

Communal to individual midwifery care: Cultural practices and the maternity journey of Sub-Saharan African women in New Zealand

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ABSTRACT

Maternal health disparities persist globally, including among Sub-Saharan African immigrant women in high-income countries. Many come from contexts where pregnancy, childbirth, and the postpartum period are embedded in communal traditions. In Aotearoa New Zealand, the birthplace of cultural safety, limited research has examined African women's maternity experiences.

This study forms part of a midwife-led qualitative exploration of the maternity journeys of women from Sub-Saharan Africa in New Zealand, using interpretive description informed by cultural safety and structural competency. Semi-structured interviews were conducted with eleven women between July 2024 and January 2025. Data were analysed inductively using Braun and Clarke's reflexive thematic analysis.

Participants described a repertoire of cultural practices, including herbal and dietary remedies, postpartum rituals, and newborn care customs. Herbal medicine was used to ease labour and promote physiological birth, while cultural nutrition supported recovery and breastfeeding. The extended family played a vital role in postpartum recovery and breastfeeding support. Migration, however, disrupted this communal model, leaving women socially isolated in New Zealand. Participants reported loneliness, lack of family care, and, in some cases, a history of postpartum depression. Despite these challenges, women demonstrated resilience, adapting practices and advocating through transnational family ties and community networks.

Participants' cultural practices strongly shape maternity expectations yet often conflict with New Zealand's individualised model of care. Addressing these gaps requires culturally safe, structurally competent maternity models that integrate positive cultural traditions and reduce the risk of isolation. The next phase of this project describes women's clinical maternity care experiences, highlights how structural barriers, misdiagnoses rooted in cultural assumptions, and limited recognition of traditional practices further compromise the delivery of woman-centred care.

Introduction

Pregnancy-related cultural customs in Sub-Saharan Africa encompass a wide range of practices, including dietary restrictions, herbal medicine, and traditional rituals aimed at supporting safe birth and postpartum recovery (Ohaja et al., 2020; Aziato and Omenyo, 2018; Makombe et al., 2023; Musie et al., 2022a). While these practices vary considerably across countries, ethnic groups, and communities, many women describe them as supporting physiological birth, postpartum recovery, breastfeeding, and emotional well-being (Mudonhi et al., 2021; Musie et al., 2022a; Sibeko et al., 2021). However, when

unacknowledged within biomedical maternity care, some traditional practices may interact with clinical interventions, potentially increasing the risk of complications including uterine rupture or haemorrhage (Fantaye et al., 2019; Musie et al., 2022b; Musie and Mulaudzi, 2024; Shopo et al., 2023; Nabatanzi et al., 2024).

In many African maternity contexts, midwives are trained to routinely enquire about culturally inherited practices during history-taking (Adamolekun et al., 2023; Musie and Mulaudzi, 2024). When care is provided in settings where such practices are less familiar, these cultural influences may not always be explored, potentially shaping how women's social and cultural needs are recognised within maternity care.

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Female genital mutilation/cutting (FGM/C) illustrates the broader complexities that arise when culturally rooted practices intersect with maternity care in high-income settings. While midwives in several African countries are trained to provide care for women affected by FGM/C, midwives in high-income countries often report limited confidence and preparedness, reflecting structural and educational gaps rather than individual clinician deficits (Besera et al., 2023; Dawson et al., 2015; Ogunsiyi et al., 2023). This example highlights how cultural practices and embodied experiences may be misunderstood or insufficiently supported within Western maternity systems when cultural safety and structural competency are inadequately operationalised (Besera et al., 2023).

The maternal journey of some sub-Saharan African women is shaped not only by medical care but also by deeply ingrained cultural traditions that promote physiological birth, breastfeeding, and resilience (Amzat et al., 2024; Fantaye et al., 2019; Kavle et al., 2019). Aotearoa New Zealand is internationally recognised for the development of cultural safety as a framework for promoting health care equity (Wepa, 2015). Despite this, evidence continues to demonstrate gaps in structural and cultural competency among healthcare providers caring for ethnic minority women, alongside broader reports of dissatisfaction with maternity care experiences (Daellenbach et al., 2024; Sharma et al., 2023). Despite a growing African migrant population, little is known about the maternity experiences of Sub-Saharan African women in New Zealand (Badu et al., 2023; Dawson et al., 2022). Existing literature highlights the central role of extended family members in the journey through emotional support and culturally appropriate care (Amzat et al., 2024; Kavle et al., 2019). The transition from communal, culturally embedded maternity systems to individualised and medicalised models in high-income countries can be particularly challenging for migrant women, who often experience isolation, loss of support, and cultural dissonance (Lowe, 2019; Pangas et al., 2019; Zhang and Hanser, 2023). The absence or disruption of this communal support following migration may underscore the need to explore how cultural maternity practices are preserved, adapted, or disrupted within an individualised maternity care system (Pangas et al., 2019). Understanding these transitions is essential for informing woman-centred maternity care, as recommended by the World Health Organization, which emphasises respectful, culturally responsive, and relational care across the maternity continuum (Hopkins, 2025; Wojcieszek et al., 2023; World Health Organization, 2025). By foregrounding women's maternity care experiences, this study may guide midwives to better recognise and engage with cultural influences on maternity care in ways that support woman-centred practice without compromising medical safety.

Aim and objectives

This study presents the first phase of a project exploring the maternity journeys of Sub-Saharan African women living in Aotearoa, New Zealand. Guided by interpretive description and informed by cultural safety and structural competency frameworks, this phase adopts an exploratory approach to understand women's experiences of maternity care following migration. The objectives of this study were to:

- Explore how Sub-Saharan African women describe culturally meaningful maternity practices across pregnancy, childbirth, and the postpartum period.
- Examine how migration to Aotearoa New Zealand shapes women's maternity care experiences, including the preservation, adaptation, or disruption of cultural practices.
- Explore how cross-cultural maternity care encounters influence women's birthing experiences and satisfaction with maternity care.

This phase of the study does not predefine specific cultural practices or evaluate clinical outcomes. Rather, it focuses on women's accounts of maternity care experiences, shaped by cultural meanings, migration,

and interactions within a new maternity system. Findings from this phase inform a subsequent phase examining women's clinical maternity care experiences and contribute to the development of a practice-based framework for culturally safe and structurally competent maternity care.

Methods

Design

This qualitative study employed interpretive description methodology (Thorne, 2016) well suited to exploring women's experiences and meanings in depth while generating practice-relevant insights for midwifery care (Thompson Burdine et al., 2021). The use of in-depth interviews enabled rich, contextual accounts of culturally meaningful maternity practices and cross-cultural care experiences, generating insights that are not easily captured through surveys or quantitative measures. Guided by the frameworks of cultural safety and structural competency, the study explored how Sub-Saharan African women living in Aotearoa New Zealand understand and navigate maternity care following migration. Cultural safety informed attention to relational power dynamics, communication, and respect for women's cultural identities within care encounters (Wepa, 2015). Structural competency informed the analytic framework by foregrounding how social, economic, and political structures influence healthcare experiences beyond individual-level interactions (Metzl et al., 2018; Metzl and Hansen, 2014; Neff et al., 2020). This approach enabled examination of how structural barriers, migration contexts, and access to maternity services shaped Sub-Saharan African women's maternity care experiences in Aotearoa New Zealand (Fougang et al., 2025a).

The first phase of the study, presented here, focused on women's culturally meaningful maternity practices during pregnancy, childbirth, and the postpartum period, and how these practices shaped expectations and experiences of maternity care. This part did not aim to produce generalisable findings or evaluate clinical outcomes, but to identify shared patterns and nuanced meanings that may inform culturally safe and structurally competent midwifery practice.

Participants

Participants were women from multiple Sub-Saharan African countries who were residing in Aotearoa, New Zealand, at the time of the study. While Sub-Saharan Africa encompasses diverse cultural, linguistic, religious, and maternity traditions, the region was selected to reflect shared migration-related experiences and structural transitions into high-income maternity systems, rather than to imply cultural uniformity. Participants were from several countries in Sub-Saharan Africa, and the cultural practices described in this study reflect variation rather than a single "African" model of maternity care. Practices are therefore interpreted as context-specific and situated within women's individual cultural, familial, and migration histories.

Table 1 summarises eligibility criteria. Interviews were conducted in English or French due to the researcher's language proficiency and the absence of interpreter funding; women unable to communicate in either language (including some who spoke West African Pidgin English only) were therefore excluded, which is acknowledged as a limitation. Time-based eligibility criteria prioritised recent maternity experiences to reduce recall bias. Although not all participants had given birth in Aotearoa New Zealand, all were living in New Zealand and had engaged with the maternity system, enabling exploration of cultural expectations and cross-cultural care experiences following migration.

Recruitment

Participants were recruited using community-based purposive sampling, supplemented by snowball sampling. Recruitment occurred

Table 1
Participant eligibility criteria.

Inclusion criteria	Exclusion criteria
Women from Sub-Saharan African countries	Individuals with professional or financial relationships with the primary researcher
Aged 18 years or older	Individuals unable to participate in English or French
Women with lived experience of pregnancy and/or childbirth in an African country	Women whose most recent birth in an African country occurred >10 years prior
Women residing in Aotearoa New Zealand at the time of the study and who had engaged with the New Zealand maternity system during pregnancy, childbirth, or the postnatal period	Women whose most recent maternity care experience in Aotearoa New Zealand occurred >10 years prior

through African community networks and cultural events, including national independence celebrations (e.g., Burundi, Democratic Republic of Congo, Ghana) and Africa Day events. Study flyers were displayed at community centres serving African populations, and the study was introduced verbally at selected community gatherings. Recruitment was supported by non-profit organisations working with African refugee and immigrant communities in Aotearoa New Zealand, including the Aotearoa Resettled Community Coalition (ARCC), New Zealand African Community Health Services (NZACHS), and a Ghanaian community centre. Interested women contacted the researcher directly after receiving the study poster. Purposive, criterion-based sampling was used to recruit Sub-Saharan African women whose maternity experiences were relevant to the study aims. Consistent with interpretive description, the target sample size was 10–20 participants, considered appropriate for generating practice-relevant insights in descriptive qualitative research.

A total of 31 invitations were distributed. Twenty-two women contacted the researcher, of whom 12 were excluded due to difficulties scheduling interviews or because their most recent birth in Africa occurred >10 years prior. An additional five women were referred through snowball sampling; one was excluded due to language constraints, as she was unable to participate in English or French. Participants received a supermarket voucher as a non-coercive acknowledgement of their time and contribution.

Interviews

Twelve interviews were conducted from July 2024 to January 2025. All interviews were conducted in English. Ten interviews were conducted face-to-face, and two were conducted online via Microsoft Teams. Participant 9 was interviewed on two occasions to allow further exploration of her most recent maternity experience following the initial interview. Both interviews were included in the analysis as part of a single participant narrative. Interviews were guided by Sandelowski's principles of qualitative interviewing, which emphasise flexibility, narrative richness, and relational engagement (Sandelowski and Barroso, 2002). This approach allowed participants to lead the conversation while ensuring that key topics were addressed, supporting culturally sensitive and in-depth exploration of lived experiences consistent with interpretive description. Interviews followed a semi-structured format, using open-ended questions to elicit detailed narratives. Rapport-building preceded formal questioning to facilitate participants' sharing of personal or sensitive experiences. The researcher adopted the role of an attentive listener, allowing interviews to unfold naturally while avoiding the imposition of assumptions. An interview guide ensured consistency across interviews while allowing space for individual experiences. Field notes were recorded during and after each interview to capture contextual details, emotional tone, and reflexive observations. Given the sensitivity of discussing pregnancy and birth

experiences, a distress protocol was in place. Participants were informed that they could pause or stop the interview at any time. Where emotional distress arose, interviews were paused, and appropriate support options were discussed. Participants were provided with information about free community and maternal mental health support services. Interview questions focused on two broad areas: (1) culturally embedded maternity practices during pregnancy, birth, and the postpartum period in participants' countries of origin, and (2) experiences of engaging with maternity services in Aotearoa New Zealand following migration. Interviews were conducted at locations chosen by participants, including community centres (e.g., NZACHS), university offices, participants' homes, or online. Each interview lasted approximately 45 min, with some extending beyond one hour when participants wished to elaborate.

Data collection

Data were collected through semi-structured, in-depth interviews exploring the maternity experiences of Sub-Saharan African women in Aotearoa, New Zealand. This approach aligns with interpretive description, which seeks practice-informed insights grounded in lived experience (Malterud et al., 2016; Tracy, 2024). The flexible format allowed women to share their stories in their own words, while ensuring that key topics, such as cultural practices, maternity care utilisation, and birthing experiences, were addressed in line with the study objectives and the guiding frameworks of structural competency and cultural safety.

Data collection was shaped by culturally responsive engagement strategies, the primary researcher introduced herself as a registered midwife and an African woman from Cameroon. This cultural positioning was both transparent and strategic, fostering trust and rapport. Consistent with African values of kinship, participants were respectfully addressed as "sister," fostering a warm, family-like atmosphere that supported culturally safe dialogue.

At the start of each interview, the researcher shared her identity as "a Bamileke woman from Cameroon" and invited participants to describe their own cultural background. This exchange underscored the significance of culture in shaping maternity experiences and aligned with the qualitative principles of ethical self-disclosure in cross-cultural research (Cresswell, 2013; Hughes, 2019; Pelzang and Hutchinson, 2018). Hospitality practices, such as offering refreshments, creating culturally familiar spaces, and wearing traditional clothing when appropriate, further promoted comfort and openness.

These strategies mitigated power imbalances, reduced participants' sense of isolation, and ensured that women's stories were shared within their own cultural frame of reference, providing rich insights into the intersection of artistic practices and maternity care in New Zealand. An interview guide facilitated discussion on cultural practices, access to care, communication with providers, and postnatal experiences. Interviews were audio-recorded and transcribed verbatim using Notta AI software. All transcripts were subsequently checked against the original audio recordings by the primary researcher to ensure accuracy, corrected where necessary, anonymised, and securely stored.

Data analysis

Twelve women completed interviews; one interview was excluded from analysis because it did not contribute additional conceptual insight relevant to the study aims, as it described cultural practices already well represented in the dataset and did not include experience within the New Zealand maternity system. In total, eleven interviews were included in the final analysis. Data collection and analysis occurred iteratively; analytic sufficiency was reached when themes became conceptually well developed and no substantially new insights relevant to women's maternity care experiences in Aotearoa New Zealand emerged in later interviews (Braun et al., 2023; Braun and Clarke, 2021). In this phase of the study, analytic emphasis was placed on

women’s accounts of culturally meaningful maternity practices and expectations. Participants without direct childbirth experience in Aotearoa New Zealand contributed by illuminating communal maternity models and cultural reference points against which New Zealand maternity care was interpreted. Data were analysed using reflexive thematic analysis, guided by Braun and Clarke’s six-phase approach (Braun and Clarke, 2021). The study does not involve statistical testing or quantitative measures. Analysis was primarily inductive, allowing themes to be developed from participants’ accounts rather than imposed a priori. Cultural safety and structural competency frameworks were applied as interpretive lenses during theme refinement and interpretation, rather than as predetermined coding frameworks.

The supervision team comprised two senior academics with complementary expertise in cultural safety, immigrant health, and qualitative research. Supervisors provided methodological guidance, reflexive oversight, and critical review of analytic decisions, while the lead researcher undertook primary coding and theme development, consistent with reflexive thematic analysis.

Phase 1 (familiarisation) involved repeated listening to audio recordings and in-depth transcript review, alongside field notes and post-interview reflections, supporting credibility through prolonged engagement with the data. Interviews were transcribed verbatim using Notta AI, a password-protected transcription platform created specifically for this project. All transcripts were manually checked line-by-line against the original audio recordings by the primary researcher and the supervision team to ensure accuracy. Transcript accuracy was further reviewed by each member of the supervision team. Final transcripts were imported into NVivo 14 for data management and coding.

Phase 2 involved generating initial codes inductively using NVivo 14, attending to both semantic content and latent meanings. Cultural safety principles were applied through ongoing reflexive consideration of power relations, cultural assumptions, and insider–outsider positioning, strengthening reflexivity and confirmability.

Phases 3 and 4 involved organising codes into preliminary themes and refining them through systematic comparison with coded extracts and the full dataset. Reflexive memos were used throughout to document analytic decisions, enhancing dependability and auditability, with regular discussion within the supervision team to support analytic transparency.

Phase 5 focused on defining and naming themes, supported by interpretive narratives and illustrative quotations to enhance credibility by grounding interpretations in participants’ accounts. Phase 6 involved synthesising findings into a coherent, chronologically organised narrative from pregnancy through the postpartum period.

Themes were interpreted through the dual lenses of cultural safety and structural competency: cultural safety foregrounded women’s lived perspectives, relational engagement, and power dynamics, while structural competency illuminated the influence of systemic barriers and institutional practices on maternity care experiences.

Cultural validity was prioritised through culturally safe interviewing practices, critical reflection on cultural assumptions during analysis, and interpretation of findings within participants’ cultural contexts rather than biomedical norms. Interpretive consultation with senior African and Aotearoa New Zealand midwives supported contextual understanding and enhanced credibility without constituting independent coding or member checking.

Trustworthiness and analytic rigour were further enhanced through interpretive consultation with five senior midwives, including one African senior midwife and four senior midwives and lactation consultants practising in Aotearoa New Zealand, each with over ten years of clinical experience. These discussions supported reflexive interpretation and contextual understanding of findings but did not involve independent coding (Carter et al., 2014). Insights from these consultations informed theme refinement and interpretation and are integrated into the Results and Discussion sections.

Ethical considerations

Ethical approval was obtained from the Auckland University of Technology Ethics Committee (AUTEC; Ref. 14/123). Written and verbal informed consent was obtained from all participants. Data were anonymised, securely stored on AUT premises, and accessible only to the research team. In line with AUTEC’s health research requirements, data will be retained for 6 years and then securely destroyed.

Findings

Table 2 describes participant characteristics and birthing context. The findings revealed that deeply ingrained cultural practices spanning communal support, spirituality, nutrition, herbal medicine, and embodied rituals were central to women’s experiences of pregnancy, childbirth, and postpartum recovery. These practices, transmitted across generations, reflected holistic understandings of maternity deeply embedded in family and community life. In New Zealand, however, adapting such practices often required creativity and compromise, particularly in the absence of extended family and traditional resources. Table 3 presents themes and subthemes chronologically, tracing cultural practices from early pregnancy through postpartum and newborn care, highlighting both continuity and disruption in women’s experiences.

Cultural practice, advice and behaviour during pregnancy

Role of the extended family and support

For many women in cultures, pregnancy and childbirth are embedded within extended family and community structures rather than being the sole responsibility of parents. Support from mothers, grandmothers, and other female relatives provides emotional, practical, and traditional guidance throughout the maternity journey. Participants described this collective responsibility as central to maternity care in their countries of origin. One woman from the Democratic Republic of Congo explained: “Most of the time, it is the responsibility of the family... they take care of you, make sure you go to the hospital... your transportation and you have to go to do all the checking...” (Participant 8, DR Congo). Similarly, a Somali participant noted: “Extended families usually come and help out with cooking and cleaning because she can’t do much. They try to support her, especially in the last two months ” (Participant 10, Somalia).

Elders were described as knowledge keepers who transmitted traditional midwifery practices and remedies. For example, one participant recalled: “My grandmother gave me some roots... apparently, they’re supposed to help make birthing easier” (Participant 3, Kenya). Another described her mother’s advice: “My mum told me to drink this thing that helps make labour easier. You start drinking it at 35 weeks, but I only started

Table 2
Participant characteristics and birthing context.

Participant	Country of origin	Years in NZ	Parity	Birthplace of children
P1	Rwanda	10	2	New Zealand (both)
P2	Kenya	6	3	Kenya (all)
P3	Kenya	1.5	1	Kenya
P4	Rwanda	23	2	New Zealand (both)
P5	DR Congo (Bukavu)	20	2	New Zealand (both)
P6	DR Congo	20	2	New Zealand (both)
P7	Somalia	3	2	New Zealand (both)
P8	DR Congo (Hema)	20	2	Congo (first); New Zealand (second)
P9	Ethiopia (raised in Kenya)	9	2	New Zealand (both)
P10	Somalia	10	2	New Zealand (both)
P11	Nigeria (Cross River State)	2	2	Nigeria (first); New Zealand (second)

Table 3
Findings summary.

Theme	Subtheme	Illustrative quotation
1. Cultural practice, advice and behaviour during pregnancy	1.1 Role of the extended family and support	“Most of the time, it is the responsibility of the family... they take care of you, make sure you go to the hospital...” (Participant 8, DR Congo).
	1.1 Triangulation insight (senior midwife perspective)	“There’s an intense relationship between LMC and the woman... many of these women are lonely, so the midwife becomes their lifeline.” (Senior midwife R.O.).
	1.2 Hide pregnancy at early stage	“In Nigeria, you don’t announce your pregnancy... We say ‘village people’ might bring bad luck.” (Participant 11, Nigeria).
	1.3 Nutrition culture during pregnancy	“They told me to eat more fruit. Orange is good for the baby.” (Participant 1, Rwanda).
2. Cultural practice for labour preparation and promoting physiological birth	1.4 Posture and Activity cultural advice	“I was advised not to squat because it is believed it can cause miscarriage.” (Participant 11, Nigeria).
	2.0 Exercise regimens for labour preparation methods	“I took my exercise seriously because the midwife in Nigeria told us that it would make labour easier.” (Participant 11, Nigeria).
	2.1 Cultural practice to ease labour using foods and herbal preparations	“You just boil it with water for 15 min... drink it from 35 weeks.” (Participant 9, Ethiopia).
	2.2 Cultural preference for natural birth	“In my culture, if you plan for a C-section, you are seen as an incomplete woman.” (Participant 11, Nigeria).
	2.3 Avoidance of some pain management approaches	“I already held the pain for so long... let me just continue without it.” (Participant 9, Ethiopia).
3. Cultural practice during postpartum communal support: complete rest for the mother	3.0 Complete rest for the mother	“You don’t do anything by yourself for the first few weeks... You just sleep, rest, and eat.” (Participant 3, Kenya).
	3.1 Breastfeeding promotion through postpartum nutrition support	“I knew that I needed palm wine for my milk to come in...” (Participant 11, Nigeria).
	3.2 Cultural practice for physical well-being and recovery	“I couldn’t find the traditional stainless plate we use, so I took the lid of my pot... and used that instead.” (Participant 11, Nigeria).
	3.3 Culturally related newborn care practices	“They use boiled roots and leaves... They believe the baby will sleep well and be protected.” (Participant 2, Kenya).
4. From communal support to individualised care: disruption, adaptation, and advocacy after migration	4.1 Postpartum isolation and food insecurity for recovery and breastfeeding	“How come we came here and there was no one, just me and you? If I had the choice, I would go back home one month before to give birth.” Participant 1 (Rwanda) <i>You don’t have support, you</i>

Table 3 (continued)

Theme	Subtheme	Illustrative quotation
1. Cultural practice, advice and behaviour during pregnancy	Adaptation through community support	<i>don’t have a family, you don’t know what to do, like what to eat, what not to eat</i> ” (Participant 8, DR Congo). “You give birth, you need the soup, something hot... How is the milk going to come?” (Participant 8, DR Congo). “In the community, they send food to the mom for a week... rice, chicken, meat.” (Participant 7, Somalia).
	Advocacy against FGM/ C assumptions and CS	“She’s Somali, they usually have genital mutilation... But no one asked me.” (Participant 7, Somalia). “They kept making it seem like a C-section was the only way... After insisting, they finally admitted that forceps were also an option.” (Participant 10, Somalia).
	Triangulation insight (midwife advocacy)	“You have to be really strong to advocate for your woman... especially if you haven’t got the right mentors with you.” (Senior midwife R.O.)

at 39 or 40 weeks” (Participant 10, Somalia). Even at a distance, guidance continued through digital means: *“My mom would tell me on video calls..., that’s why they look bow-legged!”* (Participant 11, Nigeria).

Labour and birth were also described as communal events, where mothers, sisters, and friends provided direct support: *“My sister, mother, and friend were in the delivery room with me. My husband was moving around buying things”*(Participant 11, Nigeria). Migration to New Zealand, however, often disrupted these practices, leaving women without the traditional support networks they had previously relied on. As one Nigerian participant described: *“I had to take an Uber alone with my son to the hospital”* (Participant 11, Nigeria). Another added: *“The person that was with me at the hospital was my pastor’s wife... but not my family, nobody”* (Participant 6, RDC Congo).

The absence of extended family also reshaped postpartum dynamics. A Kenyan participant explained: *“Culturally, it’s supposed to be your mother or mother-in-law. For my firstborn, it was my aunt. For the second, my mother-in-law came”*(Participant 2, Kenya). A Rwandan woman noted: *“In Africa, people are sitting, my sisters will be there. They are there. Aunties will be there. Husband provides money to buy things, but he’s not coming to cook. But here, he had to do that”* (Participant 1, Rwanda). These accounts highlight how the absence of communal maternity care in New Zealand created emotional and practical gaps, with husbands often taking on unfamiliar caregiving roles. One senior midwife (KT) in New Zealand explained that the lack of family support often creates a *“cold atmosphere”* during maternity care, which may undermine trust, collaboration, and the quality of the relationship between the midwife and the woman when culturally embedded support systems are absent. Another Senior midwife contextualised these experiences. R.O. stated: *“There’s an intense relationship between LMC and the woman... many of these women are lonely, so the midwife becomes their lifeline. That’s beautiful, but if you are a midwife doing that for multiple women, it is a lot.”*

Hide pregnancy at the early stage

In some African cultures, pregnancy is surrounded by rules of

secrecy, particularly in the early stages. Participants, especially those from Nigeria, described expectations to conceal pregnancy until later months, often by wearing loose clothing to hide the bump: “*So I begin to wear the boo-boo, what we call boo-boo... just to cover up, just to hide people from seeing from then that you're pregnant.*” (Participant 11, Nigeria). This practice is rooted in spiritual beliefs and a fear of external harm, often referred to as “village people” or evil spirits. As another woman explained: “*In Nigeria, you don't announce your pregnancy... There's a belief that if you announce it too early, something might happen to the baby... We say 'village people' might bring bad luck*” (Participant 11, Nigeria).

Nutrition culture during pregnancy

Across African cultures, nutrition during pregnancy is guided by intergenerational knowledge and symbolic meanings that extend beyond biological nourishment. Participants described being advised by elders on foods to consume and avoid, with practices often aligned to different stages of pregnancy. These beliefs reinforced a psychological sense of protection and preparedness, while shaping concrete dietary behaviours. For example, one Rwandan participant recalled early guidance emphasising fruit intake for foetal health: “*They told me to eat more fruit. Orange is good for the baby*” (Participant 1, Rwanda). Another highlighted the cultural value of *matoke* (green bananas), a staple dish considered both nutritious and restorative. “*We used to eat a lot of green bananas.*” (Participant 4, Rwanda). In preparation for labour, women were advised to shift towards lighter meals, reflecting cultural understandings of digestion and maternal readiness: “*When you are nearly ready to give birth, they say to eat soft food like green bananas, vegetables, lots of soup*” (Participant 1, Rwanda).

Among Nigerian participants, foods such as pepper soup with special species were framed as strengthening the body for birth, while restrictions on *garri* (cassava flour) were linked to fears of complicated vaginal delivery: “*I was told not to eat too much Garri so the baby's head doesn't get too big for vaginal birth*” (Participant 11, Nigeria). These narratives illustrate how dietary practices operate simultaneously as cultural rituals, nutritional interventions, and behavioural strategies for ensuring safe childbirth. Respecting and integrating these practices into nutritional counselling may reduce mistrust, strengthen engagement, and foster woman-centred care for African migrant women navigating pregnancy in New Zealand.

Posture and activity cultural advice

Women with experience in Africa described receiving detailed cultural guidance not only on diet and remedies but also on physical activity across pregnancy. In the early stages, they recalled being warned against movements considered risky or harmful to the pregnancy. As one participant from Kenya explained: “*Mainly, you try to avoid... engaging in activities that might put you at risk.*” (Participant 2, Kenya). In Nigeria, squatting was specifically discouraged: “*I was advised not to squat because it is believed it can cause miscarriage*” (Participant 11, Nigeria). These restrictions reflected cultural understandings of bodily vulnerability during early pregnancy, with the squat position seen as straining the pelvic floor and potentially leading to loss. At the same time, participants highlighted that cultural advice on activity was not uniformly prohibitive; instead, it was stage-specific. Restrictions were emphasised in the first trimester, while later in pregnancy, activity was encouraged to prepare the body for vaginal birth. In this way, physical activity was understood as a culturally mediated tool, used selectively to safeguard the pregnancy early on and to promote labour progress in later stages.

Cultural practice for labour preparation and promoting physiological birth

As previously observed, there is a restriction in early pregnancy. During labour, physical activity was also encouraged but within

culturally acceptable boundaries. Women used the restricted position in early pregnancy during labour to facilitate the process. In this context, women with experience in Africa indicated that maintaining exercise during pregnancy in New Zealand was probably linked to shorter labour and easier delivery: “*I took my exercise seriously because the midwife in Nigeria told us that it would make labour easier*” (Participant 11, Nigeria). She exercised regularly as advised in Nigeria during her first pregnancy. “*Every morning, I did exercises like leaning my back against the wall and going down and up...I was told it would help my body prepare for delivery.*” Like an Ethiopian participant, exercise is also a familiar practice: “*pregnant women walk a lot, drink plenty of water, and rest enough to prepare for labour*” (Participant 9, Ethiopia). However, a difference was noted during her first pregnancy. Participant 9 did not follow any cultural instructions and had a CS; after a CS with a 2-year gap during her second pregnancy, she ensured she followed all instructions. “*I do some exercise, like running, just you... I just keep walking*” (Participant 9, Ethiopia). These accounts illustrate how women navigated cultural expectations in conjunction with their growing awareness of new health information in New Zealand. Demonstrate a stage-specific cultural logic: early pregnancy was guided by restrictions aimed at protecting the foetus, while later pregnancy emphasised activity to prepare for labour and achieve vaginal birth. This dynamic approach reflects a culturally embedded balancing act between caution and preparation. Women navigated these cultural expectations alongside biomedical advice promoting consistent activity throughout pregnancy, often blending the two approaches.

Cultural practice to ease labour using foods and herbal preparations

Building on the earlier focus on nutrition during pregnancy, Women described using traditional foods and herbal remedies to prepare their bodies for labour, promote faster progress, and support natural birth. They illustrate the continuity between everyday nutrition in pregnancy and targeted consumption during late pregnancy and labour. Many women highlighted the use of herbal infusions recommended by mothers or grandmothers. For example, Participant 10 (Somalia) shared: “*My mum told me to drink this thing that helps make labour easier. You start drinking it at 35 weeks, but I only started at 38*” Similarly, Participant 9 (Ethiopia) explained: “*You just boil it with water for 15 min. Some people add honey to make it sweet and drink it from 35 weeks.*” A Kenyan participant described elder guidance as well: “*My grandmother gave me some roots... they're supposed to help make birthing easier*” (Participant 3, Kenya).

Foods also played a central role Okra was repeatedly cited as a food that facilitates smooth vaginal delivery. “*I used to eat okra. I started eating it one month before birth, even though I struggled to eat it. They say it helps*” (Participant 1, Rwanda). A Congolese participant echoed: “*Okra is very slippery. If you eat it, it helps the baby come out naturally without force*” (Participant 8, DR Congo). Other women described eating okra water, pineapple, and drinking rosemary tea to prepare the body for labour (Participant 9, Ethiopia). These practices were seen as natural ways to stimulate contractions and shorten labour. An experienced African midwife (TSA) emphasised that such practices are routinely discussed in some African maternity contexts: “*We always ask them during admission if they've used anything...*” In contrast, a senior midwife in New Zealand (R. O.) noted that these remedies “*may be less familiar*”, which could increase risk when traditional preparations are used alongside biomedical interventions without disclosure or enquiry. Accessing ingredients in New Zealand was often challenging, with women relying on family, migrant community networks, or specialty shops. As Participant 9 noted: “*I was drinking okra water... I even had to ask people to bring it for me because it is not easy to find here.*” Overall, these accounts highlight the importance of culturally safe enquiry and respectful dialogue about traditional foods and remedies during antenatal care to support safe, informed, and woman-centred decision-making.

Cultural preference for natural birth

For many women in Sub-Saharan Africa, birth is not simply a medical event but a rite of passage deeply rooted in cultural values, community involvement, and spiritual beliefs. Participants described how natural (vaginal) birth was strongly preferred, with caesarean sections (C-sections) often viewed as undesirable or even shameful. As one woman explained, *“In my culture, if you plan for a C-section, you are seen as an incomplete woman”* (Participant 11, Nigeria). This perception reinforced the social expectation that women should demonstrate strength through vaginal delivery. Another participant added: *“After birth, people will ask, ‘Was it normal delivery or C-section?’ They don’t see C-section as ‘normal’ birth”* (Participant 11, Nigeria).

Reconsidering Participant 11’s statement, *“Do whatever you can to achieve vaginal delivery”* explains why, in the New Zealand context, some participants resisted hospital recommendations for surgical intervention. Instead, they preferred to rely on traditional practices and trust in their bodies’ ability, as seen in the stories of Participants 10 and 9, who were both successful in achieving vaginal birth after a previous C-section: *“I kept telling them I didn’t want a C-section. My baby was not in distress, the heart rate was fine, but they were still pushing for it”* (Participant 10, Somalia) This subtheme highlights a broader cultural and psychological attachment to vaginal birth as a vital part of womanhood and identity.

This cultural preference was not only about personal pride but also linked to intergenerational traditions, dietary practices, and elder guidance. For example, women were advised to avoid certain foods or postures to prevent complications: *“I was told not to eat too much garri so the baby’s head doesn’t get too big for vaginal birth”* (Participant 11, Nigeria). Similarly, women were encouraged to consume strengthening foods such as yams and pepper soup infused with medicinal spices like *uyyak*, *uda*, and *ehuru*, believed to prepare the body for natural delivery. Okra was also cited as labour-enhancing, though beliefs about its effects varied across regions: while some saw it as easing delivery, in Yoruba culture, it was avoided due to associations with congenital conditions.

Physiological birth was described not only as healthier but also as symbolic of womanhood, conferring social respect and affirming identity. As one participant summarised, *“They expect that you go forward like the priority or first choice would always be go for vaginal delivery, do whatever you can to achieve it”* (Participant 11, Nigeria).

In New Zealand, this preference persisted despite access to free maternity care and surgical options. Women’s resistance to C-section was sometimes shaped by traumatic past experiences of surgery and recovery. For example, Participant 9 (Ethiopia) described her first C-section as deeply painful and isolating: *“I can’t sit, I can’t lay down... my stomach [was] really painful... I stayed there maybe for nine days... altogether was 14 days.”* Similarly, Participant 10 (Somalia) explained: *“I’m not gonna do C-section cause I’ve already done that and I don’t want to have that.”*

Several participants linked their determination to avoid C-sections with beliefs about faster recovery, independence, and the ability to uphold traditional postpartum care and breastfeeding practices. Participant 7 (Somalia) explained, *“It’s just a faster recovery [with vaginal birth]. The CS is a major surgery... seven layers cut open... the recovery is longer. So why go through that when you can just have a normal delivery?”*

These accounts highlight that women’s preference for vaginal birth is not simply an economic decision, as might be assumed in low-resource contexts, but rather a reflection of cultural values and embodied experiences. Even within New Zealand’s publicly funded maternity system, participants upheld a strong cultural and psychological attachment to natural birth. Supporting women’s cultural expectations where safe and clinically appropriate can build trust, reduce unnecessary interventions, and promote satisfaction with care. This alignment with woman-centred midwifery philosophy underscores the importance of integrating cultural understanding into clinical practice.

Avoidance of some pain management approaches

Participants expressed diverse perspectives on pain management during labour, shaped by cultural values, resilience narratives, and past experiences. For many, pain was seen as an expected and natural part of childbirth, reinforcing a cultural preference for minimal medical intervention and reliance on inner strength.

Several women reported deliberately avoiding epidural anaesthesia, believing it could slow labour or interfere with the natural birthing process. As Participant 9 (Ethiopia) explained, *“I already held the pain for so long. Maybe I am already at seven centimetres, so let me just continue without it.”* Similarly, Participant 11 (Nigeria) noted, *“I chose to use the gas instead of the epidural when they explained the pain relief options”* Such decisions were underpinned by the conviction that enduring labour pain demonstrated resilience and supported progress towards vaginal birth.

Cultural practice during postpartum communal support: complete rest for the mother

Following birth, participants described a range of culturally embedded practices designed to support maternal recovery, promote lactation, and assist with newborn care. These practices enabled new mothers to focus exclusively on caring for their babies. Participants consistently emphasised the expectation of complete rest for new mothers during the early postpartum period. As one participant explained: *“Yes, you don’t do anything by yourself for the first few weeks. My aunt came and looked after me... You just sleep, rest, and eat.”* (Participant 3, Kenya). Another added: *“In Africa, you just sleep and eat. They do everything for you, even wash the baby.”* (Participant 2, Kenya).

The Nigerian practice of *Omugwo* was frequently referenced as an example of communal postpartum care: *“Omugwo is when your mother or mother-in-law comes to look after you after birth. She bathes you, massages you, and cooks for you.”* (Participant 11, Nigeria). These traditions underscore how postpartum recovery is framed as a collective responsibility rather than an individual task. Somali participants reported similar practices: *“My mum moved in with me to help with cooking and everything, so I could just focus on my recovery”* (Participant 10, Somalia). Across countries, participants described how postpartum care is organised to relieve mothers of all domestic duties so they can devote their energy to feeding and bonding with their newborns.

Breastfeeding promotion through postpartum nutrition support

Participants described postpartum nutrition as inseparable from cultural practices of rest and care. Food was framed not only as nourishment, but also as *“medicine,”* therapy, and cultural continuity that supports recovery and breastfeeding. Nigerian women emphasised pepper soup enriched with specific spices (*uyyak*, *uda*, *ehuru*) and drinks such as palm wine and soaked garri as important for lactation: *“I knew that I needed palm wine for my milk to come in... I drank soaked garri overnight, and my breasts would feel like they were about to burst with milk”* (Participant 11, Nigeria). Rwandan participants highlighted *Bouillie de Mais* (corn porridge): *“In the morning, we drink a special kind of porridge... Once you drink it, it helps with labour and increases breast milk production”* (Participant 4, Rwanda).

Women from the Democratic Republic of Congo and Rwanda also described cassava leaves as essential postpartum foods, credited with restoring energy and supporting milk supply: *“Cassava leaves are full of iron and energy... Cassava leaves help with milk supply. After eating, you feel your breasts getting full”* (Participant 8, DRC). Some went to significant effort to access these foods in New Zealand, including importing ingredients. As Participant 4 noted: *“I asked my husband to bring heaps of cassava leaves from Africa... The food here doesn’t help your body recover in the same way”* (Participant 4, Rwanda). Participants from other backgrounds similarly described culturally familiar soups, stews, rice, porridge, and flour-based meals prepared by mothers or relatives as

central to postpartum comfort, recovery, and breastfeeding support, reinforcing continuity with traditions from home.

Cultural practice for physical well-being and recovery

Belly binding emerged as one of the most consistent recovery practices among women from West and Central Africa. This traditional method is believed to help the body return to its pre-pregnancy form, flatten the stomach, and maintain attractiveness, particularly for one's spouse. Participant 11 (Nigeria) adapted the practice creatively while in New Zealand: "I couldn't find the traditional stainless plate we use, so I took the lid of my pot, removed the handle, and used that instead." Participants described that belly binding is performed by an elder woman, such as a mother-in-law. However, in New Zealand, where such support was often absent, some women relied on their husbands: "My husband tied it for me every day." (Participant 9, Ethiopia). Many participants emphasised its importance immediately after birth: "In Nigeria, we tie the stomach immediately after birth to bring it back to normal." (Participant 11, Nigeria). Similarly, Participant 1 (Rwanda) shared: "We used the 'kiquenbee' to reaffirm my tummy after birth...the tummy doesn't get bigger." The practice was described as effective but sometimes painful. Participant 4 (Rwanda) explained: "We used to wrap our stomachs tightly after giving birth... But my tummy is flat. You wouldn't even think I had kids." In some cases, postnatal midwives in New Zealand expressed curiosity and sought to learn the technique, which participants welcomed. The hot water therapy, another practice described in this method, involved massaging the abdomen with cloths soaked in boiling water to "flush out" retained blood and restore the womb: "Every morning, boil water, ... until you start bleeding" (Participant 8, DR Congo). Participant 11 (Nigeria) added: "I boiled water, put antiseptic in it, and sat on the bucket to let the steam enter my vagina." Women described this as both cleansing and restorative, though painful: "Every morning and evening, a neighbour came to bathe me and press my abdomen with hot water... If you don't press your belly, it won't go back to normal" (Participant 11, Nigeria).

Sitz baths, often infused with salt or herbs, were also used to heal perineal tears and stitches: "We use warm salt water ... to help with healing stitches" (Participant 3, Kenya). These practices may not only be functional but also carry strong cultural and social meanings. They reinforced expectations around femininity, recovery, and marital roles: "People in my culture say that if your stomach stays big, it's because you didn't tie it properly... If you want to keep being attractive to your spouse, you must tie your stomach" (Participant 11, Nigeria). Notably, women recognised that these methods were not suitable after caesarean births: "When you have a C-section, they don't tie your stomach because of the wound" (Participant 8, DR Congo). This avoidance of belly binding and hot water therapy after surgical births may reinforce women's strong preference for vaginal delivery, since only physiological birth allowed them to fully participate in cultural postpartum practices essential for recovery, identity, and social belonging.

Culturally related newborn care practices

Participants described newborn care as a deeply cultural process, shaped by collective traditions and rituals aimed at ensuring infant health, maternal recovery, and social belonging. Practices such as bathing newborns in herbal infusions, daily massage, and stretching were described as strengthening the infant, preventing deformities, and promoting sleep and calmness. One Kenyan participant explained: "The baby isn't bathed with normal water; they use boiled roots and leaves... They believe the baby will sleep well and be protected" (Participant 2, Kenya). These rituals reflect both psychosocial and physical understandings of newborn well-being, integrating health, spirituality, and emotional security.

From communal support to individualised care: disruption, adaptation, and advocacy after migration

Participants linked postpartum challenges to the combined effects of social isolation and the absence of culturally familiar postpartum foods. The lack of extended family support, together with limited recognition of cultural postpartum needs within maternity services, contributed to emotional vulnerability, delayed recovery, and difficulties establishing breastfeeding. Several women described migration as reshaping postpartum experiences, replacing a communal model of rest and holistic care with a more fragmented and individualised system that often did not meet their cultural and practical needs.

Postpartum isolation and food insecurity for recovery and breastfeeding

Across accounts, food was not framed solely as "nutrition," but as a cornerstone of healing, milk production, and cultural identity. In participants' countries of origin, postpartum women described being cared for by mothers, aunts, and other female relatives who prepared hot, nutrient-rich meals believed to support recovery and lactation. By contrast, in Aotearoa New Zealand, women often reported being left to manage alone, relying on standard hospital food that they experienced as cold, inadequate, and culturally incongruent.

A woman from the Democratic Republic of Congo (Participant 8) described dissatisfaction with postpartum meals: "They give you meat, sandwiches, and then this. You give birth, you need the soup, something hot... How is the milk going to come?" Without family support, she felt nutritionally and emotionally unsupported: "If you have family, they will cook food, they will bring for you, but I have no one to cook for me." She emphasised the struggle to establish breastfeeding without access to culturally specific foods: "You just gonna eat that bread and thing... already lose 10 kg... there's no food as we eat so how the milk is gonna come." For her, the absence of foods such as hot porridge or spiced soups normally central to postpartum care intensified stress and contributed to perceived low milk supply.

The absence of extended family support also amplified emotional distress. Participant 1 (Rwanda) reflected: "Anything we are dealing with, we are dealing with by ourselves. Back home, you've got your sisters, you've got aunts... But here, it's all about you... When we came back from the hospital... I was crying in the car. I said, 'How come we came here and there was no one, just me and you?' If I had the choice, I would go back home one month before to give birth."

In one account, postpartum vulnerability was compounded by significant physical and emotional challenges. Participant 9 (Ethiopia) described being alone in the hospital for 14 days and being unable to access culturally acceptable meals, even when financially stable. She recalled being offered frozen vegetarian food that she could not eat: "It was ice food" Participant 9 also reported a clinical diagnosis of postpartum depression following her first traumatic birth and described complications after caesarean section, including wound breakdown that required readmission and further surgical management. She explained: "That dressing was not changed for 14 days. I was begging them to check my C-section wound. I kept telling them, 'I'm bleeding.'" She continued: "I was begging... I told them the blood is coming, the wound is not dry... no one cared... Even the house was smelling... it was open." Overall, these accounts show how expectations shaped by communal postpartum traditions often clashed with the realities of individualised maternity care in Aotearoa New Zealand. The absence of culturally familiar nutrition and family-based care contributed to feelings of abandonment and uncertainty, influencing women's perceived recovery and breastfeeding experiences.

Adaptive solution and creative response for maternity experience in New Zealand

Despite the richness of cultural practices during pregnancy,

childbirth, and the postpartum period, participants described challenges in sustaining these traditions after migrating to New Zealand. The absence of extended family, limited access to familiar foods and herbs, and the constraints of hospital environments disrupted continuity.

Participants described difficulties sustaining cultural practices after migrating to Aotearoa New Zealand due to reduced family support, limited access to familiar foods and herbs, and hospital constraints: “You don’t have support, you don’t have a family, you don’t know what to do, like what to eat, what not to eat” (Participant 8, DR Congo). In response, women demonstrated resilience and creativity, including substituting tools (e.g., using a pot lid for belly binding; Participant 11, Nigeria), sourcing traditional foods through family and community networks (“I asked my husband to bring heaps of cassava leaves from Africa”; Participant 4, Rwanda), and using technology for guidance (“I called my mom on Zoom... she guided me step by step”; Participant 11, Nigeria). Community

networks also provided practical postpartum support: “In the community, they send food to the mom for a week... rice, chicken, meat” (Participant 7, Somalia).. Participant 9 (Ethiopia), after a difficult first postpartum period marked by infection and delayed lactation following a caesarean section, reported significant improvement during her second birth when community members provided traditional foods: “This time... one of my community members was bringing me the same culture [food]... I was drinking oats, cultural oats” She described a faster recovery and greater confidence: “After 40 min, I just go take a shower by myself... I eat, I just do whatever I want.”

Women also described advocacy as an adaptive strategy in cross-cultural maternity care encounters. Participant 7 reported assumptions about FGM/C and pressure toward intervention: “The midwife looked and said, ‘Oh, it looks like you’ve been cut,’... I told her, ‘No, I haven’t been cut’...,” and later overheard, “She’s Somali, they usually have genital

Cultural Continuity and Adaptive Maternity Practices Among Sub-Saharan African Women in New Zealand

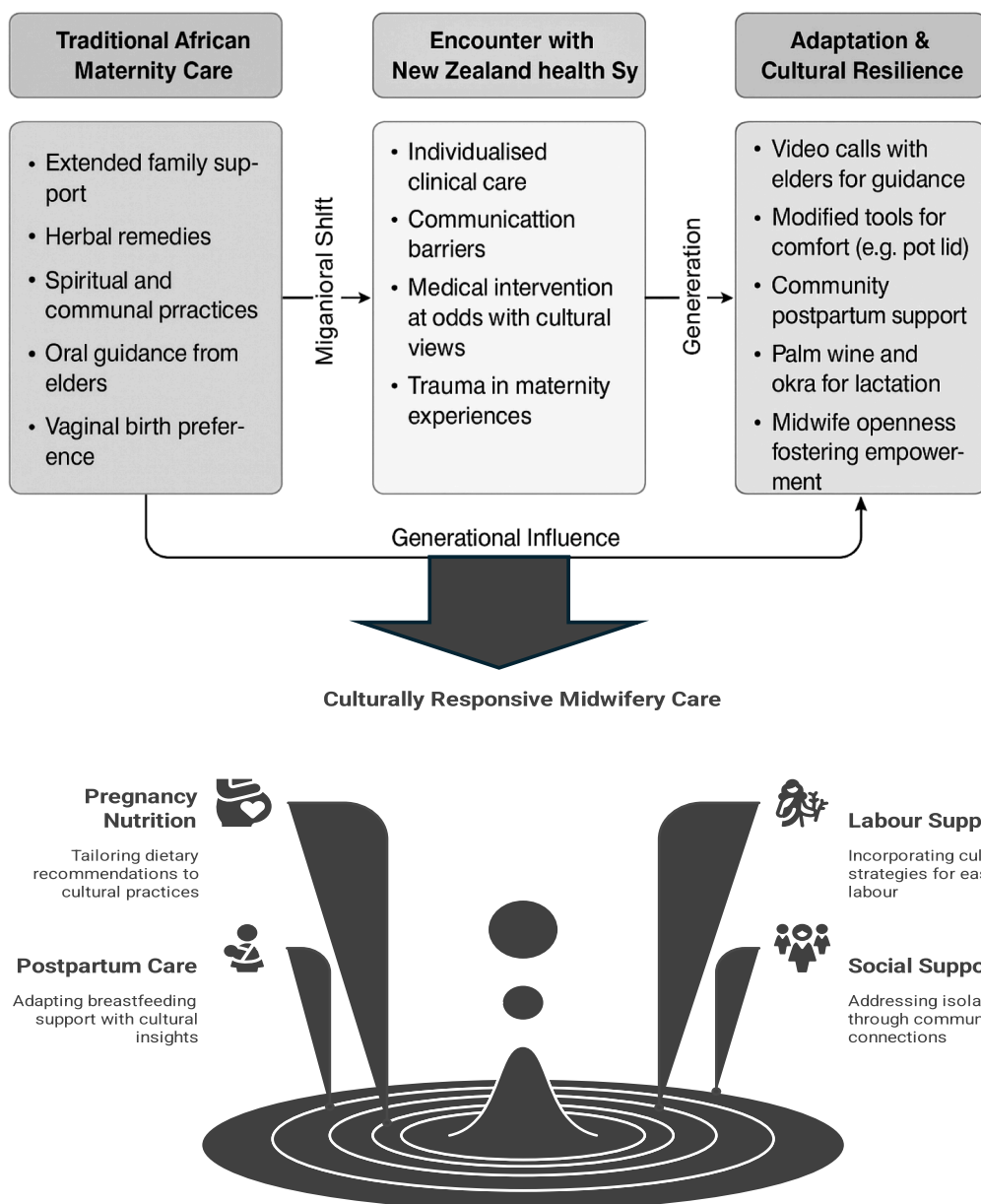


Fig. 1. Maternal care: Adaptive strategies used among Sub-Saharan African women in New Zealand.

“mutilation” (Participant 7, Somalia). She added, “I was already 6 cm when they started talking about C-section... I refused it.” However, after resisting CS pressure, another consultant stepped in and reassessed her: “After that, a consultant came, and she broke my water... And yeah, so everything started progressing... I was eight centimeters... And from there, everything just progressed really fast.” The pressure to consent to a caesarean section, based on inaccurate beliefs and without adequate examination or dialogue, left her feeling dismissed. Participant 10 (Somalia), who reported a history of FGM/C, described limited discussion of alternatives: “They didn’t explain all the options properly. They kept making it seem like a C-section was the only way.” After she insisted, “they finally admitted that forceps were also an option,” adding, “I felt like they were rushing into a C-section instead of giving me other options” (Participant 10, Somalia). Midwife R.O. noted, sustaining such advocacy requires supportive structures even for midwives: “You have to be really strong to advocate for your woman... especially if you haven’t got the right mentors with you.” Together, these accounts illustrate how women’s adaptive strategies extended beyond cultural substitution and community support to include active advocacy within maternity services.

Women’s adaptations following migration were not simply responses to loss; they reflected resilience, agency, and cultural continuity, as participants actively sourced resources, negotiated care, and maintained traditions through community and transnational networks. As illustrated in Fig. 1, this underscores the need for culturally safe and structurally competent care that avoids stereotyping and supports respectful, individualised decision-making. This foundation informs the next phase of the study, which examines clinical maternity experiences of Sub-Saharan African women in New Zealand.

Discussion

Community-centred maternity expectations and the contrast in Aotearoa New Zealand

The findings of this study show that participants’ maternity expectations were shaped by community-centred and culturally rooted care models, where pregnancy, birth, and postpartum recovery are supported through kinship networks and intergenerational knowledge. Women described the involvement of mothers, grandmothers, aunts, and female neighbours who provided practical care, emotional reassurance, and guidance on diet and traditional remedies (Participant 11, Nigeria; Participant 3, Kenya). Postpartum recovery practices such as belly binding, hot water therapy, and culturally specific foods were understood as supporting healing and lactation, while vaginal birth was often valued as an affirmation of strength and womanhood (Participant 11, Nigeria; Participant 9, Ethiopia). These interpretations align with literature highlighting the central role of communal postpartum support, traditional practices, and culturally embedded breastfeeding norms in some African settings (Mudonhi and Nunu, 2022). Traditional postpartum confinement, dietary norms, and elder support remain integral to this culturally safe care model (Adamolekun et al., 2023; Ameade et al., 2024; James et al., 2019; Kavle et al., 2019; Musie et al., 2022a). In Aotearoa New Zealand, participants described a contrasting postnatal context characterised by reduced extended-family presence and reliance on hospital routines, which often limited access to culturally familiar nutrition and communal care. This mismatch disrupted cultural expectations and contributed to isolation, slower recovery, and breastfeeding challenges, highlighting a gap between culturally grounded maternity expectations and the realities of care within an individualised system. Despite these disruptions, the findings also show that women actively adapted to sustain cultural continuity.

Cultural continuity, adaptation, and advocacy in maternity care

The resilience of cultural practices among African migrant women represents both the preservation of identity and the empowerment of

mothers. Women’s cultural attachment shaped maternity expectations and sometimes created tension with the New Zealand health system. Participants described a strong preference for vaginal birth and stigma around caesarean section, framing birth as a test of strength: “do whatever you can to achieve vaginal delivery” (Participant 11, Nigeria). Some delayed engaging with services due to fear of pressure toward unwanted interventions, while others relied on home remedies, cultural foods, and transnational family guidance to sustain traditions. Similar patterns are reported among other migrant groups, including Chinese women who continue “zuo yuezi” postpartum practices (Zhang and Hanser, 2023) and Indian migrant women who maintain recovery diets through imported or substituted ingredients (Rao et al., 2020). These comparisons reinforce that transnational motherhood involves ongoing negotiation and cultural resilience rather than passive adaptation (Cook Heffron et al., 2022).

This study contributes to understanding how Sub-Saharan African migrant women sustain culturally meaningful maternity practices while navigating an individualised maternity system in Aotearoa New Zealand. Rather than viewing migration as producing cultural loss alone, the findings point to cultural continuity as an active process of negotiation, where women preserve meaning through adaptation and selective integration. This aligns with literature describing how migrant women maintain postpartum and maternity traditions through substitution, transnational support, and community networks, including among African diasporas and other migrant populations (Ogunsiji et al., 2023; M. R. Musie et al., 2022; Zhang and Hanser, 2023; Rao et al., 2020; Cook Heffron et al., 2022).

These patterns can be interpreted through Berry’s Acculturation Theory, where many women’s accounts reflect an integration strategy maintaining cultural identity while engaging with the host maternity system (Berry, 1997). The concept of transnational motherhood further explains how cultural practices are sustained through cross-border relationships and ongoing moral and practical guidance that transcends physical distance (Cook Heffron et al., 2022). Together, these lenses frame cultural adaptation as intentional and agentic, not passive.

A key contribution of this study is the identification of advocacy as an adaptive strategy in cross-cultural maternity care encounters. Several participants described needing to actively negotiate care options and challenge assumptions to achieve respectful, individualised decision-making. Participant 7 (Somali) described experiencing an assumed clinical narrative related to FGM/C and reported feeling pressured toward caesarean section despite disputing that assumption: “She’s Somali, they usually have genital mutilation”. Similarly, Participant 10 (Somalia), who reported a history of FGM/C, described feeling steered toward caesarean section without a full discussion of alternatives: These accounts suggest that, for some women, advocacy was required not only to preserve cultural preferences (e.g., preference for physiological birth) but also to secure shared decision-making and genuine exploration of options within clinical encounters.

Interpreted through a cultural safety lens, these findings emphasise how stereotyping and assumptions can undermine respectful care and silence women’s voices in decision-making (Wepa, 2015). Cultural safety shifts the focus away from “cultural difference” as a woman’s problem and instead draws attention to power relations, communication practices, and whether care is experienced as safe by the woman (Bradfield et al., 2019). Through a structural competency lens, these accounts also highlight how system-level pressures such as institutional routines, documentation practices, risk framings, and limited time for relational care may contribute to narrow option-presentation and reduced exploration of culturally meaningful preferences (Fougang et al., 2025a; Metzl et al., 2018; Neff et al., 2020). In this context, advocacy becomes both a protective strategy for women and a marker of where structural conditions may be limiting woman-centred care.

Importantly, advocacy was not positioned only as women’s responsibility. Midwife R.O. highlighted that sustained advocacy requires supportive professional structures: “You have to be really strong to

advocate for your woman... especially if you haven't got the right mentors with you." This aligns with the idea that culturally safe care depends not only on individual clinician intention but also on workforce supports, mentorship, and organisational conditions that enable relational practice. From a service design perspective, the findings suggest that individualised models may unintentionally disadvantage migrant women whose maternity expectations are grounded in communal support systems, particularly in the postpartum period. A structurally competent response would strengthen culturally safe enquiry (including routine discussion of traditional foods and remedies), build postnatal support pathways that address isolation, and partner with community organisations to improve access to culturally relevant support. This study, therefore, strengthens the case for service and policy responses that move beyond "cultural competence" as individual knowledge and instead build structural and relational supports for culturally safe care (Kyere et al., 2022). These implications align with the World Health Organization's emphasis on respectful, woman-centred care and the importance of supporting women's preferences when safe and clinically appropriate (Avery, 2025; World Health Organization, 2025).

Conclusion

These findings demonstrate that cultural practices are not peripheral but central in shaping women's expectations of maternity care. These findings provide concrete guidance for midwives to deliver culturally safe, relational care by routinely exploring culturally meaningful practices, recognising the role of communal postpartum support, and partnering with community networks to reduce isolation in migrant contexts. Many women's births are a social and cultural milestone, and this could have been acknowledged, whilst recognising that sub-Saharan African women experience specific challenges in addressing this when experiencing pregnancy and birth in unfamiliar cultural settings. These findings have implications for maternity service design and migrant health equity by demonstrating how individualised models can unintentionally disadvantage women who rely on communal postpartum support. A structurally competent approach would embed culturally safe enquiry into routine care, strengthen postnatal support pathways to reduce isolation, and develop partnerships with community organisations to support culturally meaningful recovery practices, thereby improving alignment between service delivery and women's lived realities. The next phase of this research, therefore, examines Sub-Saharan African women's clinical maternity care experiences in Aotearoa New Zealand and their impacts, with specific attention to how institutional practices, structural conditions, and relational care shape women's trajectories, decision-making, and longer-term maternity experiences.

Limitations

The small, New Zealand-based sample may limit transferability to other settings. Interviews were conducted in English or French, which may have constrained nuance and excluded some women unable to communicate in either language. Recruitment through community networks may have introduced selection bias. The study was not designed as longitudinal; however, Participant 9 completed a follow-up interview after her subsequent birth, offering limited insight into changes across pregnancies. These limitations are offset by rich qualitative data and practice-oriented aims.

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Informed consent statement

All participants provided written informed consent prior to taking part in the study. Participants were informed of the study aims, the voluntary nature of participation, their right to withdraw, and the measures taken to ensure confidentiality and secure data handling.

Declaration of generative AI in scientific writing

During the preparation of this work, the authors used ChatGPT (OpenAI) to assist in refining the language, improving clarity, and rephrasing select paragraphs. All content was reviewed and edited by the authors, who take full responsibility for the final version.

CRediT authorship contribution statement

Daina Charnelle Fougang: Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Dianne Wepa:** Writing – review & editing, Validation, Supervision, Project administration, Conceptualization. **Charles Mpofu:** Writing – review & editing, Supervision, Project administration, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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