

NEW ZEALAND RESEARCH

Pasifika women's choice of birthplace

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ABSTRACT

Background: Birth is a socially constructed experience for Pasifika living in New Zealand that is shaped by their community and maternity provider's influences. Pasifika women in the Counties Manukau region predominantly choose to birth in a tertiary facility despite there being primary facilities available.

Aim: This study asked Pasifika women about their choices for place of birth within the Counties Manukau District Health Board region.

Method: Six healthy, low risk Pasifika women, who had given birth in the Counties Manukau District Health Board region, participated in this study. All women were interviewed individually and conversations were analysed using thematic analysis, followed by a hermeneutic interpretation.

Findings: The women shared a culture of "we birth at Middlemore [Hospital] and that is where you have babies". Their data surprised us as researchers. Those who had been transferred postnatally to primary units tended to still prefer Middlemore. We use the word "prejudice" in recognising that we thought (backed by research evidence) that they would be more likely to have a normal birth in a primary unit, and would prefer that experience. They told us that Middlemore Hospital was close to home; it was a place they knew; and it was where they preferred to give birth.

The Pasifika women's understanding of choice of birthplace was influenced by their community and, perhaps, by their midwife. While they seemed to have minimal understanding of why they would choose to birth at a primary birthing unit, there was a sense that even if they had this knowledge, they would not have changed their minds. They had a trust of, and familiarity with, Middlemore Hospital that held firm. They had their prejudice; we had ours. Recognising these different views offers a different space for conversation.

Conclusion: It is important that any new or re-designed birthing unit be planned in collaboration with Pasifika women if it is intended for their use. Further, it is important that midwives take the time to listen to Pasifika women, and those from other cultures, to understand their point of view.

Keywords: Pasifika women, maternity care system, New Zealand, Pasifika culture, place of birth

INTRODUCTION

The collective memory of the research team, of the time they have been working as midwives in South Auckland, dates back to the 1970s. We have long been struck by the paradox that the majority of Pasifika women chose to birth in a tertiary hospital (Ministry of Health, 2015). We have observed the natural ease with which so many Pasifika women give birth. It is likely that they have their own stories, or those of recent generations, of birthing in their home countries without ready access to technology. That they choose to birth at the tertiary hospital (Middlemore Hospital) in preference to a more homely primary unit appears incongruous. This research study provided the opportunity for six Pasifika women to talk about what influenced their choice to birth in Middlemore Hospital, the tertiary unit within their community. The research question was: why do low risk Pasifika women in the Counties Manukau District Health Board (CMDHB) region not birth at a midwifery-led primary birthing unit? By "low risk" we mean those women who would meet the criteria to book at a primary unit. This is a small qualitative study in which we bring a

hermeneutic lens to the data and in which questions are raised to provoke ongoing exploration.

Experiences of Pasifika women giving birth in New Zealand

Pasifika women have one of the highest birth rates in New Zealand, there being 92 births per 1,000 women of reproductive age compared to 54 births per 1,000 among Europeans (Ministry of Health, 2015). Pasifika are also the group with the highest fertility rate (Statistics New Zealand, 2013). Pasifika women giving birth are more likely to live in a socio-economically deprived area (Ministry of Health, 2015). Nationally, Pasifika (34.1%) and Māori women (42.9%) are more likely to have a physiological birth (requiring no medical intervention) when compared to Indian (19%), Asian (25.5%) or European and other ethnic groups (31.3%), exclusive of risk status (Ministry of Health, 2015). A retrospective study on a cohort of low risk women, who met guidelines to birth at primary birthing units in CMDHB in 2011-2012, found that only 10% of the study's Pasifika women started their labour at a

primary birthing unit (Farry, 2015). The CMDHB provides care for the country's most fecund population (Ministry of Health, 2015) and, in the past decade, 32% of babies in this population have been born to Pasifika mothers (Jackson, 2011; Paterson et al., 2012). The options of place of birth for women in the region include Middlemore Hospital (a tertiary unit) and three primary units: Botany Downs, Papakura and Pukekohe. There is strong evidence that, for low risk women, giving birth in a primary unit is as safe as in a large obstetric hospital (Farry, 2015).

The importance of making the choice of where to birth has been revealed in the overwhelming evidence concluding that, for women who do not have defined risk factors, birth outside of large, obstetric hospitals is safer (Birthplace in England Collaborative Group, 2011; Davis et al., 2011; Farry, 2015; Overgaard, Møller, Fenger-Grøn, Knudsen, & Sandall, 2011). Low risk women birthing in any one of CMDHB's three primary units had significantly lower odds of experiencing an emergency caesarean section, a postpartum haemorrhage, or an acute postpartum admission than those women giving birth in the tertiary unit (Farry, 2015). The babies in this study born to women at primary units had lower odds of a 5-minute APGAR score of less than 7 or an acute neonatal admission than babies born in the tertiary unit. With the existence of primary units, a woman-centred midwifery workforce providing continuity of care, and local, national and international data all concluding that a primary birthing experience has superior outcomes, why do low risk Pasifika women choose an obstetric hospital for their birthplace?

Exploring birthplace preferences requires researchers to identify the underlying assumptions influencing women. The plethora of qualitative research in this area has returned a wide range of results. Beliefs about childbirth, level of education, socio-economic background, the media discourse, women's partners, fear of intrapartum transfer, previous birth experiences, the midwife's philosophy, a woman's "sense of coherence", and her cultural norms all contribute to their place-for-birthing choices (Barber, Rogers, & Marsh, 2006; Bedwell, Houghton, Richens, & Lavender, 2011; Coxon, Sandall, & Fulop, 2015; Gottfredsdóttir, Magnúsdóttir, & Hálfhánsdóttir, 2015; Grigg, Tracy, Schmied, Monk, & Tracy, 2015; Hildingsson, 2017; Steel, Adams, Frawley, Broom, & Sibbritt, 2015). The socio-demographic background often determines which birth options are available to women (Liamputtong, 2004; Zadoroznyj, 1999).

To date, little is known about the reasons for Pasifika women's strong preference for hospital births or about their general experience of birth in New Zealand. The current study aims to explore the perspective about preferences for place of birth with a small number of women of Pasifika ethnicity within the CMDHB region.

Study design

A qualitative, descriptive approach was used for the data collection of this research. This approach was useful in facilitating the process of eliciting stories, providing insight into the views and needs of participants in relation to place of birth. However, as we began to work with the data, it became clear that a more interpretive level of analysis would draw forth a different kind of thinking. Thus, a hermeneutic hue (Sandelowski, 2000) was brought to the analysis phase of the research, in that we were now asking, "what is the meaning being revealed?" and "what are the questions that need ongoing thought?" (Smythe, Ironside, Sims, Swenson, & Spence, 2008). Gadamer, a philosopher in the field of hermeneutics, explains the way of hermeneutics:

Challenged by something not understood or not understandable, hermeneutics is brought onto the path of questioning and is required to understand. In this process one never has some advance lordship over all meaningfulness. Instead, one is answering an always self-renewing challenge (Gadamer, 2007, p.363).

On first reading, the data of this study are easily understood. On second and subsequent readings, one is called to wonder what one does not yet understand, which brings forth questions rather than answers. Such is the hermeneutic way (van Manen, 1990).

Recruitment

The researchers used their networks to identify potential participants and provide them directly with information about the study. When the women agreed to participate, they were contacted by one of the two Pasifika members of the research team to further discuss, gain verbal consent and set up a date and time for the interview. At the beginning of the interview, the researchers took time to explain again the purpose of the study and at that point the consent form was signed. There was an opportunity for the woman, after discussing the study with the researchers, to choose not to participate in the research. There was no funding for an interpreter, so, although the interviewers were able to communicate in other Pasifika languages, the expectation was that all interviews would be conducted in English. For participants to be included in the study, they needed to identify as Pasifika, to have had a baby in the past 12 months, and to mirror the criteria that qualified these women to have birthed in a primary birthing unit.

Data collection

Interviews were semi-structured and used open-ended questions, so that participants could share their views and tell their stories about why they chose to birth in a particular place. The questions began with: "Tell me where you had your baby. Why there?" The interviews took between 30-90 minutes and were audio-taped with the permission of the research participants. The interviews were transcribed verbatim.

Data analysis

The initial phase of the analysis was carried out as per Sandelowski (2010). The transcripts were first read and emerging ideas colour coded by one member of the team. These ideas and their colour coding were checked by another member. A coding tree was then created with the appropriate data linked to each code. This coding facilitated the emergence of patterns in the data leading to themes. It was when the data were presented in themes that we recognised it was just as important to highlight what was not being said, then to articulate the questions prompted by the data and, thus, to engage in a process of interpretive thinking (hermeneutics). The findings presented go beyond the original aim of the study which was focused on the woman's choice of place of birth. We came to realise we needed to situate their answers, as they did, against a broader background of understanding.

Ethics

Ethical approval for the study was granted by the Auckland University of Technology ethics committee (AUTEK) in 2015. Confidentiality was maintained by the use of pseudonyms. Women were free to withdraw from the study at any time, or to have their data removed, up to 14 days following the interview.

FINDINGS

Six women agreed to be interviewed, all were of Pasifika ethnicity. Four were born in New Zealand. Three participants were having a first baby, one a third and two a fourth.

Choice about place of birth for Pasifika women

The prompt for this research was a sense that Pasifika women have an understanding of birth that enables them to birth normally. This was affirmed by this participant who showed how she expected her births to be straightforward:

Well—with my first, I gave birth to him at Middlemore. I had natural birth; there were no problems. Everything was just—it went good, it was a fast delivery, and my midwife said he flew out when I gave birth. Second one, it took a little bit of time, only because I thought I was going to have [the] baby but it was only false contractions. So we were in hospital for probably almost six, seven hours, just to wait for the actual contractions to happen. In the end though nice natural birth for my second as well, no problems. And with my third it was a quick one as well, only two hours. And that was also a natural birth as well, no complications, everything went well. Yes for me I just always want the natural way. And I was just so used to it from my first experience, that's why I just did it with all—with my next two.

As shown in this story and in other conversations, both within this research and in our practice experience, the women who took part in our research, and their mothers, aunts, sisters, friends and community, trust their bodies to birth. We acknowledge that we bring our pre-understanding as researchers that these are the very women who “could/should” be birthing in the primary units. Our conversations with them were attuned to try to understand why that tended not to happen.

I didn't know

A common response in the interviews was “I didn't know [there was such an option]”:

Really? You can have babies at the maternity units? ...I didn't know that.

This participant, a mother of three, said:

Yes. Middlemore. It's a hospital, so that is where you give birth—yeah, you have to give birth at hospitals, don't you? With my next baby, if I have one, I would do something different like try a water birth. But I'd probably still have it at Middlemore, because it's the main place that I have given birth with my last three.

For this woman, Middlemore Hospital is where you give birth. She had already had three babies there. It is what she knew. It is where you go. She indicated that she was very open to trying something different, like a water birth, but it would still be at the same hospital. In describing it as the “main place” that she has given birth, perhaps there is an important desire for continuity. Maybe it matters that her children are all born in the same place.

Another woman told her story:

I went to Middlemore and had my baby and then went to Maternity Unit [primary unit] after that. I didn't know I could have my baby at Maternity Unit. My midwife told me to go to Middlemore; that is why I went there. For me, though, I think I would choose Middlemore, because this is the first baby I have had in this country. In fact if I have another baby I would still go to Middlemore.

It seems this woman's midwife “told her” to have her baby at Middlemore Hospital. Curiously, even after having been transferred to a primary unit for her postnatal care, this woman would still choose to give birth at the tertiary hospital next time. Has she come to feel comfortable/safe in this high tech environment? Is

there something about the familiar that is reassuring in the time of labour?

Another participant also spoke about not being given a choice in relation to where she would give birth:

No one talked really about there being a choice about where to have baby. No. No choices were given.

Perhaps there was something reassuring for some woman in being told “this is where you will birth”. Maybe the certainty of that instruction gave them confidence in their midwife. As researchers (working within a hermeneutic framework) we wondered: does the midwife have the right to take away their choice?

This participant saw Middlemore Hospital as providing a degree of safety for her:

I didn't know about other places to go give birth but then probably wouldn't have chosen them, anyway, in case anything happened—because I didn't want to go to a birthing unit where, if anything happened, if things didn't go to plan, then would have to come to Middlemore. Really, all I knew was Middlemore, so that was my choice.

These participants, if they are representative of women in this community, appear to know Middlemore Hospital. Further, they know they would get transferred there from the primary unit at the first sign of a problem. This woman did not want that to happen. She preferred to be in Middlemore Hospital from the start. Is “knowing a place” akin to trusting, to feeling safe, to feeling a sense of belonging?

While, for the women in this study, there were all the usual concerns around birthing in a hospital or primary unit, such as “safety” or convenience, this does not take away from the fact that these women were not clear about what choices they could make. They did not recall having the evidence about primary unit safety explained to them. However, we wonder if such explanations would have changed the decision they made to choose Middlemore Hospital.

Maternity units are places you go after you give birth

I really thought those ones, like maternity unit [name removed], you just go there after birth, not for birth of baby.

To be honest, until you guys [the researchers] told me, I thought those units were there for you to go to and recover after having your baby.

Yeah, my family think you give birth at the hospital. That is what we would think - not at the after-care centres like a maternity unit.

It was clear that the women interviewed had no idea that they could birth safely at primary birthing units, as well as at Middlemore Hospital. Primary units were seen as somewhere only postnatal care is provided. Use of the term “after-care centre” assumes a level of care appropriate for after the birth. It is not surprising that, if most Pasifika women birth at Middlemore Hospital, then most of their friends and family will tell each other that is where you go. It seems there were few stories in their networks about birthing in primary units. However, some women in this study had experienced a primary unit and not found it to their liking.

Experience or thoughts about primary units

I would go to Middlemore. I didn't like the primary unit when I went after the baby was born. For me it was like

a campground, how you couldn't eat in the room, and I wasn't in the mood to move around a lot. But I still ate in the room even though I wasn't allowed. But, yeah, too many rules. So my third time round, Middlemore. I think it was way better.

It is apparent that, as researchers, our assumption that the primary unit is “better” was not necessarily the experience or impression of these six women. This participant remembered her sense of there being too many rules in the primary unit. It appears she did not feel comfortable eating with other women in the dining room. Maybe she was the only Pasifika woman in the unit at the time; maybe she felt she would not be welcomed by the other women. Maybe she simply wanted to stay in her room. The point was she was subject to rules which tried to dictate what she was and was not allowed to do. She broke the rules but chose not to go back there for her third birth. In her opinion Middlemore Hospital was “way better”. Maybe that is where she found herself in a community of other Pasifika women.

Another woman shared her discomfort with the primary unit:

Postnatally the amazing midwife at Middlemore she recommended I go to primary unit. She joked “there is scones there”. And then I was like “oh okay”. So I went and I had no idea what I was going into. The staff—I think we had a midwife take us to the room, set us up and told us about the facilities that were there, and if we needed anything just give them a call, they're there for anything and everything, and about lunch, breakfasts and dinners, about showers and toilets, and nappies and changing rooms and everything. And my first night I was by myself, because my partner couldn't stay and my mum couldn't stay, so I was really—I think I maybe pushed the bell or walked up to them maybe ten times in three hours or something because I was just nervous (laughs)—like what to do, what should I do, am I doing something wrong.

Perhaps for this woman going into a primary unit felt like going to stay in someone else's place. There were so many things she needed to know about what to do and where things were. She appears to have felt alone and vulnerable, seeking reassurance from the staff about what she should do; or maybe she just needed company. For this woman, she felt alone at a time when she needed people around her.

She seemed to miss the hustle and bustle of Middlemore Hospital, where chances are she would have been sharing a room with another new mother. Where was anybody to keep her company? She felt alone and nervous. The staff became her source of company. Paradoxically she seemed not to feel “at home” in this more homely place.

This participant also went to both Middlemore Hospital and a primary birthing unit:

The reason I chose... well, to be honest, I was put off with the first one. I was put off Middlemore because it was hot and I didn't really like it at all. With my second baby I felt like I was rushed out to primary unit to make room for someone new who needed my room. I had my baby and no room so they had to rush me and I knew they wanted me gone fast.

In this story it seems the woman almost became a “thing” to be moved to wherever there was space. It did not matter where she would have preferred to be. When Middlemore Hospital needed to make space, she was moved fast. Perhaps for the staff involved

there was no opportunity for them to make this choice. When resources are limited, in a public health system, the woman has little choice but to accept the decisions made on her behalf. It is not necessarily the place itself that makes the difference, but what is going on in that place on any given day.

What mattered most for participants was the staff:

But, yeah, Middlemore is amazing. Everyone. Like, I really didn't have any problems with their staff. Their staff were amazing and they just made me feel really looked after.

Supportive staff seemed to be more important than the actual place itself. When one feels “really looked after”, where one is, is hardly relevant. Perhaps it is in labour with one-on-one midwifery attention that the woman most keenly develops a sense of being “looked after”. Arriving at the primary unit postnatally may not draw women into the closeness of a relationship that they might have experienced had they arrived in labour.

Choice is determined by what is closest to home

For some of the participants, Middlemore Hospital was actually close to their home and this was the main reason for birthing there. This participant was given choices but she knew she wanted to have her baby at the tertiary hospital:

Yes. The midwife gave me the choices of primary birthing units, or Middlemore. But I always knew that if I ever fell pregnant I wanted to have [the] baby in Middlemore, just because it's convenient because Middlemore is closest. And so my family or my mum could easily come and see me, and it was right there. So, yeah, that's probably the reason why I chose Middlemore.

This next participant echoes these sentiments:

The reason I go to Middlemore is because it is close to where we live. I have no problem to go anywhere else but, why, when this is the closest? Yes if a primary unit was closest to me, of course, I would go there as I have no worries about me or my baby.

There was no doubt that convenience and closeness to home were the main determining factors why these women went to the tertiary hospital. This raises questions about the location of services for low risk women who do not need to birth in a high risk obstetric hospital. It matters that it is located a short drive away for both the labouring woman and her family. It helps that it has a feeling of familiarity. Perhaps a birthing unit develops a sense of the culture of the community in which it is located. Certainly that could be said to be true for the three units currently within the CMDHB region. To go outside of one's locality is perhaps to move to a different cultural ambience.

Influence of friends and family

The influence of friends and family was significant as to where women birthed:

For me I always feel good when I talk to my other sister-in-law. They give birth here. She's from the Islands and then she comes back here to give birth. I always talk to her, and she said, “Oh it's really nice”, so I said “Oh, okay”. She would give birth at Middlemore and then go back to the Islands.

My friends also preferred they said it was better than Middlemore. I went to try it out the second time but, for me, Middlemore was better. I really enjoyed it.

My friend gave birth at Middlemore so I did.

My family, well, sister-in-law, gave birth at a birthing unit—that was in town near the domain. Yes, she went from Mangere to there, but everyone else in my family has given birth in a hospital and at Middlemore.

When other people amongst one's family and friends go to Middlemore Hospital and speak highly of their experiences, to do otherwise would be to go against the tide. It is as though Middlemore Hospital is a ready-made decision. Yet, that was not the experience for all participants:

Actually, all my friends were, like, "Don't go to Middlemore". They were all, "Go to Auckland, go to Auckland". I don't know if that's just because it's in South Auckland, the hospital, or what. Just because it is in South Auckland—but they all birthed at Auckland even though they live in South Auckland. For me, Middlemore was an awesome experience and I am normally skeptical about things. My husband always says I am high maintenance but I am not!

South Auckland comes with its own reputation. For some participants this is simply who they are: South Aucklanders. Others, it seems, try to escape beyond the bounds of South Auckland. Perhaps the friends of the participants above chose midwives who only had access agreements at Auckland Hospital or perhaps they deliberately sought to avoid Middlemore Hospital. Whatever their reasons, they tried hard to persuade their friend away from Middlemore Hospital. Yet she resisted their advice and had an "awesome experience".

The following woman differed from the other participants, preferring to go to the primary birthing unit:

I preferred to come to the maternity unit just because it's closer to home and my sister-in-law was discharged to there. She, too, gave birth to my niece at Middlemore but went to [the] maternity unit [name removed] afterwards and I just found the environment really good and closer to home.

While the choice is different, the influence of family and closeness to the facility reveal themselves again as critical. This woman, in contrast to others, found the environment of the primary unit "really good". It is a reminder that there is not "one" experience for all Pasifika women; rather, each have their own sense of what works for them.

DISCUSSION

The key finding of this study is that both midwife/researchers and the Pasifika participants brought their own prejudices to the decision of where these women were best to birth:

...history does not belong to us; we belong to it. ...the self-awareness of the individual is only a flickering in the closed circuits of historical life. That is why the prejudices of the individual far more than his judgments, constitute the historical reality of his being (Gadamer, 1989, pp.276-277).

Our hermeneutic approach to interpreting the data has revealed prejudices. Gadamer does not see prejudices as "good" or "bad"; they simply "are". He states: "...that all understanding inevitably involves some prejudice gives the hermeneutic problem its real thrust" (Gadamer, 2002, p.239). It was when we woke up to the thought that several of the participants in this study preferred Middlemore Hospital to a primary unit, that we realised we needed to engage in deeper thinking. It is not that our prejudices were

shutting down our thinking; rather, they were showing us how our thinking as midwives was different from the opinions expressed by the Pasifika women in the study. In everyday language we tend to think of the word "prejudice" as meaning a premature judgment or strong opinion that is ill-founded. Gadamer (2002) goes beyond this to say that we all have prejudices about everything. We have chosen to stay with his term for it "wakes-us-up". Who, me? Am I prejudiced? Once one accepts that the answer is always "yes", then one is free to begin to explore what lies behind one's taken-for-granted understandings. That is how fresh insights emerge.

The prejudices of our research team were born of a commitment to supporting normal birth wherever that is a safe option, a belief that women are more likely to labour without intervention in a primary maternity unit, and an appreciation of the more relaxed atmosphere of the primary units. Underpinning these beliefs is substantive research evidence (Birthplace in England Collaborative Group, 2011; Davis et al., 2011; Farry, 2015; Overgaard et al., 2011).

Each of the six Pasifika women in this study brought her own prejudices. For some it seemed that Middlemore was a better, safer, preferable option. Importantly, it was also closer to home. These things mattered to them. It piqued our interest that, when they did get to a primary unit, several of them gave us the impression that it was not a place where they could feel at home. Perhaps the different culture of a small homely primary unit exposed these women in a way that made them feel different and vulnerable. It raises even bigger challenges around how to offer informed choice in a manner in which midwife and woman come to a shared understanding of the reasons that lie behind that choice.

It was clear that, for our participants, midwives were one component in the decision of where to birth. Barber et al. (2006) found that midwives were the greatest source of information about the various choices for place of birth for expectant parents in Britain. However, it was also found that, in the United Kingdom, midwives did not appear to be promoting options other than hospital birth. This is despite the exhaustive evidence behind the recommendation that healthy pregnant women birth at home or in primary units (National Institute for Health and Clinical Excellence, 2014). It is not uncommon for birthplace options available to pregnant women to not be discussed (Houghton, Bedwell, Forsey, Baker, & Lavender, 2008; Lavender & Chapple, 2011). As a result, most women in the United Kingdom see hospital births as the norm and do not know to seek further information about alternatives from their maternity providers (Bedwell et al., 2011). The predominant choice of where women birth is not dissimilar in New Zealand, where, also despite a plethora of evidence that it is safest for healthy women to birth in primary settings, 87% of women birth in secondary or tertiary hospitals (Ministry of Health, 2015). How do midwives move beyond their own prejudices when opening a conversation about the choice of where a woman could birth? Houghton et al. (2008) found that some professionals had their own perception of which hospitals were the safest for birth and this bias was reflected in their consultations with women, which in turn influenced the women's decisions.

A "prejudice" we became aware of as researchers is that low risk Pasifika women have a right to know they are more likely to have a safe, normal birth in a primary unit. But perhaps these women have every confidence that they will birth without intervention, wherever they are. There are clearly differences in the experience of being in a primary unit to being in a tertiary hospital. Each has its mood (Freeman, 2014). While our prejudice is that primary units are more relaxed (Smythe, Payne, Wilson, & Wynyard, 2013),

some of the Pasifika women in this study found them foreign. There seemed to be too many rules. They did not know what to do; they felt vulnerable and alone. A place is never simply a building. It is always embedded in community with values and customs pervading its ways (Smythe, Payne, Wilson, & Wynyard, 2009). When people of the dominant culture impose their prejudices on another group, we run the risk of engaging in a subtle form of colonisation (Lampert, 1997).

It is now time for the maternity service providers to work with Pasifika women and their communities to understand their specific perspectives and needs. Some women have moved to New Zealand recently; others were born within the Pasifika communities established here. It is clear little is known about the reasons for Pasifika women's birth preferences or their experiences of birth in New Zealand. The current study has attempted to shed some light on these issues and address the challenges that are being laid before us in terms of accessible and appropriate services. We maintain our prejudice, supported by research evidence, that low risk Pasifika women need a primary unit option of care. What this research has suggested is that it needs to be close to where the family lives and it needs to be a place where Pasifika women can feel at home. It is interesting to note that there are plans to build a new primary unit close to Middlemore Hospital, in the Mangere area, a strongly Pasifika community (Wiggins, 2017). From the thinking that has arisen from this study we believe that this is an important initiative. It would likely give Pasifika women a place to birth for which they have some sense of affinity, while at the same time uphold a space for labour and birth to unfold, free from intervention.

STRENGTHS AND LIMITATIONS

This was a small study undertaken in one urban geographical area of New Zealand, thus the findings cannot be generalised to the larger total population of Pasifika women birthing there and in other areas of New Zealand or elsewhere. Despite this limitation, the women freely shared their experiences, shedding light on some of the issues that other Pasifika women might also experience in terms of what influences their choice around place of birth.

RECOMMENDATIONS

This is a small study. It is not our intention to generalise; nevertheless, the thinking that has emerged from the study leads us to recommend that, when primary birthing units are being designed or changed, consultation with Pasifika women may make the facility more fitted to their needs. Just as we have paused to consider our own prejudices, we encourage other midwives to take time to listen to the stories and opinions of the women they serve, particularly those from cultures other than their own.

CONCLUSION

Birth is never without prejudice, born of history, culture and personal experience. We began this research thinking that Pasifika women simply did not know they could birth in a primary unit. To some extent this was true of our small sample. However, we became aware that regardless of knowing or not knowing about the alternatives, some of these women preferred to birth in the tertiary hospital. Choice is much more complex than a rational weighing up of the research evidence. The way forward is to find ways of working with Pasifika communities that ensure the high rate of normal birth amongst their women is maintained and even improved, and that these women have a real choice of birthplace that includes a primary unit they perceive as culturally attuned to their needs.

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