



families commission
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NEW SPACES AND POSSIBILITIES: THE ADJUSTMENT TO PARENTHOOD FOR NEW MIGRANT MOTHERS

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EXECUTIVE SUMMARY

Parenthood and migration are both major life events which, while stressful, can be mediated effectively with appropriate support. International research indicates that parenting in a new country without support, networks or access to information creates additional stressors.

There is a paucity of research about the transition to parenthood in New Zealand for migrant families and this research project explores the maternity experiences of women from five different migrant backgrounds. It is a starting point for further research about migrant families and the development of a migrant family life-cycle research agenda.

Forty migrant women were interviewed about their experiences of the adjustment to parenthood in a new country in order to ascertain their support needs. Early motherhood was chosen as a focus because migration policy selects healthy women and therefore the maternity experience is often when many migrant women are first initiated into the New Zealand health system. In consultation with Plunket, five groups were chosen for the study; three were from the largest Asian communities, Chinese, Indian and Korean (Chinese make up 44 percent of all Asians, Indians 26 percent and Koreans 8 percent). Two other new migrant groups were also selected for inclusion for different reasons. European migrant women were chosen because they are the largest migrant group yet little is known about their needs. These are assumed to be similar to those of other Pākehā because of their familiarity with language and systems. Arab Muslim women were chosen because their faith and cultural needs are not well understood. One focus group was undertaken for each group. AUT University's Centre for Asian and Migrant Health Research and the Royal New Zealand Plunket Society conducted the research together in March 2006.

KEY FINDINGS

It is hoped that the research findings will inform policy, the development of appropriate resources and other research in this area, and will assist both health professionals and migrant communities in New Zealand. The key findings of the research were that:

- > migrant women lose access to information resources, such as family and friends, in the process of migrating and come to depend on their husbands, health professionals and other authoritative sources. Importantly, the expectations from their country of origin come to inform their experiences of pregnancy, labour and delivery in a new country
- > migration has an impact on women's and their partners' roles in relation to childbirth and parenting. The loss of supportive networks incurred in migration results in husbands and partners taking more active roles in the perinatal period
- > coming to a new country can result in the loss of knowledge resources, peer and family support and protective rituals. These losses can lead to isolation for many women.

RECOMMENDATIONS

The findings of the research suggest that:

- > support services for women who have a baby in a new country need to be developed and services also need to be 'father-friendly'
- > the information needs of migrant women from all backgrounds need to be considered in planning service delivery (including European migrant women)
- > services need to develop linguistic competence to better support migrant mothers, for example by providing written information in their own language

- > those developing antenatal resources must consider the needs of migrant mothers; for example, by having antenatal classes available in a number of common languages, eg Korean
- > workforce development occurs among health professionals to expand existing cultural safety training to incorporate cultural competence
- > health and social services staff must become better informed as to the resources that are available if they are to provide effective support for migrant mothers.

FUTURE RESEARCH

Further research is required to:

- > explore the experiences of New Zealand-born women to identify whether the issues raised in this report are peculiar to migrant women or to women in general
- > explore the information needs of migrant parents through the family life-cycle
- > identify the factors that support breastfeeding in the absence of social support
- > understand the experiences of migrant father
- > understand the needs of additional migrant groups, including African, Middle-Eastern and Latin American communities
- > review the effectiveness of cultural safety for migrant women by focusing on outcomes.

1.0 INTRODUCTION

The New Zealand Government has oriented its migration policy toward obtaining skilled migrants. Often migrant women are viewed as passive appendages to skilled men in the migration process and the complexities of women's motives and their active roles in decision-making processes have been ignored, as seen by the paucity of research undertaken on women's experiences of migration prior to the mid-1970s (Kofman 1999; Leckie 1989). Migration is liberating for many women, who are freed from traditional roles and expectations, but for many it leads to the greater 'feminisation' of women's roles, as women find themselves taking up more traditional gender roles as wives and mothers (C. Ho 2006). Migrant experiences in the domestic sphere and in particular the experiences of mothering, which is a common aspect of migration, have been under-researched in New Zealand. There is a burgeoning research agenda examining a range of migrant issues, including employment (New Zealand Immigration Service 2003; Office of Ethnic Affairs 1996; Pernice, Trlin, Henderson and North 2000; Pio 2005; Selvarajah 2004), mental health (Abbott et al 2003; Abbott, Wong, Williams, Au and Young 1999), settlement (Daley 1996; Dunstan, Boyd and Crichton 2003; E.S Ho, Cheung, Bedford and Leung 2000; E.S. Ho, Lidgard, Cowling and Bedford 2003), historical research (Bönisch-Brednich 2002; Fraser and Pickles 2002; Ip 1990; Murphy, New Zealand Chinese Association and New Zealand Office of Ethnic Affairs 2002; Nola 1994) and health (DeSouza 2005, 2006; DeSouza and Garrett 2005; Tse, Bhui, Thapliyal, Choy and Bray 2005; Tse and Liew 2004).

Using focus group interviews, this report highlights findings from a research project exploring the maternity experiences of migrant women from five different ethnic backgrounds. It is a starting point for further research about migrant families and the development of a migrant family life-cycle research agenda. The research took place in the greater Auckland area in March 2006 and consisted of five focus groups held with Muslim, Korean, Indian, Chinese and European migrant women.

The report begins with a background section to contextualise the research project, findings and discussion. This is followed by an outline of the research methodology and a discussion of the main study findings, covering the three key perinatal stages of pregnancy and the antenatal period, labour and delivery and the postpartum period. The report concludes with a discussion and recommendations for further research.

2.0 BACKGROUND

This section contextualises the research project and choice of methodology. It outlines demographic changes in New Zealand and suggests that policy has failed to keep pace with these changes and to consider the health needs of migrants. It establishes that early motherhood for migrant women is a stressful life event, that this transition is largely unexplored in New Zealand and has significant implications for healthcare service delivery. It demonstrates that migrant mothers enter a health system that is Eurocentric by design, and that strategies for health professionals to work with migrant mothers are limited. This is despite the explicit expectation that health professionals provide care that is attuned to the cultural needs of their clients (Ramsden 2000).

2.1 CHANGING DEMOGRAPHICS

Ethnic and religious diversity is increasing in New Zealand. Census projections to 2021 suggest that Māori, Pacific and Asian populations will grow at faster rates than the European population but for different reasons. The Asian population is expected to more than double mainly due to net migration gains, while Māori and Pacific peoples' increases will be due to higher fertility rates (Statistics New Zealand 2005). The 2001 Census found that 23 percent of New Zealand females were born overseas, predominantly in the United Kingdom and Ireland, Asia and the Pacific Islands (Statistics New Zealand 2005). European/Pākehā made up 79.6 percent of the population, Māori 14.5 percent and Pacific Island peoples 5.6 percent. For the first time, the number of people identifying as Asian exceeded Pacific peoples, more than doubling in the period from 1991 to 2001 to comprise almost 6.4 percent of the population. Chinese are the largest ethnic group within the Asian category, making up 2.2 percent of the overall population, followed by Indians (1.2 percent). The term 'Asian' is gaining currency as a mechanism for collective mobilisation and advocacy, although the validity and utility of such an umbrella term is contested because Statistics New Zealand uses the term 'Asian' to describe peoples with origins in the Asian continent, but excludes peoples originating in the Middle East and Central Asia. This uniquely New Zealand definition of 'Asian' is unspecific and homogenises people with diverse languages, cultures, religious and political backgrounds, and social and health needs (Rasanathan, Craig, and Perkins 2004; Workshop Organising Team 2005).

In the period 1991-2001, the number of women originating from the Republic of Korea has increased 23 times from 408 to 9,354. The number of women from China has quadrupled from 4,620 to 20,457 and the number of women from South Asia has doubled in the same time period (Statistics New Zealand 2005). These increases have significant implications for the development and delivery of health services to these women. The Asian community has the highest proportion of women (54 percent), followed by Māori and Pacific (53 percent each) and European (52 percent) (Scragg and Maitra 2005). Asian women are most highly concentrated in the working age group of 15-64 years compared to other ethnic groups. To some degree this is a reflection of migration policy, with Asian women migrating for study or work.

2.2 MOTHERHOOD AND MIGRATION

Most of the research about migrant mothering has assumed that migrants are from non-English speaking backgrounds or are culturally and linguistically different from the receiving community. However, the 2001 Census shows that women from Ireland and the United Kingdom made up the greatest number of overseas-born women at 5.9 percent of the population, followed by women born in Asia 4.6 percent, the Pacific 3.2 percent, Australia 1.6 percent, Europe 1.5 percent and 'Other' 5.8 percent (Statistics New Zealand 2005). Women from the traditionally preferred source countries of migration (UK and northern Europe) continue to be favoured, making up approximately 9 percent of migrant women. Their experiences have been researched in New Zealand (Beaglehole 2002; Brednich 2002; Fraser and Pickles 2002; Nola 1994; Wittman 1998) but little is known about their experiences of parenthood.

Motherhood and migration are both major life events. Migration can result in the loss or disruption of specific cultural practices and beliefs. Many cultures and societies have developed particular postnatal customs that include diet, isolation, rest and help in the household. Women who are separated from

their social networks through migration must find new ways to recreate these rituals or lose them (DeSouza 2002). Previous research (Barclay and Kent 1998; Liamputtong 1994) suggests that the loss of supportive networks, protective rituals and a move to a nuclear family model can result in isolation and postnatal depression. Access to help can be further impeded if a new mother has language and communication problems and services are not culturally competent. Migrant mothers sometimes face additional cultural and social demands and losses, including the loss of lifestyle, control, sense of self and independence, family and friends, familiar birthing practices and care providers.

Liamputtong and Naksook (2003) found that Thai women in Australia who became mothers had several main concerns, including social isolation, different childrearing and child disciplinary practices to those of their country of origin, and the desire to preserve their culture. Findings of isolation, loneliness and negotiating between traditional and Western childbirth rituals were significant issues in a New Zealand study (DeSouza 2002). An Australian study (Ward 2003) found that raising a child in a new country without family and community was problematic and that migrant women with children missed the close support of family networks. This and other research strongly suggests that migrant mothers, regardless of origin, benefit significantly from effective and familiar social support networks.

Having a child is one of the most culturally and spiritually significant events for women (Khalaf and Callister 1997), yet women are more likely to develop emotional problems after childbirth than at any other time in their lives (Kohen 2001). A systematic review and meta-analysis on interventions to reduce postnatal depression by Lumley, Austin and Mitchell (2004) found that one in six women experiences a depressive illness in the first year after giving birth. Thirty percent of those women will still be depressed when their child is two years old. Lumley et al add that women who experience problems during the early stages of motherhood also report problems with their relationships and their own physical health and wellbeing. Lack of support, isolation and exhaustion are commonly reported experiences. Psychiatric illness occurring at this time can have an adverse effect not only on the woman herself but also on her relationship, family and the cognitive and social development of her infant. The impact on a child of a mother's depression can include behavioural problems, relationship problems and cognitive deficits (Murray and Cooper 1997). Research shows that infants who had a mother who was depressed in their first year of life are more likely to develop cognitive deficits and behavioural problems than infants whose mothers were not depressed in that first year (Beck 1998). Maternal depression has also been identified as the strongest predictor of paternal depression during the postpartum period (Goodman 2004).

2.3 ETHNOCENTRISM AND MIGRANT MOTHERHOOD

Being a mother is influenced by factors such as ethnicity, class and gender (Collins 1998), however Woollett and Nicholson (1998) argue that the dominant beliefs that influence policy about parenthood in multicultural Western societies come from white, middle-class parents, researchers and policy makers rather than from poor families or ethnic minority communities. Other writers have noted the increased authority and privileging of knowledge by parenting health professionals within healthcare discourses (Grant, Luxford and Darbyshire 2006).

Women in Western countries whose parenting behaviours do not fit within the dominant cultural norms are at risk of being pathologised as 'other' mothers on the basis of class, colour, ethnicity, race, sexual preference, education, employment or disability (Jolly 1998). Equally, women who do 'fit in' are at risk of being ignored as it is assumed that they will know and understand how to access the health system. A UK study found that health practitioners perceived non-white users of maternity services negatively and in turn used the notion of culture to withhold recognition of their needs, seeing the meeting of their needs as a responsibility of the private sphere, rather than the universal public health system (Davies and Papadopoulos 2006).

Barclay and Kent (1998) have also noted the hegemony of the health system, observing that the needs of migrant mothers have been ignored by society and health professionals. They suggest that the care given to such women can be ritualised, inappropriate and professionally dominated; for example, in a previous New Zealand study, migrant women from Goa, India, were torn between offending professional and familial authority figures. On one hand midwives were recommending that women go outside for a walk and on the other family members of new mothers were suggesting that they had to stay inside for 40 days as is the custom (DeSouza 2005). Reactions from Western health workers to traditional postpartum practices of immigrants range from "at best insensitivity and at worst derisory" (Barclay and Kent 1998:6).

A study by Bowler (1993) of Asian women's experiences of healthcare by midwives in the United Kingdom found that midwives used stereotypes to pitch their interactions and make assumptions about appropriate care and service delivery. Bowler's (1993) findings revealed that midwives saw Asian women as demanding, having a low pain threshold, lacking in a maternal instinct, difficult to communicate with and lacking in compliance with preventative care and family planning. They were also seen as abusing services by having large families and having unrealistic expectations. Midwives did not acknowledge the positive characteristics of Asian women in relation to pregnancy and childbirth, such as their abstention from smoking and alcohol. Bowler recommended midwives have education that challenges racist attitudes and the hegemony of the Western medical system. Similarly, a study by Day (1992:23) found that Asian women were frequently seen as "oppressed by their role as mothers, suffocated by domesticity and lacking independence". Many health professionals would be shocked to be called racist, yet Bowler's (1993) study highlights the incongruencies prevalent in the behaviour of health professionals. In the study, midwives paradoxically held stereotypes of Asian women, yet saw themselves as sympathetic toward them. Institutionalised racism is one possible explanation for this incongruence. This is where health workers see Western health practices as superior and come to expect minority women to assimilate to these practices (Marshall 1992).

The ethnocentric and stereotyping behaviour of health professionals has also been raised by Foss (1996) with regard to the care given by public health nurses. Foss accuses the research on parenting as being 'Eurocentric' and reductionist because of the focus on the mother and not the broader context of parenting. Foss argues that public health nurses base standards of what good parenting is (as defined by the dominant culture) on personal belief, interpretations, and stereotypes based on professional experiences with other cultural groups. Foss recommends that nurses avoid judging parenting by the standards of the country of residence and proposes that a new framework be developed to assess 'normal' behaviours and cultural variations in immigrant populations and investigate immigration-related health problems. Foss highlights the importance of developing a research agenda on parenting in immigrant communities in order to better plan services. There is also a need to examine the issues of universalism and particularism; that is, whether all services should be the same, or specific to meet the needs of diverse groups with a focus on outcomes (DeSouza 2004a).

There is no research about how midwives and Plunket staff work with migrant mothers and what informs their practice. The Royal New Zealand Plunket Society is the largest provider of well child services in New Zealand and its staff work in the community with the parents of new babies and pre-school children. Their staff comprises nurses, Community Karitane and Māori health workers (Kaiawhina), whose role involves child health surveillance and practices generally carried out in the context of a relationship between the nurse and the mother. The Plunket Society was founded by Dr Truby King in 1907 as part of a campaign to improve infant care by educating women about motherhood and to promote breastfeeding (Kedgely 1996). Originally named 'The Society for Promoting the Health of Women and Children', Lady Plunket later gave her name and support to Dr King's cause. Plunket operate clinics and family centres as well as visiting women in their own homes. According to Wilson (2003), the role of Plunket has conflicting objectives of being both an inspector and family friend. In contrast, midwives argue that central to their practice are woman-centred discourses which construct mothers as consumers, who take responsibility for themselves and their babies (Marshall and Woollett 2000).

2.4 RESPONSES TO CULTURAL DIVERSITY IN NEW ZEALAND

The bicultural nature of New Zealand is shaped by Te Tiriti O Waitangi/The Treaty of Waitangi, New Zealand's founding document. The Treaty defines the relationship between Māori and Pākehā and is strongly evident in healthcare and social policy. The contemporary application of the Treaty of Waitangi involves biculturalism and the notion of cultural safety, which are at the forefront of the delivery of health services (Durie 1994). Cultural safety means incorporating "principles of partnership, participation, protection and equity" into the care that is delivered (Cooney 1994:9). Cultural safety shifts the focus from the person who is different and is a recipient of care to critically examining how one's own assumptions and beliefs about the world impact on the care that one provides (DeSouza 2004b; McPherson, Harwood and McNaughton 2003). However, critics suggest that cultural safety needs to encompass new and growing ethnic communities as well as people who may differ from the health professionals because of their socio-economic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief or disability (Ramsden 1997). In practice the focus remains on the relationship between Pākehā and Māori, rather than migrants (DeSouza 2004b) or other marginalised communities (Giddings 2005).

2.5 THE LACK OF MULTICULTURAL HEALTH POLICY

Despite long histories of migration to New Zealand, ethnic communities have been absent from discussions of nation building and healthcare policy (DeSouza 2006). This has in part been due to the relatively small numbers of migrants from non-traditional source countries until the early 1990s, which meant that the concerns of a relatively homogeneous Pākehā people were reflected in policy (Bartley and Spoonley 2004). This monoculturalism has been challenged by the increased prominence of Māori concerns since the 1970s and increasing attention to biculturalism and negative health outcomes for Māori. Developments have also occurred with regard to Pacific peoples, largely concerned with health disparities. This concern has not been extended to ethnic communities, despite their increasing visibility in long- and short-term migration statistics. This is partly due to an assumption of a 'health advantage' of immigrants on the basis of current migration policy which selects healthy people. However, evidence is growing that this advantage declines with increasing length of residence in a receiving country (Johnstone and Kanitsaki 2005).

Expanding the bicultural to a multicultural framework is necessary. Despite the significant shift in our ethnic make-up, New Zealand has yet to encompass multiculturalism in its social policy framework. According to Bartley and Spoonley (2004), this is because our migration source countries have traditionally been the United Kingdom and Ireland. This in turn has shaped the development of activities and concerns with regard to settlement and the incorporation of newcomers (as they argue, racist and Anglocentric assumptions of a colonial New Zealand). When the time did come to explore issues regarding nation and nationality, this coincided with a rise in concerns over indigenous rights and the Treaty of Waitangi. Thus while countries such as Canada and Australia were developing multicultural policies, New Zealand was debating issues of indigeneity and the relationship with tangata whenua (Māori). As a result, New Zealand has yet to develop a locally relevant response to cultural diversity (multiculturalism) that complements or expands on the bicultural (Māori and Pākehā) and Treaty of Waitangi initiatives that have occurred (Bartley and Spoonley 2004).

2.6 CULTURAL COMPETENCE

Cultural competence is "the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs" (Betancourt, Green and Carrillo 2002:1). Changing demographics in New Zealand mean that there is a need for health professionals to be educated and prepared for working with cultural diversity if they operate from the premise that people from different cultures are entitled to equal respect and concern. The introduction of the Health Practitioners Competence Assurance Act 2003 has meant an additional responsibility to ensure the cultural competence of health practitioners. There are a number of legislative and policy frameworks that support culturally competent health service provision, such as the Health and Disability Commissioner Act 1995 and the Health and Disability Code of Rights 1996. These require that services acknowledge people's needs and provide for them while also protecting them from coercion, discrimination and exploitation. A culturally sensitive approach and acknowledgement of the person's cultural and ethnic identity, language and religious or ethical beliefs, is also advocated in the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the 1999 amendments. In addition The New Zealand Public Health and Disability Act 2000 recommends that health outcomes be improved for Māori and other population groups through the reduction of health disparities. The Human Rights Act 1993 requires that health services do not unlawfully discriminate on the grounds of culture and ethnicity. Despite these frameworks being in place, the practice remains monocultural with minor concessions to difference.

The foregoing review of pertinent literature suggests that:

- > the New Zealand health system tends to be ethnocentric and monocultural by default
- > migrant motherhood is a stressful life event for many women
- > existing strategies for health professionals to work with migrant mothers are limited
- > there is a legal requirement for health professionals to be culturally competent
- > policy has failed to keep pace with the changing demographics or to consider the health needs of migrants
- > there is a lack of research of the experience of migrant motherhood in New Zealand and on how health professionals respond to the needs of this group.

3.0 METHODS

This study intended to ascertain the nature and extent of supports that migrant women used, what they found to be most useful and what challenges existed for them in the puerperium.¹

3.1 STUDY CONTEXT

Drevdahl, Taylor and Phillips (2001) suggest that the use of race and ethnicity as variables in research has increased, however confusion is evident about the terms used, and in particular there is a lack of definition of the variables defined. This research is no exception; labels remain fraught and complex, particularly when considering multiple identities and ethno-religious diversity. Drevdahl et al recommend that researchers are explicit regarding the rationale related to their use of the categories and the assumptions underlying particular racial and ethnic categorisations. This study took place in Auckland, among European² migrants (from the United States, South Africa and the United Kingdom), Arab Muslim women³ (from Palestine and Iraq) and Asian women from three ethnic communities (Korean, Chinese and Indian). Ethical approval was obtained from the AUT University Ethics Committee and the Royal New Zealand Plunket Society Ethics Committee. The information sheets and consent forms were provided in four languages: English, Korean, Arabic and Chinese.

3.1.1 Participant recruitment

Forty participants were recruited through Plunket by Community Karitane and nurses with similar ethnic backgrounds, who invited women to participate. Selection criteria originally limited participation to ethnic⁴ migrant women who had become mothers within the last 12 months in New Zealand, however as the project proceeded it was decided to include migrant women from European backgrounds who comprise a large percentage of migrant women. Pacific Island women were excluded from participation because their maternity experiences are beginning to be documented as part of the longitudinal Pacific Island Families study (Abbott and Williams 2006). Women were identified by Community Karitane/Plunket Nurses as meeting the criteria for participating in the focus groups (see Appendix A for a demographic summary of the women in the focus groups). They were provided with an information sheet and consent form in their language and there was a follow-up phone call a week later to confirm their availability. Transport to the venue and childcare were provided for the women.

3.1.2 Data collection

Data collection involved conducting five focus groups. Two were in English (one for the European migrant group and the other for the Indian group) with the others conducted in Chinese, Arabic and Korean. A schedule of open-ended questions guided the discussions in the five groups to generate qualitative data concerning the experiences of motherhood in a new country (see Appendix B). The questions were developed and refined in consultation with Australian colleagues, Professor Bryanne Barnett and Dr Rhonda Small, as well as discussion with the research team, including the cultural consultants and community researchers who facilitated the focus groups. A self-report questionnaire (completed before the group discussion) gathered socio-demographic information, including age and marital status (see Appendix A).

The groups were facilitated by interviewers proficient in English and the language spoken by the women. Training had been provided for focus group facilitators. Each focus group ran for approximately one-and-a-half hours in order to provide the opportunity to obtain a range of perspectives. The semi-structured interview schedule aimed to identify the strategies used by women to manage the transition (such as, what formal and informal support systems did they use and how effective were these perceived to be). Each focus group had a facilitator and a co-facilitator who acted as an observer/note-taker, taking notes and helping with the logistics. After the discussion, the co-facilitator provided a brief summary of the major issues that were discussed and participants then had an opportunity to clarify points or offer additional insights. After the participants had left the room, the two facilitators had a debriefing session where they discussed their overall impressions and the main themes.

1 The six weeks following childbirth.

2 The term 'European' has been selected to label the group of migrants originating from the UK, US and South Africa, bearing in mind that this is by no means a homogeneous group.

3 There were also Muslim women in the Indian group but they identified as primarily Indian.

4 A term defined by New Zealand policy-makers to define people who are not Pākehā, Māori or Pacific peoples.

Focus groups were selected as a method for data collection for this study because they allowed for economical use of bilingual facilitators and partly because they allowed for the expression of many voices, views and experiences. This contrasts with the predominant focus on individuals in positivistic quantitative studies. Being in a group can be more satisfying and less intense than an individual interview because participants can choose how much they wish to contribute to the discussion and when. Focus groups also provide opportunities for reflection and time to frame a response while others are speaking. The principal investigator's previous experience of being a co-therapist for group therapy with women who had postnatal depression also influenced the choice of data collection method. Seeing the therapeutic advantages of talking about their experiences, being validated for those experiences and becoming experts of their own experience, were viewed as possible benefits for participants who were potentially isolated. Other advantages of focus groups include having access to large numbers of people at one time and enabling interaction and the exchange of ideas within a flexible structure (Hudson, Aranda and McMurray 2002). There are drawbacks to using focus groups, such as the risk of some people dominating the discussion and not allowing quieter members to be heard and a risk of those with stronger views being dominant (both in agreeing to take part and in the focus group discussion itself) and influencing the contributions of others (who did not realise something was a problem for them until they took part in the discussion). This was managed to some degree by having trained and highly-skilled group facilitators who had prior experience in research or counselling.

3.1.3 Data analysis

The focus group interviews were recorded and transcribed, then translated into English and verified by an independent translator where necessary. The translators were not only bilingual but also culturally-located, coming from the same ethnic group or similar cultural values as the women in the focus group. The interview transcripts were coded and analysed. The codes were clustered according to similarity and reduced. Similar phenomena were grouped into categories and named. The process was one of constant comparison, iteratively classifying and grouping the material to identify preliminary themes and sub-themes. Attention was paid to corroboration and divergence in the data. A draft report was reviewed by other members of the research team. This was then reviewed by the co-researchers (bilingual facilitators and recruiters) to verify the accuracy of the findings.

After the research staff debriefed, and the notes and tapes were transcribed, a narrative report was written to present the focus group results. A narrative report is a traditional focus group report that typically is composed of the key questions or the big ideas that have emerged from the discussion (Krueger 1998). The narrative report consists of a summary paragraph for each question, followed by illustrative quotations (Krueger 1998). Daly, Kellehear and Gliksman (1997) suggest that additional categories for analysis should be defined and then an explanation of similarities and differences within each group and between groups, followed by an account of how people see or experience a problem.

4.0 RESEARCH FINDINGS

Five major themes emerged across all groups, namely: the need for information; isolation related to migration; cultural needs; changing roles; and satisfaction with care. These are described in the research findings across the three key periods:

- > Antenatal period
- > Labour and delivery
- > Postpartum.

4.1 ANTENATAL PERIOD

Women are confronted with a number of issues around their changing bodies and roles when they become pregnant. An added issue for women who are migrants is that they have to deal with an unfamiliar health system in the absence of a support network and knowledge resources they might have had in their countries of origin. Migrant women, like all pregnant women, had to make decisions that required access to information in order to choose a maternity carer and access antenatal classes. At this time, women who were not fluent or confident English speakers had to contend with issues of language and culture.

4.1.1. Information needs

Participants in the study lost traditional sources of knowledge when they migrated, creating a vacuum that needed to be filled by other sources (DeSouza 2005). Pregnancy in a new country meant that they had to become proactive and seek out information. This knowledge relates not just to the birth and labour process (that is, biological knowledge) but also includes social knowledge and institutional knowledge (Lazarus 1994). The latter are more difficult to access as they rely on context and social networks, rather than authoritative knowledge which can be obtained from experts. Many women valued very specific information about the stages of their pregnancy, which allowed them to become more involved in the pregnancy than if they had been in their country of origin where other family members could have shared the responsibility. This meant also that many husbands became more involved in the pregnancy than they might have been in their countries of origin.

Knowing where to begin the process was difficult:

I had no idea at all about the system here. It was through the pregnancy test kit that I found out I was pregnant, but did not know what the next step was. I wondered whether I had to show my test result to my GP. I had no knowledge of how to get the necessary information. (Korean participant)

In the main, women from the European groups were happy with the information they received:

I got good information and all along my pregnancy I had good information. I had an easy, smooth pregnancy, no complications. (European participant)

However, many Korean women were unhappy with the information that they were given, which was not available in their language. Being given broad encouragement was not a substitute for specific information and was perceived as a laissez-faire attitude to their wellbeing:

I was given some information, but I didn't read it, as it was not in Korean. I always felt that I was one step behind. It was not only the midwife who did not give enough information or necessary support. Everyone kept saying, 'It is okay, you are doing well' but gave few information or specific support. (Korean participant)

Pregnancy raised the need to develop active decision-making strategies and to choose a healthcare provider. For some this led to developing increased knowledge about their pregnancy and greater self-sufficiency. Many of the women were proactive about finding out about the New Zealand health system and turned to authoritative sources for information:

Luckily, I was attending school and the assignment from school was to complete a project. I chose 'New Zealand's maternity system' and that was how I got some ideas about my situation. (Korean participant)

4.1.2 Taking more responsibility

One Indian woman found that she was more engaged in her pregnancy because her previous pregnancy was a joint responsibility with other family members while this time around she had to take more personal responsibility:

Why didn't I get the feelings the first time? Time passed with families, mother-in-law, sisters, brothers, and time passed like anything but here we are alone, thinking about the baby early and so every moment for me was a first-time moment, even though I'm a second-time mother. (Indian participant)

For some women the absence of family members and the access to information meant that they could monitor themselves through the stages of pregnancy and this led to developing increased knowledge and greater self-sufficiency:

I have to take care of my own self. I found this good thing in New Zealand that you should take care of the baby and you should be aware of foods and what is going on each and every month, each and every week, what really is important. (Indian participant)

4.1.3 Family support

The absence of social support from family members and peer groups meant that women required more support from their husbands, who were able to step forward into a space that was traditionally female-dominated:

Step-by-step they accept it and I feel that amusement once you get pregnant, the partner cares more than what you can expect them to, you know in India. Because there are a lot of people taking care about a pregnant lady in India but here ... you know. (Indian participant)

Many husbands became more involved during the pregnancy and were more in tune with what was happening to their partner's bodies:

I still remember we had this bounty pack before my daughter got born and my husband and I used to read what's going to happen next week exactly on Friday. We used to wake up and the first thing we used to do was take a book and read 'Okay, so now our baby's doing that' and he will pat me on my tummy saying 'Oh my little one' you know? So I doubt whether the same feeling would have come if my pregnancy was in India. (Indian participant)

4.1.4 Cultural needs: Someone from my own culture or a local?

Participants used a number of different criteria and strategies to find a Lead Maternity Carer (LMC). Separation from family and other cultural resources and English proficiency had a bearing on the choice of LMC for Chinese and Korean women, who used their cultural networks to obtain an LMC, while for many European participants the process was more random and depersonalised.

Many Korean participants wanted a midwife who could speak their language (as several could not speak English) but who also understood Korean 'bodies'. Culturally specific information has to some extent been excluded as a strategy in the cultural safety dialogue because of the risk of stereotyping and having a 'tick list' and recipe book approach for cultural groups (DeSouza 2004b). One woman would have considered a New Zealand midwife if she felt she was culturally competent:

Since I could not speak English at all, I wanted to have a Korean one. Koreans know more about our bodies and Korean practices better. More knowledge culturally and more understanding of fellow Koreans. If New Zealand midwives were more knowledgeable about Korean people and our ways we might choose New Zealand midwives. (Korean participant)

The lack of confidence with English meant that some women were prepared to have an LMC with a bad reputation rather than make themselves vulnerable with someone from a different ethnicity with whom they could not communicate.

Choosing an LMC from one's own community and of the same gender was also a strategy for ensuring good communication:

It was important that my GP was a woman, and Arabic, because I needed someone to help me with expressing myself well. (Arabic Muslim participant)

However, this strategy had its own risks as well as the same participant noted:

To be honest, the first one didn't help that much ... she was the one who allowed my situation ... my kidney situation to occur and deteriorate. So, when I feel pain and go to her, I mean when I first got married ... you know ... she'd say use things to clean yourself properly. But I would tell her I feel severe pain, I knew it was unnatural. When I got to the hospital the doctor said how could you be in such a bad situation. (Arabic Muslim participant)

Like the Korean participants, language dictated the choice of LMC for many Chinese women. They, more than any other cohort, relied on their networks to find a care provider. Chinese newspapers were a useful knowledge resource:

She speaks English and can speak Chinese. After I met her, I had a good impression of her. So I decided to have her as my midwife. My midwife has a partner who is also a Chinese (Malaysian Chinese). When I gave birth to my child, her partner delivered my child. The whole process was quite smooth. (Chinese participant)

There were a few Korean participants who deliberately chose New Zealand care providers on the basis that Korean was not necessarily better:

Many of you say good things about Korea, but the fact is it is not so. Wherever it is, there is good hospital, good doctors and it also applies here in New Zealand. (Korean participant)

However, a Korean participant who had chosen a New Zealand LMC stated she would use a Korean midwife in the future, not because of the language issue but because fellow Koreans were more caring and understood Korean bodies better than a New Zealand LMC would:

I chose a Kiwi midwife even though I knew I could choose a Korean one. However, I would go for a Korean midwife if I have a baby again for the reason of the caring minds of Koreans, not because of the language. The Korean midwife may have better knowledge of our body structure. I suffered from mastitis seven times in three months. I was in a great pain, but [the Kiwi midwife] didn't understand that. (Korean participant)

Another Korean participant expanded the definition of caring to include pampering, sincerity and sympathy:

Next time though I think I will choose Korean midwife. I want to be better looked after in a pampered way. It is important to me to feel understood and cared for with sincerity and sympathy. (Korean participant)

None of the Indian respondents chose an LMC on the basis of language and culture. Of more importance was friendliness and continuity of care:

The responsiveness and experience does count but at a time when you are really selecting a midwife, it's important that you select someone who is recognised, someone who has the link with the team who is going to handle you during your delivery, they have some contacts in the hospital. (Indian participant)

In contrast with the Korean, Indian and Chinese participants who used their networks, a European participant 'cold called' LMCs from the telephone book, which made the process depersonalised and somewhat random:

My initial problem was actually finding that midwife. I didn't know how to go about finding; you can look in the Yellow Pages and pull a number out. I rang up a few but I didn't get a response back. And because at the time I didn't really have that many friends who had babies, so again you haven't got anyone to consult who you know. (European participant)

4.1.5 Satisfaction with care

Satisfaction with care was linked with the perceived expertise, competence and knowledge of the health provider. Participants were disappointed with health service provision when their LMC was not familiar with resources that might be available, or when they were kept waiting, or asked the same questions multiple times. This is likely to be true of all pregnant women and not necessarily specific to these migrant groups.

A Korean participant wanted to recreate a social network that could provide support and information. She was perplexed by her midwife's lack of knowledge of resources in the community and her assumption about the size of the Korean community was inaccurate.⁵ The desire for knowledge about rights when accessing healthcare services is a significant aspect for migrants (DeSouza and Garrett 2005). Being able to compare the different aspects of both her country of origin and New Zealand would have been a useful mechanism for sifting out and processing what was useful about both:

If it was in Korea, I could share my experience with my friends or other mothers. When I had my first baby, I enquired about the Plunket group for the Chinese mums, which I had heard about, but my midwife didn't know much about it even although she was aware of it. I tried to gather some information on a Korean mothers' group, but there was nothing. There was a Korean helpline only. There are as many Koreans as Chinese here, but no network to share information. It was a shame not to have such a group to discuss our rights and the good side of both countries. (Korean participant)

The perception of an LMC not being sufficiently informed was extended to the New Zealand health system. This was seen as inefficient by an Arab Muslim participant who noted that many appointments with health staff seemed unnecessary, with long waiting periods and the repetition of previously obtained information:

Sometimes, the visits are a bit of a nuisance. You needed to have a bit of patience with them. They'd give you a 10am appointment but not see you till 11.30 or 12pm. When I was pregnant with my first son I wouldn't be that annoyed but when I had my other children and I had to take them, they would be such a hassle. Their service was good, but you had to wait for a while. Unless you tell them you're in a hurry and have other things to do, then they may speed your processes. Some appointments were unnecessary, they just repeat the same information that the GP or midwife would have probably told you before. Sometimes the doctor gives you that impression – 'What are you doing here?' – you know. (Arab Muslim participant)

The notion of health professionals being surprised to see the woman and not knowing her health needs or history was echoed by several participants, who found that continuity of care was poor. They were annoyed by having to repeat information about themselves, as well as by the reliance on notes, rather than what the women were presenting with. This finding is probably not specific to migrant groups or to pregnant women:

I'm really happy about the services that we get in New Zealand but there are also some loopholes in here. For instance, whenever you are sent to the Greenlane Hospital for the visit to the doctors, the doctors are surprised at why you are visiting them, like they don't have the notes, though they are in the file but they don't read them too early and they just take you in and they ask 'How can I help you?' you know? And then they are wandering through the notes, whether whatever you are going through is written there or not. (Indian participant)

5 The Korean community makes up only 8 percent of the Asian population versus the Chinese who make up 44 percent of all Asians. Koreans were the fastest growing of the top 50 ethnic groups in 2001, numbering 19,026, a percentage increase of 1,946 since the 1991 Census (Statistics New Zealand 2005).

However, another Indian participant felt she was being informed with regular communication from her health provider about her own health status:

I was a diabetic patient and so I was sent to National Women's where I was taken care of very nicely. I still am surprised that they took so much care of me. They used to call me two days in a week and tell me what's going on with you. (Indian participant)

Feedback from many of the Arab Muslim mothers was positive from the point of view that staff were accessible and in regular contact. Many of the Arab Muslim participants felt that they were a priority, that staff appeared competent, that the timing of care was good and communication was effective and encouraged to be a two-way process:

You know, this is the only country that I have experienced which provides such care for pregnant mothers. They care for you. As a pregnant woman you have such priorities. (Arab Muslim participant)

These findings reflect other research findings which show that dissatisfaction with antenatal care is associated with insufficient number of antenatal visits, long waiting times at appointments, lack of continuity of caregiver and of care content, and lack of information and explanation. In addition, factors associated with satisfaction with care providers are clinical and technical competence and friendliness (Hildingsson and Radestad 2005).

4.1.6 Antenatal classes

Women were prepared informally for childbearing and childrearing by other women and through living with extended family members such as aunts and grandmothers and learning from practical experience of assisting with childrearing (Ho and Holroyd 2002; Renkert and Nutbeam 2001). Over time, changes in family structure, participation in higher education and the workforce, as well as the increased medicalisation of childbirth, have led to an increased dependence on formally organised antenatal classes for the development of knowledge and skills. The advent of formal antenatal education in the West was in response to the desire to improve antenatal care and maternal-infant outcomes in the early 20th century. Antenatal classes are thought to fulfil three key aims: provide information about the process of and choices for labour and infant feeding; an opportunity for women to develop peer networks that are supportive; and to help women to learn skills to cope with labour (Spiby, Henderson, Slade, Escott and Fraser 1999). Classes also assisted husbands:

When you know something it's better than just going without knowledge and you're worried. Yeah and as a first-time mother I didn't really know what was going to happen or what to expect and then, yeah, I learnt a lot from that. (Indian participant)

And for gaining confidence about what was to come by having some broad knowledge:

I felt it was not so relevant to my delivery. But I felt more at ease and more confident during delivery. There are Chinese people in the class. The midwife was also careful when teaching us. We could understand her. My husband's English is very good. He escorted me to the class. It was about some basic ideas. I didn't find it useful for my delivery. During delivery, you follow the instructions of your midwife and have no time to reflect on what was taught in the class. But you feel relieved and less anxious. You roughly know what is going to happen and what is what. (Chinese participant)

I never went to lessons as such for my first child, I was too preoccupied, but then even with my second child, I already had the experience, so that helped me. (Arab Muslim participant)

I went to a lesson about the types of anaesthetics and things like that, and it was quite useful. I was worried about the epidural. But then things were clarified in that lesson. (Arab Muslim participant)

Classes helped partners to engage with the pregnancy and coach their wives:

The fact that my husband whom I can trust most listened to everything in the antenatal class was a big help, as he could take care of me. The video even showed him how to massage me on the back when I am in labour. It was a great help that my husband understood everything and explained it all to me. (Korean participant)

But language barriers made classes inaccessible for some:

I felt frustrated because I could not understand everything. (Korean participant)

Both my husband and I have poor English so only attended once. (Korean participant)

Many women from the European group attended antenatal classes, unlike women from the other migrant groups who found that there were barriers such as lack of English proficiency, lack of transport and lack of childcare:

I found the antenatal classes were excellent, very informative and I think a lot of the success of the class was revolved around who was in the class as well. ...we had a great crew. (European participant)

This resulted in women developing a support network which they maintained throughout their pregnancy and in the postpartum period:

We had a great group of people and we learnt, and we interacted really well, and we've met up afterwards and all kept in contact with each other. (European participant)

This meant that they had support throughout their pregnancies from a new peer group:

Well, it meant that you had continued support until you actually gave birth and what was really good was that we were all due I think it was within 10 days to two weeks to each other. And so the first two went into labour on the same day so you got that feedback on how everything had gone and what went well and what didn't go well. (European participant)

This section highlighted the information needs of migrant women, who were unfamiliar with the New Zealand health system and separated from knowledge resources such as family and friends. Information was needed in order to be able to make decisions and this process began as soon as a woman became pregnant. The information gap meant women had to take more responsibility and become more informed. The space created by being away from family and friends led many men to become more involved in their partner's pregnancies than they might have in their countries of origin. The importance of receiving detailed and specific information in one's own language was highlighted. For many of the Asian participants language proficiency and cultural needs (such as an understanding of culture and gender matching) influenced the choice of LMC or attendance at antenatal classes. For women and their husbands who wanted to take an informed consumer role there were resources available which led women and their husbands to be more self-sufficient, proactive and engaged in the process. In the absence of family and peers who are traditional sources of information about maternity, antenatal classes have the potential to fill the knowledge gap. Women identified continuity of care, feeling nurtured, having regular contact, professional expertise and knowledge of community resources as key influencers of satisfaction with care.

4.2 LABOUR AND DELIVERY

Labour and delivery were a time when information, support and cultural needs were especially important. Women wanted information that was specific to their stage of labour and that was individualised (some felt they had too much and others too little information to feel that they could make the best choice for themselves). Women felt most supported by the advocacy and discussion of natural birth promulgated by midwives and where there was continuity of care. Cultural needs also came to the fore for many of the participants, in particular the Korean participants, who struggled to incorporate their traditions and rituals into institutional care and felt that there was not only no room for cultural practices but also that they were discriminated against. In addition, many women were very anxious about labouring on their own and felt like they were made to wait too long at home which

resulted in them feeling traumatised⁶ about their births. The issue of lack of family support was raised. It was felt acutely by some participants but was not an issue for others. However, the absence of family members created a space for husbands to be present for the birth which may not have been possible in their countries of origin.

4.2.1 Information needs

Having good information made women feel confident about the process and helped them develop a trusting relationship with their LMC:

For me, the midwife was with me, she explained to me so well the best way to give birth. Like, what is delivery, if it were natural or Caesarean, what types of pain relief could I get. So you can say that I went to the delivery room with confidence. The main thing I kept in mind was that I trusted the midwife. That was the most important thought that helped me a lot actually. And thanks to Allah, my delivery was very easy, both of them. And that is why I was actually quite encouraged to maybe have another child, God-willing. (Arab Muslim participant)

A South African participant was happy with the information she was given verbally and in written form and, in particular, having the right information at the right stage of her delivery. In addition, the fact that her midwife understood her cultural context was also significant:

The midwife who delivered my baby is from New Zealand but she worked in Cape Town for three years so that was good, that connection and she told me, you know, she told me step-by-step where and what stage I'm at. I think that's the biggest support that you really need in the delivery room is to tell you at what stage you are at and what's happening. (European participant)

A Korean participant stressed the value of specific stage-by-stage information, rather than broad encouragement:

In Korea mums are given lots of warning and feedback of what is happening during labour, and told by doctors what to do regularly. This was missing in New Zealand. When I rang up the hospital to say I was having contractions and that I wanted to stay in hospital, I was told to go home. By the time I made it into the hospital I was already five centimetres dilated. It would be good to be given feedback of our progress of labour and how many centimetres we are at each stage after the vaginal examinations. I was not told this. Not enough explanation and only told that 'You are doing well'. (Korean participant)

The need for not only specific information but also to be told the best option or given enough information to make the best choice was also voiced. The facilitative role of health providers was called into question with some participants wanting a more authoritative role. The partnership between the midwife and the woman underpins the midwifery model in New Zealand maternity services and is based on equity and the acknowledgement that both parties make equally valuable contributions. Midwives bring their knowledge, skills and experience, and the woman brings her knowledge of herself and her family and her needs and wishes for her pregnancy and birth. According to Tully, Daellenbach and Guillard, midwifery practice has shifted from authoritative models to partnership and collaboration, to both empower women and to distinguish midwifery from the more hierarchical professional models of medical, nursing and obstetric practice. However, partnership rests on consumers who are informed and want to be informed and requires several factors to come into play:

In New Zealand different delivery options are given to mums and we are asked to choose by ourselves but unable to choose the best options for ourselves due to lack of sufficient knowledge. Want more advice and guidance and even want to be told which better option for us is. So in the end we have limited options due to not enough knowledge of all the pros and cons of delivery methods. (Korean participant)

6 Approximately 1.7 percent to 6 percent of women develop Post Traumatic Stress Disorder (PTSD) following a traumatic childbirth experience. Common experiences include physical pain, not being heard, powerlessness and loss of control.

The theme of the need for information to be individualised and culturally appropriate arose in the antenatal period and is revived here in the feedback from an Indian participant, who felt that she was given too much information:

During the labour the ladies said that I need an epidural because I can't go through the pain anymore. The anaesthetist comes in the room and says out of 150 million there are 10 percent of cases with risk, all that information beforehand. (Indian participant)

4.2.2 Natural birth versus medicalised birth

A common midwifery assumption about childbirth is natural childbirth which assumes that pain is a *natural* part of birth and that, with the right attitude, preparation and reassurance, women can control and manage that pain without chemical pain relief (Dick-Read 1933, 1959; Kitlinger 1964; Lamaze 1958, 1984). A competing medical view is that pregnancy and birth are a potentially pathological time where something could go wrong. The idea of natural birth was taken up by many of the participants who found the experience of childbirth easier and empowering in New Zealand, and for one participant this experience gave her the confidence to consider having another child:

In New Zealand women use no pain relief. I had my child delivered with no pain. So I have been thinking childbirth is such an easy thing. I may take into account to have one more baby. (Chinese participant)

Others appreciated the different philosophies between medicine and midwifery, which meant that intervention was minimised:

I have found the doctors force for the Caesarean and the midwife goes for the normal but I think the midwife prefer normal delivery, they want normal only by any chance and doctor, if they find patients in trouble and things, they just advise for the Caesar. The midwife goes for normal and doctor goes for Caesar. (Indian participant)

I had my labour pain and my midwife was fighting for me for getting normal delivery and the other doctors were just forcing my midwife to make it Caesar because I was in a bad pain and after the baby I really feel like it's good. (Indian participant)

In comparing the advantages and disadvantages of both countries, a Chinese participant found that although she would have had more support in China from family members, the experience of labour and delivery were more satisfying in New Zealand:

In China I have many family members around me. I didn't need to cook after childbirth. But here the labour and delivery are more comfortable. Although I had C-section, my feeling is quite good. I don't know why. I had 10 hours of labour in China. The doctors complained to my husband that why your wife was so bothersome and what on earth she hadn't had delivery yet. In here the situation is much better. (Chinese participant)

One of the Arab Muslim participants expected a whole staff of doctors:

But I was surprised to find only the midwife with me. I probably thought that delivery is such a huge thing that requires more than one person there, you know. (Arab Muslim participant)

The experience of a natural birth versus obtaining a Caesarean arose for an Arab Muslim participant:

I trust them, I believe in them. Thanks to Allah the baby was normal. They were trying to calm me, and things like that, and they were preparing me for the operation. I was dressed for a Caesarean. Everything was prepared. But their first choice would be a natural birth. I trust them, I believe in what they think. (Arab Muslim participant)

These competing philosophies of childbirth had material effects, in that participants felt caught in the conflicts between the various groups involved in maternity care:

During labour and that thing is not good here, like during labour we are dependent, we want to be dependent on some doctors or midwives but some of them used to fight with each other only and some of them will not attend to you. (Indian participant)

4.2.3 Continuity of care

Continuity of care refers to care provision by the same caregiver/s throughout pregnancy, labour, delivery and postpartum. A recent Cochrane review found that there were clear benefits for women from continuity of care during pregnancy and childbirth. In particular, women who had continuity of care by a team of midwives experienced a number of events, including being more likely to discuss antenatal and postnatal concerns, attendance at antenatal classes, birth without painkillers, saying that they were confident and felt well prepared and supported during labour, and prepared for infant care (Hodnett 2000). Continuity was identified as a key factor in feeling prepared by several participants and played a part in how happy participants were with the care that was given:

I had an independent midwife and I had an obstetrician as a stand-by in case of any complication I had so I was all prepared with my, you know, antenatal classes and all the advice and all that and then I never got a labour, I was induced, so ... so I was in the hospital and my midwife was with me from the beginning to the end and no one else was there only my midwife and the specialist was coming and checking every time and going and saying 'Yep, it's all good' and I had a good delivery as well, so I never had any other outsider people come in or changing over of midwives or anything like that. (Indian participant)

Others were unhappy with the continuity of care that they had experienced:

Yeah, I mean she was there, she was all the time there monitoring the baby's heart and all but when the time came out to push him out it was some two different people who were there and they just put their hands up and they said 'I don't know how to handle it' you know? (Indian participant)

For some, the issue of continuity of care also related to the reading of notes and finding out information:

I feel is that it's very annoying, you know, once you are going into the labour, you have handheld notes with you. Why can't they read that notes and see what is the case instead of asking the woman who's going into labour? It's so painful actually that you are going in that trauma and you are having heaps of pains and still you know they're annoying you constantly with questions. (Indian participant)

4.2.4 Cultural needs and caring

Migrant mothers often hold parallel beliefs from both their home culture and their receiving culture. However, migrants also want to fit in and are in turn expected to 'assimilate', especially by health providers in the context of health (DeSouza 2005). Many of the Korean participants felt forced to compromise between their home cultures and receiving culture. Practices from their home culture, such as keeping warm, eating special food and being nurtured, were difficult to maintain in hospital. Eating not only the right food but also the right quantity of food was very important, but the hospital was not flexible about the provision of food or staff were not supportive of people bringing in their own food:

I'm not picky with food and I still enjoyed food even after giving birth. The Kiwis said that the food had all the nutrition, but the portion was too small for me. Kiwis probably eat the same thing, but how would I produce milk with a portion like that? They gave me the same amount of food (it was sort of watery...) as if I was an ordinary person, and it wasn't quite enough. I couldn't bring my own food under the circumstances, and didn't want to bother the other mums with the smell of my own food – when I had my first child, the nurse had told me off for the smell. In both children's birth, I had to share a room with another mother, as there were too many patients, and the midwives showed an obvious sign of dislike. They even said to me if I had 'brought fish'. This experience after my first child put me off from bringing food again – this is why I was hungry. (Korean participant)

Migrant women were also caught between current practice that encourages women to be independent with mothercraft as soon as possible (through rooming-in) and traditional practice that supports the woman having a period in which to recuperate while being attended to by family. To some degree this was once the case for all New Zealand women but has changed over time with the introduction of 'rooming-in' which was established to promote early and continuous contact for mother and baby,

prevent separation and enhance attachment and breastfeeding (Enkin, Keirse, Chalmers and Enkin 1989). However, a study found that when women were asked about hospital routines that were difficult for them, the practice of rooming-in was found to be their major concern (Rice 2000). They did not like the practice and felt that the policy did not meet their cultural needs, because they perceived that postpartum rest was crucial for physical and emotional wellbeing. Not taking proper care of oneself after one of the most vulnerable periods in a woman's life would result in long-term health consequences. For many participants, this led to unmet expectations of being cared for:

I had to take care of myself. Before I gave birth I had to go to the toilet very often. Because of the pain, I couldn't manage to wear shoes so I was bare feet. Because of this, now I have sore toes and my thumbs are stiff in the morning. I gave birth at 1:30 and went home the very next morning. I just did not want to stay in the hospital. I had heard that the nurses were not very kind. I just hated being there. It was so inconvenient and I just wanted to go home and keep myself warm. (Korean participant)

Instead they felt that they were treated unkindly and like the baby was more of a priority than the mother:

I said I wanted to go home, as nobody was available to help me. The nurse's care was only limited to looking after the baby when I was eating. Isn't it chilly even in December? It was cold for me as the windows right next to me were open. But my attempt to shut the window ended up with a grumbling nurse opening it again while I took a short break. (Korean participant)

Several participants felt as if they were left on their own to manage with their babies:

It would be nice if a nurse could help me. Even though I rang the bell the nurse didn't come. I was changing my baby's nappies and [s/h]e wet the bed. I was sore all over and I rang the bell but a nurse still didn't come. So I took the baby to ask a nurse for some nappies, but the nurse only told me where it was and left me to do it on my own. Although I requested several times for help, they took one glance and left. Nurses weren't much of help. Even if I'd stayed another night, they wouldn't have been much help. (Korean participant)

4.2.5 Support

The expectation of attentiveness and 'endless care' that is typically received from extended family (Shin and Shin 1999) can be lost in the process of migrating, leading many women to expect it from their caregivers. The same could be said for mothers in general as there is frequently a mismatch between the help new mothers expect and actually get:

The thing is that back in India we have our families and extended families so that in India we are prepared for the whole thing, emotionally and whatever but when we are in this country, we are looking out or trying for that emotional support and since our extended family is not here, so we are trying to get whoever is coming first in that field, the doctors or the nurses. (Indian participant)

Increasingly, consumer satisfaction with healthcare is associated more strongly with communication skills and interpersonal interactions than with staff's clinical skills (Baker, Choi, Henshaw and Tree 2005) and, for many Korean participants, poor communication led to feeling mistreated and offended:

I rang the bell to call the nurse, and when the nurse came, she sounded annoyed and sarcastically asked me if this was my first child and why I acted like it when it was my second one. I understand that there were a lot of people, but from the way the nurse was treating the Kiwi lady opposite me, I felt very mistreated as I could sense the differences in her attitude. (Korean participant)

Yes, the way she was talking was so different. It was because I was tired, but the nurse thought I could not understand her. She treated me like a child. Although she called me by names such as love, sweetheart and honey but it did not feel like they really meant it. They must have thought that I didn't know. The attitude towards me was different and so were the contents of the conversation. It was beyond description... I was too upset, offended. (Korean participant)

In contrast many of the Arab Muslim women were full of praise for the quality of care that they received from midwives and nurses:

The most important thing was that they gave you drugs to ensure you did not feel the pain. I was really grateful for that, it made those labour and delivery moments bearable. I realised it was such a different experience when I compared giving birth to my children at Arab countries, from those who I gave birth to in New Zealand. They both were pleasant experiences here. (Arab Muslim participant)

I mean, I saw the care, the consideration ... you know, in the hospital, that you are something special, to the point that they bring the wheelchair to you, or to the car. She'd tell me, 'Save your energy'. So that was a very nice thing, so I wasn't worried, no problems, I had no concerns [laugh]. (Arab Muslim participant)

An Indian participant and an Arab Muslim participant found their midwives maternal and caring:

Especially the midwife I had, Jenny her name is, but she acted like my mum, my mother, not my mother-in-law! Jenny, she was wiping my face and everything, like I felt like my mother was standing next to me. (Indian participant)

I'll tell you something, when I gave birth, my first child especially, I didn't know what to do when it cries. The nurse would take him, and say don't worry, I'll get the spa ready for you, you sit in the spa and we will take care of him. So she would then take me to the spa, towels are ready, a flower on top of the towel, and a drink, because she said the water is hot, so we don't want you to dehydrate. To the extent where I felt like I was the Queen. (Arab Muslim participant)

These findings suggest that migrant mothers value clinical competence and good communication and have expectations that midwives are caring and understanding. However, having access to mothers and family members was still important:

Well, it was really hard for me because I'm quite close to my family, but I think you know it's the same thing when you have your family, there are other issues but I really felt that I wanted that support. I never wanted my mother in the room and she would never want to be in there, but I wanted her around. (European participant)

Some participants disagreed that family support was necessary and in some cases could be an added burden:

They gave you more trouble while they helped you. Without them you can concentrate on looking after the child. Since she had come, you had to show her around. You couldn't ask her to stay at home every day, right? The child was so young, but you had to carry her to many places every day. I was completely worn out. Besides, our views of looking after children are different. She said you shouldn't have a bath. Is it possible that you don't have bath? Not possible. They said you shouldn't eat cold food. At least you can eat some fruits. If you don't follow their instructions, they felt unhappy with you. (Chinese participant)

My parents were actually here for the birth and I actually found that stressful because I was late and they were having to extend tickets and things and that actually put more stress on me which is a terrible thing to say. The fact that they were here put more pressure on me than anything else because I eventually opted... I mean I went in to get induced and the midwife sort of said, 'Look you're going to go yourself tonight anyway really, you can go home.' But I was like, 'Look I'm here, this is Thursday my Dad goes home on Sunday you know I'm under pressure to produce here.' (European participant)

4.2.6 The role of husbands

The 'new involved father' constitutes a standard or benchmark (Lupton and Barclay 1997). In contrast with the past, fathers are expected to participate in antenatal classes, labour and delivery. For many migrant mothers, the absence of other family members led to many partners and husbands participating to a greater extent. In some cases, fathers provided a barrier against what was perceived as motherly interference or provided the care and support that an ideal mother would have provided:

Having my partner there who I trusted to make those decisions for me was really helpful. My mum was there unfortunately, and part of my partner's duty was to keep my mother out of the room 'cause she wanted to be there so badly and at the end of the day my midwife would basically snap at my mother and said, 'My concern is for your daughter and you have to go into that waiting room and stay in there until I come and get you.' (European participant)

My husband was there and all I remember is I didn't want to be on my back, that was the main thing. I could be in any other position but not on my back and I ended up being in this position just reclining. And my midwife was holding my one leg and my husband was holding the other one, he was like my midwife, she was looking at him and he's saying, 'go', and he's just repeating and I had such a positive experience with him being there. And I was happy that he was there. My husband faints at the sight of blood. I was, 'Oh my God I'm going to give birth on my own, my mother's not here' but he was amazing. He actually watched her crown, he watched the whole thing because there was just the midwife and my husband. And he cut the umbilical cord and he was just absolutely amazing. It was like, wow, my husband's new, so he was my biggest support really. (European participant)

For the Muslim women in the study, having husbands attend the birth in New Zealand added to their wellbeing as this was an event that wouldn't have happened in their country of origin:

You feel one main thing, that the pain you're going through, he [the husband] is the cause of it all. And that he is experiencing it with you when he sees you go through it. (Arab Muslim participant)

You reach a point of pain where you just want to hit someone [laugh]. I mean not to beat him up, but to grab his hand or something and squeeze tight on it. I was doing that with the bed sheet, the doctor said, 'That's our bed sheet, hold onto your husband' [laugh]. You truly sense that he is sharing the painful experience with you. (Arab Muslim participant)

My husband insisted to be there, though he has diabetes. We initially thought I would have a natural birth, but then it turned out I had to have a Caesarean, so I told them that when he comes, don't allow him in, he is ill, but he insisted on being there with me. He was so patient, then when they got the child out of me, he fainted [laugh]. I told him, 'I am awake and you're not!' (Arab Muslim participant)

Views of participants varied in terms of their perception of being cared for during delivery, with women valuing continuity of care, being provided with information relevant to their stage of labour and delivery, and being able to have their husbands present. Women also felt more cared for when their cultural needs were considered during and after delivery. The discourses of natural birth were well-received by participants and whether family members were present at delivery had mixed reviews.

4.3 POSTPARTUM

The postnatal period is a critical time for women but it is also a time when their needs are often not met (Baker et al 2005). A key issue was that of breastfeeding, with many of the women identifying a lack of advice and support, and negative attitudes of health professionals in relation to infant feeding, especially when it came to bottle-feeding.

Similar themes arose again, such as information issues, being isolated with no one to help, lack of support for their cultural needs and the emphasis on breastfeeding at the expense of other options.

Many women felt that postpartum there was a focus on the baby rather than on the mother and that there was an expectation of a rapid return to life as normal for many new mothers. Such a focus does not recognise the vulnerability and special status of new mothers:

I had C-section in delivery. They gave a lot care and attention to the baby. However, they gave little care to the mother. I was very anxious but I had no idea what I should

do about it so I had to go back to China. I feel there is language communication problem. They gave less care and attention to mothers. (Chinese participant)

In New Zealand babies are well treated. However, in treating the mothers, what should I say? Because local women do the same – after delivery they do the same things like other normal people. They feel they don't need to give care and attention to mothers. (Chinese participant)

Even though there are a lot of impolite hospitals in Korea, the mothers are always the main concern, as the baby will survive anyway. Aren't there nurses and other family members to look after the baby anyway? They give you warm water and Seaweed Soup⁷ and keep on checking you. Here, they abandoned me with my baby. (Korean participant)

For many women, the main focus of their energy had been on the labour, and for some the postpartum period was overwhelming:

I just want in say in terms of thinking after the birth, and how it was compared to expectations, I didn't really have any expectations of after the birth, everything was concentrated about the labour and, 'Oh God, it's going to feel terrible' and after the birth it just hit me like that and it was hell for six weeks more or less, it was just hell. (European participant)

4.3.1. Information needs about infant care

In the postpartum period, information needs also became apparent. All new mothers need to know how to handle an unpredictable and unknown baby, as well as managing infant feeding. However, there were also cultural variables related to feeding culturally-specific foods and receiving information in an appropriate format that were identified:

I didn't even know how to care for her after delivering baby. No knowledge. Had to cook and clean and do everything after delivering baby; had no one to help. Breastfeeding was hard; received no help. Got sore bones and joints. No Korean-appropriate services available, so often missed out altogether on information and the right kind of help. (Korean participant)

The baby is a small, strange creature, who you are now responsible for. How are you going to feed him, or know when he's hungry? If he cried, how would you know what is wrong with him? You feel as if he's an outsider, not someone who was inside of you. But with time, you feel ... you learn. You're its mother; when it cries, you know what is wrong. You may not believe it now, but you feel the child speaks to you. You're the mother. (Arab Muslim participant)

However, not everyone wanted to be an informed consumer:

Yeah, you just want to get out of that place and these people are giving you, like, the advantages and disadvantages of various things. You don't want to hear all these things. (Indian participant)

Others thought it was just right and appreciated the access to written information:

That is a good thing too. There are always pamphlets and information to help you become aware of different matters. I read booklets they provide for us, from page to page. How to change them, how to know things, it explains things to you step-by-step. (Arab Muslim participant)

4.2.2 Infant feeding

An important theme in the postpartum was the inconsistency of advice about how to breastfeed as well as a lack of information about bottle-feeding and when to introduce solid food. Many women felt pressurised to breastfeed in the absence of support systems:

Inconsistency of advice from nurses on breastfeeding was difficult while in hospital. Would have liked more information on options of feeding. No one advised me about bottle-feeding. (Korean participant)

7 A nutritious traditional Korean food rich in iron and minerals.

I found that... I had a Caesarean section and I found the information that I was getting from the nurses and the midwives on the Tamaki ward was quite conflicting. (European participant)

There was a lack of information about bottle-feeding as an option for those who were considering a return to work:

I'd like to say is that encouraging breastfeeding is good but I would've liked some information on formula as well. The baby was hungry but I couldn't give [him/her] any milk. They said that they give formula only once. There was no information. In three months' time, I had to go back to my work so I asked them what kind of formula was best, and they replied that it was illegal they recommend one and that I should just choose something at a supermarket. (Korean participant)

Some women felt that breastfeeding was a real pressure for them and midwives provided less advice and support than was needed. Inadequate help from midwives has been found to be a key reason for discontinuing breastfeeding. A theory for why breastfeeding rates among immigrant groups are low compared to the local-born population is that breastfeeding is strongly ritualised and influenced by culture even in the context of a new socio-geographical space and that elements that sustain breastfeeding are lost in migration (Groleau, Souliere and Kirmayer 2006).

One participant attempted to utilise the internet to get the information she needed. A study about breastfeeding information on the internet (Shaikh and Scott 2005) found that most breastfeeding websites surveyed provided accurate information and complied with the international standards, with half complying with medical internet publishing standards:

Here, the midwife talks about breastfeeding as something much greater than what I've known. So it's a bit pressurising. Breastfeeding ... my breasts wouldn't produce any but the baby keeps sucking so it hurts and bleeds. Apparently, you have to persevere. The midwife came for once a day only, but I had many questions. There wasn't anyone else I could ask about breastfeeding. I searched the internet and it seems many young mothers in Korea breastfeed their babies, and in some cases, biting on towels to ease the pain. This was some comfort to me. Only breastfeeding and no formula milk is called 'WanMo'⁸ which gave me hope. (Korean participant)

Many women wanted to know about when to introduce solids and specifically food from their own culture:

We need more information. Iron deficiency for example. We don't know what to feed our babies for this. And solid feeding too. We don't know how to begin solid feeding with Korean food. The information is only on Kiwi way of feeding. (Korean participant)

4.2.3 Lack of family support

Being away from family was difficult for many reasons, such as not having someone to help. For the Muslim women it was mostly about not being able to share their happiness:

Seeing the pride and joy in the eyes of my parents. Yes, I wanted to see the happiness in their eyes. I was deprived of that, I could hear it on the phone, but I couldn't see it. (Arab Muslim participant)

You know, I think our need for our family isn't merely to help you raise your child. No, but it's the moments, when you feel you want sometime to share your happiness with, or look what the baby said, what he did ... or someone to give you half an hour of rest. (Arab Muslim participant)

Trying to contact family was also difficult whilst in hospital:

Yes, you know, whereas for people here it's just the cell phones, everyone had cell phones, but I found there was quite an ethnic community and all of us were like, 'Oh, hi, waiting for the phone you know', just looking for an opportunity to call home whereas it would've been very easy if I were a Kiwi and all my family were here, just have your

8 Abbreviated Korean word meaning purely breastfeeding.

cell phone, but I found that that was a huge hardship on me, the fact that I was from another country, that there wasn't that availability. (European participant)

4.3.4 Loneliness and isolation

Many of the women found that once their partners went back to work and mothers had returned home, that the reality of being a migrant mother hit them. In particular they missed old friends and peer networks that would have provided support and reassurance:

To be honest I developed this psychological problem. I wouldn't eat or drink, I would just cry. Because of the loneliness here, I had no one. (Arab Muslim participant)

While many of the European women had developed new networks through antenatal classes and appreciated being able to talk to adults, they missed having close confidants in the shape of their old friends with whom they could have compared notes:

It would've been different in that I would've had a lot more support and for me a lot of my anxieties around that was I didn't have anyone to talk to, and particularly (baby crying). And yes, ok, you meet people at your antenatal group but at that time they're not your closest friends that you can say anything. (European participant)

You do miss the support network, friends as well, as I've got a lot of friends back home who have got kids and I think you miss that as well. I think that hit it home for me was that how alone I was and I really needed somebody and that was hard. (European participant)

4.3.5 Developing self-reliance

As a result of pushing themselves through language barriers and not having support, many women appreciated their ensuing growth and self-reliance. Others would have preferred the help of language-specific services:

To be honest, my language was strengthened as a result of me discussing things with doctors, etc. You talk about things that you never knew you could express, just to ensure you're expressing the feelings, the pain inside, so they can help you. So I personally think my language developed. (Arab Muslim participant)

Yes. I compare myself to my sister who had my parents around her during her delivery. I realise that because of my experience that I am stronger than she is. (Arab Muslim participant)

I think that would be better if every service department can have a Chinese speaker to provide service to us. (Chinese participant)

4.3.6 Religious and cultural needs: Food and privacy

Food was an important aspect of the postpartum period. Previous research has found that pregnancy and birth are marked by nurturing and celebration of women who are to become mothers. This nurturing is expressed through the giving of special nourishing foods which are prepared by other women to return the body to balance (DeSouza 2005):

For the hospital food, if you have been here for many years you feel ok with it. At least its nutrition and energy are enough. If some Chinese people don't like the food they can have some more soup of their own. (Chinese participant)

I felt like I was the Queen. The food ... of course because we are Muslim, the food was vegetarian, but the best vegetarian meal ever. (Arab Muslim participant)

For some this led to conflict between old and new traditions and the possible risk of incurring family wrath and the potential to alienate traditional and new authority figures. One Chinese participant took the notion of assimilation to heart and threw herself stoically into the New Zealand ways of doing things:

I gave birth at 9pm. As soon as I had the childbirth someone asked me if I wanted to have ice milk. I said I just had childbirth, I shouldn't have ice milk. But everyone just had it. I then did as the Romans do. I had the ice milk. But I dare not tell my family about this. On the first day I was not able to get out of bed. On the second day I had to wash myself as usual. In my hometown I won't be allowed to use cold water. But in here the water is lukewarm. I thought, never mind. The Kiwis act in this way and then I can also do like them. In the recuperation month following childbirth no one helped me. I cooked by myself. I didn't feel it was a big deal. (Chinese participant)

4.3.7 Lack of privacy

One of the Arab Muslim women found that the lack of privacy during her hospital stay was difficult in terms of her religious needs for modesty. The arrival of a doctor with a team of students, who gave her no warning of their arrival, caused a problem:

I initially gave birth at the National Women... yes and it was not a pleasant experience to be honest. Four in the room, and I also told the staff later on that there was something that wasn't nice, which is that they did not respect Islam. The doctor, with a team of med students, would just instantly come and in no time open the curtain and not allow time for me to wear my hijab. (Arab Muslim participant)

Only after complaining to the head nurse did things change and notes were made in her file to ensure that 'women only' cared for her. Other Arab Muslim women were more fortunate with being given a room of their own and further away, without needing to ask for it:

No, they just automatically gave it to me, and I was so comfortable, I was sitting there without my hijab. (Arab Muslim participant)

The lack of privacy made it difficult to manage a crying and unsettled baby:

My first child was born in National Women's. After delivery I ran to the toilet and cried there. I felt I sort of had postpartum depression. My baby was crying. Once I put her back on the bed, she started crying again. I felt embarrassed 'cause four people shared the room. These mothers are very experienced as this is their second or third baby. Their babies were quiet. But my baby kept crying. Others couldn't sleep because of her. At 3 o'clock in midnight I pushed her to the baby's room. Only the mothers who have C-section are allowed to leave their baby in the baby's room. It happened there was a Chinese-speaking nurse at that night. She helped me feed the baby. I didn't have a rest until my baby was full. (Chinese participant)

4.3.8. Praise for Plunket

Several participants stated that Plunket had been beneficial in the transition to parenthood process, which is similar to previous research (DeSouza 2005). There was high praise from all the groups about the value of Plunket and the support that they provide to women:

I don't think Plunket substitutes [for family], but it helps to alleviate. I mean, the nurse may be around for a bit, but only temporarily. But it never fills in the emotional role of the aunt or grandmother. (Arab Muslim participant)

After birth we have nurses come and in India we don't have anyone coming and taking care of us. (Indian participant)

The Plunketline telephone service was an effective source of support and information, providing a safety net at all times, as well as providing detailed step-by-step information which was considered very useful:

You can ask the Plunket Nurse anything and she would tell you. Yes, she visits often. I only found out recently from here that there is a 24-hour helpline ... based in Wellington I think, which would help answer concerns you may have. So you're surrounded ... you don't worry. I mean, my husband is away right now, but you know you can handle it. My parents call and say, 'Oh dear, how are you coping on your own?' I tell them there is no problem at all. As long as help is only phone call away. (Arab Muslim participant)

I found the Plunket helpline very helpful. You know, the fact that you could actually call, even though it's hard to get through ...that in the middle of the night you could actually call someone with, and for, information and they actually take you step-by-step what to do. And then finally I just couldn't imagine doing all of this in the US, no I couldn't.
(European participant)

However, one of the participants suggested that midwives needed to tell more women about Plunket:

The one thing that I would like to say is that if there are any midwives who get to hear about this survey make sure that they always make you aware that Plunket is available, that a family centre is available. I knew that there were family centres. I knew the locations but I didn't really know how they could help me. I had a problem with engorged breasts and baby lost such a lot of weight in two days so for me it's been a pretty emotional experience and if I'd just known I could go to the family centres and get checked out it would've helped. (European participant)

This section has highlighted the key aspects of the postpartum period. Many women noted the shift in focus from the experience of the woman to a focus on the baby and physical care rather than emotional support. Information issues, particularly the importance of having consistent information about breastfeeding and introducing solids, were identified. Being able to contact family and see the 'pride in their eyes', and feeling isolated were themes. However, some women were able to push through isolation and language barriers and find a new self-reliance. Issues of culture clash, particularly with regard to postpartum rest, food and privacy, were highlighted and the importance of support available from Plunket was emphasised. The following section now discusses the research findings in more depth.

5.0 DISCUSSION

The preceding section described the key findings across the five new migrant groups through the stages of pregnancy, labour and delivery and the postpartum period. It was evident across all the migrant groups and stages of motherhood that a lack of familiarity with the health system, cultural differences and the need for information that was timely and accurate were important factors. Clearly these findings are applicable not just to migrant women but to many New Zealand-born women as well. The following section discusses the findings in relation to implications for the health system and for migrant women and their families.

5.1 ISSUES FOR SERVICE PROVIDERS

Service providers need to consider how they support diverse cultural and religious needs which could clash with their established ways of doing things within an assimilatory health system. This is especially important to consider when traditional ways of taking care of the self, for example postpartum rest and special food, assist in the maintenance of good health outcomes such as good mental health and breastfeeding. Communication and providing language support and detailed information are also important for women who are not familiar with the New Zealand health system. In addition, providing women with explicit information about how the health system works, as well as making clear the expectations that health service providers might have of them, such as mobilising earlier than they might expect, are important. These are discussed in more detail below.

5.1.1 Accessible and acceptable antenatal education

Antenatal education is an important way in which to develop knowledge about childbearing and childrearing that many women might have received from their family and peers in their countries of origin. Classes provide women and their partners with the tools for managing skills and information for labour and infant feeding as well as providing an opportunity to develop peer networks. If antenatal classes are to be accessed then factors such as availability, accessibility, organisation of services, affordability (in terms of transport and childcare) and acceptability need to be considered. Crucially, antenatal classes are a way of being oriented to the New Zealand health system and forming realistic expectations of healthcare. Research has evaluated antenatal education in terms of maternal satisfaction by considering factors such as increased knowledge and reduced anxiety or good obstetric outcomes (I. Ho and Holroyd 2002; Renkert and Nutbeam 2001). In this study, satisfaction with antenatal classes resulted in reduced anxiety and increased knowledge. In addition, classes assisted women to develop peer networks, especially in the European group, and also helped husbands come on board. However, real barriers to attending classes exist. These include language barriers, trying to settle in New Zealand and not having transport. One of the criticisms of antenatal education is that it focuses on facts about pregnancy, labour and basic baby care skills with discussion of pain management options and obstetric interventions. However, confidence and emotional insights that are gained through informal communication with other women, and the practical experience of childcare in extended families, cannot be attained in the context of a class. Nor can classes prepare women (and their partners) for parenthood while there is a focus on managing decisions during pregnancy and childbirth. A further criticism is that classes are instructional rather than oriented towards empowering women to make informed decisions about their health and the health of their baby (Pairman 2001). In the absence of knowledge resources such as extended families and peer networks, antenatal classes can fill the knowledge gap for migrant women, but those who miss out on classes can potentially miss out on being informed about pregnancy, labour and basic baby care skills with discussion of pain management options and obstetric interventions.

5.1.2 Cultural competence

The findings highlight the need for cultural competence. Cultural competence refers to the ability of systems to tailor the delivery of care to people who have diverse values, beliefs and behaviours, and diverse social, cultural and linguistic needs (DeSouza 2004b). Betancourt et al (2002) suggest that there are three types of cultural competence: clinical cultural competence, which refers to the relationship between health providers and clients; organisational cultural competence, that is strategies that maximise diversity and incorporate leadership and workforce issues; and systemic cultural competence, that is improving healthcare system structures, such as providing health information in the appropriate language.

Satisfaction with care was linked with the perceived expertise, competence and knowledge of the health provider and continuity of care. Participants were disappointed with providers who were not familiar with resources that might be available, or when they were kept waiting or asked the same questions multiple times. Continuity of care during pregnancy and childbirth was a key factor in satisfaction with the childbirth experience. These are factors that are also important for New Zealand mothers.

5.1.3 Supporting cultural needs

There is a need for further investigation about cultural safety, which has been part of the nursing and midwifery curricula, but which has focused on the relationship between Pākehā and Māori (DeSouza 2004b). Furthermore, little is known of how it translates into safe care for new migrants in New Zealand as it has not been evaluated and some would argue that the focus has been on the educational setting (Jeffs 2001). Research is needed on the possible relationship between cultural safety, cultural competence and health or care outcomes (Johnstone and Kanitsaki 2005). The cultural expectation of attentiveness and endless care that is typically received from the extended family of women from collectivist cultures (Shin and Shin 1999:611) can be lost in the process of migrating, leading many women to expect it from their caregivers and partners. Health professionals can play a pivotal role in ameliorating the impacts of the loss of support networks and knowledge resources by assisting women to link with existing resources such as Chinese mothers' groups. Migrant mothers often hold parallel beliefs from both their home culture and their receiving culture. However, many participants felt forced to choose their new culture and abandon traditional practices in hospital such as keeping warm and eating special food. Many researchers support the claim that rituals related to childbirth keep women well (DeSouza 2005; Kruckman 1992). However, most of the resources and structures that are available to support new mothers are geared towards the needs of the majority culture. There is a need to further investigate how health professionals working with new migrant mothers utilise the concept of cultural safety. A key recommendation from a similar study about migrant mothers by Tsianakas and Liamputtong (2002) was the need for improvement in communication between healthcare providers and women. This improvement included not only acknowledgement of language differences, but also cultural appreciation among healthcare providers. Many Korean women felt that they were unable to get adequate amounts of sleep and rest with having to feed their baby regularly. This contrasted with Korea, where the baby is taken away for a bottle feed so mothers can have a sleep.

5.1.4 Communication and relationships with LMC and caregivers

Central to migrant women's satisfaction with care was the issue of having information needs and cultural needs met by caregivers, so that they felt like they had choices and control. This in turn depended on the quality of the relationships between the migrant mother and the LMC and in particular the quality of the communication. The issue of control has been identified as central to the childbirth experience and women's satisfaction with childbirth (Baker et al 2005). For many women who were dissatisfied, factors such as a lack of continuity of care, inadequate information provision, unsupportive care and little influence over decision making prevented them from feeling in control. The choice of LMC was influenced by cultural factors and language proficiency in the case of Korean and Chinese women. Many of the Chinese and Korean women utilised their cultural networks in the absence of peer and family networks to find an LMC who could speak their language. In the case of a few participants, women were prepared to put up with an LMC with a bad reputation rather than risk communication difficulties with someone of a different ethnicity. Participants who did choose New Zealand midwives suggested that in the future they would revert to LMCs from their own community because of what they perceived as their more caring, sincere and sympathetic style. Among many Korean participants, New Zealand LMCs were perceived as not having these qualities. The notion of caring among Korean migrant women would be worthy of further exploration. A possible explanation is the New Zealand focus on being independent conflicting with the expectation of nurturing support. For European participants, the choice of midwife was more random in the absence of peer and family networks, while Indian participants were less concerned about language and more concerned about friendliness and the connection that an LMC had with their place of delivery.

5.1.5 Postpartum needs

Postnatal experiences were generally positive but for some of the migrant mothers, staff on postnatal wards were perceived as unhelpful and insensitive. Many women felt that the baby became the priority and the woman's needs became secondary postpartum. The tension between the needs of the infant and the needs of the mother was highlighted in the area of breastfeeding. Many women felt that there was too much of an emphasis on breastfeeding and a paucity of information on bottle-feeding and the introduction of solid food from their culture. Sarwar (2002) suggests that variables such as socio-

economic and cultural factors, parental age, personality and educational attainment, the infant's birth order in relation to other siblings and the influence of health professionals need to be considered in order to optimise infant-feeding practices. Understanding such variables is important because they impact on both infant-feeding practices and whether mothers will implement health providers' recommendations. Comparisons of infant-feeding between women who have migrated and those who have remained in their country of origin have been made in studies by women in Pakistan and women in Nottingham, England, of Pakistani origin (Sarwar 2002), and by Li, Zhang, Scott and Binns (2005), who examined differences in feeding between women in China and Chinese women in Perth, Australia. Sarwar's study found that although mothers in Nottingham received more information on infant feeding, it was the mothers in Pakistan who were generally more confident about infant-feeding practices. Sarwar suggests that this may be for several reasons, including mothers finding health professionals critical and patronising rather than supportive. Sarwar argues that, in Pakistan, mothers tend to live with their in-laws and receive their primary information and advice from other mothers in the family, rather than from health professionals, which makes them more confident. Mothers in Nottingham were less confident because of the conflicting advice given by relatives and health professionals, and consumer choice of baby foods in shops.

Sarwar recommended that health professionals receive continuing education about lactation management, infant feeding and nutrition and have greater awareness of the different commercial foods available for infants. Sarwar also found that how information was provided was important and that giving mothers information verbally relied on the mother's understanding and her memory. Mothers who were given booklets or audio tapes written in English and their own language felt that information could be reinforced and kept for reference. Demonstrations and group discussions held by health professionals at clinics were also thought to be useful, as they provided an opportunity to discuss feeding problems, share experiences with other mothers and gain further information. The study by Li et al (2005) found that Chinese-Australian mothers' infant feeding practices in Australia were influenced by both East and West. Crucially, Chinese mothers introduced complementary foods earlier, suggesting that culturally-specific programmes are necessary to encourage exclusive breastfeeding for the first six months. Li, too, emphasise the need to understand the factors that impact on Chinese women's decisions to initiate and maintain breastfeeding, suggesting that healthcare professionals need to develop and implement more effective strategies for promoting breastfeeding in Chinese migrants. Li et al's study found that the most common reason for the cessation of breastfeeding was breast milk insufficiency. This highlights the importance of providing culturally-specific breastfeeding education to allay concerns of migrant mothers. In addition, Groleau et al (2006) suggest that lower breastfeeding levels in migrant mothers is because breastfeeding among migrant women is strongly ritualised and influenced by culture even when women migrate to a new socio-geographical space; and secondly that the elements that sustain breastfeeding are lost in migration. They suggest that the loss of rituals and, in particular the loss of social support to enact rituals (such as eating particular food and keeping warm), prevents women from maintaining breastfeeding. This is similar to findings in previous New Zealand research, which found that the loss of rituals was a critical aspect of migrant motherhood (DeSouza 2005).

5.1.6 Need for better information provision and communication

This study found that many women felt that they were given insufficient information and were poorly communicated with, particularly in the postpartum period, which led to feelings of disappointment and anger. These findings mirror an English study (Baker et al 2005) about women's experiences and feelings associated with the childbirth process, which found that many women experienced fear, anger, disappointment, distress, guilt and inadequacy due to two key factors. One was feeling like they had little control due to poor information provision and communication, and no opportunity to influence decision making. This, combined with under-staffing and negative attitudes and behaviours of maternity staff, led many women to feel like they'd been in jail. In addition, several women felt that the emphasis of care was on the physical aspects rather than the psychological dimensions of care. The findings suggest the need for attention to women's psychological and emotional needs in addition to physiological needs, and the importance of self-awareness of maternity staff and the need to consider the impact of their behaviour on women's experiences.

5.1.7 Providing detailed and individualised information

Healthcare providers have a responsibility to make available accessible and up-to-date information. However, this is not as easy as it sounds when facilitating informed choice. Midwives are caught in a difficult position and have to strike other balances, such as between giving enough information for the woman to make a choice but not giving too much information and frightening her (Levy 2006). They also have to delicately meet the needs of women and to appear neutral in their advice, when they

might have strong feelings regarding certain issues. In this study, migrant mothers looked to health professionals to fill the vacuum of knowledge they experienced in the process of migrating. Research shows that information is more effective when it is tailored to the individual and their needs (Rapport et al 2006) and relevant to the women's current stage of pregnancy (Benn, Budge and White 1999). In addition, information that was detailed rather than 'big picture' was valued. Therefore, there is a need for information that is individualised and detailed to an individual's needs, which can vary and should be taken into account in the planning and provision of maternity information (Soltani and Dickinson 2005). Information that is available in one's own language or written information is important. While translated information is available about childbirth in New Zealand from the Maternity Services Consumer Council of New Zealand, it is not clear how well this information is distributed or whether LMCs are aware of its existence.

5.1.8 Language support

Communication as a part of information support can be improved with a two-pronged strategy, where health professionals and systems become more skilful at information provision through:

- > linguistic competence
- > identifying and assisting in the extending of sources of information.

Health providers can assist new migrants to identify information sources. Similarly, they may assist and encourage the exchange of information between women who have often lost their peer groups and other sources of knowledge in the process of migrating, and encourage women to develop information-seeking skills. There is a need for the development of policies that focus on linguistic and cultural competence. Linguistic competence could be achieved by:

- > providing or training bilingual/bicultural staff
- > providing foreign language interpreting services
- > having link workers/advocates
- > having materials developed and tested for specific cultural, ethnic and linguistic groups

and by providing translation services, including those of:

- > legally-binding documents (for example, consent forms)
- > hospital signage
- > health education materials
- > public awareness materials and campaigns and ethnic media in languages other than English; for example, television, radio, internet, newspapers and periodicals (Szczepura 2005).

In the United States healthcare organisations are required to both offer and provide language assistance services such as bilingual staff and interpreter services at no extra cost to clients who require it. It is recommended that information about services is provided both in writing and in a timely manner with credentialed interpreters and bilingual workers available (United States Department of Health and Human Services 2000). There is a need to develop a research agenda to assess the level of unmet information needs among new migrant women in more depth, particularly for women who are not able to communicate with service providers.

5.1.9 Preparing women for new paradigms/discourses of maternity

The study findings highlight the need for health providers to assist women to socialise into new ways of understanding maternity. The three main discourses or paradigms are the discourses of partnership, being an informed consumer and natural childbirth. The partnership rests on the assumption that women want the responsibility of being informed consumers, and being information-literate is a necessary prerequisite for this role. For women to take up more informed positions, obtaining more specific and detailed information to make choices was required. Those who wanted their LMC to have a more authoritative style and to be told the best option found the facilitative role difficult to deal with. The second discourse that migrant women in addition to other pregnant women had to grapple with was the natural childbirth discourse, which was taken up by many of the migrant women in this study who found childbirth easier in New Zealand. However, for the Korean women who were more familiar with medical discourses, there was a perception that the care that they were receiving was not adequate. Health professionals need to understand that different people want and expect different things from maternity services (for example, in the areas of natural or medicalised childbirth and in decision making about childbirth) and that these differences might be affected by the migrant background of the mother.

5.2 IMPLICATIONS FOR MIGRANT MOTHERS

There are important issues for migrant mothers, their families and communities to also consider for managing migrant motherhood. Fluency and familiarity are critical for becoming informed consumers; there is a need for women to be literate about maternity and to take up new roles with migration. Developing social networks is crucial for wellbeing and good health. Migration also creates new spaces for different experiences of fatherhood for many men.

Immigration can lead to a process of extended change and adaptation in all domains of a parent's life. These changes may include adjusting to a new home, social environment, language, culture, place of work and profession. Often, economic, social and familial support systems are lost or changed. Under such circumstances, parents' physical and psychological health, self-image, ability to withstand stress and anxiety levels may all be challenged (Roer-Strier, Strier, Este, Shimoni and Clark 2005). The study findings show that there are some ways in which parents can be resourced to manage the transition to parenthood in a new country. As there was no comparison with New Zealand-born women, it is difficult to know whether the dissonance between expectations and experience is peculiar to being a migrant mother whose information and cultural needs were not met.

5.2.1 Developing fluency and familiarity

This study demonstrates that language fluency does not guarantee that women will have satisfying and empowering experiences. In fact European migrants and New Zealand-born mothers may also have information and support needs. With this in mind, the research highlights the needs for all migrant women to be supported, not just those who are visibly different. This is important also because New Zealand's key migration gains are from countries that are English-speaking, such as the UK, the US, South Africa and Zimbabwe, as well as migrants who speak English as an additional language.

Lack of English language proficiency affects access to healthcare, employment prospects, income levels and other factors which determine health status (Asian Public Health Project Team 2003). The link between language and accessing healthcare is further strengthened by the findings of a New Zealand study where self-rated fair or poor health was found to be associated with Chinese-only reading knowledge, residency of more than five years and regretting having come to New Zealand (Abbott, Wong, Williams, Au and Young 2000). A study of Chinese American women found that lack of English language ability was a major barrier to accessing services (Liang, Yuan, Mandelblatt and Pasick 2004). Ensuring that migrants are aware of Language Line and encouraging them to take up their English for Migrants language courses is important, as English proficiency is a key settlement enhancer. The migrant levy that migrants pay when coming to New Zealand entitles them to take up English language classes (English for Migrants). The Tertiary Education Commission pays for English language tuition on behalf of migrants to New Zealand who have pre-paid for their training, however recent anecdotal reports suggest that few migrants take up these classes.

5.2.2 Developing health literacy

Migrant women need to develop health literacy to make better use of health services. Health literacy is defined by the World Health Organization as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health" (World Health Organization 1998:10). Health literacy is a stronger predictor of health status than socio-economic status, age or ethnic background (Speros 2005). Speros claims that the lack of health literacy can act as a barrier to navigating the system and functioning successfully as a consumer; ethnic background would also compound the issue of access. Speros cites a large study by Williams et al (1995) which found that one-third of English-speaking patients at two public hospitals in the USA could not read and understand basic health-related materials. Sixty percent could not understand a routine consent form, 26 percent could not understand information written on an appointment slip and 42 percent failed to comprehend directions for taking medications. While little is known about health literacy in New Zealand, overseas research suggests that being culturally and linguistically different magnifies the problem.

5.2.3. Taking up new discourses of maternity

Migrant women had to become informed and proactive consumers in the absence of their knowledge resources. While this would have been a more familiar role for the European group, decisions were made in the absence of knowledge resources in an environment that was no longer familiar even if language was not an issue. Many women took up the role of informed consumer with relish and involved their husbands in the detailed aspects of their pregnancies and labour and delivery, which

their partners might not have experienced if they hadn't migrated. For some Korean women the taking up of the informed consumer role was made difficult by their preference and alignment with a highly medicalised society where technological intervention was the norm and the notion of natural childbirth was anathema. However, for many of the Indian, Chinese and Arab Muslim women the advocacy that midwives provided was complemented by natural birth discourses and led to empowering experiences.

5.2.4 Developing new social networks

This study highlights the disconnection that occurs for many women in the absence of family and peer groups and how new social networks need to be created or re-established (DeSouza 2005). The absence of a support network meant that there was a bigger space for husbands and health professionals to fill. Social networks would also have assisted in helping women filter and supplement the information they were receiving from health providers as well as provide information about rights to do with accessing healthcare services. Research by Paris and Dubus (2005) found that mothers of newborns benefit from social and emotional support because women develop and function optimally in relation to others. This requires that they understand and are understood, experience and provide empathy and feel connected, and this in turn helps them to develop both a sense of self and skills and values. The authors suggest that the disruption of having a baby can result in disconnection from primary forms of support (usually partner and family members) because of the tumultuousness of the birth and perinatal experience, and the transition to parenthood, which can contribute to postpartum anger, sadness and depression.

For migrant mothers this disconnection is further exacerbated. Many women attempted to develop alternate connections. For example, the European group developed an electronic network of support for each other and one of the outcomes of the focus groups was the desire to develop new social networks, with members of all groups indicating the desire to meet again and to share their experiences. A good support network also assists in breastfeeding maintenance (Groleau et al 2006) and good mental health postpartum. Home visiting in particular provides an opportunity to offer support and education and this study showed that some midwives, Plunket and Community Karitane were considered a very valuable resource for women in the absence of family members, providing networks, information, validation, a constant presence and supporting competence. There is also the potential for the development of volunteer paraprofessional workers to provide culturally appropriate home visiting interventions or link workers' services such as mental health support workers. They could provide linguistic and cultural support, affirm effective cultural practices and rituals and support them to access community resources. Given the isolation and loneliness described by many study participants, such an intervention could improve women's experiences of the perinatal period.

5.2.5 Changing roles in families

The issue of lack of family support was raised. Familial absence was acutely felt by some participants and was a relief for others. However the absence of family members created a space for husbands to be present for the birth, which would not have been possible in their countries of origin. There is a need to explore the role of partner support and how expectations of fathers change with migration, from absence to helping fulfil responsibilities. Compared with the relatively limited range of studies on children and women, the impact of immigration on fathers has received even less attention (Roer-Strier, Strier, Este, Shimoni and Clark 2005). Most immigration studies focus on the negative consequences of immigration for families and for parenting. For example, immigration is perceived predominantly in the literature as a source of stress and a risk factor for families and children. Engaging women in groups or developing couples' groups that would also serve the needs of new fathers could educate participants and provide support and information. Supporting the whole migrant family is critical, particularly when often a key motivation for migration is to provide a better life for children (DeSouza 2005; Roer-Strier et al 2005). Families can provide a buffer and the strength and safety to cope with what might seem an unfamiliar, and at times hostile, receiving community (Roer-Strier et al 2005).

6.0 LIMITATIONS OF THE RESEARCH

There are several limitations of the current research that must be acknowledged. First, all of the women in the current study were accessing Plunket services and the issues may be different for women who are not engaged in or accessing those services. The opinions and stories told by those who have accessed services could underestimate the barriers to access that even more isolated migrant mothers might face. Second, because several of the groups were co-facilitated by a Plunket staff member, questions related to services may be subject to bias because women are likely to be reluctant to criticise those who are in a position of helping them. Third, these focus groups included a small number of women whose experiences may not be representative of the diverse community of migrant women living in Auckland. Future studies should attempt to include greater numbers of women, those who speak other primary languages and those of varying socio-economic status to expand or confirm these findings.

7.0 RECOMMENDATIONS

To summarise, the recommendations are divided into three areas: policy, practice and research.

7.1 POLICY

- > Cultural safety and the possibilities of a cultural competence framework should be further explored.
- > Review how maternity information is provided.
- > Review the information needs of migrant mothers (including European migrants).

7.2 PRACTICE

- > Ensure that translated information produced about childbirth options in New Zealand, such as that produced by the Maternity Services Consumer Council of New Zealand, is well distributed and LMCs are aware of its existence.
- > Access to antenatal education is vital for socialisation into parenthood and needs to be available, accessible, affordable (in terms of transport and childcare) and acceptable.
- > Systems need to be 'father-friendly' as husbands are the key support for migrant women who have often left behind friends and family.
- > Workforce development should be made available for health professionals to increase their knowledge of cultural safety and incorporate cultural competence.
- > Systems need to develop linguistic competence to better support migrant mothers, for example the provision of written information in their own language.
- > Primary health professionals have a key role in assisting women develop their new support networks, but they also need to be aware of what is available and to be mindful of linking women with other women. This means that they need to be better informed as well.

7.3 RESEARCH

Research is needed that:

- > examines the relationship between cultural safety, cultural competence and health or care outcomes
- > examines parenting in immigrant communities in order to better plan services
- > explores how migration impacts on women's roles in supporting the careers of their partners and facilitating resettlement
- > considers the needs of additional groups, including African, Middle-Eastern and Latin American communities
- > explores whether the experiences raised in this study are pertinent to New Zealand-born women
- > explores the information needs of migrant parents through the family life-cycle
- > considers the factors that support breastfeeding in the absence of social support
- > explores the experiences of fathers, so the whole family can be supported.

8.0 CONCLUSION

Healthy migrants are likely to first encounter the New Zealand health system when they have a baby here. Overall, the maternity experiences of participants in this research were positive and empowering for the women. However, having a baby can raise issues of culture and identity. Motherhood is culturally constructed and many migrant women attempt to integrate their traditional expectations with the New Zealand reality to form a unique version of motherhood.

Migrant mothers have to become self-reliant informed consumers and their partners are more involved with the experiences of pregnancy, childbearing and childrearing. Their cultural and religious needs remain a significant source of support and continuity. Many individual health practitioners attempt to meet the cultural needs and expectations of migrant women but the health system is organised in such a way that it assumes motherhood is a standard physiological experience. This results in a universal assimilatory response which can preclude the enactment of traditional self-care rituals and mechanisms, such as eating special food and resting. There is a growing need for health and social service providers to be better resourced to be able to support cultural practices that assist migrant women to maintain good health. A greater knowledge and links to community and cultural resources will assist staff to support migrant women and their families. Information, familiarity and linguistic competence are necessary in order to navigate a complex health system.

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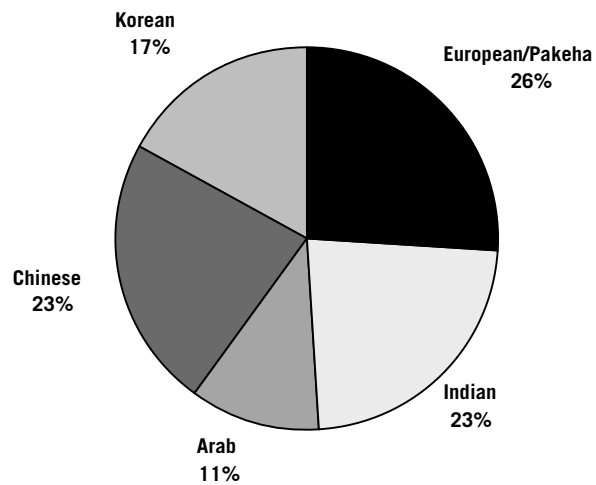
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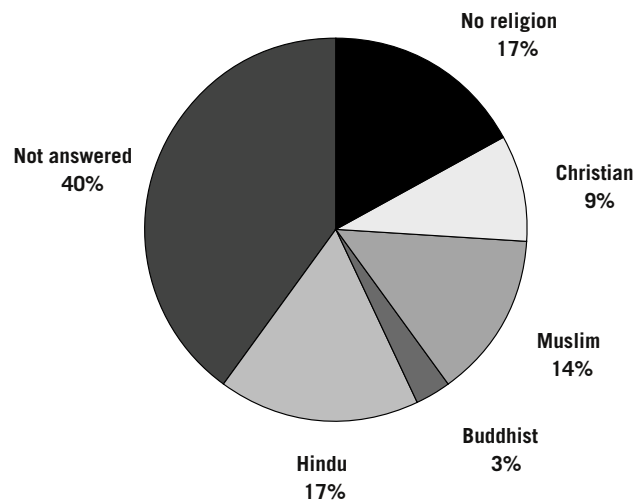
APPENDIX A: SUMMARY OF PARTICIPANTS AND GROUPS

Total number of participants:	40
European migrant group:	10
Indian group:	9
Chinese:	8
Arabic:	4
Korean:	9

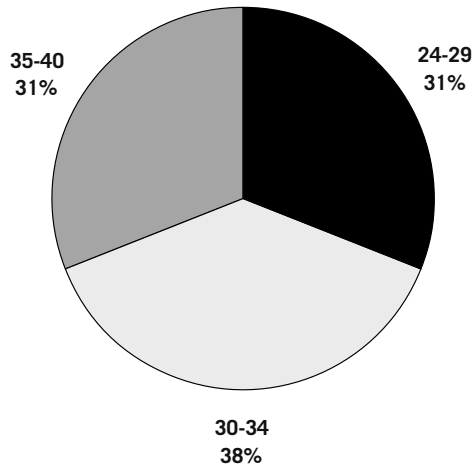
What ethnic group/s do you identify with?



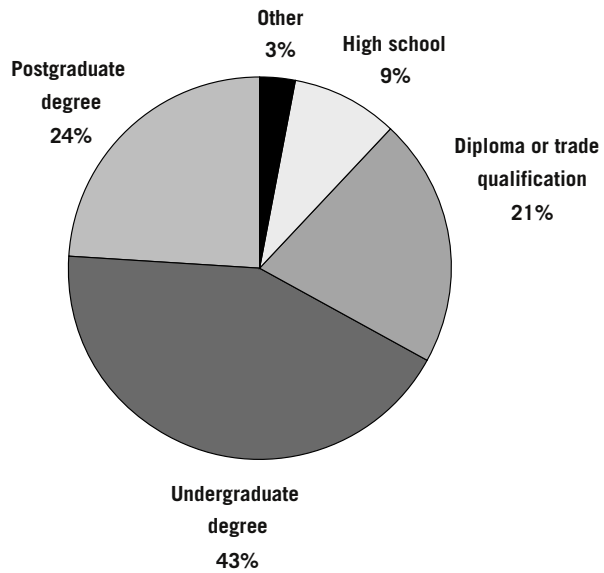
Religion



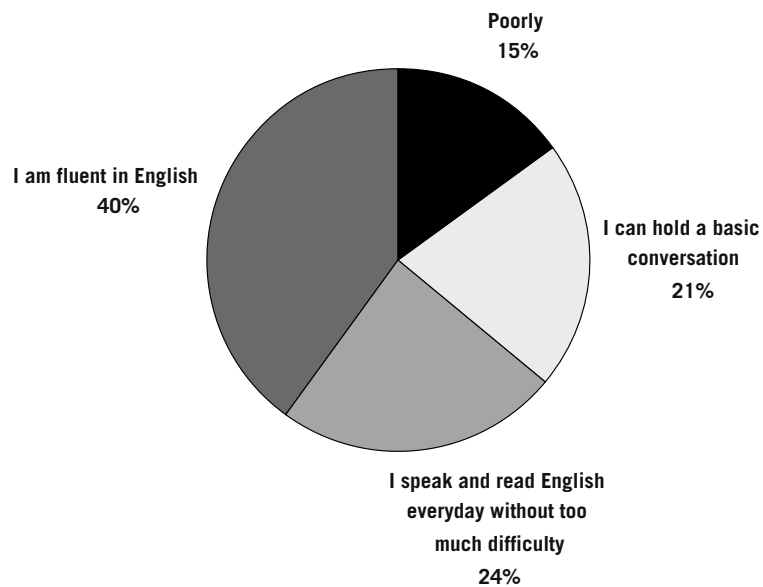
Age of participants



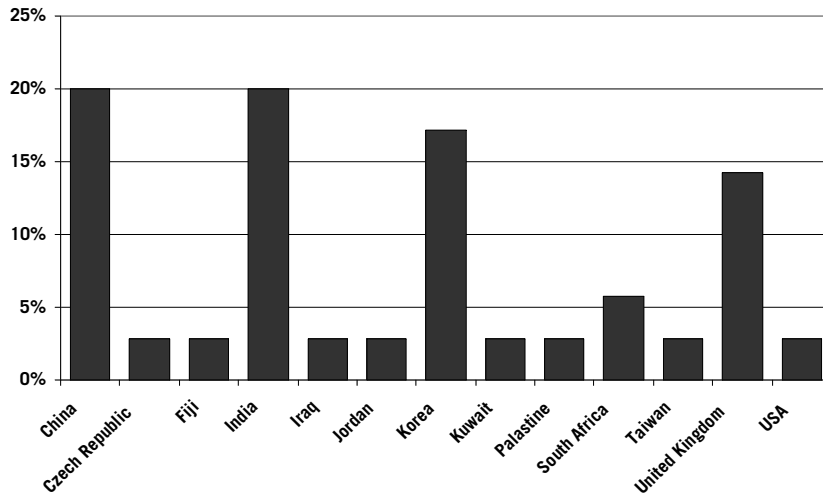
What is your highest educational qualification?



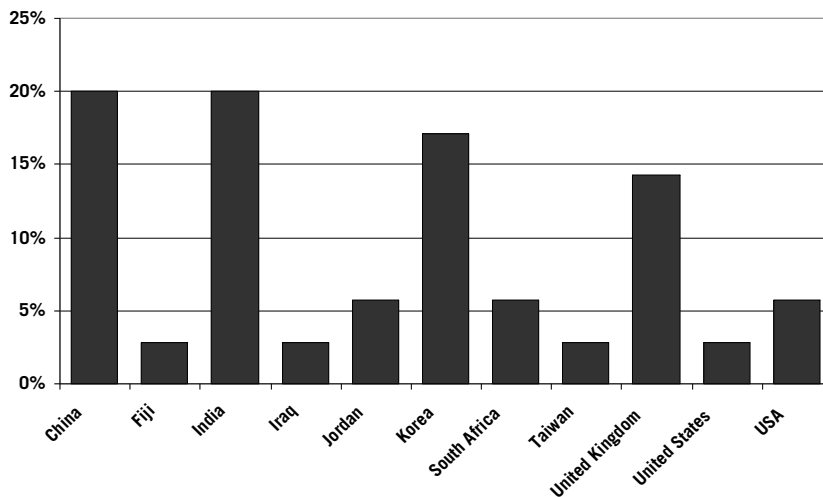
How well do you speak English?



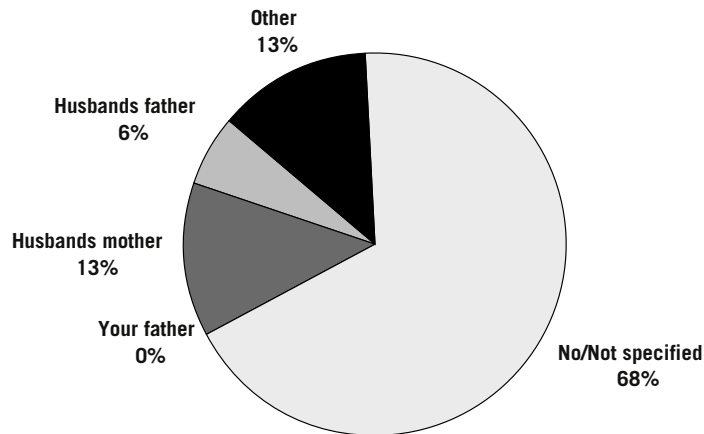
Where were you born?



When you moved to New Zealand, what country did you migrate from?⁹



Do you have extended family living with you?



9 Nine percent of participants had migrated from a country other than the one in which they were born.

APPENDIX B: SEMI-STRUCTURED FOCUS GROUP INTERVIEW SCHEDULE

1. Thinking about before you had a baby:
 - a. In your culture how important is it to be a mother?
 - b. How did you feel when you found out you were pregnant? What did your partner think?
 - c. How important was it to you that the baby was a boy or a girl?
 - d. How did you make the decision to have a child in New Zealand?

2. Thinking about your pregnancy:
 - a. What were your expectations of pregnancy?
 - b. What did you feel you needed in order to cope with being pregnant in New Zealand?
 - c. Did you use antenatal services?
 - d. Are there any special things you would do if you were in your home country that you did/couldn't do?
 - e. How did you choose your lead maternity carer? (eg GP, midwife, obstetrician)
 - f. Did you prefer someone from your own community or a local midwife? Why?
 - g. Did you use antenatal services or classes?
 - h. What did you think of them?
 - i. Did you have any problems with following the programme (eg language problems, uncomfortable environment)?

[Prompt for other issues]

3. Thinking about the labour and delivery:
 - a. What were your expectations of labour and delivery?
 - b. Were your expectations met?
 - c. Are there any special things you would do if you were in your home country that you did/couldn't do? Why?

[Prompt for other issues]

4. Thinking about after the baby was born:
 - a. What were your expectations of the postnatal period?
 - b. Were your expectations met?
 - c. Are there any special things you would do if you were in your home country that you did/couldn't do? Why?
 - d. Did you stay in hospital? How did you find the food? Service?

5. What did you think of the healthcare you received in New Zealand? Is there anything else that could have been useful? For example, bringing your mother/mother-in-law over?

6. Do you have a General Practitioner? Did he/she have a role during your pregnancy, labour or delivery? How did you choose your GP? Eg location, language skills, empathy with migrants.

7. What else would you like to tell us about becoming a mother in New Zealand?
 - a. What have been the worst things about having a baby in New Zealand?
 - b. What have been the best things about having a baby in New Zealand?

8. What would you like to happen next time?

9. Is there anything else you would like to add?

Blue Skies Research

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- 12/06 *The Role of Whānau in the Lives of Māori with Physical Disabilities*, Adelaide Collins and Huhana Hickey, September 2006.
- 13/06 *New Spaces and Possibilities: The Adjustment to Parenthood for New Migrant Mothers*, Ruth DeSouza, November 2006.

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