for Sāmoan people to centralise their cultural values, spirituality, customs, and beliefs. Secondly, fa'a Sāmoa provides a safe platform upon which, and out of which, their sense of belonging is practiced, negotiated, maintained, reciprocated and passed on to the next generations. Thirdly, fa'a Sāmoa as a way of life provides an important context for viewing a cherished heritage by offering a set of structural principles for ordering one's social life. Fourthly, fa'a Sāmoa offers guiding principles for one's behaviour by forming an anchor that stabilises one's ethno-cultural identification. Finally, fa'a Sāmoa serves as a moral praxis in achieving relational harmony with God, the gods, the environment, and one's people.

> It remains central to how Sāmoan people live out their existence in the past, in the present and in the future.” (pp. 31- 32)

While significant migration from Samoa has occurred, many Sāmoans still base their way of life on varying versions of Fa’a Sāmoa (Muaiava, 2015). For instance, the matai (chief) hierarchical system found in Samoa is still found in social gatherings around A/NZ, whereby the matai is pivotal to maintaining relationships amongst gatherings. Food is still used in significant ways to establish connection and relationship and still holds a central role in gatherings (Shahab et al., 2019).

Fundamental principles of ava (respect), fa’a’a loalo (humility) and alofa (love) underpin Fa’a Sāmoa and help to further understand this worldview. Ava refers to the respect Sāmoan people give people of seniority or of high spiritual or cultural standing (Ngan-Woo et al., 1985). This includes church ministers, matai, grandparents, and other elders in the family. This principle guides how to behave and interact appropriately with others in the community and therefore impacts on the healthcare relationship.

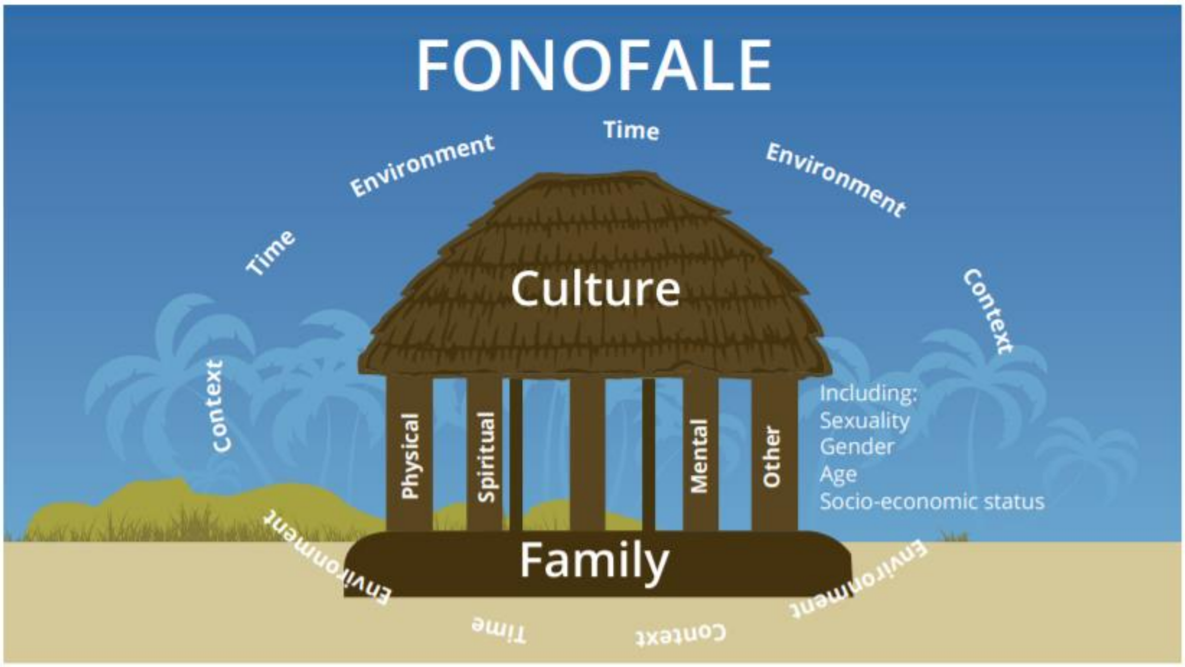
Fa’a’aloalo (humility) is the behaviour that shows ava. This means to be polite and humble and to prioritise others, particularly in terms of hierarchy and authority. Following this principle means that those in authority or seniority are deferred to, and to challenge any views or opinions is offensive.

Alofa (love) includes “the unconditional sense of commitment to a Sāmoan’s identity” which is founded on family and protected by culture (Ioane & Tudor, 2017). Alofa is demonstrated by the loyalty and commitment shown by individuals to their āiga emotionally and financially, and in contributing to family and community gatherings.

Fa’a Sāmoa has endured here in A/NZ, and while it continues to evolve as the population is influenced by the surrounding cultures, Pacific models of health have gained recognition. Fonofale is a model of health developed by Sāmoan-born Fuimaono Karl Pulotu-Endemann that best describes how Pasifika perceive wellbeing holistically, in the A/NZ context (Figure 3) (Pulotu-Endemann et al., 2009).

Figure 3

Fonofale model of Pacific cultural worldviews (Pulotu-Endemann, 2001, p.3).



The Fonofale model was developed in the style of the traditional meeting house a fale (a communal resource), with different individual components pulled together to support and relate to each other. The floor or foundation represents the āiga (family) while the roof represents culture, beliefs and a values system that provides protection and shelter. Pou (pillars) support the fale representing the spiritual (traditional or Christianity), physical (biological well-being), mental (emotions, thoughts, feelings) and ‘other’, which include sexuality, socio-economic status, and gender. The pou link and connect the relationship between the family (the floor) to culture (the roof).

Although Fonofale is a pan-Pacific health model it helps to explain some of the Sāmoan health beliefs. The pillars give context to appraisal of causation and contributing factors of illness and health as well as guide treatment choices. Macpherson & Macpherson, (1990) describe illness diagnosis as being considered as natural or physical, as in the case of trauma (ma'i fa' afusae'i). Mental health causes which produce physical symptoms, as in ma'i manatu (thinking sickness). Lastly social causes where relational conflicts between two individuals cause ill health. Finally, supernatural agencies are believed by many Sāmoan people to observe and shape their activities.

Even prior to contact with missionary teachings, strong beliefs in spirits and gods influenced how communities understood human suffering, by attributing illness as directly caused by gods, or indirectly caused by removing protection (Ihara & Vakalahi, 2011). These causes of illness are reflected in other studies (Tamasese et al., 2005), which have presented Sāmoan understandings of the causes of mental health disorders. Today, the Christian faith remains strong in the A/NZ Sāmoan community, with 78% professing to be Christians (Statistics NZ, 2019). Biblical scriptures influence contemporary interpretations of Atua's /God and the relationship with humanity. Further still, expanding understanding of illness causes, supernatural agency in illness, has shifted from a central idea to more a residual one (Macpherson & Macpherson, 1990).

The Fonofale model also recognises that wellbeing is complex and has many interrelated factors, and sits within a cocoon recognising the physical environment of the fale, time, and context (Pulotu-Endemann et al., 2009). The model helps reflect common Pacific cultural values which drive and influence individual's health behaviour and decision processes. This includes the central role of family, collectivism (where the groups goals are put ahead of the individuals), and the importance of relationships, reciprocity, and respect (Pacific Perspectives, 2019).

This health framework helps to strengthen our understanding of how Pasifika individuals, families and communities use the current healthcare system and expectations of care. The Fonofale model gives Pasifika people, healthcare workers, and health researchers a framework in which to improve their health and well-being in a culturally appropriate way, and has proven to be preferred by Pacific peoples to other mainstream psychological models (Ministry of Health, 2020).

It has been shown that Sāmoan people utilise healthcare systems differently compared to non-Pasifika, and commonly access traditional healers, often pre-empted by a quest for symptom relief and a cure (Wai et al., 2010). As yet, there is little documented evidence of how Sāmoan people in A/NZ view or interpret chronic pain, how chronic pain impacts individuals and their āiga, and furthermore how they manage it.

There is urgent need to address health inequalities for Sāmoan people, particularly the impact of chronic conditions. In starting to address the community's needs of those with chronic pain, it is critical to investigate the beliefs and perspectives of pain in this process to better understand how pain services can become more culturally relevant. Understanding the reasons underlying poor attendance at pain services and reporting of pain may help to create tailored pain management services for ethnic minorities like Pasifika (Peacock & Patel, 2008). With clear understanding of what might enable culturally effective pain services, the disparity between the Sāmoan community and the general population has potential to be narrowed.

2.8 Summary of Key Points

Chronic pain is one of the most prevalent long-term conditions in A/NZ that absorbs considerable medical care costs. Chronic pain is also burden to individuals, families, and communities having considerable physical, psychological, and economic consequences.

Pain is a dynamic combination of biological, psychological, social, and cultural factors and therefore is treated using a multidisciplinary approach. Pain management guidelines for best practice are based on a biopsychosocial framework. While culture is shown to significantly influence interpretation and expression of pain, most pain management guidelines are based on evidence provided by research dominated by Western worldviews.

Chronic pain is more prevalent in low socio-economic and migrant communities. Discrimination in care for pain has been demonstrated in ethnic minority and low socio-economic communities internationally. In A/NZ, ethnic disparities in access to chronic pain services as well as efficacy of treatment also exist. The Sāmoan community have been disadvantaged in A/NZ healthcare and already face health inequities with persistent disparities in health outcomes and health care. Factors contributing to disparities in health status and healthcare among Sāmoan people living in A/NZ are complex, and include historical colonisation, migration, socioeconomic status, biological factors, bias, and discrimination.

Sāmoan people have unique perspectives and beliefs about health that affect the way they interact with the healthcare system. There has been little research documenting the Sāmoan perspectives of pain or understanding the factors that facilitate engagement or non-engagement in pain services.

Chapter 3. Methodology

The primary aim of the study was to better understand Sāmoan perspectives and beliefs around chronic pain. The methods chosen to investigate this are outlined in this section. This section begins by outlining the researcher's positionality, before discussing the theoretical positioning of the study. Justification for a qualitative research design is given before presenting the interpretative theoretical orientation that was selected. Alongside this perspective, two Pacific based research methodologies, tālanoa and teu le va were embraced to inform and underpin this work. Both methodologies are discussed in the context of Pacific research methods and values.

3.1 Researcher Positionality

Our worldview shapes our reality and interpretation of reality. Because qualitative research is co-constructed, with both researcher and participant shaping any knowledge gained during the research process, acknowledging the subjectivity of the researcher is important (Braun & Clarke, 2013). Positionality acknowledges the researcher's background, including beliefs, culture, values, and assumptions that shape and inform their work, giving readers a greater perspective into how their own position influences their research. This is particularly important as the researcher themselves is seen as the data collection instrument in the nature of research (Bourke, 2014). By understanding this start point, it is hoped that others will better understand this research. This research was undertaken in partnership with Jessee Fia'Ali'i acting as a cultural consultant. Our backgrounds are reflected in statements below.

I am Angela Spurdle nee Upsdell a New Zealand European who grew up in Thailand, attending a local Thai school where my sister and I were the only farang / foreigners. At age eight, I moved with my family to South Auckland completing my schooling at local multi-cultural schools. After graduating from Physiotherapy school, I have spent the majority of my time working within the South Auckland community, and for the last 11 years I have worked at the Chronic Pain Service at Counties Manukau Health. These experiences have contributed to insights into living and working with other cultures and amongst Pasifika. Other strong influencing factors include my father, who works as a solo GP in Māngere East, and my commitment to my church, which has a large Pasifika representation. As such, South Auckland is not merely a location of work, but my community; where I live, worship and care for others. However, it is with humility that I recognise my lack of experience and knowledge of fa'a Sāmoa/Sāmoan way of life. Subsequently, there was much to learn and acknowledge in undertaking this work. It is my hope that grace will be extended, particularly from any Sāmoan audience, to overlook where my navigating this cross-cultural space has fallen short. It is with curiosity and humility that I have learnt from and guided by Jessee and the key informants involved in this study for guidance and knowledge.

My name is Jessee Fia'Ali'i and I am a New Zealand-born Sāmoan raised in South Auckland. My family come from the villages of Fogāsavai'i and Āfega in Sāmoa. I have personal and familial experience in navigating the healthcare system for support in managing chronic health conditions. I am a Health Psychologist working in the Counties Manukau Pain Services and I also work alongside the South Auckland community in primary health care settings. Therefore, I have had opportunities to improve my health and healthcare navigation literacy. I have experience in designing and conducting research focusing on Pasifika mental health using quantitative, qualitative, and indigenous methodologies. These experiences provide me with some valuable insights into some experiences of Sāmoan peoples in navigating health systems, however, I acknowledge that I am limited in the experiences of women, parents, and those born in Sāmoa living with on-going pain. My involvement in the current research is motivated by a desire to understand Sāmoan perceptions of pain and pain management as a means to improve service provision and support health outcomes for members of this community.

3.2 Qualitative Research Design

Qualitative research has gained increasing validity in healthcare research, particularly when describing different cultural perspectives, experiences, and understandings (Fossey et al., 2002). The paradigms informed by qualitative research are also considered appropriate when there is little knowledge in the research area (Liamputtong, 2010). Qualitative research also gives an opportunity to convey subjective experience of individuals, understanding meanings with sensitivity to interpretation, and set context for research questions and findings (Denzin & Lincoln, 2008; Liamputtong, 2010). This approach has been described as particularly appropriate when working with communities that have been historically oppressed (Walsh-Tapiata, 2003), as it allows researchers an opportunity to hear, question and understand more deeply from those that are marginalised (Hesse-Biber, 2017). Further to this, Williams & Elliott, (2010) describe the power of narratives in deepening our understanding of the impacts of social structures, and the social realities of people's demographics. It is the ability of qualitative research to provide 'thick description', giving meaning and context to individual lives as well as the ability to draw out 'lay knowledge' that makes this method ideal to explore those questions posed in the current study.

3.3 Theoretical Perspectives

Ontologies are "beliefs about the basic entities that make up reality" (Giacomini, 2010 p.127). Health research ontologies range along a continuum. At one end is a 'reality' view, where "reality is entirely independent of human way of knowing about it" (Braun & Clarke, 2013 p.27) and knowledge can be 'found' observed objectively and therefore measured and counted. On the other end of the continuum is the 'relativist' or 'interpretive' ontological view "where reality entirely depends on human interpretation and knowledge" (Braun & Clarke, 2013 p.28) and knowledge already exists and therefore is socially constructed. This approach allows for the possibility of multiple realities existing simultaneously. This study draws on the latter interpretive approach acknowledging each individual research informant and both researcher's own ideas, values, culture and perspectives all create many realities of the 'truth'. Anae (2019 p.3) supports this approach, particularly for indigenous studies, as it is seen as better equipped to "reflect local indigenous ways of knowing, of seeking knowledge" and allows researcher's to participate closely, becoming part of the research process. The interpretivist research approach also encourages "digging deeper into underlying values, meanings and interpretations of the participants" (Kazi, 2003 p. 804) and allows for the process to be more focused on embedded values, ethics, morality and politics (Robson & McCartan, 2016).

3.4 Pacific Research Values

This study strives to uphold the Pacific cultural values stated in the Pacific Health Research Guidelines of communal relationships, reciprocity, holism, and respect (Health Research Council of New Zealand, 2014). As a way of framing this research within the context of these values, Jessee Fia'Ali'i was recruited to support the research activity that underpins this thesis. Participatory research methods where the Pacific culture can be upheld, are seen as necessary in Pacific cross-cultural research (Naepi, 2015; Palafox et al., 2002). Consequently, as a Pālangi researcher conducting research with Sāmoan people, this partnership with Jessee was critical and seen as advantageous as both insider and outsider perspectives contribute to the inquiry. As stated by Naaeke et al. (2011), "each researcher's insights help to see the picture more clearly". It is in this collaboration between researcher, cultural consultant and with informants, where engagement with a Sāmoan worldview and values could influence this work.

Jessee was involved in a consultative fashion from early research and initial stakeholder discussions right to the end process of writing results. Cultural sensitivity and empathetic approaches in the conducting of research is imperative to being a responsible researcher (Palafox et al., 2002). The inclusion of Jessee allowed for information and modelling of appropriate protocols and etiquette, particularly in the tālanoa process, providing access to language and cultural understanding, and culturally informed interpretation of results.

A further reason to include a Sāmoan consultant was to allow for greater participation. Ethnic minorities are underrepresented in health research due to many barriers including stigma, lack of information and access to information, mistrust, competing demands (George et al., 2014) and English proficiency (Stanaway et al., 2017). One of the facilitators to improving engagement has been to include an ethnically congruent researcher (George et al., 2014).

3.5 Pacific Methodological Approaches

Western research paradigms do not always reflect the underlying values and beliefs of Pasifika people (Amituanai-Toloa, 2009) and therefore Pacific methodologies were important to incorporate into and lead this study. Pacific research approaches are well recognised, inspired by Pacific ways of knowing and being and are important in engaging and empowering community (Tualaulelei & McFall-McCaffery, 2019). Furthermore, it is important to account for indigenous Pacific cultural paradigms which can consider the attainment and processing of knowledge, time, individual vs communal priorities and worldviews (Palafox et al., 2002).

With a desire to move away from Eurocentric ways of conducting research concerning indigenous communities, advances in creating Pacific-centred research methodologies have been made, particularly over the past decade (Fotu & Tafa, 2009; McCarthy et al., 2011; Tualaulelei & McFall-McCaffery, 2019). These methodologies embrace the cultural values and beliefs of Pacific communities and help to further strengthen Pacific causes (Naepi, 2015).

Strength based research became popular in indigenous research methods in the early 2000s (Brough et al., 2004), and has been strongly advocated for in A/NZ (Durie, 2004). This approach endeavours to draw out individual and community strengths to improve disparities. This is rather than a deficit orientation, which focuses on problems or weaknesses which has prevailed, Westernised research protocols and outcomes focusing on indigenous experiences. Additionally, strengths-based inquiries can help to stop the perpetuation and reinforcement of stereotypical beliefs (Huria et al., 2019). It is argued that while not always easy in practice, this approach is the right way of working with indigenous people to give voice, insight and power (Askew et al., 2020). This study attempts to uphold a strength-based approach in several ways. First, in seeking to incorporate Sāmoan methodologies which value the Sāmoan worldview, ways of knowing and connectivity. Second, key informants were positioned as the experts in cultural knowledge, drawing on their expertise and experience to guide the research process and outcomes. Thirdly, strengths within the Sāmoan community, families and in individuals are highlighted during data analysis and write up.

3.5.1 Tālanoa

For Pacific people, tālanoa refers to a face-to-face conversation, ‘talk’, ‘discuss’ or ‘tell stories’ that is formal or informal between at least two participants (Vaioleti, 2016; Wendt, 1999). In this way, the tālanoa is used to exchange ideas or thoughts as well as tell stories or relate experiences. This interview approach allows for the interviews to flow whereby relationships are built with “malie (humour) and mafana (warmth)” (Ponton, 2018). Tālanoa continues to give benefits by allowing interviews to be less structured with minimal formality, which allows participants be more comfortable giving a greater opportunity for more mo’oni (pure, real, authentic) information (Suaalii-Sauni & Fulu-Aiolupotea, 2014). Furthermore, tālanoa helps to reduce researcher-participant power imbalances and encourages informants to lead and guide the conversation, creating space for narratives of their upbringing, practices and traditions, as well as acknowledging their values and positions within their āiga and community (Amituanai-Toloa, 2009). Lastly, tālanoa allows researchers the ability to clarify and understand ideas that are shared giving the opportunity for the researcher to take more active involvement in the creation of knowledge and more importantly, build positive relationships and connections with participants (Ponton, 2018). Vaioleti (2006) describes a good tālanoa as one that “creates the space and environment and allows for researchers to partake deeply in the research experience rather than stand back and analyse” (p. 26). This positions researchers in a participatory role, inviting all parties to engage in the construction and negotiation of knowledge in a context that befits Pacific traditions.

Data were gathered using individual tālanoa to facilitate the exploration of Sāmoan pain beliefs and healthcare utilisation. The centrality of tālanoa to this project was prioritised early in its design, in order to allow my own engagement with Sāmoan protocols and process. Each tālanoa was conducted with the support and guidance offered by Jessee, who is accustomed to tālanoa as a social and knowledge generating activity. The principles of tālanoa were facilitated by positioning the key informant as expert, relying on their experiences and knowledge to guide conversation. While both Jessee and I asked questions and shared our own experience, care was taken to allow the key informant the freedom to direct the conversation and length of time the tālanoa took. In this research, the use of tālanoa aims to facilitate the sharing of our participants' stories in light of their context, culture and experiences of chronic pain.

3.5.2 Teu Le Va / Nurturing the Relationship

Va is a key concept across Pacific cultures and plays a significant role in this study. Va is defined as a relational space or the "space that relates" (Wendt, 1999 p.402) that upholds Pacific values of "love, service, spirituality, respect, reciprocity, collective responsibility, gerontocracy, and humility" (Anae, 2019 pp 1). Teu le va describes processes relating to the on-going nurturing and valuing of these spaces and relationships (Ponton, 2018). These help provide guidance to how to relate, conduct and interact with others and is considered an important construct to consider within Pacific research (Anae, 2019; Ponton, 2018). The principle of va was used in guiding the relationships at tālanoa between researcher and informant, particularly to help address the appropriate Sāmoan behaviour and customs. Ongoing reflection throughout the research process and consultation with Jessee facilitated this. Furthermore, as stated by Mila-Schaaf (2009) it is the maintaining of relationships that is integral to ethical practice.

Several measures were taken to show the principals and values of va during interactions with informants. This included respecting informant's time and expertise. Researchers travelled and made time to meet where it was most convenient for informants. Informants were given time to consider participation in the study prior to the tālanoa with written information but also with conversation. Food was provided at each tālanoa where appropriate, incorporating it into the meeting either prior to or following. At the start of the tālanoa, informants were invited to lotu/pray, and the tālanoa was ended by Jessee or I closing with a lotu/prayer. During the tālanoa, Jessee and I shared parts of their own narratives and experiences. A meaalofa/gift in the form of a $30 petrol voucher was given to each informant at the end of each tālanoa. A meaalofa is a recognised way of sharing power and responsibility and acknowledging the participants contribution in time and knowledge (Seiuli, 2013).

Particular attention was given to continue to foster relationships with informants not just during the interview process, but maintaining connection and relationship following interviews. A tālanoa was held for all informants following interviews; however, individual discussions and communications were deliberately made to allow for informants to continue to influence interpretation and analysis of results and continue the relationship. This continuing cultivation of relationship is essential to producing relational accountability and responsibility for the researcher, principles this methodology embraces (Anae, 2019).

3.6 Summary

A qualitative descriptive approach was selected to guide and inform this research. In choosing this approach, the focus was in understanding the perspectives of Sāmoan with chronic pain, what help they seek, and how. A Sāmoan cultural consultant was recruited to add cultural integrity to the research process, and was instrumental throughout the research project. The philosophical and theoretical underpinnings of this research incorporated interpretive and Pacific paradigms. It is the fusion of these paradigms which characterised the approach taken to uphold Sāmoan values and align with New Zealand health research guidelines for carrying out research with Pacific people (Health Research Council of New Zealand, 2014). It is hoped that by conducting interviews following the principles of tālanoa and va, informants would be able to speak freely and forthrightly about their experiences, thoughts and beliefs, so data would be rich, insightful and full. These principles can also help provide better understanding for the researcher, as rapport is built, and conversation can flow guided by the relationship. Furthermore, these principles uphold the informants as being the experts in this knowledge, and as such respecting and keeping balance and reciprocity within the relationship space.

3.7. Research Design

This section outlines the methods used in the study including participants, recruitment, data collection and data analysis. This chapter ends with quality control designs and ethical considerations.

3.7.1 Key Informants

Individual tālanoa were facilitated by myself and Jessee with seven of the key informants, and one tālanoa was facilitated by me alone with two informants. Key informants were used to give the advantage of obtaining in-depth information and insight, with a small sample size (Marshall, 1996). Key informants can be differentiated from 'ordinary' informants by their expert or specialist knowledge about particular topics, in this case, Sāmoan health and pain beliefs (Payne & Payne, 2004). Key informants often occupy 'leading' or formal positions of authority within communities, which give privileged insights, broader knowledge, and rich ideas, including recommendations (Mumtaz et al., 2014, Terry 2021). Further still, this expertise and specialist knowledge is advantageous in interpretation of knowledge and enhancing understanding.

3.7.2 Sampling

Purposive sampling was used for recruitment of key informants to ensure coverage of a diversity of perspectives. Nine Sāmoan individuals with expertise and knowledge of the South

Auckland Sāmoan community and healthcare were sampled for the project. All individuals were identified as 'experts,' whose knowledge could help to answer the research questions. Some held significant community positions, including eldership at their respective churches and a traditional Matai position. All informants lived in the Auckland region, varied in age, gender and all identified as Sāmoan. The age range was from 32 to 65. All key informants in this study had experience of working with the Sāmoan community in South Auckland, with many having worked in health settings with those experiencing chronic pain. Informants also reflected on more personal experiences of family members who experience chronic pain. See Table 1 below for a list of key informants chosen.

Table 1

Key informant gender and profession.

Pseudonym	Gender	Professional Activity
R	Female	Community Social Worker
S	Female	Taulāsea/Sāmoan Traditional healer
T	Male	Physiotherapist
U	Female	Sāmoan Interpreter
V	Female	General Practice Registered Nurse
W	Female	Occupational Therapist
X	Male	Mental Health Social worker
Y	Female	City Council Social Worker
Z	Male	Local General Practitioner

Key informants were contacted by email, phone or through Facebook Messenger. Two participants contacted the researcher requesting participation after hearing about the study from other sources. All who were approached agreed to participate. Informants were provided with the Participant Information Sheet (Appendix 1) through email prior to the tālanoa.

Most key informants had connections to the primary researcher. Connections included workplace, childhood schooling, church and family. This allowed for rapport to be established quickly and a depth of conversation during the formal tālanoa, but also for conversations to be continued after formal data collection.

3.7.3 Data Collection

Face to face individual tālanoa were conducted by both researcher and cultural consultant within the participants' work environment, at homes or at the Manukau Superclinic. Face to face tālanoa have been established to help Pasifika to create a meaningful relationship (Bennett et al., 2013).

Tālanoa lasted from 57 – 105 minutes and were generally conducted in English. Jessee was familiar with Sāmoan culture, protocol and common Sāmoan language so Sāmoan terms, phrases and descriptors were able to be made by participants.

As stated above, tālanoa allows for informants to discuss issues in a genuine way that is dynamic and fluid which often led to discussion of issues not anticipated by the researcher (Mila-Schaaf, 2009; Patton, 2005). A guide was developed collaboratively by both Jessee and I with open ended questions however, the guide was not strictly adhered to. Questions were developed around three broad domain areas, which were derived from gaps in literature: Sāmoan worldview of chronic pain, their attitudes towards treatments and healthcare utilisation. Refer to Appendix 2 for the tālanoa schedule.

Prior to commencing the tālanoa, written and verbal consent was gained (Appendix 3). Informants were given another opportunity to read the Participant Information Sheet and discuss any questions. Consent to record tālanoa with an audio device was sought so that the conversation could be captured in its entirety; this was clearly explained to informants.

Tālanoa recordings were transcribed verbatim by myself, which was seen as an important step to becoming familiar and immersed in the data (Braun & Clarke, 2013). Any Sāmoan words used in the interview were interpreted by Jessee. Transcribing verbatim helped to capture participants' own words, language and expressions and allowed the research to “decode behaviour, processes, and cultural meanings attached to people’s perspectives” (Liamputtong & Ezzy, 1999, p. 88).

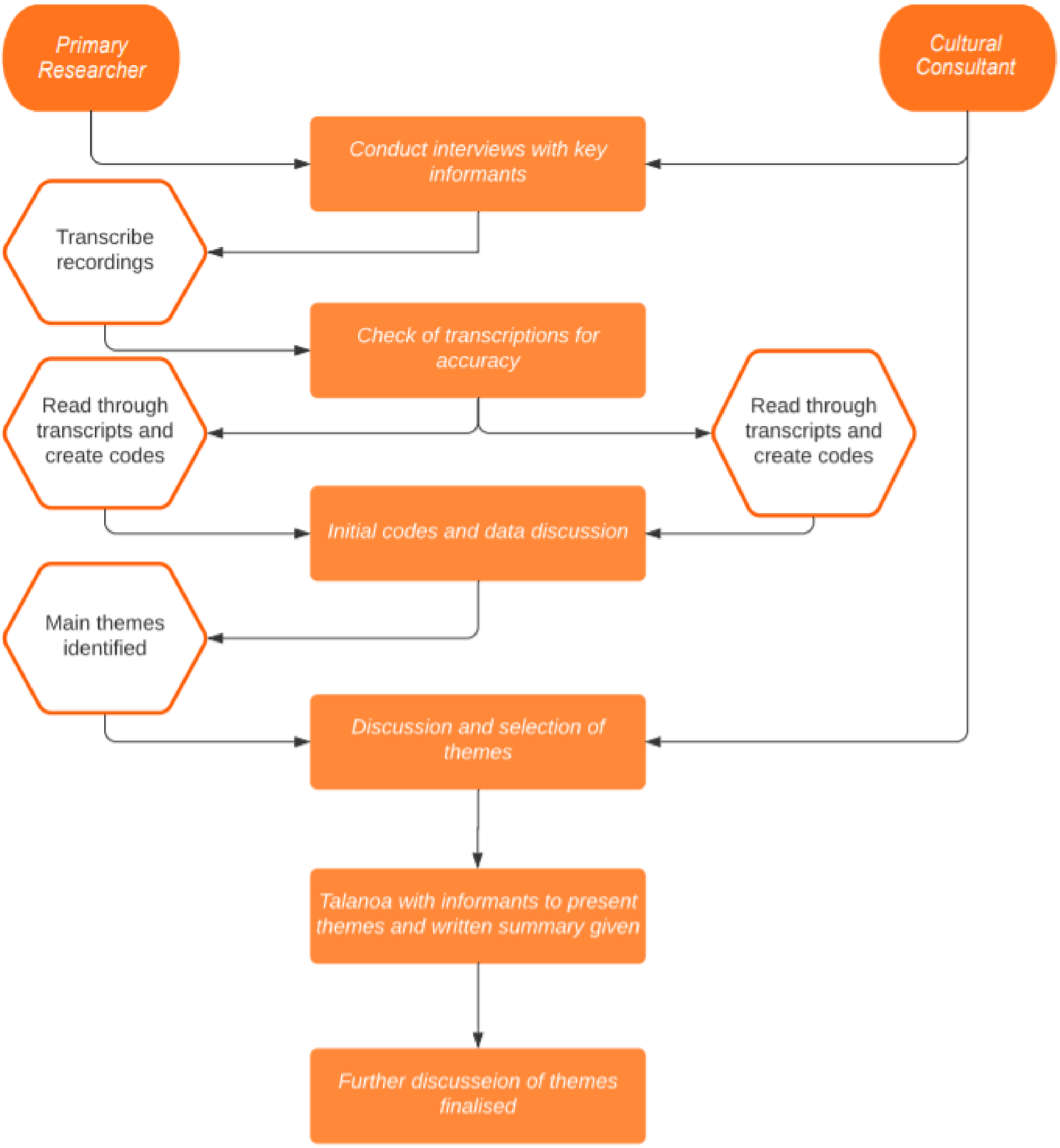
3.7.4 Data Analysis

All tālanoa produced rich data due to the key informant’s insights and expertise. Thematic analysis, as described by Braun & Clarke (2020), was used to analyse transcripts to gain insight into the beliefs around aspects of chronic pain and related management. This approach emphasises “an organic approach to coding and theme developments, with quality coding resulting from depth of engagement” (Clarke & Braun, 2018 pp 23) allowing for a flexible analysis of data, as there is no one ‘right way’ (Terry et al., 2017). This approach also emphasises the importance of the researcher’s subjectivity as an analytic resource (Braun & Clarke, 2020). Rather than focusing on accuracy of analysis, researchers are encouraged to reflect and engage deeply with the data moving “beyond the obvious surface level” (Terry et al., 2017 p22) and reflexively engage with theory, data and interpretation.

Analysis followed a six-phase process outlined by Braun & Clarke (2020). A flow chart of the process and how each researcher took part in the analysis is displayed below in Figure 4.

Figure 4

Flow diagram depicting data analysis process and roles played by each researcher.



3.7.4.1 Phase 1: Data Familiarisation and Writing Familiarisation Notes. Both Jessee and I engaged in careful reading and re-reading to familiarise themselves with the transcripts with casual notes taken about the content. Regular conversations between Jessee and I occurred throughout the familiarisation process to discuss findings, interpretations, and perspectives. To enhance my own understanding, interpretation, and meanings of Sāmoan words or phrases were discussed and clarified with Jessee and other Sāmoan speakers. The familiarisation process allowed for ‘immersion’ into the data, allowing for questions to be generated and reflexivity, reflecting questions onto myself (Braun & Clarke 2020).

3.7.4.2 Phase 2: Systematic Data Coding. Transcripts were manually coded, categorised and sub-categorised independently by both Jessee and I. Codes are concise labels used to create meaningful ideas and theories that are identified systematically throughout the transcripts (Braun & Clarke, 2020). Codes were produced primarily with an inductive approach (that is driven and generated by the data into codes) focusing on identifying noticeable and meaningful ideas repeated through transcripts. Regular meetings with Jessee allowed discussion and refining of codes to allow both researcher’s perspectives and insights to inform interpretation. These codes became the basis for organising data and pattern recognition and were made into a visual representation using Miro software (Miro, 2021).

3.7.4.3 Phase 3: Generating Initial Themes from Coded and Collated Data. I constructed themes by grouping codes together into bigger and more meaningful patterns. In this analysis, themes are described as “patterns of shared meaning, united by a central concept or idea” (Braun & Clarke, 2013 pp 223). Comparing, revising and merging similar codes into groups helped to establish a number of ‘candidate’ or prototype themes. A thematic map was created to help visualise themes in relation to each other and the overall dataset using Miro software (Miro, 2021). This software allowed researcher, cultural consultant and supervisors the ability to communicate digitally. This was particularly helpful over the COVID 19 lockdown periods where face-to-face meetings were not possible. Miro software was also helpful in sorting and organising large amounts of data, facilitating analysis.

3.7.4.4 Phase 4: Developing and Reviewing Themes. Discussions between myself, Jessee and supervisors helped to test the value of prototype themes and establish if they captured the meaning of the collated codes and the dataset as a whole. Themes were further shaped and clarified to create more focus. Themes were also discussed and revised in relation to the research question. Some potential themes were excluded due to lack of data, because they were too divergent from the initial research questions, or because they did not contribute to the best possible story of the dataset.

3.7.4.5 Phase 5: Refining, Defining and Naming Themes. Further revision of themes enabled three main overarching themes with several subthemes to be defined. Boundaries surrounding themes were identified with paragraphs created to present the central organising concept with scope and purpose. Relationships between themes were also identified to understand how an 'overall story' from the data could be fashioned (Braun et al., 2018). These themes were presented in a tālanoa with six of the nine informants attending. All informants were given a summary of themes in written form and given the opportunity to correct, clarify and understand themes better in person, or in telecommunications. Communication made following the formal tālanoa did not impact the three main themes however contributed to clarify and expand on these ideas.

3.7.4.6 Phase 6: Writing the Report: Writing up of the results and discussion was completed by myself, with constant revisiting of transcripts, codes and thematic mapping. Revisions were made to themes particularly to the structure and content of each. Data were then considered within the context of current literature and woven together with data and analysis. Extracts of data were selected to be used illustratively throughout the results section as the best reflections of the themes developed.

3.7.5 Quality of Research

During thematic analysis, the Braun & Clarke (2013), 15 point checklist was used to help guide the process (Table 2). While thematic analysis remains flexible and a reflective process, and cannot be subjected to the same applied rigor of quantitative approaches, methods to integrate into both data collection and analysis do exist (Yardley, 2000). Braun and Clarke (2013) give a systematic process to conduct a trustworthy analysis.

Table 2

15-point checklist of criteria for good thematic analysis (Braun & Clarke, 2013, p. 287).

Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'
Coding	2	Each data item has been given equal attention in the coding process
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive
	4	All relevant extracts for all theme have been collated
	5	Themes have been checked against each other and back to the original data set
	6	Themes are internally coherent, consistent, and distinctive
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described
	8	Analysis and data match each other – the extracts illustrate the analytic claims
	9	Analysis tells a convincing and well-organised story about the data and topic
	10	A good balance between analytic narrative and illustrative extracts is provided
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly
Written Report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated
	13	There is a good fit between what you claim you do, and what you show you have done – i.e. described method and reported analysis are consistent
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'

Note. Adapted from *Successful qualitative research: A practical guide for beginners* by V. Braun, & V. Clarke, 2013, p. 287.

An initial framework to establish 'trustworthiness' in the methods of data collection and analysis was proposed in a framework in 1985 (Lincoln & Guba, 1985). While further debate has continued and new insights offered as to best practice for qualitative researchers, (Braun & Clarke, 2013; Smith & McGannon, 2018; Tracy, 2010), this framework is still used and easily recognised today (Nowell et al., 2017). This study used Lincoln & Guba (1985) framework centred around four key concepts: credibility, dependability, transferability, and confirmability to strengthen validity.

3.7.5.1 Credibility. Credibility was addressed by ensuring I spent considerable time with Jessee and other Sāmoan friends, spending time particularly understanding the fa'Sāmoa worldview. This is often described as peer debriefing. Regular conversations to explore ideas, viewpoints, reflections and ask questions, allowed for Western views to be challenged, critique made to assumptions and new ideas and outlooks developed.

Alongside peer debriefing, consultation with informants was had following tālanoa. A two page summary of key themes, messages and understandings was sent in written format to all informants (Appendix 4). Informants were given 8 weeks to respond to this. Transcriptions can place a large literacy burden on some participants, do not account for analysis and interpretation, and can be difficult to follow due to the delivery of spoken word (as opposed to written language) for people untrained in qualitative methods (Smith & McGannon, 2018). The summary gave key informants the opportunity to correct inappropriate interpretations or expand on the results described. Furthermore, a tālanoa for informants and researchers was held to discuss key findings, recommendations, and give further clarification and interpretation. This tālanoa allowed for reflections from all participants involved and enriched understanding through generating greater insights and dialogue.

Further credibility was added by taking field notes including analytic memos and recording a diary of interactions after each tālanoa. Memos recording discussions between both researchers as well as with supervisors were made. Keeping analytic memos recorded, developing analysis thoughts, ideas and reflections systematically, ensures dependability in the interpretive analysis by providing clear evidence on how the interpretation of data was made (Liamputtong & Ezzy, 1999; Tracy, 2019).

3.7.5.2 Dependability. Descriptions of the methodology and the unique context of this study are included for readers to recognise how repeatable this study could be. Transcripts were initially coded individually by each researcher before analysing collaboratively. This was not to come to agreement (producing inter-rater reliability which is not appropriate for reflexive thematic analysis, (Braun and Clarke, 2020), but rather to have an opportunity to acknowledge and view multiple perspectives and viewpoints. Furthermore, both supervisors to this study reviewed transcripts and oversaw data analysis, adding to the richness of the conversation and questioning results in the research process. To further dependability, collaboration with Jessee throughout data analysis ensured Sāmoan beliefs and language nuances were not lost in translation, and that themes were congruent with conversations held.

3.7.5.3 Transferability. Transferability is enhanced by using ‘thick description’ in reporting of findings with participants “words and ideas embedded clearly within it” (Lincoln & Guba, 1985). Quotes from informants and details with explicit descriptions of the tālanoa were included in the write up. This helps readers to reach their own interpretation of whether the findings could be transferred into another context or time (Lincoln & Guba, 1985).

Purposive sampling was used to access informants who would have the required experience, positions, and insights to be able to answer the research questions. This type of sampling allowed for identifying informants from a range of professional backgrounds and a range of experience working with Sāmoan people in Auckland. This helped to provide rich conversations that could be analysed to produce ‘thick description’ of interpretive findings.

3.7.5.4 Confirmability. Reflexivity recognises the central role a researcher’s own beliefs, values and worldview plays in the active interpretation of knowledge being constructed (Dean, 2017). Ultimately, it determines the nature and philosophical stance of the study, interpretation of data, and how data are produced and used. Being transparent in disclosing this information allows for readers to understand and interpret study results and consider alternative possibilities, making confirmability easier to evaluate.

As a cultural outsider, constant reflection of my own cultural values, assumptions, and interpretations towards Sāmoan people was explored. Time was spent consciously considering these reflections at each research stage. I initially engaged in this process to think through the implications of my prior knowledge and experience in this space as a clinician and as a community member. During tālanoa, the focus of the reflections was on how my presence may be influencing participants' ability to engage or not-engage in open conversation. Then finally, through the interpretation of findings, analysis, discussions and write up of the research process, I critically reflected on what material is being produced. Throughout this work, observations including ideas, feelings, concerns, problems, fears, and frustrations were journaled to help with this self-reflection and aid thought processes.

3.8 Ethical Considerations

Ethical approval was sought from the Auckland University of Technology Ethics Committee (AUTEC). Key ethical considerations included privacy, confidentiality, informed consent and cultural safety. Approval was given on 19th of August 2019 application no: 19/262 (Appendix 5).

Locality approval was sought and gained from CMH. Consultation with representatives from the research office was also made prior to undertaking this research, particularly to gain cultural advice and guidance.

A research grant to pay for the Sāmoan research consultant's time spent on this study was granted by Auckland University of Technology.

The ethics of this study is framed by Pacific cultural values of communal relationships, reciprocity, holism, and respect (Health Research Council of New Zealand, 2014). These values guided the relationships formed between researcher and participants with the goal of engaging meaningfully in a two-way reciprocal process. Within the principle of reciprocity is the responsibility to protect and care for participants, upholding their dignity and avoiding harm. Privacy and confidentiality of all participants was maintained throughout the study. All confidential information was kept safely on password protected systems. All identifying information, including comments, were removed from data and replaced by pseudonyms.

Respect holds significant importance in Pacific cultures. All participants were given the right to withdraw from participation at any time. Informed consent was gained orally as well as written and was obtained following initial discussions and prior to audio recording. Discussions during the tālanoa ensured that participants understood the purpose of the research, parties involved, the research design, data collected and how results may eventually be shared with the community.

3.9 Summary

This study design used nine key informants to investigate Sāmoan pain beliefs and attitudes towards seeking pain care. Data were collected using eight tālanoa conducted by both Jessee and I. Data were analysed thematically using the Braun and Clarke (2020), six phase process. Both researcher and cultural consultant were involved in this process; however, after initial coding the majority of analysis was completed by myself, with consultation with Jessee during each phase. Through the analysis process, the 15-point checklist for good thematic analysis was also used, with considerations made to each criteria (Braun & Clarke, 2013). Additionally, this study incorporated quality criteria including the concepts of credibility, dependability, transferability, and confirmability. Ethical considerations have also been included to provide transparency and demonstrate principles used in conducting this study.

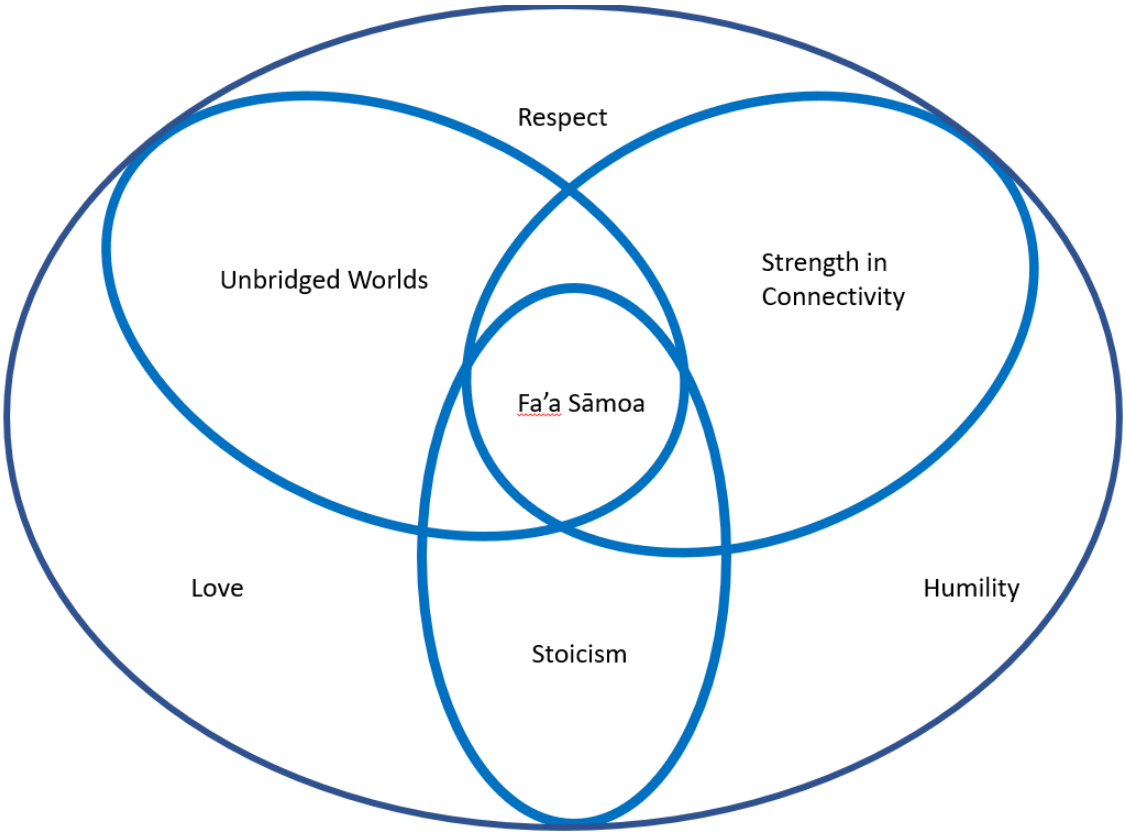
Chapter 4. Results and Discussion

4.1 Overview of key themes

Three overarching themes were constructed from informant interviews: stoicism, describing the attitude towards enduring pain; strength in connectivity, describing the inherent strengths that naturally occur within this community; and unbridged worlds, describing the disconnection between the Sāmoan community and healthcare. These three themes are held together by fa'a Sāmoa – the Sāmoan way. Over all interviews, the Sāmoan worldview was seen shaping how our informants described the Sāmoan community's view of health and pain. An individual's worldview is influenced by several factors, including their connection to their āiga and community, and connection to their spiritual, mental, physical and emotional worlds, values and beliefs, and the dominance of the Christian paradigm held generally by Sāmoan communities. The overarching themes are illustrated in Figure 5.

Figure 5

Diagram of overarching themes.



It is difficult to understand Sāmoan concepts of health or pain without appreciating the context of the Sāmoan worldview in which they are made. Sāmoan people bring their own unique fabric of knowledge, with heritage, customs and beliefs built on the platform of fa'a Sāmoa. Centring the three themes around fa'a Sāmoa brings understanding of fa'a Sāmoa and how it impacts on pain beliefs, community values, and help seeking for pain. Fa'a Sāmoa is not used as a separate theme but rather acts as an interpretative lens through which the three themes might be understood, bringing a connectedness and context between themes. The themes are enveloped in a circle holding the three fa'a Sāmoa values, love, respect and humility. These values help us understand how Sāmoan people interact and influence the choices and decisions that they make.

4.2 Stoicism

The first theme explores the belief that persistent or chronic pain should be endured without display or complaint. Causes of chronic pain were understood holistically with pain being attributed to many sources, including spiritual and relational ones. Although acute pains that can be attributed to biological or mechanical causes should receive attention, this is under the proviso that pain is severe and detrimental enough to cause harm. This theme continues exploring pain beliefs, including the ability to endure pain being virtuous. Finally, how stoicism is displayed within a person's social and family context is explored, with discussion on how decisions are made on accessing help for pain.

4.2.1 Pain is Seen Holistically

Informants discussed pain within a holistic health model, with pain being attributed to many causes. Beyond pain being caused by trauma, injury or pathology, pain was also attributed to other causes including spiritual or relational. Spiritual causes were discussed by several informants where pain was constructed as a consequence of sin[1] or punishment for sin committed by an individual or family member. Curses placed by others on the individual or family was provided as another explanation. For example, informant W stated:

> "Sometimes pain is an honourable thing to go through, and so therefore you wouldn't want to take it away. Some people believe that they deserve to be in pain to pay for some sins. Often that has come from familiar lines, family curses, and things like that, so they think they don't deserve to ask for help."

---

[1] Sin is defined as an offense against religious or moral law that causes separation from God (Merriam-Webster Dictionary, 2021).

Furthermore, breaking of protocol or relationships was also presented as another cause for persistent pain, as described by informant T:

> ""I deserve this. I wasn't respectful to my parents," or my father married, or married his cousin," um or there has been some other curse that is there from some family discord. And so, "I deserve this, so I don't deserve to have this taken away.""

Holistic understanding of health is widely associated with indigenous health models, such as Te Whare Tapa Whā (Durie, 1985) used to support and understand Māori health, and in the Pasifika Fonofale model (Pulotu-Endemann et al., 2009). Several other cultures also attribute pain to non-physiological causes, including the Hindu culture whereby pain can be associated with past discretions (karma) (Pillay et al., 2015) and other cultures where pain should be tolerated for greater reward in the afterlife (Lovering, 2006).

In a similar vein, pain was an expected part of the aging process. This was seen particularly in participants' narratives around their parents and elders. For example, informant U reported:

> "I meet a few people that they do open up about pain and you can see the pain on their face, the pain they are going through, and some they just ignore it. It's a part of growing up, it's a part of life, it's part of growing old."

Within the Sāmoan worldview, key informants reported that pain was a symptom that did not necessarily warrant attention, nor was worthy of seeking help. It was merely a symptom and unless it was deemed "bad enough" it was to be endured. Healthcare was reserved for acute, severe conditions, or with visible effects. Informant T described the Sāmoan attitude towards pain as being a symptom of inconsequence to be dealt with independently:

> "Pain particularly for Sāmoans is not something that would send them to the doctors. It will be (*sigh*), it won't be pain. It will be something that they are not familiar

> with, like maybe the loss of feeling in their arm, or you know maybe a droop on one side. It would have to be something drastic to send them to the GP. I know so many Sāmoan patients, even family that suffer from gout. But even that, I look at their joints and it looks awful, they still won't go to the GP. Man. "Nah, I'll deal with it. Take a few Panadol.""

Another informant R, further described pain from significant trauma or obvious injury as being acceptable to seek help for, but pain that does not have an obvious physical precursor was not:

> "If there's no blood, harden up. And unless your bone is sticking out of your leg, then we'll respond. I kind of feel as if our Sāmoans represent our A and E. Unless you're actually bleeding, or have bones sticking out of your body, then you react and quickly and you get some attention. But it's not. If it's not seen, then it's like, you're all good. (Pause) You can just sit there and hack it a bit longer."

Using healthcare services for emergency care and delaying seeking help for more 'minor' symptoms appeared prominent in our tālanoa. This is a common attitude reported in Pasifika health service literature, with Pasifika two to three times more likely than non-Pasifika to present to hospital with preventable conditions, such as asthma and diabetes, while being less likely to receive preventive therapy (Buetow, 2002). This is a concern as evidence strongly suggests emergency services are not suitable for the complex and long term needs chronic pain patients present with (Brady et al., 2021; Glynn et al., 2019).

Informants discussed how health is seen in a reactive not proactive way; that is that health symptoms are to be dealt with when related issues arise. In our tālanoa, shared experiences indicated that health was often low on the hierarchy of needs for an individual. Therefore, unless there is something that requires immediate attention, help is often not sought. Competing responsibilities are described by informant V as a barrier to seeking healthcare from a GP clinic.

> "There are other things that are more important than going to the clinic. It's just like, if you tell a family member, "you have to go and see the doctor for that wound on your leg," and they say "ah, yeah, if I have time." They will do everything, shopping, you know, blah, blah, blah and last on the list, then they will see doctor."

Key informants indicated that expectations of healthcare services were that they will be seen quickly and receive prompt interventions with an immediate response and easing of pain. Dissatisfaction and disconnection were expressed when these expectations were unfulfilled, as explained by informant V:

> "They want the fast fix and then go and then come back again…. I do believe there is a gap there if like what you are offering you are thinking long term, and they are thinking short term. They are thinking now. Fix it now, or otherwise I'm not coming back."

Informant U discussed the difficulty for Sāmoan patients to see benefit of attending tertiary pain services that offer non-interventional care:

> Interviewer: "Is it understanding that is the biggest barrier (to attending tertiary pain services)?"
>
> Informant: "Yeah, I think they do (understand), but I think they don't think they need it. That it is a waste of time to go."

Other informants agreed there was difficulty for Sāmoan patients to see beyond an acute healthcare model, where short quick interventions are sought, for several reasons. First, there appeared to be a failure to fully understand the benefits of longer-term health management that did not produce immediate benefit and second, commitments in terms of time and finance for ongoing appointments also appeared as a barrier to engaging in services. This misalignment of expectations in healthcare is mirrored in a recent Australian report which found chronic pain users of emergency services were driven by ‘cure focused’ interventions, with dissatisfaction ensuing if this is not provided (Brady et al., 2021).

Pasifika use of primary care shows significant barriers, including competing priorities particularly in regards to financial and social obligations, (Manhire-Heath et al., 2019) as well as appointment availability, and transport, making attending to health issues more difficult (Ryan, 2012). However, difficulty in seeing benefit in attending such appointments may also be a contributing factor as informants suggested. Access to primary health care services has improved significantly over the last 20 years, however, the NZ Health Survey shows that Pacific people continue to experience high rates of unmet need for care compared to the total NZ population. One in three Pacific peoples report not seeing their primary care practitioner when they needed, and one in five Pacific peoples report not filling a prescription due to cost (compared to one in ten of the total population) (Ministry of Health, 2019). Other barriers that contribute include, evidence that Pasifika have lower satisfaction rates in regards to being treated with dignity and respect by their health care professional (Ryan, 2012) and inadequate time given to discuss health needs (Gerritsen et al., 2008). Furthermore, a study of patients with chronic conditions based in South Auckland (over half of whom were Pacific) found that low engagement with health services was associated with the sense of powerlessness during clinical consultations (Sheridan et al., 2011). Further reports find general practitioners express lower rapport, shorter consultations with Pacific people and fewer referrals and tests are ordered (Davis et al., 2005). Collectively, this contributes to Pasifika missing out on pain services particularly referrals to specialist care, as general practitioners are the main gate keepers to referrals.

4.2.2 The Impact of Spirituality on the Experience and Presentation of Pain

The predominant attitude towards enduring pain without complaint may be connected to the Christian faith. Traditionally, Sāmoan people have a strong trust and faith in a transcendental being that is in control, all knowing, all powerful and can be sought for comfort and guidance (Macpherson & Macpherson, 1990). The Christian faith was presented by informants as enabling acceptance of the presence of pain without an endless search for a panacea, and a lower reliance on medication or interventional treatment.

Spirituality can be difficult to define but is recognised as distinct from psychology (cognitions and emotions) with the defining feature being a person’s relationship with a transcendent being (Tse et al., 2005). Spiritual relationships influence the core of a person’s identity and motivation for life and has a strong influence on a person’s attitudes, emotions and behaviours (Siddall et al., 2015). There is limited research on the influence of spirituality on chronic pain. Recent studies suggest that spirituality can impact the pain experience particularly through a psychological influence, giving hope, optimism and a sense of purpose which can serve to promote pain coping and resilience (Ferreira-Valente et al., 2019; Feuille & Pargament, 2015).

Pacific based studies show growing evidence that the Christian faith found in the Pasifika community benefits the community by improving self-worth among those experiencing mental health distress (Malo et al., 2000), and greater meaning to those enduring pain in cancer (Sabado et al., 2010). Similar findings were described in another migrant chronic pain community where spiritual faith brought solace and hope amid pain (Brady et al., 2017).

In our tālanoa the Christian faith appeared to provide a framework through which pain could be understood and acknowledged in a positive sense, including to continue engagement in normal activities. This has also been found in past literature with those living with chronic pain (Esteve et al., 2020; Viane et al., 2003). In Western culture, it can seem counter intuitive to have reduced cognitive control that may lead to negative thinking or passivity, e.g., hopelessness. However, in the context of the current study, pain acceptance through faith was largely seen to help patients shift from looking for a cure to continuing to engage in life goals and activities with the acknowledgement that pain may not change.

Beyond faith providing strength to endure and withstand pain, there is also strong faith in God to guide the journey to healing through people and directly through prayer, with all healing being attributed to God. This is described by informant Y:

> “…”well, only God will help us. Yep, amen, Malo, Malo. Oh yes, pray, pray for the doctors” and they will pray for you. And they will say “God will look after you, God will honour you”, so it’s very much part of the consultation.”

In the lotu/prayer that was said prior to interviews, many informants sought God to guide the interview to bring knowledge and wisdom in the conversation. The use of prayer and inclusion of God in the conversation was a way of acknowledging God’s overall sovereignty over an individual’s health, life and integration into the everyday.

4.2.4 Stoicism in Reporting Pain

Stoicism also refers to the tendency for Sāmoan people to understate their reports of pain, and the repercussions of this for assessment or treatment decisions. Key informant V described her experiences with Sāmoan patients attending healthcare services, without disclosing their pain issues in this way:

> “I have advocated on behalf of many of the Island people that I come across, and you know like it’s the same thing. They do the same thing, they go into the doctors, and the doctor will say, “Are you in pain?” “No, no, yes, yes, I’m fine.” And then they come out and it’s a different story. They haven’t even told the doctor exactly why they came to the clinic or the hospital. I think they tend to hold back, until it gets to the stage that it’s too late.”

Six of the informants described Sāmoan patients being shy, reserved and embarrassed of asking for help, which leads to communication difficulties with healthcare professionals who assume responses transparently reflect the patient's experience. Pain seen to be caused by either spiritual or relational discord was for the most part to be endured and kept private. This may be due to the shame or guilt that revelations would bring to the individual or their family. This attitude towards keeping pain private can be likened to Māori perceptions of pain. Previous studies involving Māori report pain is rarely openly discussed due to whakamā/shyness/embarrassment/shame (Magnusson & Fennell, 2011; McGruer et al., 2019) or is seen as a necessary part of healing that should be tolerated without complaint (Bassett, Tango, 2002). Explanations for experiencing whakamā have been attributed to the stigma often attached to chronic conditions, with blame placed on individuals as being self-induced disorders (Walker et al., 2017). The preference to manage health issues independently or within their own social group is later discussed in the third theme – Unbridged worlds.

A reason for understating pain may be due to the belief that the ability to endure pain is a character virtue. Tolerating pain, and the suffering that comes with this, was perceived as a sign of strength. Conversely, not managing pain was seen as weakness or a lack of resilience or courage, and appeared to hold particularly true for talk that involved men. This depiction of masculinity and how a Sāmoan should respond to pain with stoicism and self-reliance was described by informant W:

> "You would never let the other person know that you are in pain or you are weak until you are at that point where you can't tolerate it."

Evidence suggests that women are more likely than men to report or experience chronic pain (Greenspan et al., 2007), seek help for pain (Mills et al., 2019), and express pain more overtly (Archey et al., 2019). Biological and psychological effects are thought to contribute to these differences (Musey et al., 2014). However, identity, society and gender-role expectations are thought also to heavily contribute to these gender differences (Rosenberg, 2009; Samulowitz et al., 2018; Wise et al., 2002). Pain can be found as part of traditional Pasifika rituals. For example, withstanding pain of traditional body tattooing for a young male is part of the overall transition into manhood (Hamogeekgirl, 2013). Part of the ritual is the ability of the male to manage pain without complaint, showing he is ready for coming of age, and shows mental fortitude to see the completion of the pe'a/traditional male tattoo. Natanielu (2019) discussed the pain from a tatau/tattoo further, describing it as acting like a "silent teacher" to find meaning and purpose, ultimately connecting a person to their identity. There is a Sāmoan saying: "Fanau le tenine fana fanau, fanau le tama le tatau". Translated, this means "If a girl is born it must bear pain of birth, if a boy is born it must bear pain of tatau." This saying enforces the belief of pain being part of life and transition into adulthood, with importance of tolerating and even embracing the pain and adversity that comes with this. This was voiced by informant W:

> "The tattoo is like the symbol of a man, because it's very painful. You go through that and come out is like a sign of manhood and being a man, and that you are a warrior, so it's about putting up with that pain that shows."

Traditionally, Pacific masculinity is synonymous with warriorhood and can be seen contemporarily through sporting accomplishments, particularly in the A/NZ rugby culture, where the All Blacks are seen as the epitome of masculinity (Grainger, 2012). Pasifika players are admired as "natural fighters", strong, large, staunch, and with athletic qualities likened to warriors (Chen, 2014). Continued visibility and high profiling of Pacific males athletes being successful financially and socially makes professional sports attractive and reinforces this view of masculinity (Grainger, 2012). Values of toughness, competition, and ability to tolerate pain have been shown in A/NZ rugby players (Pringle & Markula, 2005), and were used as an example of how Pasifika view pain by one participant. This was explained by informant Z:

> "Yeah, it's like a male thing. If you can't handle pain, and so the guys will say, "harden up mate, take it" and you have to just show that strength and resilience…… you see it when they play rugby, they just go hard out, and hit each other. If they get hurt, they don't show it. They could be broken in six places, but it's a sign of coming of age, of manhood, strength and hey even though I was broken I still went on….." "You are the man!"

The prevailing attitude of keeping up this masculine appearance has implications for those in the community with chronic pain. Pain and pain related impairment was associated with weakness and inferiority to peers. Further still, a vital part of wellbeing was the appearance of being physically strong, independent and able to undertake their responsibilities, such as work and their āiga. The ability to for fill these responsibilities are particularly pertinent for Sāmoan people who live within a communal, collective context with significant roles and commitments.

4.2.3 Stoicism in the Āiga

The Sāmoan culture is a collective community, where the importance of role and responsibility within the āiga is critical to an individual's identity and value (Fairbairn-Dunlop et al., 2014). Stoicism in the family and social context allowed people to function despite pain. Informants described the strong commitment and loyalty Sāmoans make to their āiga, parents, children, elders, church and communities. These commitments have a profound impact on identity as an individual, as they identify as a part of a group. It may also mean that until an individual is unable to fulfil their role within their āiga /family or community, help for pain may not be sought.

Informant T describes his mother having persistent pain in her knees, while not perceiving the benefit of seeking help she feels her pain is attributed to other causes and not her diagnosis of osteoarthritis. With an attitude of stoicism to accept the presence of her pain, she continued with her roles and daily activities within her abilities:

> “She’s quite accepting of it (her pain). Um, you know, I’m in this pain, but I will just carry on. It’s never affected her relationship with her children. I don’t know what it’s like with Dad! (Laughter). But with us. It’s been fine. She tells us she’s in pain, but it doesn’t stop her from, we tell her not too, like stop cooking us food and you know, doing things that she doesn’t need to…..”Yeah, it’s ok, I’ll deal with it. Life goes on. I’ve got to go to church. I have to continue with my life.” That’s essentially how they see it.”

Informants described the ability of individuals to continue to fulfil roles, responsibilities and uplift their āiga, encompassed their sense of health and wellbeing. This has been found in other migrant cultures with chronic pain, where psychological distress developed in patients from their inability to fulfil their family role (Brady et al., 2017). Informants described the ability to continue, despite pain, positively, but also negatively as pain was at times inappropriately ignored.

Informants discussed the influence of the āiga and collective culture on an individual’s ability to attend medical appointments for pain, leading at times to further reinforcement of stoicism. Help seeking was often a collective decision, shared amongst the āiga. Sharing these decisions meant that, although an individual may want to attend a medical appointment, this may be overridden by others in the āiga, or vice versa. However, individuals may decide to prioritise the welfare of the āiga, and for go seeking treatment without consultation. Attitudes in decision making was discussed by all informants, offering insights into how Sāmoan people prioritise pain and wellbeing. This was described by informant Z:

> “I always say the Pālagi perception is my health first, then my family, then my church, whereas we say, family first, then my church, and myself last. And that’s the way we believe.”

This was expanded to explain healthcare decisions by informant Y:

> "That (āiga/family) is more important than my health, or fix up my pain, I'll tough it out, because the most important thing is that as long as my family in Sāmoa is being looked after, my church is being looked after, then I will look after me after that. So, I'm the last on the rank. And you know, I'll come if it's end stage type of thing, otherwise no. I'm going to look after my family first, so when you get that appointment sort of thing, they'll say, "oh, no, no, no, I've got to go to work", or "no, no, it's a funeral, or it's a wedding. I can't come.""

While both A/NZ and Sāmoa share Christian informed histories and Judo-Christian worldviews, it is the community living and collectivist mindset that is inherently different to the Western individualist mindset that dominates Pālagi New Zealanders. International studies show that ethnic minorities with a collectivist culture have a high reliance on their own community and family for minor health needs and only seek Western healthcare for emergency care (Nguyen & Kagawa-Singer, 2008; Queensland & Division of the Chief Health Officer, 2011). The āiga, which includes extended family, are collectively responsible for the welfare and health of the family unit. The needs of the individual are secondary to the needs of the āiga, with decisions around wellbeing, seeking healthcare and following treatment being made collectively. It has been suggested the strong influence of collective decision making can influence individual's help seeking and treatment choices (Norris et al., 2009), and these data suggest this is also true in the context of chronic pain.

Informant X described the consideration of financial implications as another barrier to expressing pain to others:

> "They don't want to say, "oh, I'm in pain," because they are scared of what's going to happen afterwards. Like if I tell you, "oh, I'm in pain," oh, you are going to say, "we have to do this, this, this" and then there is the financial side of it as well. Not having enough money. We think like that."

Findings suggest that individuals have to consider the impact that exposing their pain condition will have on the people that they are connected to. Members of the āiga are often juggling several responsibilities and asking for help may not be practical or may be considered culturally shameful. Cultural and practical barriers has been cited as a barrier to accessing mental health care for Sāmoan āiga (Suaalii-Sauni et al., 2009).

4.2.4 Summary

The attitude of stoicism towards pain was clearly seen in the data, which presented significant implications to how Sāmoan people report, access care and manage pain. Pain beliefs were predominantly informed by a holistic Sāmoan worldview which included a significant Christian faith influence. Pain was seen holistically, and was attributed to different causes including spiritual and relational breakdowns or conflicts. Pain was traditionally seen as a symptom to be endured, especially by men. Help for pain was often not sought unless there was severe and immediate need with the expectation of pain to be relieved quickly with interventions. Findings also explained that Sāmoan people have much to consider, with decisions often made collectively with their āiga, before attending to their pain. Factors included āiga/family and work responsibilities, financial implications and time prioritisation.

4.3 Strength in Connectivity

The data highlighted that Sāmoan community in Auckland has multiple strengths that support recognised pain management strategies. This theme brings to the forefront the community's unique competencies and group practices, focusing on what enhances health and wellbeing. The theme speaks to the importance of connectivity with self, family, community and faith-based activities and the benefits of this in managing chronic pain. This theme particularly resonates with Pacific values of drawing strength from relationships (New Zealand & Ministry for Pacific Peoples, 2018). First, pain is described as a shared experience that is shared collectively with the āiga. This is expanded with reference to community social gatherings and practices that bring people together. Lastly, individual and corporate spiritual practices are discussed, with particular attention given to the value placed on prayer.

4.3.1 Pain within the Āiga

Across the data, pain was described as a shared experience felt by the whole āiga by all informants. An individual's identity and purpose are intertwined with their position and role within family. Pain and illness becomes a collective experience and responsibility for the whole āiga. Informants expressed the importance of seeing a patient from within a wider framework taking into account their context, particularly their family, social position, and roles, and discussed the therapeutic benefit of belonging and sharing of illness. This was described by informant X:

> "It's more or less other people in the family will feel, like when you are sick they can sense, they can feel one person, and they affect the whole family….Supporting is very important, and that's why the feeling within the family affecting when you are sick and when you feel pain, they will also feel pain as well."

This was also described by informant Y:

> "When you do find someone who is suffering quite a bit you will always find a big extended family network around them, and for them seeing cousins, aunties, uncles, and those sorts of things, is much more therapeutic than taking something specifically for the pain."

Chronic pain has been strongly associated with a decrease in social opportunities and interactions (Breivik et al., 2006). For Sāmoan people social, emotional and practical support is often found in their āiga. Even in A/NZ where there is no longer a traditional "village," informants describe the connectedness that āiga make through gatherings, church communities, and social media.

Informants described the community fostering the sharing of information, supporting a collective knowledge that leads and guides individuals to treatments/remedies or to people and services for their health. The āiga are also described as essential for advocacy and support, and to help re-enforce treatments given to patients. Evidence shows this collective sharing of health responsibility leads to protective and positive health behaviours (Nguyen & Kagawa-Singer, 2008) and increased active participation in health programmes for Pasifika (Firestone et al., 2021). Encouragement for clinicians to include āiga in all aspects of consultation was offered by all of the informants. However, one informant did identify that family involvement can lead to difficulties in information sharing in relation to confidentiality, as many families would expect all information to be shared from all healthcare interactions and do not always understand clinician confidentiality processes.

Family involvement has long been associated with improving patient adaption to chronic illness and chronic pain (Swift et al., 2019) and individual outcomes (Lemmens et al., 2005). Recommendations have been made for pain clinicians to include routine assessment of family and social context of their patients and to include family in interventions (West et al., 2011). Interventions often include facilitating open communication between family members, and/or encouraging sharing daily tasks as a means of building family bonds or creating opportunities for communication, e.g., eating a family meal together (West et al., 2011). These interventions are seen naturally occurring within Sāmoan communities and serve to create purpose and meaning, as well as strengthening identity into an individual’s life. The ability to look, create and appreciate different forms of social support has been found to help people with chronic pain to be less dependent on healthcare resources, particularly pain clinics, and less concerned when support is withdrawn (Kennett et al., 2008). Further to this, there is evidence that when Sāmoan individuals receive healthcare education, there can be a significant positive impact on the surrounding āiga as well (Wong Soon et al., 2021).

These findings appear in direct contrast to stoicism discussed in theme one, where pain is kept private and careful consideration is given when reporting pain. Social standing, hierarchy and roles within the āiga maybe one element that contributes to creating differences in acceptability of what is shared and expected amongst the āiga. There appeared to be some family members who have a higher social standing, e.g. a grandmother, where it appeared appropriate for her to complain, report pain and ask for āiga assistance to get help. However, this attitude was not extended to children, as described by Informant R:

> "Like we (children) don't tell anyone because there are negative repercussions. (…) You just don't tell anyone, because it's the fear. And I guess as you get older, you don't want to tell anyone again, because you don't want to burden people. You just hope the pain will go away."

Informant R described the implications of the community's hierarchal structure in the context of cross-generational communication:

> "From our (Sāmoan) cultural perspective, we know we've got roles and it's hierarchal. It's like, I'm New Zealand born Sāmoan and one in my 40s, my mum is in her 60s and Sāmoan born. There are certain things we can talk about and certain things we can't talk about."

Conversely, it was noted by informants that if someone was isolated from their āiga or the community, this was a significant negative impact on them, particularly with self-motivation. Suaalii-Sauni (2020), warns not to assume that all Pasifika people have supportive families and, additionally, some families now reflect the typical Western nuclear family unit rather than the traditional Sāmoan extended structure. The Social Connectedness Report, (2016) shows that the rates of loneliness are similar for Pasifika (13.5%) and European/other people (13.2%) (Ministry of Social Development, 2016b). This is surprising given the focus on socialising in this culture. However, it may reflect the changing and complex context of Pasifika adapting to life in A/NZ.

4.3.2 Togetherness Practices are Central to Sāmoan Pain Coping.

The Sāmoan community have strong social connections that foster organic methods of healing and expressions of coping through the use of story telling, tālanoa/talking, singing, music and laughter. These practices were presented as naturally occurring within the community, promoting mental health and giving opportunity for those in pain for distraction and emotional and spiritual support. Informant W described some of the ways Sāmoan people cope with pain:

> "Music, entertainment, laughing, laughing, laughing."

Informants describe collective humour being an integral part of most Sāmoan gatherings, small and large. Humour is used informally with openness and appears to promote social bonding, restore perspective and increase positivity. The adage that laughter is the best medicine has been supported with evidence validating the benefits of collective humour in chronic health conditions (Lebowitz et al., 2011). In the context of pain, genuine smiling and laughter has shown benefits to increase pain threshold, pain tolerance, and pain perception (Zweyer et al., 2004). Humour has also been identified as a key component that participants sought in chronic pain support groups (Finlay et al., 2018).

Informant R described her grandmother and friend's daily activities, a daily routine of social interactions, spiritual practices and attending to family roles. This makeshift support group appears to act as a buffer to the frustrations of living with pain, enhancing an individual's coping strategies by sharing and distracting from individuals' suffering:

> “They could sit around for hours and hours, laugh, backstab and gossip, and make up stories and bring things up in the past. … They repeat these stories, over and over and I wonder if it helps them manage their pain. They laugh, and laugh, and mock and laugh, and gossip, and then they sit there and read their bibles and pray, then they go back to gossiping. This is their daily cycle. They get up, they clean their houses, they sit down, talk, laugh, talk, laugh, pray, read their bible, talk, laugh. I wonder if that is a component towards managing all of that, or minimising some of what is physically going on.”

A study by Finlay et al, (2018) found a similar preference to not talk about pain in support groups, but rather focus on the importance of comradery and congeniality of conversation. Further still, there is literature reporting the benefits of the use of singing, laughing, chanting and storey telling in the Sāmoan community to help reduce stress and anxiety, bring connectedness and relaxation (Menon & Mulitalo, 2006).

Informants discussed the strong customs of meeting together within the community as family, extended family or wider friendship and church connections, allowing for people to check up on others and bring accountability and social support. Informant W describes a local community exercise programme where health is being enhanced by social gathering:

> “But it worked (exercise programme) because of relationship, being in it together, yep, community, belonging, identity, and all of that sort of stuff…… It was all about being together, belonging, being seen, being heard, which is essentially what we all want, you know, because we are all human.”

The strong social supports of the Sāmoan community provides those with chronic pain a place to adjust to these impairments, by promoting a sense of inclusion, empathetic friendship, and emotional and spiritual support. Literature has suggested it is difficult for chronic pain populations to connect with those without pain, but has identified that social connectedness is what patients want and need (Hearn et al., 2015). Furthermore, there is strong literature linking social connectedness to improvements in mental health (Saeri et al., 2018) and physical health (Leigh-Hunt et al., 2017), including prevention of loneliness (Lay-Yee et al., 2021). Additionally, Pacific people appear to benefit from social support network involvement in facilitating health behaviour change (Matenga-Ikihele et al., 2021).

4.3.3 Spiritual Practises Supporting Pain Management

Beyond the wider social support, informants also described the specific positive effects of spiritual practices such as church going. These practices give those with chronic pain social connection (through church community and pastoral connections) as well as an outlet to turn to private religious activities as a way to cope, for example, in prayer.

A study with Sāmoan people in Wellington showed informants were genuinely committed to maintaining Sāmoan culture here in A/NZ, including by participating in communal activities (Levine, 2003). This study suggests that as Sāmoan people migrate to A/NZ, the church becomes a substitute for the village and occasionally the family, where many fa’alavelave (special activities) take place, and the pastor or minister take on roles that traditionally the Matai would. However, while the Sāmoan community strongly identify as Christian, this is not always linked to attending traditional Pacific churches. Today, many Pasifika, particularly young or A/NZ born, are exploring different social and spiritual identities outside of traditional norms (Ministry of Health, 2008b; Macpherson, 2018) and this may mean that many Sāmoan risk being estranged from this social context.

Informants described spiritual practices being part of everyday life that help to bring hope and optimism. Prayer, in particular, is used at times of personal and community pain and hardship. As informant Z commented:

> "Prayer is very strong, it is very, very strong in our culture. Even at time of extreme personal pain, like death or at funerals, the common saying is pray, pray. Be strong, pray, pray, pray (…). Pray into the very painful personal situations."

Ihara & Vakalahi's (2011) study with Sāmoan elders found that prayer was integral for wellbeing by being a remedy or treatment for problems and granting spiritual connection with God. This was seen as a daily practice.

Although there is limited evidence available, prayer has been shown to not only be an effective coping skill but also shows promise to have a therapeutic effect by improving pain severity and increasing pain tolerance (Dezutter et al., 2011; Feuille & Pargament, 2015; Illueca & Doolittle, 2020). This has been attributed to prayer being a positive reappraisal technique (Dezutter et al., 2011).

Informants reasoned that acknowledgement of prayer as a component to the patient's health was greatly appreciated when it was included in their interactions with healthcare professionals, and encouraged this as a way to strengthen the patient/clinician relationship. As informant U noted:

> "We always start off with a prayer and end with a prayer. That's our journey. That's our life."

There is increasing recognition of the importance and value of incorporating spirituality into clinical care even within pain management (Culliford, 2002; Siddall et al., 2015). However, barriers for clinicians have been reported in the form of insufficient, inadequate training or confidence, concern about offending patients, and general discomfort with discussing religious matters (Curlin et al., 2006). Our findings support this and encourage clinicians to find ways of acknowledging Sāmoan spirituality as a way of providing cultural and holistic care. Several benefits have been shown including, strengthening the clinician-patient relationship (DˈSouza, 2007a) and in identifying barriers and promoters to making health actions (Isaac et al., 2016).

4.3.4 Summary

The Sāmoan community in A/NZ has multiple strengths that support pain self-management strategies offered by healthcare providers. Connectivity with self, others, āiga, and community are important and help people cope with pain. Furthermore, the Sāmoan community has practices, including gatherings, that incorporate storytelling, laughter, singing and prayer which enhance wellbeing and connection. This, in turn, helps individuals with pain by distracting and sharing suffering, enhancing coping practices, as well as encouraging healthy adaptations. The role of the āiga for Sāmoan people living with pain, was described as helpful in promoting and supporting healthcare and wellbeing practices.

4.4 Unbridged Worlds

An overarching theme in the data is the disconnection that Sāmoan people feel from the A/NZ health system, represented in the title of this theme, Unbridged Worlds. Initially, health attitudes and beliefs are explored with a focus on how Sāmoan people navigate between two often opposing worldviews; traditional Sāmoan and Pālagi. This theme continues with further exploration around cross cultural tensions and power differentials, with particular attention to the patient/clinician interface. Finally, the disconnection and alienation that Sāmoan people contend with in navigating the mainstream healthcare system is examined and explained.

4.4.1 Divide Between the Pālagi and Sāmoan Worldviews

Informants discussed the tension of holding both a biomedical framework of pain, where pain is attributed to organic pathology and a more traditional cultural understanding of pain, where pain is to be tolerated and accepted without necessarily understanding the causation. The treatment decided upon is dependent on which framework is chosen. For example, if there is a belief that their pain was due to a spiritual cause, it may be deemed more appropriate to seek help from a healer with a religious connection. The Western healthcare system is seen as a place where only symptoms that are of biological cause (organic pathology) are to be treated. This was described by informant U:

“Sāmoans see healthcare as a physical thing as opposed to all the other things, cos they get that from church, or family.”

Within the Sāmoan community there are diverse perceptions of health and illness. Macpherson and Macpherson (1990) report that some Sāmoan people distinguish between two kinds of illnesses: ma’i Sāmoa (Sāmoan illnesses) and ma’i Pālagi (European illnesses). This perspective is seen in several Sāmoan studies where Sāmoan illnesses are attributed to God or punishment or a wider range of misfortunes (including relational conflicts), and Pālagi illness have a biological basis (Harrington & Scotese, 2001; Ioasa-Martin & Moore, 2012; Norris et al., 2009; Tamasese et al., 2005).

Dividing illness between Sāmoan and Pālagi were also present in three informants’ explanations for who Sāmoan people went to see first, that is, a traditional Sāmoan healer or a Western healthcare practitioner. Norris et al., (2009) suggests this as a way of explaining why Sāmoan people are regarded as “impatient patients’’. For them, this is an experiment to determine what kind of illness (Sāmoan or Pālagi) is involved and if a treatment does not have an immediate effect, then the mode of treatment might need to change. This was described by informant W:

> “When a man is getting his pe’a, his tattoos, or a woman, they are not seeking Panadol or ibruprofen. They are being sung, they are having a bit of alcohol or kava to get through that. Western medicine is considered Western medicine, it is not a Pacific answer to Pacific problems.”

Traditional Sāmoan healing practices to alleviate pain were sought first in most instances. Massage was particularly popular and "used for everything". Seeing a fofō/traditional Sāmoan healer skilled in massage or a taulāsea/traditional healer were also options that were often sought before Western healthcare. Informant Y commented:

> "We don't go to hospital for pain. There is always someone that you know if it was someone knows how to do it at home, or they have their own way of dealing with it. … yeah, when I'm in pain with something, I will try and fix it myself, unless it's pain like you're giving birth, then that's different."

The traditional method of seeking health treatment in Samoa is by first seeking out a fofō in their village that is known or connected to them (Macpherson & Macpherson, 1990). A significant part of the traditional fofō or taulāsea treatment is the interaction, relationship and time spent with the clinician (Harrington & Scotese, 2001). This interaction is a well established motivator for using traditional, complementary, and alternative medicine (Agu et al., 2019). Time is spent listening and talking, laughing and sharing together, which is in stark contrast to the Western primary healthcare system that places emphasis on efficiency, diagnosis and treatment outcomes. Informants also suggested that visiting a pastor may be seen as more beneficial than a healthcare professional. Informant S described their interaction as a taulāsea and how much time and empathy they are able to offer their patients:

> "We laugh, we cry, we talk about the week. I reason around the table, they come home and talk at the table …. Here I am the healer, counsellor, psycho-analyst, everything all at once."

These data suggest that this type of interaction is one of the primary motivators in the preference to using traditional Sāmoan practices, and is often sought before seeking Western healthcare options.

Just as causes of pain were separated into Sāmoan and Pālagi, treatments were also differentiated. Those that aligned with their view of health and wellness were seen as Sāmoan, while other symptoms or illnesses were more appropriately treated with Western methods. For example, attitudes to taking long term medication and undertaking exercise were often construed as Pālagi and not in alignment with the perceptually 'natural' Sāmoan way. In contrast, traditional Sāmoan treatments including fofō, taulāsea and herbs, were seen as more 'natural' and more acceptable way to experience symptom relief as they were safer, particularly in comparison to medications. This attitude has been identified as a significant motivator for ethnic minority populations in other countries (Agu et al., 2019) and was described by informant W:

> "It's not a natural thing (medication), it's a manmade thing, and so even though my husband, his sister, no matter how much pain they are in, they try and avoid pain medication and they say "oh, no, I might get side effects."…"I'm going to stick to the natural stuff.""

Medication was viewed as a short-term fix or cure that is less 'natural' and had measurable efficacy based on perceived impacts on symptoms. Once symptoms stopped, taking medication also ceased. Informants describe this becoming problematic when engaging Sāmoan people to take longer term medication, for example, blood pressure, mental health or cancer medication, and was a significant challenge for health professionals. As described by informant Z:

> "I think the thing is when they see Western medicine they see it like a gimmick sometimes, and for some they will see that this is something I can use, it should get better with this pretty quick. "Yep, if I'm sick, then you fix it up" and end of story. If I've got diabetes, "Yep, I'll take this, now I'm right, don't need anymore, I'm cured." You know, it's sort of a gimmick quick fix."

This lack of understanding and perceived lack of safety around taking long term medication for health appeared to be a significant barrier in adhering to use. Informants also identified poor communication from the health professionals giving medication, particularly in explaining how and why they should take pain medication, and the financial cost involved. However, Panadol was described as a very acceptable use for pain relief in the Sāmoan community by informant X:

> "The reason why I mentioned the Panadols is because people know more about Panadol. This is the main one. The reason they don't take other medication is because they don't know why, they don't know what other medication is available, and also what is the cost to them."

Attitudes toward long term medication use for chronic conditions may be a challenge for this community. Reports of low rates of adherence to taking antihypertensives for Sāmoan people in Auckland have been linked to lack of transport, family commitments, forgetfulness, church activities, feeling well and other priorities (Wai et al., 2010). Traditional beliefs have been shown to also provide a significant barrier (Ioasa-Martin & Moore, 2012; Tamasese et al., 2005), particularly for mental health medication, and there are also concerns about medication side effects (Paddison, 2010).

Informants explained that many Sāmoan people perceive recommendations of exercise as unnecessary or ancillary to daily activity, which was deemed as sufficient. It was offensive for health professionals to encourage exercise outside of this "as this would insinuate laziness." Informant Y commented on attitudes to exercise growing up in Samoa:

> "Where I grew up there was no such thing as going for a run. No such thing as walking because whatever you do it's all hard labour. It's meant to be active, so most kids the normal thing is collect coconuts, walk all the way to the plantation. There was

> no such thing as recreational walk or run. But it is changing, even the back villages you walk. There is always that little, “oh, it’s the Pālagi way””.

Similar findings have been found in Sāmoa where physical inactivity was linked to prioritisation of community over individual well-being and associated with high status (Hardin, 2015). Despite this traditional perspective, informants felt exercise was becoming more acceptable and more popular, particularly for younger generations motivated by sporting role models. Exercising in groups was also a potential motivator to exercise as described by informant Y:

> “They go walking, but it’s become like a social thing where they turn up and then some people stay back and sit there and chat, a few will walk, come back… So walking is becoming like a thing to be part of, especially for the older Sāmoans… It’s a social gathering, but it’s far more too. It’s their mental health being dealt with.”

Misunderstanding about the Pālagi medical system also applied to staff and their roles within health services. This was particularly evident in the roles of the allied health professionals. “Unless you say, they assume everybody they see is a doctor.” Specifically, there appeared poor understanding of the role of psychological services within pain management. These services were for those with mental health issues, which also appeared to be poorly understood and associated with stigma within the community. This was described by informant U:

“”You are going to see the psychiatrist or the psychologist?” “Do they think I’m crazy,” and “I am not making up my pain. That’s for crazy people.””

A study by Faleafa & Niu, 2020 supports this traditional attitude of mental illness not being from biological causes but psychological causes, like straying from traditional and cultural values, or relational conflict, or not meeting family obligations. Spiritual causes were also found in way of spirit possession or punishment through curses (Ioasa-Martin & Moore, 2012; Tamasese et al., 2005), with mental illness treated by spiritual healers. This was explained by informant U:

> “They don’t realise there is a connection between the pain causing the emotional part of it, and the physical part of it. That is, they don’t understand why the need to see a physio and psychologist.”

Psychological therapies, including counselling and psychology, are regarded as a relatively new intervention by Sāmoan people (Ioane & Tudor, 2017). Evidence suggests that the Sāmoan community identifies spiritually, and views the benefit from spiritual interventions like seeking advice from church ministers or directly from God, as the primary therapeutic intervention required (Faalogo-Lilo, 2012). Informant T describes this well when discussing his mother’s response to being offered psychological services.

> “I have a reverend minister for that. To pray for me and maintain my spiritual health and my mental health.”

Another difficulty Sāmoan people face when sharing distress or relationship challenges is the sense of shame, as this is admitting that they are unable to manage this within their own spiritual world or support network or āiga (Ioane & Tudor, 2017). This not only reflects badly on themselves but also their family/āiga, can become a barrier to seeking or accepting support (Faleafa & Niu, 2020).

Findings point to a disconnection between traditional Sāmoan health beliefs and expectations from Western medical services. Implications of these findings may mean many Sāmoan have misaligned or unmatched treatment expectations and goals when attending to mainstream pain services. Many pain management programmes are focused on physical and psychological rehabilitation, to improve quality of life, placing management of pain central, rather than meaningful pain reduction (Cohen, 2021). This is difficult for patients to engage in without thorough explanation and understanding. This disconnection could manifest in several ways including non-attendance or seeking alternative pain services/treatments. A recent Australian study, supports this notion, showing a factor for culturally and linguistic diverse (CALD) populations with chronic pain attending emergency services, rather than clinicians/services in the community was the misalignment of treatment expectations (Brady et al., 2021).

Informants noted that beliefs and attitudes to health and pain appear to be changing with increasing health education and knowledge. Informants highlighted that there is great variation between individuals in how much they hold onto traditional health beliefs. Differences in navigating traditional and biomedical illness paradigms were discussed. Generational differences were noted where the younger generation, and those more removed from fa'a Sāmoa traditions, were more open in approaching Western forms of pain management. This was framed as being, due to their exposure to and understanding of the multifactorial influences on health and wellness. This is mirrored in other studies that found older Pasifika and those born in the Pacific Islands were more familiar with traditional medicine and seek traditional healing more readily (Ministry of Health, 2008a). In particular, these sorts of suggestions arose when discussing psychological aspects of health and pain.

4.4.2 Cross Cultural Tension Impacting on Quality of Care

The overarching expectation that Sāmoan people must enter into a cultural space not their own, and be the ones to operate cross-culturally to receive medical care, led to further marginalisation and misunderstandings between patients and clinicians. Health service delivery was framed as depersonalised and positioned in direct conflict with Sāmoan culture, where the core value is of relationships, above qualifications and titles. This is explained by informant X:

> "I think the connection… it's the way we are, eh. The way we acknowledge when you are seen face-to-face, when you go in person-to-person, rather than sending a letter, or you give us a call if you are coming or not. You know."

The lack of Pacific healthcare workers and language difficulties were also cited by four informants and were identified as barriers to open communication. A preference for Sāmoan or Sāmoan speaking health professionals was identified, allowing for patients to understand recommendations and explanations more effectively. However, three other informants felt that regardless of ethnicity and language, the ability for a health professional to build rapport and show "genuine care and understanding" was of higher importance, as concordant ethnicity did not guarantee quality of healthcare. The mixed view on the importance and preference of primary care ethnicity is matched by other A/NZ studies. Pio & Nosa (2020) found Sāmoan mothers preferring non-Sāmoan doctors due to confidentiality concerns. This is in contrast to Māori patients reporting a cultural disconnect between themselves and non-Māori clinicians (Cram et al., 2003). These differences in preference have been identified in the United States, where Latino's were found to prefer ethnically matched/concordant doctors but African American people did not have a preference for ethnicity but valued communication style above ethnicity (Cuevas, et al., 2017).

Some informants also felt that non-Sāmoan healthcare workers were unable to understand and appreciate the spiritual aspect of health. Spiritual beliefs were not often shared due to the fear of being judged or misunderstood. Informant R commented on the difficulty of expressing spiritual aspects of wellbeing to health professionals due to a lack of understanding or acknowledgment, comparing Westernised health professionals with traditional practitioners:

> "…and you think the doctor knows everything, well sometimes they don't understand the spiritual stuff. The wairua stuff. And these ladies (fofō clinicians) know, how to calm it."

Spiritual aspects of health appear to be often left out of routine medical consultations, even when there is evidence that patients would like this aspect included in their care (Sheridan et al., 2015). Furthermore, previous literature identifies that A/NZ GPs do not always understand patient priorities in health and wellbeing, whereas clinicians may show more concern with pathophysiology, perpetuating the mismatch of patient health values and goals (Corin, 2019).

Informants argued that the fostering of a relationship requires inclusivity and acceptance of traditional alternative healing practices. Non-disclosure of these practices is high within ethnic minority communities internationally, with migrants fearing the disapproval from conventional health professionals (Agu et al., 2019).

Informants stressed the importance of relationships with health professionals for making a positive impact on people's health and ability to engage with healthcare. This fits with Bright et al., (2017) argument that engagement is co-constructed between clinicians, patients and their support systems, rather than being an individual characteristic. Health professionals with long term relationships, where rapport has been made, were valued and trusted, while advice or recommendations from others was less so. Informant Z reported:

> "If you build relationship over a period of time, you have long term connection that's far more valuable and that's when you will respect and listen to someone that you have relationship with. Unfortunately, in tertiary care you only see them for a brief period in their whole life and that's why, ok they will listen and they will take out what they want, but they will go back to that foundation."

Trust in clinicians is valued highly in rehabilitation settings, and the quality of the relationship is often established by clinicians spending time and relationship building with patients (Terry & Kayes, 2020). Establishing trust cross-culturally with migrant chronic pain patients has been shown to be difficult. Brady et al., (2019) reported migrant patients feeling stigmatised by clinicians' negative stereotypes, and patients holding differing expectations of the patient-clinician relationship. This emphasises the effort needed by clinicians to maintain humility and avoid harmful stereotypes (Huynh & Dicke-Bohmann, 2020).

The importance of good connection and relationship with General Practitioners in primary care was noted as a strong determinant of effective healthcare utilisation. Further to this, informants discussed how trust and confidence was given to those health professionals they had closest relationship to rather than being based on qualification or status. This became particularly evident when patients were given differing opinions or advice.

Time was associated with relationship building and, specifically, trust. As self-management is integral to chronic pain treatment, health practitioners and service providers should consider how best to engage with Sāmoan people to influence how practice and service delivery can better respond and be more culturally sensitive. Rushed appointments or perceived time pressure during appointments are known to have detrimental effects on the establishment of relationships and communication with health professionals (Pio & Nosa, 2020). These findings suggest that fostering positive clinical relationships also requires health system changes, including clinic atmosphere/environment and time management.

4.4.3 Disempowerment from Being on Someone Else's Terms

The informants in this study argued that a power differential is experienced and felt by Sāmoan people as they interact with the physical health settings, health system protocols and health personnel. This Sāmoan - Pālagi interface is further complicated when, in trying to create a familiar space, Sāmoan people might try to follow appropriate cultural etiquette and protocols in the clinical space that can inadvertently exacerbate the power differential. Health care consultations encompass a complex hierarchy of social, professional, and cultural systems which are difficult for Sāmoan patients and families to navigate.

Our findings suggest that Sāmoan people, like other ethnic minorities, defer to those in authority, and this in turn leads to restrain in communication, and creates a power deficit between patient and clinician (Scheppers, 2006). Informants described doctors as positioned as all-knowing, all-powerful and to be highly respected for their education and intelligence. Data also indicated Sāmoan people will often not question, show dissatisfaction, or challenge health professionals because of wanting to honour and respect the status of the profession. For instance, informant R commented:

> "When you are going to the doctors it's like going to visit the queen or king, you have this qualification. And they know the hard work to get there, so there's this."

This barrier to open communication was also identified in informants describing the difficulty patients had in concealing that they did not fully understand what a health professional was telling them, or not disclosing the full medical issue that they attended for. This was described by informant V:

> "They will be like, "ok, ok, ok" (when with the clinician), and then they come out and say, "oh, I didn't tell him I had this, this, this, this…" I think it's the fear of, especially now being in a foreign country, it's the fear of saying the wrong words, you know the language barrier, not being able to express clearly what's happening."

Social stigma and shame are associated with low literacy rates and can be reinforced and exacerbated by health professionals assuming a higher level of understanding (von Wagner et al., 2009; Williams et al., 2002). This prevents effective questioning and open communication. Similar communication barriers have been found in the Māori population in NZ, with patients and whānau recognising judgement or blame-based attitudes from GPs (Houkamau, 2016; Cassim et al, 2021; Smeijers & Pfau, 2009). This was intensified by medical professionals not picking up subtle, potentially culturally bound communications (Cassim et al., 2021). Language barriers have known negative implications, including poor levels of satisfaction for patients and clinicians, quality of healthcare delivery and patient safety (Al Shamsi et al., 2020).

4.4.4 The Healthcare System: Distrust and Disconnection.

The NZ health system is seen as Western, built and governed by Pālagi to respond to, and treat Pālagi health needs. Navigating an unfamiliar, complex organisational system appears overwhelming for many Sāmoan people. Informants discussed how the healthcare system is ultimately not designed to welcome them and favours Pālagi at an organisational level. This was expressed by informant R:

> "….when we are engaging with the health sector or government departments, for them it's massive, it's a beast, it's a white system, and for them it's the Pālagi man."

Informant R further described the initial healthcare experience and interaction with the physical healthcare setting as a significant barrier:

> "It's geared for a Western delivery and so when you go in, or even right from the carpark, shit! You already don't want to go in there."

Findings highlighted the structural and organisational barriers Sāmoan people face when accessing healthcare. New Zealand's public funded health system has been found to privilege the dominant individualistic approach, biomedical discourse and designed primarily to respond best to acute need (Gifford et al., 2017). This can make service delivery for managing and preventing chronic conditions difficult, especially among non-Pālagi groups. Inequitable access and quality of care has consistently been shown for Māori (Jansen et al., 2009) and Pasifika (Ludeke et al., 2012). Furthermore, and as discussed above, Māori and Pasifika also report negative healthcare experiences and discriminatory behaviour (Graham & Masters-Awatere, 2020; Harris et al., 2012), which leads to further exclusion and separation from the health system. These findings mirror a recent Australian study where culturally and linguistically diverse (CALD) communities with chronic pain reported a sense of being overwhelmed when trying to negotiate a complex health system, which is largely left to the individual to self-direct (Brady et al., 2021).

All informants discussed how inadequate communication, language difficulties, cultural literacy and lack of knowledge and resources in the form of educational and promotional materials placed Sāmoan people at a disadvantage to accessing pain services. This was expressed by informant X:

> "….they don't understand the process (the healthcare system). I believe an important one is understanding the language is another barrier, and that is a very crucial part of this process."

Further to this, informants described the Sāmoan community feeling uninformed about chronic pain and the available pain services, particularly of specialist tertiary care services. There is a lack of education generally around chronic pain, including what services are available, how to access these services and how these services could benefit them. Suggestions on how to provide information to the Sāmoan community were given by the informants, including the use of Pasifika radio, leaflets written in Sāmoan language and use of Sāmoan cultural support or interpreters.

Health literacy refers to the ability for an individual to understand and use skills to make informed choices about their health (Malloy-Weir et al., 2016). The Sāmoan population has lower rates of health literacy, with reporting approximately 90% of Pacific adults having poor health literacy skills (Statistics NZ, 2019; Ministry of Pacific Affairs, 2008).

In our tālanoa, lack of understanding was also linked to mistrust. Cultural mistrust is seen in perceptions and interactions with the predominant culture or the system controlled by the predominant culture influences a person's opinion, attitudes and intentions with regards to utilisation of that system (Brooks & Hopkins, 2017). Cultural mistrust in A/NZ's healthcare system may be the result of decades of institutional inequities, as Sāmoan people interact with a system dominated by a Western approach with Pālagi in control. Fear and mistrust can manifest in mistrust of Pālagi and Pālagi controlled services. Medical mistrust that is, mistrust in medical health workers and medical organisations, has been associated with a variety of negative health related consequences, including treatment adherence, accessing preventative care and satisfaction with healthcare (Benkert et al., 2019; Williamson & Bigman, 2018). Understandably, recognising and addressing medical mistrust is a critical factor in advancing health equity for Sāmoan people.

Dissatisfaction directed at health professionals who do not make efforts or taking time to help Sāmoan people understand was evident across many informants tālanoa. The use of medical jargon was also raised as a barrier to communication, regardless of the health professional's ability to speak in their first language, as well as asking closed questions, and making patients feel 'rushed'. As informant S commented:

> "I'm tired of our people coming in and just nodding their heads. 'Cos that's all they do in their time frame that has been allocated to actually discuss their issues…. If you don't have time to explain to them, then find somebody please!"

All informants described the importance of seeking information and gaining knowledge in order for patients to be able to make informed decisions and advocate for themselves and their family. Education is seen as an important aspect of patient centred care (Rathert et al., 2013). However, informants reported that often Sāmoan people would miss this aspect of treatment due to language difficulties, or clinicians not spending enough time or attention to confirm understanding. Communication plays a key role in clinical outcomes (Belasen & Belasen, 2018) as well as affecting patient's satisfaction (Paternotte et al., 2015) and trust in clinicians (Terry & Kayes, 2020). A systematic review into factors influencing cross cultural communication cited clinicians' good language skills, including listening and avoiding medical jargon, to be of higher importance than being the same ethnicity in facilitating successful communication (Paternotte et al., 2015). This is supported by current A/NZ literature where medical jargon and limited consultation time have been shown to increase miscommunication, and give poor satisfaction for Sāmoan people (Pio & Nosa, 2020).

Further to this, non-verbal communication has also been identified as a potential barrier for ethnic minority groups (Goldstein et al., 2020; Konstantynowicz et al., 2016; Stepanikova et al., 2012). A lack of understanding of cultural etiquette, such as direct eye contact being disrespectful among many groups, can contribute to cultural misunderstandings (Andrews & Boyle, 2002) and mistrust (Whaley, 2001).

Building of trust and confidence in Pālagi systems can come through relationships and positive medical encounters. This study emphasises the importance and value Sāmoan people place on positive relationships with individual health clinicians. Patient centred care given by clinicians that show genuine care and concern, and who can understand and acknowledge Sāmoan values, will help patients build the necessary rapport they need to engage in a therapeutic alliance. This view is highlighted and supported by Pio & Nosa (2020), who interviewed Sāmoan mothers living in Auckland. They suggested that patients respond to patient centred care and acknowledgement of Sāmoan values with greater trust in diagnosis and an increased likelihood to follow self-management recommendations.

This theme was still relevant for A/NZ born Sāmoan people. They face these same difficulties but have the added expectation of representing and advocating for their family, who may not have grown up with knowledge of the A/NZ health system. Informant T noted:

> "… there's an expectation that because we know the Pālagi world we should be a bit more assertive, a bit more knowledgeable and so they don't have the NZ context in

> their forefront, there's an expectation too on us to lead the way and speak on their behalf."

Informants also described the heavy weight of responsibility and difficulty in leading healthcare encounters and decision making when they themselves feel ill equipped. This was described by informant R:

> "Being New Zealand born, our parents have relied on us heavily from very young ages to kind of represent them and speak on their behalf. The pressure is just enormous."

Many A/NZ born Sāmoan people will have parents or grandparents who are Sāmoan born and may have limited English. Most A/NZ born Sāmoan people may not be fluent in the Sāmoan language but will have enough capability to communicate with their island-born family (Anae, 2015). Having family members used as interpreters and health advocates is not always ideal (Gray et al., 2011). This places the often younger, A/NZ born Sāmoan with a language advantage when attending to healthcare services with this responsibility. However, they are also in a difficult position, as they are generally of lower status and may not necessarily have any more health knowledge or understanding than the people they are representing. Further still, as with many interpreter-based situations, the technical or advanced languages of health and biomedicine may be outside of their translation capabilities (White et al., 2018).

There has been an expectation that, as Sāmoan people move to A/NZ, the next generation will have fewer health needs. However, there is increasing evidence that New Zealand-born Pasifika face significant health challenges. This population demonstrates higher levels of poor mental health, particularly self-esteem and personal health indicators (S. A. Foliaki et al., 2006; Kapeli et al., 2020b), and have poorer adaptation outcomes (Berry et al., 2006) than their Pacific-born counterparts.

4.4.5 Summary

Many Sāmoan people are navigating between the traditional Sāmoan and Pālagi worldviews. This navigation has direct influence on their beliefs of illness causation and in turn where help is sought. When seeking care from contemporary Western healthcare services many Sāmoan people feel disconnected between what is offered and what they want, expected or value. Sāmoan people felt left to navigate complex, and unfamiliar processes within a health care system. Furthermore, encounters with healthcare professions lead to a greater sense of exclusion, as they attempt to bridge the gap between the Sāmoan and Pālagi worldviews with inadequate communication, limited resources, and differences in cultural etiquette.

Chapter 5. Recommendations

This study adds to previous research that shows Pasifika experience significant barriers to accessing healthcare in A/NZ (Jatrana & Crampton, 2009; Teevale et al., 2013). Significant barriers for Sāmoan peoples living in Counties Manukau in accessing pain services were identified, including health literacy, cultural, logistics, finance, linguistic, and system based barriers. These barriers may help us understand why Sāmoan people are not attending or benefitting from pain services to the same extent as other ethnicities.

Results also highlight the importance of addressing the chronic pain needs for the Sāmoan community by including Pacific models of healthcare, integrating the principles of fa'a Sāmoa – respect, love and humility. This requires a patient- and va-centred multidimensional approach across different levels of the healthcare system. Interactions between patients and clinicians, organisational and professional factors, and health policies will all need consideration to facilitate better pain care access and outcomes for members of our Sāmoan communities.

5.1 Patient Clinician Interface

Informants identified several barriers at the patient clinician interface. These included; poor lingustic communication, lack of time or feeling time pressured, power imbalance, poor relationships, and lack of acknowledgement of Sāmoan culture in healthcare interactions. A lack of trust in the healthcare system, process and professionals was also identified.

Patient-centred care refers to the prioritisation of a patient’s individual values, needs and preferences, and is associated with improved healthcare outcomes (Pluut, 2016). Building a strong clinician patient relationship is a vital aspect of care, particularly as patients recall and remember interactions with staff rather than specific pain strategies given in pain management programmes (Kennett et al., 2008).

One model of engagement with Pasifika clients has been proposed: “…through honouring the sacred space by having a va-centred approach to relationships, which emphasises that they are sacred, and are characterised by harmony, balance, reciprocity and mutual respect” (McRobie & Agee, 2017 p124). Taking a patient-centred approach in the context of fa’a Sāmoa requires a va-centred approach. Respecting the therapeutic space between clinician, patient, and āiga with empathy and reciprocal respect is imperative for Sāmoan patients in relationship and trust building.

Teu le va/the act of building and maintaining relationships, is predicated on notions of respect and reciprocity. In the clinical setting, this has been shown to be fostered through the appropriate sharing of personal information between the patient and clinician. This reduces hierarchical structures and allows patients, and indeed members of the Sāmoan community, to enter more collaborative healthcare relationships. This also aligns with the process of whakawhanaungatanga/establishing relationships with Māori patients and whānau, serving as a way to show respect and establish balance and commonality, as well as trust within the relationship (Bright et al., 2017; Cassim et al., 2021, Graham & Masters-Awatere 2020). Practical recommendations include clinicians sharing who they are and where they come from during introductions with patients. This can give a greater freedom for patients to enter into more authentic and relaxed relationships, that might be extended from traditional roles or boundaries (Ioane & Tudor, 2017; Terry & Kayes, 2020). Taking time and genuine care in establishing and maintaining rapport may give benefits that far outweigh the time invested in the process.

Attending to patient-centred care requires cultural safety[2] and responsiveness in clinical practice; being critically conscious of power relationships and inequities within health, as well as taking a holistic perspective. Cultural responsiveness training for clinicians that develops skills and attitudes as well as includes clinicians examining their cultural biases and stereotypes, can go a long way to help improve cross cultural connections with patients and trust in healthcare services (Curtis et al., 2019). Evidence suggests that mental and physical healthcare utilisation attitudes can be influenced by culturally responsive interventions in individuals high in cultural mistrust (Brooks & Hopkins, 2017).

As part of being culturally responsive, health professionals need to incorporate holistic healthcare models into their interactions with this community. Holistic care acknowledges and incorporates the whole person, including the biological, social, psychological and spiritual, and understanding patients' life context (Pluut, 2016). Findings suggest that often spirituality is overlooked in consultations and informants strongly recommend this to be included in assessment and management by clinicians. Discussions of the importance of spirituality have been recognised and recommended, particularly in the palliative care setting (Cheng et al., 2019). However, it is arguably just as important in the chronic pain setting where long-term physical limitations are often

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[2] 2. Cultural safety is defined as: a reflective practice, showing respect for the values inherent in a culture and the social differences of others in providing services. Pacific cultural competence is the ability to integrate Pacific values, principles, structures, attitudes and practices into the care and delivery of services to Pacific clients, their families and their communities. (New Zealand & Ministry of Health, 2020).

impacted on activities and relationships that provide meaning, purpose, and identity (Puchalski et al., 2009). Strengthening spirituality is a vital component in the journey to wellbeing for Sāmoan people (Hardin, 2015), and failure to address the spiritual aspect may be a missed opportunity, particularly as evidence suggests a significant number of patients turn to spiritual and religious faiths following the onset of chronic pain (Glover-Graf et al., 2007). Findings highlighted the significance of prayer, and could be incorporated into consultations by invitation. Use of Pasifika health models, such as Fonofale, in explanations of health help to validate and incorporate spiritual aspects of well-being. The use of inquiry during assessments into the spiritual practices, for example church attendance, also shows merits (D'Souza, 2007), as this shows patients interest in their worldview. This conversation can also provide important insights and opportunities to discuss the role that spiritual beliefs and practices potentially have in their health journey. Use of chaplains and other pastoral supports for those with spiritual needs should also be considered (Moreira-Almeida & Koenig, 2008).

Central to pain management is a strong pain assessment and this cannot be achieved without disclosure and recognition of the complex factors that affect the pain experience. Research suggests that many health professionals presume to have the same cultural beliefs and attitudes around pain as their patients (Spencer & Burke, 2011). Recognising cultural norms, beliefs, and how to approach sensitive topics is critical in healthcare interactions. Findings point to the need for recognition that some aspects of health, including pain, remain culturally bound, and therefore difficult to discuss openly. Assuming an openness to discuss certain topics may cause a clinician to insult the va. Rather than applying rigid formulae, taking opportunistic approaches in consultations has shown success in other sensitive subject matters in A/NZ (Gray et al., 2018).

Language and communication difficulties were a barrier for many Sāmoan people in their interaction with healthcare professionals. Suggestions given by informants included the use of illustrations or models by clinicians, accessing cultural advice by using Sāmoan speaking colleagues and use of cultural advisors and/or interpreters. This has been achieved effectively in the area of mental health by translating health information into Pacific languages (Faleafa, 2020; T. Suaalii-Sauni, et al., 2009). Checking for understanding by clinicians was also suggested and has been shown to increase patient and doctor satisfaction in recent literature (Foliaki et al., 2020).

Our study identified that systemic issues that impact upon a patient's relationships with primary healthcare providers is the variability in clinician contact. High turnover of staff and medical centres working in a model where patients see multiple GPs, rather than one designated doctor, presents difficulty for this population to establish continuity of care and cultivate meaningful relationships. This may have implications on pain assessment, diagnosis and referral patterns and therefore suggests a need to re-examine how primary healthcare is delivered, including the model of practice.

Responsibility needs not only rest with primary care health professionals. Given the dearth of Pasifika clinicians, it appears pertinent to find ways to expand and include healthcare personnel of diverse ethnicity. Having a health workforce that is diverse in backgrounds, and includes those of underrepresented ethnicities, has been shown to be critical in improving healthcare disparities, as well as increasing patient-centred care (Goode & Landefeld, 2019). Axillary Pacific health workers have also shown to be beneficial in working to promote interventions within this population (Kaholokula et al., 2017), and even the use of church peers (Simmons et al., 2004). Overseas, community leaders have been used to provide culturally adapted pain management programmes with success (Brady et al., 2017). This creative and inclusive use of health support workers gives an opportunity to overcome barriers like language and cultural understanding, providing important links between health professionals and the Pacific community.

The use of support health workers may also establish connections and improve communication between primary and tertiary care services. This may help patients with referral and transition into specialist services. Evidence suggests there is a degree of transferability of trust between health providers (Terry & Kayes, 2020). By providing strong links through communication and, where possible, face-to-face contact, patients receive a sense of safety and care enabling a smoother transition between services. Foliaki et al., (2020), highlight the importance Pasifika place on having co-ordinated and continuous health care services, to provide consistent messages and establish relationships. Clear explanations on what tertiary pain services offer and how they can benefit patients are critical in helping to avoid dissatisfaction and misalignment of expectations. Furthermore, easier referral pathways to access specialist care also need to be considered as ethnic minority groups appear to traverse more complex pathways to specialist services (Ryan et al., 2019).

Having a positive healthcare experience can have long-lasting consequences for a Sāmoan individual and their āiga. This can reduce negative experiences and improve confidence in the usage of healthcare services.

5.2 Healthcare Organisation and Professional Factors

Findings pointed to the Sāmoan community struggling to trust in the A/NZ healthcare process, system and clinicians. Cultural mistrust in a healthcare system has detrimental effects on healthcare utilisation, health outcomes, and in turn contributes to ethnic disparities in healthcare (Benkert et al., 2019; Meyer et al., 2008). “If trust is the result of complex relationships/interactions between the physician, the medical system, and broader social systems that influence the health system, trust on all levels needs to be addressed when determining how to improve trust within health.”(Meyer et al., 2008. p.184). Therefore, responsibility does not only lie with clinicians to improve the communities trust in our health services. Culturally responsive, patient-centred, holistic care with social wrap-around services requires clinicians to have considerable support. A key component essential to this is sufficient time for medical appointments (Pack, 2018). Venues for pain clinicians to work in collaboration, learning and sharing are also vital, as this can result in more effective teamwork and support more efficient processes (Griffin & Hay-Smith, 2019). These principles apply also to primary care physicians. High complexity and growth in the Counties Manukau population is disproportionately served by the smallest GP workforce compared to other regions in A/NZ (The Medical Council of New Zealand, 2019). This makes care and extra support for clinicians in terms of funding models important to attract and sustain a strong workforce.

Findings highlight the need for a culturally safe healthcare service as well as an increased perception of increased equity in services to help improve healthcare utilisation and build trust in health services (Brooks & Hopkins, 2017). Cultural safety needs to be further extended from individual healthcare clinicians to healthcare organisations and systems (Curtis et al., 2019). Findings point to broader implications as Sāmoan people struggle to interact with the mainstream healthcare system. National pain services continue to use questionnaire based assessments that have not been validated for Māori or Pasifika and require a high level of literacy to complete (Lewis & Upsdell, 2018). Furthermore, some services require questionnaires to be completed as entry criteria. A new pain assessment has risen that shows potential in helping culturally and linguistically diverse patients present their pain narratives and should be considered and tested in the A/NZ context (Brady, et al., 2019).

Health literacy is known to contribute significantly to health disparities for Pacific people (Lambert et al., 2014; Pio & Nosa, 2020). Improving health literacy is more than helping a patient understand information; it is helping them to process and think critically to be able to make informed decisions, evaluating, and acting to improve their self-efficacy (von Wagner et al., 2009). Furthermore, evidence shows that improving health literacy in this community can impact the health of both individuals and āiga (Wong Soon et al., 2021). Traditionally, low health literacy is considered in a framework that places a significant portion of blame on the individual or culture. More recently, responsibilities have shifted to a wider framework of reference which incorporates health practitioners, organisations such as district health boards and policy makers (Farmanova et al., 2018). Everyone involved in providing and receiving information has shared responsibility to ensure decision making and care management is made with equal understanding. This is particularly pertinent considering low health literacy rates are associated with perceived higher intensity of pain (Köppen et al., 2018). Pain education is therefore a core aspect of most pain management programmes (Geneen et al., 2015), and when knowledge is applied there is a reduction in the burden of persistent pain (Henry, 2008).

Ideally, health organisations should provide and deliver pain services that do not require patients, or their families to have advanced health literacy, helping to improve equity in access to pain services. Improving communication avenues with this community may help improve navigation and access (Farmanova et al., 2018). Actions for improvement include raising awareness by communicating to the Sāmoan community about chronic pain and what services are available. This could include use of Pacific radio stations, and educating and linking in with those already working in Pacific services in the community (such as Pacific health workers), as well as improving or providing chronic pain materials in Sāmoan and simple language, without medical jargon.

Findings promote moving away from a deficit based model towards a strength based approach to support patients and their families to utilise their inherent attributes. This approach has been shown to help clinicians to see families in a more positive light (West et al., 2011), and offers potential to develop and work alongside families in the Sāmoan community towards more effective and culturally appropriate pain management (Matenga-Ikihele et al., 2021). Involving āiga in all aspects of care is an imperative part of taking a strength-based approach, as the Sāmoan worldview and the Sāmoan relational self cannot be separated from the relational collective space (McRobie & Agee, 2017). Looking after the elderly and ill family members is a fundamental family obligation for this community (Foliaki et al., 2020). Sāmoan patients may be reliant on family members for advocacy, communication, as well as practical support at home and transport, and thus need to be included within consultations with the patient. This is particularly pertinent as social isolation for those with chronic pain is associated with high levels of pain interference, and low levels of physical function (Karayannis et al., 2019). Thus, understanding a person’s social context may lead to better treatment plans in pain management context.

Part of supporting a patient and their āiga may mean incorporating social care within healthcare. Improving healthcare provision and pain management for Sāmoan people would require a systemic shift in paradigm to focus on the broader factors important to care provision. Recognition of the complex needs of the community is imperative due to high and competing priorities. While family is traditionally expected to support Pasifika, this may not always be possible or wanted. Consideration for the need of state-funded services, church or other avenues of support may need to be taken. Our findings mirror previous reports highlighting cultural, family and work commitments as barriers to attending health programmes (Firestone et al., 2021). Providing practical support including transport, using local venues, or venues with good public transport, and having varied times and durations of programmes, such as afterhours, may allow for greater accessibility for this population.

Involving the wider āiga, including church communities, may also hold benefit by enhancing social support and promoting positive behaviour change. A study of Auckland Sāmoan church ministers found that health interventions that were not closely related to church activities were the least successful (Hopoi & Nosa, 2020). Further still, delivering interventions alongside community based organisations (Dobl et al., 2017), and using alternative spaces such as workplaces may hold benefits (Matenga-Ikihele et al., 2021). This is pertinent as evidence shows increasing health knowledge alone does not necessarily influence healthy behaviours (Simmons et al., 2004) and effects have been limited on interventions that are focused on individuals for Pasifika (Mhurchu et al., 2019). Therefore, provisions with funding and materials need to be made for Sāmoan communities, in so doing building capacity for them to self-determine their use.

Findings highlighted the strength of the Sāmoan collective culture. Incorporating and facilitating Pacific led pain programmes within services could enhance this community's inherent capacity to support each other. This may mean integrating hospitality and other practices that bolster and facilitate va with one another and clinicians; providing space for open sharing. Pain education programmes may consider incorporating alternative methods of communication, such as the use of narratives/talking therapies (Te Pou, 2010), and tālanoa where patients can share knowledge, question and discuss health concerns within a culturally bound and appropriate practice. Alternative therapies in the form of music and/or art may also have benefits in this group (Sam, 2019). While telehealth and online options for booking, consultations and even pain programmes have become more popular, and indeed necessary, informants warned that this may not be suitable for the needs of this population.

5.3 Health Policy Level

At present, there is limited knowledge of Aoteoroa/New Zealander's attitudes and beliefs around chronic pain. Further pain research that incorporates ethnicity and examines access and pain care utilisation would be greatly beneficial for policy makers to make decisions with Sāmoans and other ethnic minority populations.

While making policy recommendations goes beyond the scope of this study, acknowledging that many Sāmoan people face multiple health inequalities is important. Chronic pain holds physical, psychological, social, and economic consequences. For Sāmoan people interfacing with a pain care health system that is informed by mainly Western influences frames this issue as a result of the system, rather than responsibility for this community to address. As such, greater recognition of the complex factors needs to be made and encouragement for healthcare policy makers to respond.

Chapter 6. Strengths and Limitations

This study makes a contribution to A/NZ Sāmoan experiences of chronic pain by developing a greater understanding around Sāmoan health and pain beliefs, and how these affect their pain experience and help seeking. The study strengths included the use of tālanoa to capture rich narratives of Sāmoan experiences of pain and help seeking from experts in the Sāmoan community. Key informants were given the opportunity to speak openly and were unrestricted by time, or rigid questioning, allowing for experiences and thoughts to be fully explored and shared. This resulted in rich, in-depth data, and the themes generated were a product of data from across the tālanoa, with many similarities in opinions and sentiments shared across informants.

All key informants were connected to healthcare and the healthcare system, with all participants either currently working in or with the South Auckland Sāmoan population, or they had worked in South Auckland in the past. This made for both a limitation and a strength, as they represent in-depth expert knowledge and opinion, but not necessarily lived experience of chronic pain. Nevertheless, key informants who participated in the study, often spoke of their patients, families and communities to illustrate their points, and reflect their own experience supporting Sāmoan people with chronic pain in the Auckland community. While these findings should not be generalised or extrapolated to all Sāmoan people or Pasifika, findings do give good insights and perspectives of the Sāmoan community resident in Auckland.

The adoptions of tālanoa and va can be seen as strengths in this study, both in data gathering and in validating results and analysis. Principles of both tālanoa and va set a foundation to establish strong relationships between researchers and key informants, and created attitudes of respect and reciprocity. As referred to earlier, these protocols contributed heavily to the ability to gain honest, rich and genuine tālanoa, and therefore produce meaningful data. These research protocols also held researchers to commit to their obligations to key informants, particularly demonstrated in the group tālanoa after individual interviews were completed.

This research was conducted with the ongoing awareness of the limitations of having a culturally dissimilar background and what this may impose on the research process as outlined by Anae et al. (2001). This research was carried out by a Pālagi and Sāmoan partnership. Embracing cross-cultural collaboration and consultation with Pasifika have been shown to be successful (Fletcher et al., 2006). It is hoped that this study is seen as a further example of this, particularly in its ability to adopt indigenous methodologies and use of cultural consultation throughout the study design. Nonetheless, it is acknowledged that I conducted this study from a cultural outsider perspective, with constrained understanding of fa’a Sāmoa, limited cultural commonality, and little to no understanding of the Sāmoan language. All tālanoa were conducted predominantly in English, presenting further limitations as language plays an important role in allowing participants to fully articulate and express themselves in their own words (Suwankhong & Liamputtong, 2015).

Chapter 7. Conclusion and Research Recommendations

This study presents important characteristics of A/NZ Sāmoan views which underpin their understanding of pain, their decisions about how to seek help for pain and the acceptability of pain services.

Pain is traditionally seen as a symptom to be endured, rather than a condition that is needed to be treated. Pain was seen from a holistic lens, and was attributed to several causes, including organic, spiritual, and relational origins. Sāmoan people often under report pain due to prioritisation of the āiga and collective responsibility. Furthermore, the embarrassment of showing weakness, and an inability to manage pain independently compounds this problem. Stigma was found with pain originating from relational or spiritual discord. Reporting these beliefs drew concerns of misunderstanding and lack of potential benefit from interactions with Western medical services and served as a further barrier to seek contemporary pain services.

Sāmoan beliefs and perceptions of pain hold implications for how Sāmoan people interact with the healthcare system. Traditional pain healing methods, including fofō, were preferred to using contemporary health services. Health care options were often differentiated between what was appropriate for Pālagi or Sāmoan ailments and often with the consultation of others. When Western health services were utilised, it was reserved for severe, acute pain with known or observable cause. When seeking help, there is an expectation for a fix or cure, and not for managing or preventing further pain, or pain associated impairments. This attitude presents a significant clash of expectations when Sāmoan people present to chronic pain services which centralise long term management of pain rather than resolution.

The Christian paradigm has a significant impact on how Sāmoan people experience and respond to pain. This paradigm is brought into interactions with clinicians and had a positive influence in coping practices, particularly the use of prayer. Furthermore, the Christian faith allowed many to accept the presence of pain without need to pursue a restorative cure, and be able to respond by continuing normal daily responsibilities and activities. Additionally, findings reported Sāmoan people appreciated and welcomed clinicians that incorporated this aspect into consultations.

A key finding of this study was the inherent strengths the Sāmoan community has that help with managing and coping with chronic pain. These include close family, extended family, and community contacts. Traditions of gathering together, story telling, music, and laughter foster pain coping strategies. The āiga was a strong social support and a source of advocacy. The importance of clinicians including and supporting āiga in healthcare decision making and planning was highlighted.

This is particularly important as healthcare utilisation and response to pain was also found to often be a collective decision.

As with other healthcare needs, barriers to accessing pain services exist for the Sāmoan community. Barriers could be found in multiple domains. Barriers to accessing pain services through primary care included transport, cost and responding to multiple competing responsibilities presented. Lack of knowledge and understanding of available pain services were also a barrier to healthcare utilisation. Understanding chronic pain particularly the psychological impact of it were limited, and explanations from clinicians insufficient. This created potential for misunderstanding and a struggle to comprehend the benefits of attending chronic pain services. Barriers in interactions with health professionals were also found with a lack of health literacy, language insufficiency and understanding of the roles of allied health professionals. Furthermore open communication was often restricted with clinicians as Sāmoan people attempt to follow cultural etiquette with its inherent hierarchy.

Findings hold implications at an individual level for health practitioners. Best approaches need to emphasise the importance of interpersonal relationships focusing on building trust and rapport between individuals, aiga and nu'u. Findings call for health professionals to be culturally sensitive and aware of the wider social context of Sāmoan patients. Further to this, healthcare systems should support clinicians in this area. Providing adequate time, cultural safety training, and appropriate physical healthcare environments are required for patient-centred care.

Broader implications are also shown as Sāmoan people struggle to engage with mainstream health systems. Examination of how health systems can work with, and include, the Pacific community is needed. Organisational and systemic structures have traditionally favoured Pālagi, and without challenging and examining the culture, power, and privilege, inequities in healthcare will continue.

This study supports the idea that social, contextual, and cultural factors influence the experience of pain. Further investigation into beliefs and perceptions regarding pain may emerge in other community participants. Key differences in health attitudes and health outcomes, for example, have been made between A/NZ born Sāmoan and those born in Sāmoa and need to be considered (Kapeli et al., 2020). Future research may also explore intergenerational perspectives on health issues like pain and those living with chronic pain. Moreover, research needs to be undertaken with other vulnerable populations, including other ethnic minorities or sociodemographic communities who may also be in disadvantaged positions.

Additionally, findings strengthen calls for further research that forges effective partnerships with clinicians and the Pasifika community. Community led research helps to inform health providers so that interventions are culturally tailored, relevant, and meet the needs of the community. This may include research exploring the usefulness of adapting current educational pain resources or traditional pain management practices or creating alternatives. For example, pain management strategies like relaxation techniques may be able to be adapted. Further research determining the medical, social, and economic benefits of using cultural navigators with this community may also be of benefit, as providing professional translators and educational literature is not enough to overcome cultural barriers (Shommu, et.al., 2016). As pain and primary care services examine how to adjust and change to become more inclusive, it is hoped that the Sāmoan community will be able to access and benefit from pain services as other ethnicities do.

Chapter 8. References

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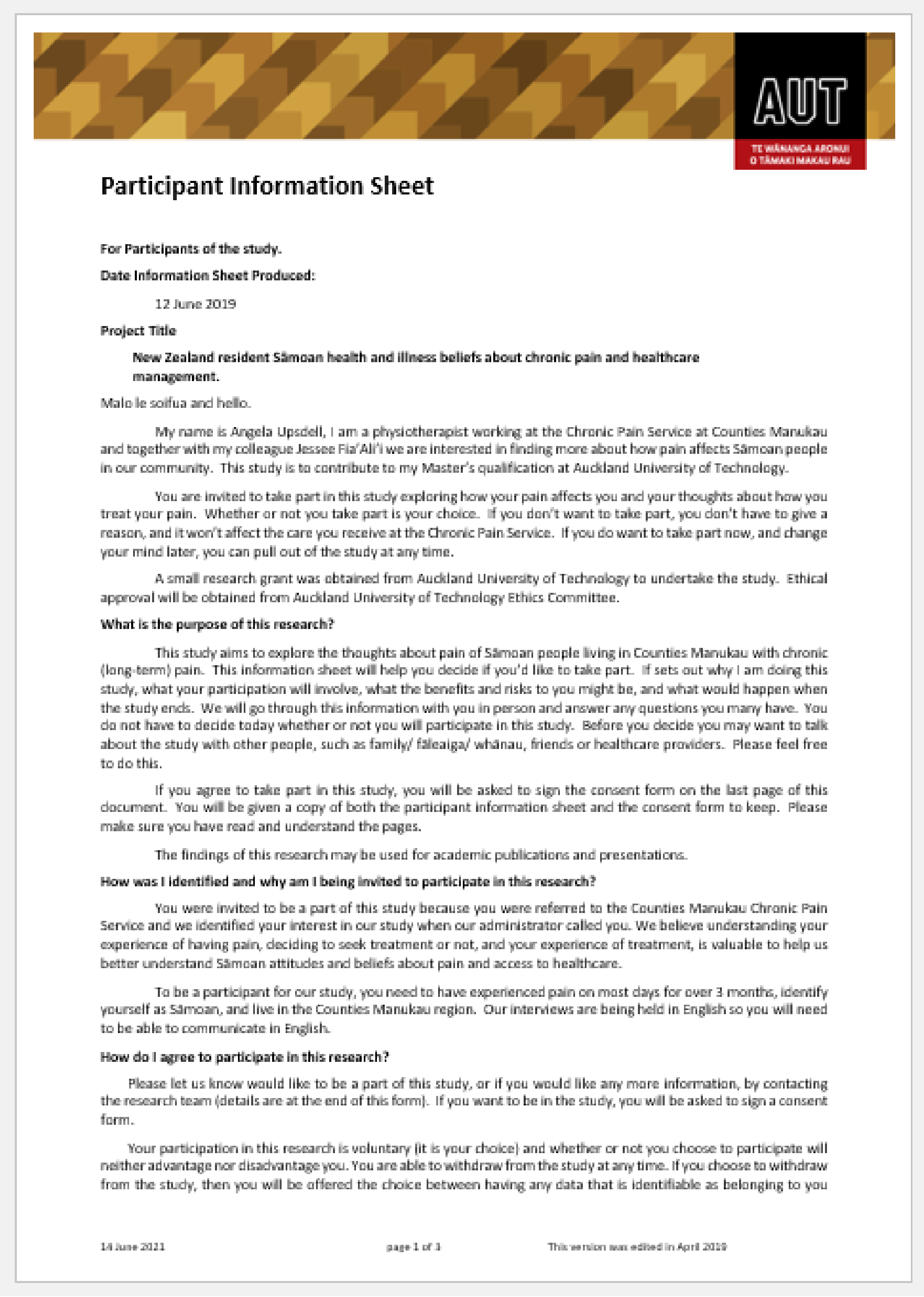
Appendix 1. Participation Information Sheet



AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Participant Information Sheet

For Participants of the study.

Date Information Sheet Produced:

12 June 2019

Project Title

New Zealand resident Sāmoan health and illness beliefs about chronic pain and healthcare management.

Malo le soifua and hello.

My name is Angela Upsdell, I am a physiotherapist working at the Chronic Pain Service at Counties Manukau and together with my colleague Jessee Fia'Ali'i we are interested in finding more about how pain affects Sāmoan people in our community. This study is to contribute to my Master's qualification at Auckland University of Technology.

You are invited to take part in this study exploring how your pain affects you and your thoughts about how you treat your pain. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason, and it won't affect the care you receive at the Chronic Pain Service. If you do want to take part now, and change your mind later, you can pull out of the study at any time.

A small research grant was obtained from Auckland University of Technology to undertake the study. Ethical approval will be obtained from Auckland University of Technology Ethics Committee.

What is the purpose of this research?

This study aims to explore the thoughts about pain of Sāmoan people living in Counties Manukau with chronic (long-term) pain. This information sheet will help you decide if you'd like to take part. If sets out why I am doing this study, what your participation will involve, what the benefits and risks to you might be, and what would happen when the study ends. We will go through this information with you in person and answer any questions you many have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family/ fāleaiga/ whānau, friends or healthcare providers. Please feel free to do this.

If you agree to take part in this study, you will be asked to sign the consent form on the last page of this document. You will be given a copy of both the participant information sheet and the consent form to keep. Please make sure you have read and understand the pages.

The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You were invited to be a part of this study because you were referred to the Counties Manukau Chronic Pain Service and we identified your interest in our study when our administrator called you. We believe understanding your experience of having pain, deciding to seek treatment or not, and your experience of treatment, is valuable to help us better understand Sāmoan attitudes and beliefs about pain and access to healthcare.

To be a participant for our study, you need to have experienced pain on most days for over 3 months, identify yourself as Sāmoan, and live in the Counties Manukau region. Our interviews are being held in English so you will need to be able to communicate in English.

How do I agree to participate in this research?

Please let us know would like to be a part of this study, or if you would like any more information, by contacting the research team (details are at the end of this form). If you want to be in the study, you will be asked to sign a consent form.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you

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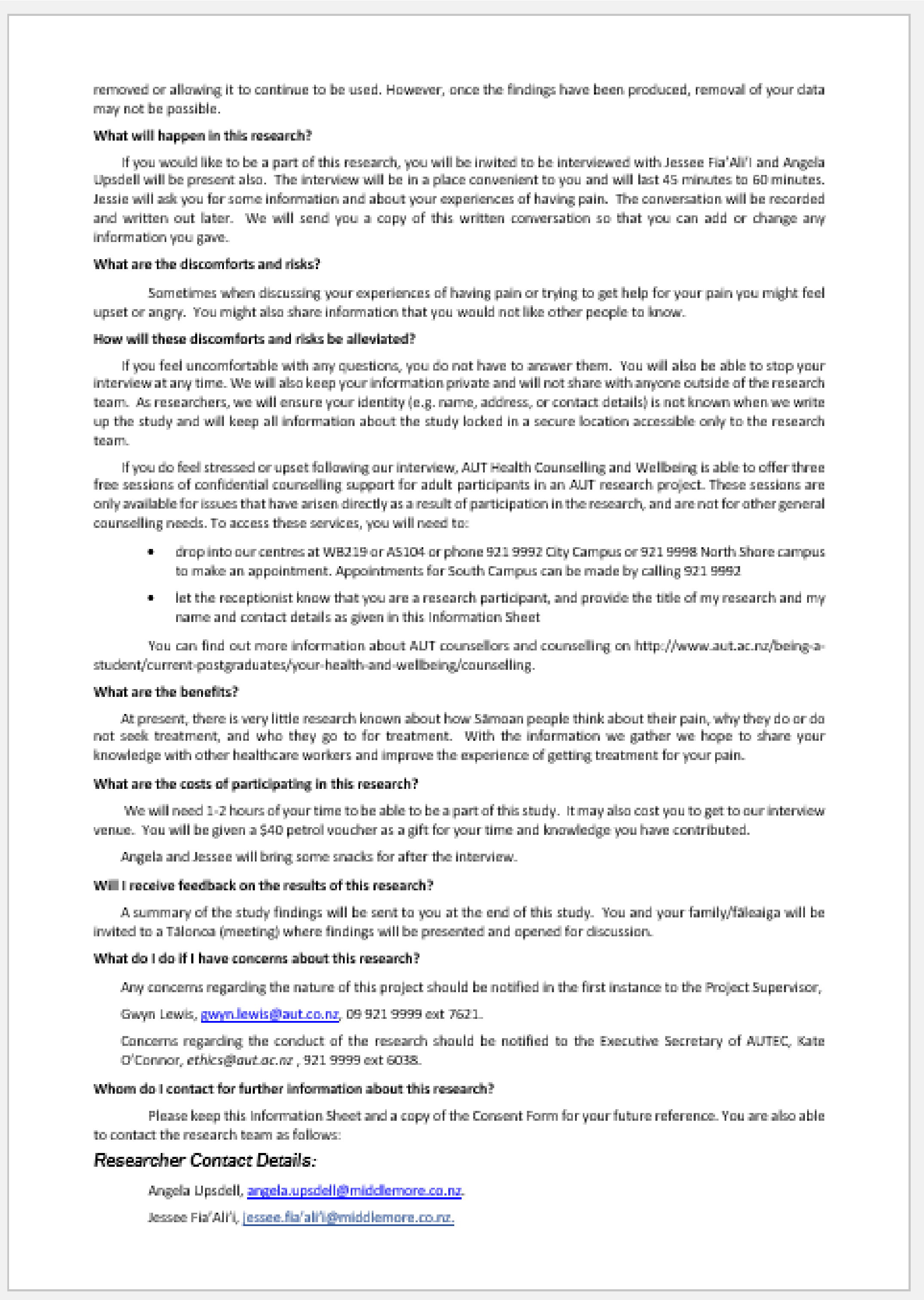


removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

If you would like to be a part of this research, you will be invited to be interviewed with Jessee Fia'Ali'I and Angela Upsdell will be present also. The interview will be in a place convenient to you and will last 45 minutes to 60 minutes. Jessie will ask you for some information and about your experiences of having pain. The conversation will be recorded and written out later. We will send you a copy of this written conversation so that you can add or change any information you gave.

What are the discomforts and risks?

Sometimes when discussing your experiences of having pain or trying to get help for your pain you might feel upset or angry. You might also share information that you would not like other people to know.

How will these discomforts and risks be alleviated?

If you feel uncomfortable with any questions, you do not have to answer them. You will also be able to stop your interview at any time. We will also keep your information private and will not share with anyone outside of the research team. As researchers, we will ensure your identity (e.g. name, address, or contact details) is not known when we write up the study and will keep all information about the study locked in a secure location accessible only to the research team.

If you do feel stressed or upset following our interview, 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?

At present, there is very little research known about how Sāmoan people think about their pain, why they do or do not seek treatment, and who they go to for treatment. With the information we gather we hope to share your knowledge with other healthcare workers and improve the experience of getting treatment for your pain.

What are the costs of participating in this research?

We will need 1-2 hours of your time to be able to be a part of this study. It may also cost you to get to our interview venue. You will be given a $40 petrol voucher as a gift for your time and knowledge you have contributed.

Angela and Jessee will bring some snacks for after the interview.

Will I receive feedback on the results of this research?

A summary of the study findings will be sent to you at the end of this study. You and your family/fāleaiga will be invited to a Tālonoa (meeting) where findings will be presented and opened for discussion.

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,

Gwyn Lewis, gwyn.lewis@aut.co.nz, 09 921 9999 ext 7621.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

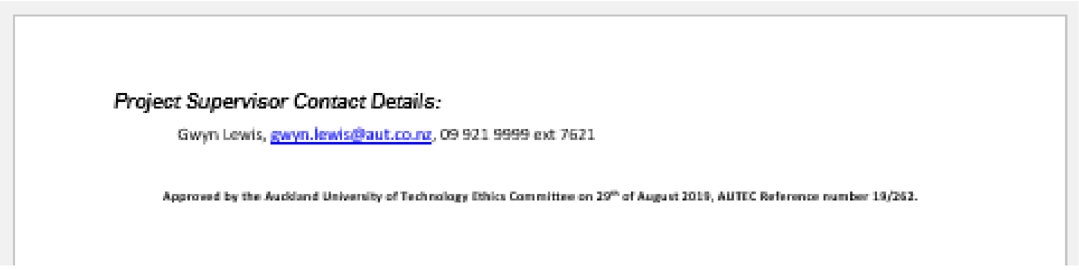
Whom do I contact for further information about this research?

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:

Angela Upsdell, angela.upsdell@middlemore.co.nz.

Jessee Fia'Ali'i, jessee.fia'ali'i@middlemore.co.nz.



Project Supervisor Contact Details:

Gwyn Lewis, gwyn.lewis@aut.co.nz, 09 921 9999 ext 7621

Approved by the Auckland University of Technology Ethics Committee on 29th of August 2019, AUTEC Reference number 19/262.

Appendix 2. Tālanoa Schedule

Tālanoa/Interview Schedule

Project title: New Zealand resident Sāmoan health and illness beliefs about pain and access to healthcare.

Research team: Angela Upsdell and Jessee Fia'Ali'i

Pain beliefs

- How do Sāmoan people think about chronic pain?
- What are the causes of pain, or what can pain be attributed to?
- How does pain affect Sāmoan individuals?
- How does it affect their family and/or community?
- Who do people talk to about their pain? (fāleaiga, friends, minister, healer)
- Where else do people look for information? (internet etc.)

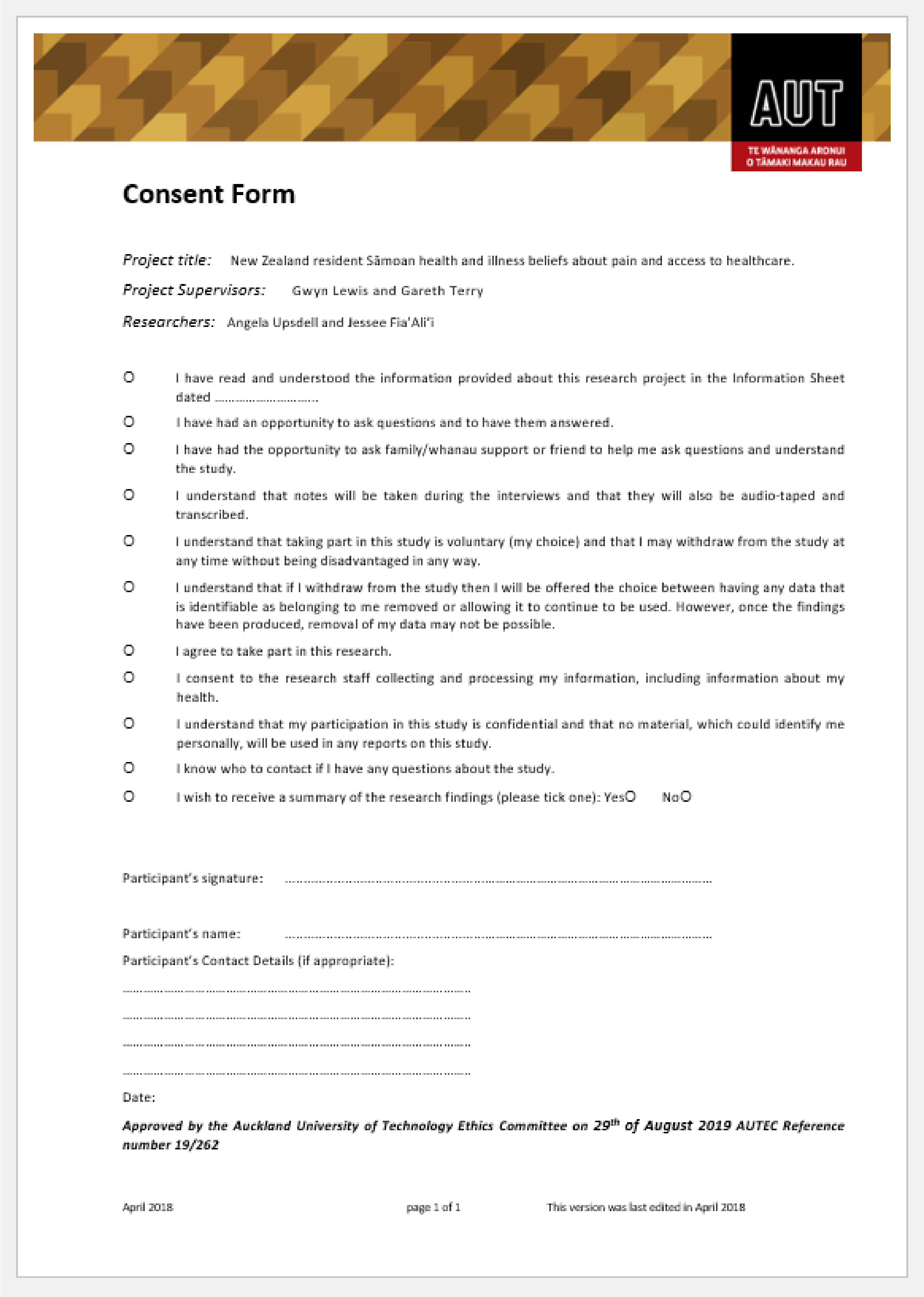
Initial treatment provider

- Who do Sāmoan people often see about their pain?
- Why did you see them?
- Can you tell me what that makes them decide who to go to seek help?
- What do Sāmoan people expect when they see contemporary healthcare?
- What are some of the barriers people face in seeking healthcare?
- In your experience, how satisfied are they with the treatments they receive?
- Can you tell me about traditional Sāmoan healing or other alternative treatments? Are they used or popular?
- Whose advice do they trust the most and why?

Pain Management

- How do Sāmoan people manage pain?
- What are the most appropriate forms of treatment?
- What has been your experience with people taking pain medication?
- What do people think about exercise? How do they respond when they are asked to exercise?
- Do Sāmoan people understand the different roles of health professionals included in a MDT? E.g. Psychologist or physiotherapist.
- What would people think if you are referred to a psychologist for pain? What are the attitudes around psychology and physical health?
- Are there any additional thoughts we might not have discussed?

Appendix 3: Consent Form



Consent Form

Project title: New Zealand resident Sāmoan health and illness beliefs about pain and access to healthcare.

Project Supervisors: Gwyn Lewis and Gareth Terry

Researchers: Angela Upsdell and Jessee Fia'Ali'i

○ I have read and understood the information provided about this research project in the Information Sheet dated ……………………….

○ I have had an opportunity to ask questions and to have them answered.

○ I have had the opportunity to ask family/whanau support or friend to help me ask questions and understand the study.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I consent to the research staff collecting and processing my information, including information about my health.

○ I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.

○ I know who to contact if I have any questions about the study.

○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: ……………………………………………………………………………………………

Participant's name: ……………………………………………………………………………………………

Participant's Contact Details (if appropriate):

……………………………………………………………………………………

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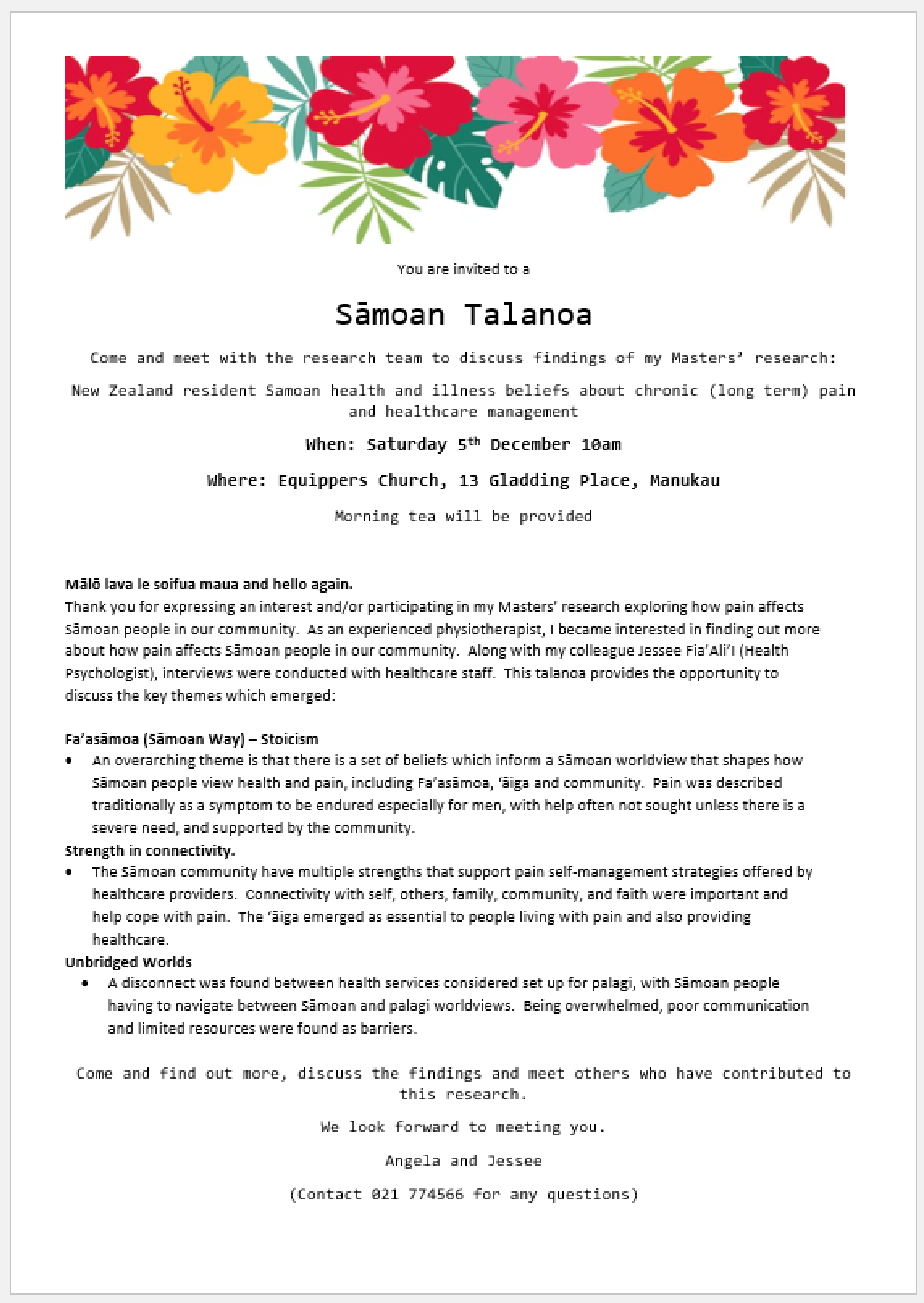
……………………………………………………………………………………

Date:

Approved by the Auckland University of Technology Ethics Committee on 29th of August 2019 AUTEC Reference number 19/262

April 2018 page 1 of 1 This version was last edited in April 2018

Appendix 4: Tālanoa Invite with Summary of Findings



You are invited to a

Sāmoan Talanoa

Come and meet with the research team to discuss findings of my Masters' research:

New Zealand resident Samoan health and illness beliefs about chronic (long term) pain and healthcare management

When: Saturday 5th December 10am

Where: Equippers Church, 13 Gladding Place, Manukau

Morning tea will be provided

Mālō lava le soifua maua and hello again.

Thank you for expressing an interest and/or participating in my Masters' research exploring how pain affects Sāmoan people in our community. As an experienced physiotherapist, I became interested in finding out more about how pain affects Sāmoan people in our community. Along with my colleague Jessee Fia'Ali'I (Health Psychologist), interviews were conducted with healthcare staff. This talanoa provides the opportunity to discuss the key themes which emerged:

Fa'asāmoa (Sāmoan Way) – Stoicism

- An overarching theme is that there is a set of beliefs which inform a Sāmoan worldview that shapes how Sāmoan people view health and pain, including Fa'asāmoa, 'āiga and community. Pain was described traditionally as a symptom to be endured especially for men, with help often not sought unless there is a severe need, and supported by the community.

Strength in connectivity.

- The Sāmoan community have multiple strengths that support pain self-management strategies offered by healthcare providers. Connectivity with self, others, family, community, and faith were important and help cope with pain. The 'āiga emerged as essential to people living with pain and also providing healthcare.

Unbridged Worlds

- A disconnect was found between health services considered set up for palagi, with Sāmoan people having to navigate between Sāmoan and palagi worldviews. Being overwhelmed, poor communication and limited resources were found as barriers.

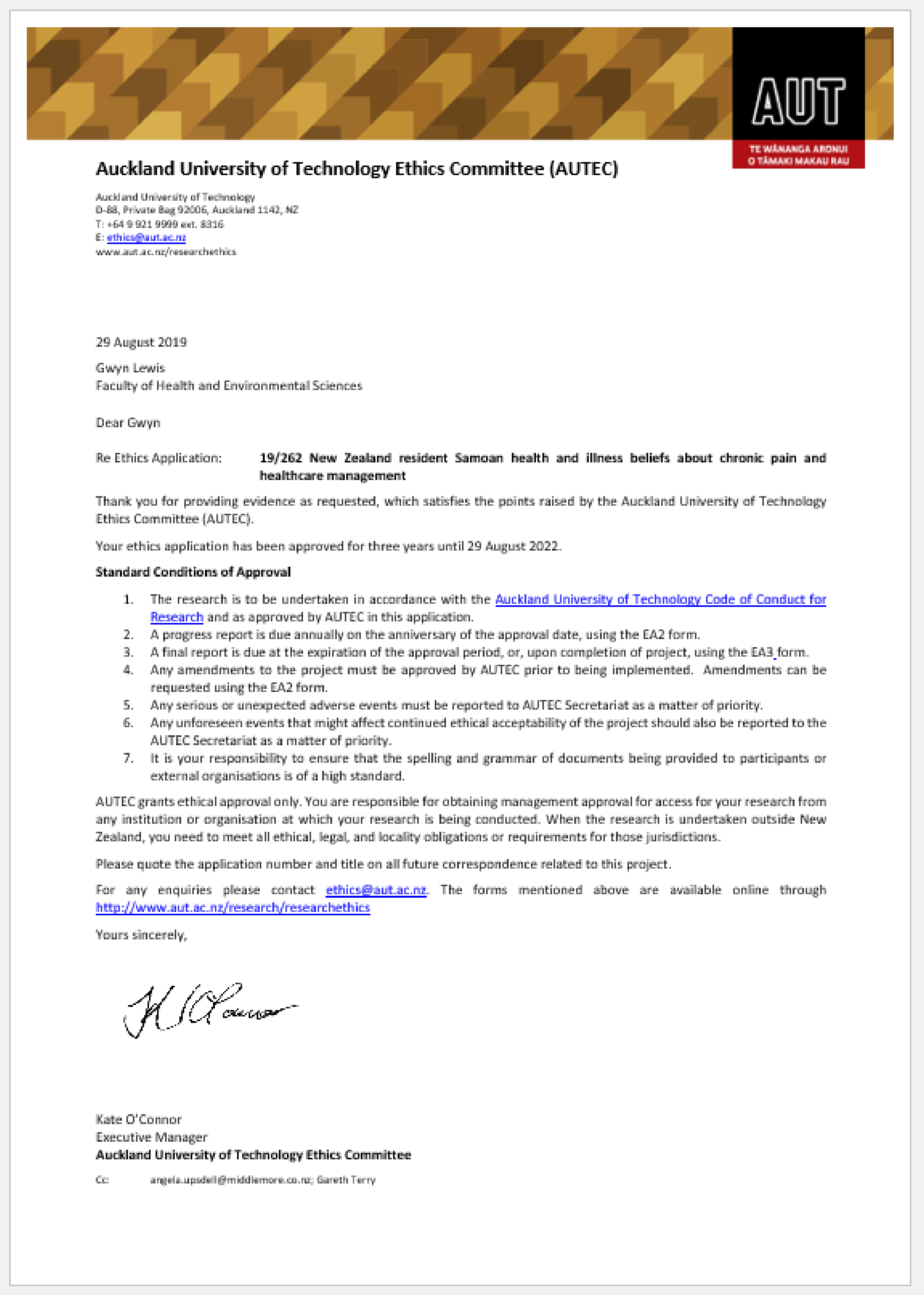
Come and find out more, discuss the findings and meet others who have contributed to this research.

We look forward to meeting you.

Angela and Jessee

(Contact 021 774566 for any questions)

Appendix 5. Ethics Approval



Auckland University of Technology Ethics Committee (AUTEC)

TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

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

29 August 2019

Gwyn Lewis
Faculty of Health and Environmental Sciences

Dear Gwyn

Re Ethics Application: **19/262 New Zealand resident Samoan health and illness beliefs about chronic pain and healthcare management**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 29 August 2022.

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

Yours sincerely,

Kate O'Connor
Executive Manager
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