Structural and cultural competencies in maternity care for ethnic minority and migrant women: practitioner perspectives from Aotearoa New Zealand

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Abstract

Purpose – *With global migration, the number of ethnic minority and migrant women receiving maternity health care in dominantly Anglo-European societies has increased significantly but they consistently have among the worst pregnancy and maternal outcomes. This paper aims to analyse gaps in structural (migration-related inequalities) and cultural (responsiveness to ethno-cultural practices) competencies among maternal health practitioners in Aotearoa New Zealand (NZ).*

Design/methodology/approach – *Using a semi-structured interview guide, in-depth interviews were conducted with 13 maternal health practitioners in NZ. Data were analysed using a thematic analysis framework.*

Findings – *The results highlight significant barriers around language and communication, cultural stereotyping by professionals, ethnic women's own constraints around family and cultural expectations and their lack of knowledge about reproductive health. In addition, practitioners' own ethnic differences are inseparable from their approach to structural and cultural competencies; there were instances of 'over-' or 'under-' reading of culture, practitioner constructions of ideal pregnancies and anti-racism concerns that shaped maternal care practices that were sensitive to, but also marginalised, ethnic migrant women who attended maternity services.*

Originality/value – *To the best of the authors' knowledge, this is the only study in NZ that examines the impact of complex dynamics of migration and culture on knowledge, beliefs and values of practitioners, in context of their own personal biographies. Identifying strategies to improve the way diversity is practiced in hospital settings can be transformational in improving maternal outcomes for ethnic migrant women in NZ.*

Keywords *Structural competency, Cultural competency, Migrant, Ethnic minority, Pregnancy, Maternal care, Positionality, Equity, Aotearoa New Zealand*

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Introduction

With the rise of global migration and rapid demographic diversification in labour-receiving European and white-settler societies, the largest increase in childbirth is among migrant groups from ethnic minority backgrounds (Fair *et al.*, 2020). Current international research (Fair *et al.*, 2020; de Freitas *et al.*, 2020; Phillimore, 2015; Small *et al.*, 2014; Downey and Gómez, 2018; Knight *et al.*, 2021) consistently points to poorer childbirth outcomes – both infant and maternal – for women from migrant and ethnic minority backgrounds, drawing attention to knowledge gaps in the needs of these population groups before, during, and post-pregnancy and the capability of maternity services to deliver care that is culturally appropriate and adequate.

Although there is broad evidence of some biologically driven vulnerabilities particular to some ethnic minority population (Read *et al.*, 2021; Wong, 2011), childbirth outcomes for ethnic minorities are LARGELY associated with cultural, migration and equity factors.

These include language and communication issues, low-income backgrounds, isolation and absence of social networks, inability to navigate health systems, lack of adequate information, racism in health care, lifestyles, lack of understanding by practitioners of global infections that impact migrants and care that may be clinically but not socioculturally appropriate (Read *et al.*, 2021; Fair *et al.*, 2020). Although these conditions are exacerbated for first-generation migrants, adverse health outcomes continue in second-generation migrants as well (Phillimore, 2015).

The dominant institutional response to migrant needs entails the adoption of 'cultural competencies', i.e. the recognition of diverse cultural beliefs, values and practices around pregnancy and childbirth (Betancourt *et al.*, 2003). Increasingly, there is growing disquiet with the overwhelming focus on cultural competency, as the reframing of health care specifically to and about ethnic groups tends to pathologise culture Phillimore (2015, 2016) while conveniently overlooking the role of structural inequalities. In the specific context of reproductive health, Downey and Gomez (2018) propose 'structural competency' as distinct from cultural competency, highlighting systemic factors that result in differential access to socio-economic and political opportunities for minorities. Practitioners, unwittingly or otherwise, medicalise broader social problems such as poverty and racism, participate in gatekeeping rendering reproductive services and technologies inaccessible to minority women and contribute to the intensification of medical surveillance of "minority bodies" (p. 213). Structural competency, therefore, is a distinct set of skills that rearticulates "cultural" presentations in structural terms and as concerns of equity and justice (pp. 213–217). Thus, a comprehensive approach to ethnic and migrant women's maternal health would focus on cultural practices related to reproduction as well as the socio-structural effects of migration, or *both* cultural and structural competencies.

Set in the context of Aotearoa New Zealand (henceforth, NZ), this paper examines 'cultural' and 'structural' factors in maternal health care for ethnic[1] and migrant women, who currently make up around 17% of the total NZ population. Births from ethnic populations are among the highest in the country; in 2020 alone, names such as Patel, Kaur and Singh were among the top family names registered for babies (Kronast, 2021). However, migrant maternal health outcomes also present a troubling picture; there is an over-representation of Indian babies among NZ's neonatal mortality figures and they are classified as one of three groups at a "higher risk of serious adverse outcomes" (PMMRC, 2021, p. 13). Being Asian has been noted as a risk factor in maternal mental health (Low *et al.*, 2021; Ho *et al.*, 2021). Institutionally, critical scholarship (DeSouza, 2008, 2013) notes that maternal care has not accommodated the cultural needs of ethnic groups. Given the ongoing health inequities among indigenous Māori experienced through white-settler colonisation, institutions prioritise bicultural competencies (Reid *et al.*, 2019; Rutter and Walker, 2021; Walker, 2021). In addition, NZ is a super-diverse society (Auckland City Council, 2018); as a population group, there is tremendous heterogeneity among the ethnic minority population in terms of nationalities, cultures, religions, languages, socio-economic position and whether people are ethnic (i.e. born minorities) or migrants (having arrived in NZ in their lifetime). The heterogeneity and stratifications amongst migrants call for an intersectional analysis of their health needs and delivery of diverse services (Simon-Kumar *et al.*, 2020).

Following de Freitas *et al.* (2020), we examine the complex dynamics of migration and culture on health-care staff's beliefs, values and practices, given that practitioners are the primary point in patient care where structural and cultural competencies are enacted. In a novel extension of work in this area, our analysis also considers ethnicity differences *among* health-care staff, whether they identify as "ethnic/minority" or "non-ethnic/majority". Personal biographies have been demonstrated as pertinent to the practice of diversity in hospital

settings (Lee *et al.*, 2020; Lee *et al.*, 2021) but this factor is under-explored in the context of maternal health care. It is this gap that the current analysis addresses.

Methodology

Research design

This study is part of larger mixed-methods research that examined abortion practices among ethnic minorities in NZ. The wider study included interviews with 13 practitioners and 19 parents. It also included findings from a stakeholder consultative workshop comprising 35 participants conducted in 2022 to disseminate and discuss study findings. In this analysis, although we present our findings from the interviews conducted with practitioners – midwives, gynaecologists, obstetricians and fertility specialists – our analysis is informed by this wider research context.

Participants were recruited using multiple methods: social media, including in multiple languages, relevant medical centres and through the networks of the research team. Interviews were conducted both in-person and online (via Zoom) due to COVID-19 lockdown restrictions. The interview guide examined practitioners' perception regarding pregnant ethnic women, experience of caring for these women during pregnancy and childbirth, their own understanding of pregnancy as viewed in different cultures, challenges in providing optimal health services and opportunities for systemic changes to enhance user experience and subsequently better health outcomes both for the expectant mother and her child. Alphanumeric identifiers have been used to ensure confidentiality (EM is ethnic minority; P is Pākehā; OB is obstetrician; GYN is gynaecologist; MW is midwife; OS is other specialist). Ethics approval was given by the University of Auckland Human Participants Ethics Committee in 2019 (Reference no. 023303).

In total, 13 practitioners were recruited and interviewed. Our participants were predominantly female aside from one who identified as male. Practitioners were recruited irrespective of their ethnicity. Considering Asians comprise one of the largest ethnic minority groups in NZ, and a significant proportion lives in Auckland, most of our study participants were located in Auckland. Among our participants, some worked in hospital settings, others were independent practitioners and others worked in private health facilities offering specialised reproductive health services. As Table 1 shows, participants were also diverse with respect to their ethnicity identity and personal biographies (namely, place of birth and migrant status), which, as we demonstrate, have implications for their understanding of their ethnic and migrant clients.

Data were transcribed initially using the software *Transcribe Wreally*^{TM} followed by a manual clean for accuracy. Thematic analysis (Clarke *et al.*, 2015) was used. During data collection, interview transcripts and field notes were reviewed and analysed. This interim analysis helped monitor data saturation and pursue emerging avenues of enquiry in further depth. Codes were analysed and collated to identify overarching themes and sub-themes and were verified across authors. As authors, we recognise our own positionalities as significant in informing our interpretations of practitioners' views regarding different cultural practices prevalent among ethnic communities in NZ. We are non-clinical researchers, female,

Table 1 Ethnicity and place of birth of participants

Ethnic identity	*Personal biography*	*Participants*
Ethnic minority	Born and raised in NZ	GYN1EM, MW1EM, OS2EM
Ethnic minority	Migrant to NZ	GYN2EM, GYN3EM, MW2EM, MW3EM, OS1EM, MW1P
Majority group (European/Pākehā)	Migrant to NZ	OB1P, GY1P, GYN2P, OS1P
Majority group (European/Pākehā)	Born in NZ	

Source: Table by authors

belonging to diverse ethnicities (Indian/Fiji Indian, Taiwanese and Pākehā2) with different migration histories (born in NZ/arrived as a migrant). One of the researchers has recent experience of accessing maternal health services in NZ, whereas another has used child health services in the late 1990s.

Results

Structural competencies and communication

Structural factors are those features inherent within societal structures that facilitate differential access to social, political and economic goods, resources and opportunities for creating group-differentiated vulnerabilities (Downey and Gómez, 2018). Migration catalyses a unique set of structural inequities, such as loss of social capital, poverty and economic insecurity, and precarity of legal status, constituting "transmigration trauma" (GYN2EM) that impact pregnancy outcomes. Structural competencies ensure that practitioners are able to "recognise, analyse, and intervene" in systemic factors that create these disparities (Downey and Gómez, 2018, p. 212).

Differences in structural competency among ethnic and non-ethnic practitioners are discussed specifically with reference to the barriers ensuing from language and communication. 'Sub-optimal communication' with practitioners has been identified in international research as a key barrier to immigrant women's care (de Freitas *et al.*, 2020; see also Small, 2014; Knight *et al.*, 2021). Language is an important window to explore diversity in structural competencies: at a minimum, it covers issues of translation between English and native languages but can also refer to tonality, gestures, and meanings. Downey and Gómez (2018, p. 215) refer to the use of "patient-centered language" and "extra-clinical" language that draws on "concepts from social, political, and economic theory into the health care encounter" so as to structurally empower minority women.

In our study, the inability to communicate in the English language was reported as one of the most common barriers to accessing pregnancy and childbirth-related care. Even when patients used English, in some cases, direct translation from their ethnic language and aspects of intonation or a bluntness of speech were perceived as rude, impacting the quality of care that they received:

> [. . .] as English is not your first language and [in] a lot of the Indian languages, everything's quite direct. So the direct translation, or the way you express yourself when you're speaking, or the emphasis that you put on some words, can come across rude (MW3EM).

In other instances, practitioners mentioned that although treatment was explained, it was done superficially, overlooking the deep engagement with cultural worldviews and meanings needed for patients to make informed choices (Phillimore, 2016). GYN2EM highlights the example of "maternal serum screening" where information is not sufficiently "patient-tailored" resulting in low up-take:

> The number of patients, Indians, I come across who have not been offered a maternal serum screening is huge. And it's not that the midwife doesn't want to offer it [. . .] she probably did mention it, *like she'd mentioned to anybody else.* It's *not patient-tailored* and the patient didn't understand it and go for the test (GYN2EM).

Similarly, even when translated information was available, the translation itself did not necessarily factor in differences of cultural worldviews and practices. Instead, practitioners pointed out that it was the "same health message" that was given to ethnic women patients as if literal translation was tantamount to culturally responsive health care:

> And we are meant to provide the same health message, health education, choices, options in a guideline-based approach, irrespective of the person in front of us (GYN3EM).

The language barrier tended to be treated differently by ethnic and non-ethnic practitioners. Ethnic practitioners were more likely to engage with clients in a shared language, automatically 'code switching' for optimal communication (Wood, 2019). As the Indian practitioners below note, the ability to speak in the native language of the patients is "helpful"; it is both emotionally reassuring as well as an efficient way of providing the "facts of the matter":

> So, fortunately for me, I speak three languages […] when I am able to speak in the language then that is very helpful. Yesterday […] I saw this Punjabi couple and the woman was speaking about reduced foetal movements […] [w]hen that happens, I find that is very easy to resolve that and say, yes, putting anxiety aside, I do understand you, but these are the facts of the matter […] (GYN3EM).

> […] many of these women are Punjabi. And they come from Punjab (a state in the northern part of India). […] and I am able to converse with them in Hindi. I think that's quite helpful for them as well as me (MW3EM).

Ethnic practitioners not only translated for their own patients but they were also often called on to be translators for their European or non-ethnic colleagues. OB1P, a male European medical practitioner, notes that language has "certainly not been an issue", pointing to the benefits of an ethno-linguistically diverse workforce at the hospital: "there's someone on staff who can speak most of the common languages […] So certainly, that's not been an issue". Being an ethnic practitioner also had wider symbolic meaning than just the advantages of translation. As the comments below reiterate, clients felt a sense of "comfort" in seeing a health professional who would be familiar, empathetic and potentially non-judgemental about their cultural worlds and practices:

> I do feel that there is a level of comfort that they find when I walk through the door […] and it's nice, but it's also unfair for them to feel that way as well (MW3EM).

> I think they find it helpful to have that sense of connection in what they might perceive [to be] a very foreign health system. Culturally there's a lot of similarity […] this shouldn't be like this, but I think I just have more empathy for certain experiences that ethnic women go through (GYN1EM).

MW3EM's comment that it is 'also' "unfair for them to feel that way as well" and GYN1EM's "this shouldn't be like this" touch on the conflictual nature of the 'foreign' health-care setting that ethnic women encounter. In principle, all clients should feel comfortable with their health-care providers, regardless of their ethnic and cultural diversities. That they could only be comfortable with another ethnic professional is revealing; while clearly valued for their ability to navigate cultural differences, the reliance on ethnic practitioners reflects the failure of the system to address ethnic women's needs.

Furthermore, contrary to global evidence (de Freitas *et al.*, 2020), our data suggests that patient-centered mainstream health-care approaches can have counterproductive effects on ethnic women. Ethnic practitioners noted the stresses caused by "patient-led" care, the benchmark for health care in NZ that demands high patient involvement and "informed consent" (Bhutta, 2004). Patients are offered treatment options, risks-benefits explained, vesting ultimate decision-making with the patient. Contrary to expectations, ethnic women clients were daunted (or "lost" as GYN3EM notes below) rather than empowered by the opportunity to make their own health-care choices. The stress of decision-making may be attributed to their familiarity with directive and expert-led health systems, or they may come from cultures where women are not decision makers. For women, especially with significant language barriers, sufficient support systems may not be in place to help them make their own decisions. GYN3EM notes this below:

> If we were to take a recently migrated Indian woman who has been part of a family, where the family structure was such that she was always told what to do and she grew up believing in a

> duty as to how she was to be [. . .] and was never given the opportunity to make choices [. . .]. Then she's very lost in a system where you give her the choice because she's never made them before (GYN3EM).

> [. . .] here it's all about informed consent, patient autonomy in decision-making. And so I give them the facts and kind of ask them what they think, and they'll say, 'I just want you to tell me what to do, doctor'. Which I don't get as much from non-Asian women, or non-immigrant woman (GYN1EM).

As noted by the ethnic practitioners, patient-centered approaches, although appropriate within the mainstream, clearly disadvantage recent-migrant women. There was notably a perceptible shift between first- and second-generation migration as THE LATTER became more acquainted with the system. It is also likely, as proposed elsewhere, that although women may not wish to be the decision maker, they are still keen to be informed about their care (Fredriksson *et al.*, 2018).

Many non-ethnic practitioners were sympathetic to the language barriers faced by ethnic women and took efforts to minimise their impact on care. NZ's public health system does offer free-of-charge interpreters but in practice, there are issues with patient care via translators. Sometimes, women from very small communities preferred to have their own family members rather than assigned interpreters, given concerns of privacy and confidentiality. Having family as the primary source of communication, however, raises additional concerns, further contributing to sub-optimal communication including misinterpretations and breaches of confidentiality (Davies and Bath, 2001; Binder *et al.*, 2012). Non-ethnic practitioners, in our study, communicated a sense of helplessness in having no choice but to accept the families' translations as "genuine". Despite deep concerns about what was being communicated, non-ethnic practitioners must take people at "face value", because it is "reasonable" practice and to not do so risks being labelled "racist":

> I suppose it's just being untrusting [. . .] but because I'm not getting an answer myself, I'm getting it through somebody else as to whether I actually know that is a genuine answer that they've given or whether they've been asked the question that I've asked them (MW1P).

> Well [. . .] it's reasonable to take people at face value and what they're telling you is genuine and not necessarily presupposing there's a subversive reason, and I imagine you could miss things [. . .] but I guess there is a fear of being perceived as being sort of judgemental or racist by just asking somebody [. . .]" (OB1P).

Some of the underlying concerns around miscommunication may be removed by developing enduring patient–doctor relationships through the period of pregnancy. Relationship-building, however, is obscured because there was absence of "continuity of care". Across the spectrum of care, the participants (who were mostly hospital-based) noted the transience of their interactions with their patients. Some see them only for "three days", others "once or twice" or at a "late stage" or at the outer extreme, for "seven weeks" in care that is compared to "a conveyor belt":

> We see them *once or twice* throughout pregnancy and that's it [. . .]. You don't necessarily have a relationship where someone would say 'well, hey this is what's going on at home, or we're really upset' (OB1P).

> it's the public health system for you. There is no continuity of care and that's why I think it doesn't work in lots of ways because it's very conveyor belt (GYN3EM).

The lack of continuity of care signals a lack of opportunity to build trusting relationships between ethnic women and practitioners, where cultural nuances could be learnt on both sides. Similarly, there was lack of continuity with community support networks. MW1EM, an

ethnic midwife, pointed to the need for wraparound services for ethnic women ("there could be more wraparound support for these women [. . .]") and greater connections between health-care providers and community groups and support people. These would be beneficial in supporting new parents from conception to after the birth of the child, from within and outside the health system. Thus, there was an urgent need, as one practitioner noted, to "break through a siloed way of working and involve other disciplines [. . .] a complex care pathway which includes midwives, GPs, psychologists and support workers" (GYN2EM). In lieu of these more transformative institutional reforms, the emphasis on language and translation is one, step to ethnically sensitive maternal care.

Overall, this section examined the implications of language – an instance of structural marginalisation of new migrations – for maternal care. Structural competencies, therefore, were unevenly distributed among staff and contingent on personal positioning of the practitioners. For ethnic practitioners, shared language offered opportunities for empathetic care. However, this required continually invoking personal identities alongside their professional ones. Non-ethnic practitioners responded to ethnic women clients by working through their colleagues, using the most risk-free avenues open to them by allowing significant concessions in the care clients sought or expressing reluctance to take on clients who cannot speak English, simply because of the additional labour it entails.

Cultural competencies and constructing the ideal patient

Cultural competency refers to the ability of practitioners to reflect on their own views and biases when making health-care decisions for patients who come from diverse cultural backgrounds (DeSouza, 2008; Medical Council of New Zealand, 2019; Rodin, 2020; Betancourt *et al.*, 2003).

Cultural competency for culturally diverse and migrant populations tends to focus on ethno-cultural sensitivity and respectful care, with calls for transformative organisational changes that recognise power, privilege, racism, and history more muted for these groups (Lee *et al.*, 2020, 2021). In our study, and similar to studies elsewhere (Phillimore, 2016; DeSouza, 2013), we found that gestures of cultural competency could be empowering for ethnic women clients but also simultaneously reinforce stereotypes about culture. As in the case of structural competencies, there was unevenness in ethnic and non-ethnic practitioners' understanding and enactment of cultural competency. The management of pain and anxiety during pregnancy, labour, and after childbirth presents an exemplar of the contradictions of cultural competency.

Most participants unanimously noted a stereotype of very low threshold for pain, specifically among their Indian clients. Indian women, particularly, had a distinct way of expressing their experiences of pain – which is more likely to "sort of wail in labour during contractions [. . .] express their pain in a very outward way" (GYN1EM), creating an impression that they are unable to tolerate pain. Indian women particularly tended to use the colloquial neologism "paining" – a reference to generalised discomfort "anywhere in the body" (GYN1EM), characterised by ethnic practitioners as somatisation of psychological distress. Ethnic women's expressions of labour pain are shaped by several cultural factors: representations of women's labour pains as manageable, which this frames their expectations but not their experience; that it was "culturally acceptable to shout and cry in labour" (GYN2EM); or misconceptions that pain levels can be regulated by the doctor and it is by expressing pain that they will receive medical attention. Participants also mentioned a widely shared perception that Indian women are more anxious than pregnant women from other ethnic groups and especially so among first-time mothers. Participants noted that Indian pregnant women, regardless of occupation or education, were more likely to have questions about minutiae of everyday health such as diet, activity, rest and pain. A similar perception also prevailed in the fertility world where Indian patients were construed as hyper-anxious, seeking specific

medical instructions on every aspect of their daily lives. Their perceived lack of independence, their demands that "they should be looked after and shouldn't have to do anything" (GYN1P) while waiting for the embryo to implant are noted as distinct cultural proclivities:

> The Indian patients are the ones that often ask the most about whether they need to rest, do they need to have two weeks off work, do they need to rest and just wait for this [embryo to implant] – I'm like, 'oh no'. You very rarely hear that from the Pākehā women [. . .]" (GYN1P).

From the perspective of positionality and competencies, our ethnic and non-ethnic participants responded to Indian patients' dispositions differently. Of particular note is the contrasting use of metaphors such as "queen" and "princess". The former, "queen", came up in the ethnic practitioners' interviews referring to cultural practices of treating women who have just given birth with great care and even fragility. The cultural norm is for them to have complete rest and focus only on the baby and their own recovery, even to the exclusion of domestic concerns:

> Usually the mother-in-law [or] the mother comes and stays with them [. . .] none of my Indian ladies ever get postnatal depression because they always have someone there cooking, cleaning and they just sit like a queen [. . .] called it first 1000 days or golden days [. . .] because the majority of Asian, Indian, Middle Eastern, even in Africa, the families look after the mothers who have babies (MW2EM).

In contrast, within the mainstream, Indian pregnant women were characterised as "princesses", a pejorative connotation for someone who is over-anxious, heavily dependent on their caregiver, and unable to manage the pain and discomforts of pregnancy and labour:

> [. . .] I actually find it quite [. . .] degrading in a sense because you do hear that 'oh, Indian women are such princesses when it comes to labour. They can't handle the pain [. . .]'"(MW3EM).

What non-ethnic practitioners see as a sweeping cultural attribute contradicts international evidence, which shows that pain relief needs during delivery are different for culturally diverse groups (Lindsay *et al.*, 2016). Ethnic practitioners interpreted pain relief needs of ethnic women in more nuanced ways. Among the explanations they proposed included that ethnic women's ability to handle pain is justifiably augmented by their lack of knowledge of and fears about pregnancy and childbirth. Others suggested that it results from anxiety about giving birth in a "foreign"/new system and is most pronounced among recent migrants during their first pregnancy:

> it's usually the first pregnancy history is bad and gradually it improves [. . .]. as they get more power, they get more knowledgeable, they learn the way, they fit into the system (GYN2EM).

In fact, for some ethnic practitioners, these 'hyper-anxious' tendencies are part of the particularly "empowering" character of ethnic women. Rather than seeing the persistent and interrogative nature of ethnic women as nervousness, ethnic practitioners frame this very trait as ethnic mothers' dedication to their pregnancies:

> They seem to be more aware; they seem more empowered; they will be very focused on their and their child's well-being. So, they'll put it above everything else (GYN3EM).

Meanwhile, in the mainstream health-care system, ethnic women are compared to an idealised Pākehā/European pregnant woman against whom they were found to be consistently lacking. The health system, noted MW2EM, prefers "the perfect, white, privileged, educated" client because they are not "hard work", a construction that ethnic women did not fit in:

> The wanted ones - the perfect white, privileged, educated. Because they're not hard work. They do their own research. They read; they learn about pregnancy. They don't call you every two seconds about can I eat this? Can I do this? They carry on with their own life and then they just come to your visits (MW2EM).

These dominant perceptions of ethnic women have ramifications for care. Several midwives refused to take on pregnant Indian women as their clients ("Indian women are the topic of [how] no one wants to have [them as] first-time mothers" (MW2EM)) or regard their request for treatment with some scepticism. GYN1EM, a participant, noted the widespread staff perception to expect Indian patients – given their low pain tolerance – to present to the hospital early in the labour process. Staff acting from this perception tended to disregard Indian women's requests for help.

> [. . .] there are Indian women that have called the midwives and have been told "No, No, you are not in labour" and actually they were in very advanced labour, and potentially this stereotype affected these sequential events (GYN1EM).

There was also a leap to "write off the woman" by prescribing epidurals and Caesareans without seeking to allay their concerns or persist with normal deliveries:

> "[. . .] because you'll have doctors or midwives who are ready to just write off the woman and say, "oh, she won't have her baby normally, let's just call it a day and give her a Caesar [Caesarean]" (MW3EM).

Ethnic practitioners also highlighted that dominant medical discourse, that pregnancy and its attendant discomforts are natural, supports the overriding of ethnic women's "anxieties" and could in fact be counterproductive, especially as it may deter women from recognising or articulating real signs of maternal or foetal distress (GYN3EM).

As in the case of language, ethnic practitioners were also called on to fill in gaps in cultural knowledge for their colleagues when treating ethnic women patients. The example of a newly arrived Indian woman following an arranged marriage was a case in point. Not uncommon to young Indian women from very sheltered backgrounds, she did not have any prior exposure to sex education. Consequently, routine gynaecological procedures such as vaginal examinations were severely traumatising for her, which in turn distressed the practitioners conducting them. In this particular case, the woman was extremely reluctant to comply when asked to take off her underwear for a medical examination. Midwives were frustrated at being unable to carry out care as required, but also extremely distressed themselves, because in insisting on the examination "they feel like they're abusing the woman" (GYN3EM). Ethnic practitioners, therefore, step in offering "a lot of cultural training".

Often, for ethnic practitioners, the line between cultural translation and advocacy was blurred. Advocacy on behalf of ethnic women was not restricted to within the health-care system alone; it often also included intervening in intra-family dynamics. In our sample, ethnic practitioners were more likely to point to controlling husbands ("sometimes I feel some husbands are a bit too controlling", MW2EM) or strict mothers-in-laws ("some of the women I've cared for who have very strict mothers-in-law", MW3EM). Advocacy also extended to all minority patients, including Māori and Pasifika clients, covering gaps in workforce diversity. GYN3EM, an Indian practitioner, for instance, commented "in terms of our workforce, we have only one Pasifika women's health doctor. We do not have any Māori doctors. So, I kind of see myself as part of advocating for all of those people".

In contrast, non-ethnic practitioners were less likely to intervene in intra-family issues of cultural minorities. Some clearly recognised that they may miss aspects of harm or bias experienced by the women who come to them, but equally there was a concern with being on the wrong side of culture ("but I'm an outsider. I just don't see it", OB1P). OB1P noted cases when the client and their families' decision was to "leave it (health outcome) to God" and "you just have to accept that for them it makes sense, even though you may not make

sense with it". MW1P positioned herself as a counsellor and advisor, offering choices but not insisting on any specific outcomes ("my role is to help them and to advise them but I can't force, nor would I want to force them [. . .]"). Non-ethnic practitioners recounted a range of ways in which they strategized their care when confronted with cultural aspects. Some integrated ethnic co-workers into patient care ("most of the Indian women were seen by the Indian nurse who was very, very astute": OS1P). Equally, in a busy workplace, some practitioners under pressure of time and workloads are also reluctant to raise questions about cultural aspects that "they know will take a long time to sort out sometimes when they're really busy" (OB1P). Less commonly, they would enter into direct conflict with their patient's husband or families. GY2P noted the instance of a client's husband who she perceived as controlling in his demands for an abortion for his wife. In this case, GYN2P insisted on seeing her client without the husband, although it contravened cultural practices:

> I don't always insist on seeing the women by herself but in this situation I'm definitely going to see her by herself. [. . .] I spoke to him on the phone and he was just a really arrogant, rude man who just felt like it was his right [. . .]"

Overall, this section has demonstrated the skills and challenges of practising cultural competencies for ethnic versus non-ethnic practitioners. Despite genuine interest in accommodating cultural diversity, non-ethnic practitioners were constrained by a range of factors: a normative frame that implicitly privileged Pākehā/European women's experiences of pregnancy; the complex everyday instances that called for cultural responsiveness and the resultant strain on their own beliefs; and the intractability of workplace demands that restricted the ability to respond with care. The complexities of cultural entanglements led MW1P to note: "I'd prefer to treat everyone as an individual rather than according to their culture or their race". For ethnic practitioners, in recognising cultural differences more easily, there was added 'cultural labour' of advocacy and literacy training to undertake; to educate their colleagues about cultural diversity but also to respond to intra-familial gender norms.

Discussion

This paper is a study of maternal care delivery for ethnic and migrant women in NZ, a population group that globally has been noted as having poorer childbirth and maternal health outcomes. Part of a broader study into migrant women, gender bias and reproductive health, this paper draws on frameworks of structural (Downey and Gómez, 2018) and cultural competency (DeSouza, 2008) as two distinct facets of maternal care. The former highlights the lack of "healthcare capital" (Phillimore, 2016) of immigrant women in white-settler contexts whereas the latter focuses on the ramifications of values and practices resulting from cultural group membership. Cultural factors, enveloped in values, belief, feeling, and affect, heightened during and after pregnancy, whereas structural determinants highlight disconnection from the real-world contexts ethnic women live in and seek health care from. The juxtaposition of maintaining a sense of belongingness and experiences of estrangement mark ethnic minority and migrant women's journey of motherhood.

In many respects, the findings in the context of NZ mirror the constraints and barriers reported elsewhere around language and communication, stereotyping by professionals, ethnic women's constraints around family and cultural expectations and their lack of knowledge about reproductive health more generally (de Freitas *et al.*, 2020). Our analysis, however, goes beyond the current literature by taking into account practitioners' own personal positionalities and in doing so, adds new insights to the existing scholarship on maternal care and cultural diversity. Although existing scholarship recognises cultural

diversity among patients, differences among practitioners and their implications for care tend to be under-researched.

The first insight from the findings highlights the uneven capabilities within the health system in relation to cultural and structural competencies. Ethnic and non-ethnic practitioners had differing levels of understanding about cultural diversity. Ethnic practitioners brought with them advantages of prior cultural knowledge as well as their own lived experiences of being a migrant that informed their recognition of the nuanced needs of ethnic patients, whereas for non-ethnic practitioners, this was an on-the-job and recently learned skill. Thus, in the context of this research, instances of "overreading" or "underreading" the effects of culture and migration were not uncommon, resulting in different approaches to care. More fundamentally, what emerges are instances of discursive struggles in the constructions of ethnic pregnant women's attributes, capabilities and behaviours – from ignorant and difficult to resolute and resilient – in ways that non-ethnic women tend not to be constructed. In fact, the latter group were perceived as the desirable norm against which cultural and structural competencies were measured as a "fix" for the troublesome minority women who were positioned as an anomaly in the system. The findings point to the need to demystify construction from reality, given their very real implications in everyday care.

A second insight highlights that the unevenness within maternal health care requires different forms of responses from ethnic and non-ethnic practitioners. Ethnic practitioners are more likely to take on roles as cultural go-betweens, translating language as well as gender norms and cultural practices in the interests of client care. This cultural translation underpins struggles for the legitimisation of alternative worldviews and perspectives in dominantly Eurocentric workplaces. Their daily work life, therefore, entails a blurring of their own personal and professional identities, managing claims of expertise given their cultural positionality, on the one hand, and the risks of their ongoing declarations of being an ethnic "other". Non-ethnic practitioners, on the other hand, are overcautious in their reading of other cultures' biases and harm, opting for the least interventionist or confronting approaches where possible as a corrective for decades of cultural blindness but also for fear that to not accept cultural diversity as presented risks being seen as racist. The differences in responses by practitioners to patient cultural diversity highlight that care and competency is contingent not only on learned skills but also on *embodiment*, i.e. who is delivering the care. Efforts to bolster structural and cultural competencies need to recognise the significance of embodiment in care, as a one-size-fits-all approach fails to serve practitioners, whether they are ethnic or non-ethnic.

Strengthening structural and cultural competence involves reviewing current institutional settings related to diversity. One recommendation would be to increase the diversity of the maternal care workforce. Furthermore, training in the NZ health system needs to better address the capability needs of ethnic and migrant women. Currently, existing maternal health training focuses on the equity needs of Māori and Pasifika communities, which can come at the expense of other ethnic minority groups. As one practitioner noted: "[. . .] New Zealand has not yet accepted the fact that it is a multicultural country, not a bicultural country" (MW3EM). In a similar vein, MW2EM reflected that there is an substantive effort to respect Māori traditions but for ethnic minorities were treated as "individuals" and devoid of cultural context: "[. . .] there's lots of provisions provided for this group of women, but when the bigger bubble is 'other ethnicities' [. . .] [that] is an individual person" (MW2EM).

Aside from workforce development, workplace cultures and the positioning of ethnic/non-ethnic male and female staff also impact pregnancy care. Ethnic women typically hold marginalised professional positions within mainstream occupations, are paid less and are themselves often subject to racism and sexism within their workplaces and their own

communities (NZ Public Service Commission/Te Kawa Mataaho, 2023). GYN3EM, an ethnic practitioner, notes the stigma and inferior treatment she experiences in comparison to male white counterparts:

> "[. . .] the stigma or the judgment I face at work for who I am gives me a very beautiful insight into how that affects others. So, I have gone into interviews at my own work and said, yep, so you are able to say this to me because I'm a brown woman who will not complain, and you wouldn't do this to a white man".

These intractable workplaces further accentuate vulnerabilities in care. Ethnic women practitioners are cautious in asserting themselves in the workplace in ways that are contrary to norm; yet, their voices are profoundly important for the care of ethnic women patients. At the other extreme, Pākehā male practitioners, conscious of their privileged positioning, are less likely to intervene in 'cultural' matters. Cultural differences, although salient, are not the sole significant markers of identity. Our findings also highlight the persistence of gender as relevant in the delivery of care. Ethnic maternal care practitioners, often women themselves, in being cultural translators are in essence providing unrecognised additional labour to make up for gaps within the systems and to deliver services that are effective for minority patients. As advocates challenging cultural practices and health system indifferences on behalf of their patients, they risk exposing themselves to harm from both. The gender–ethnicity intersection is an important factor in pregnancy care: it informs considerations of risk and consequent system-defined or self-imposed limits in how practitioners approach care.

The findings therefore reinforce the basis for a third strand of competencies that we call "institutional competencies". Institutional competencies reflect the need to isolate clinician-focused skills from broader institutional transformations that are needed to address ethnic minority maternal care needs including gaps in workforce diversity, a workplace culture that is respectful of minority ethnicity-gender and ethnic representation in decision-making roles. Finally, at the institutional level, as our participants pointed out, there is a lack of recognition of ethnic minorities and migrants as an equity group. NZ has made some advances in recent years in integrating Māori and Pacific perspectives into maternal care but in doing so – or perhaps because of it – any further cultural perspective is deemed secondary. For the 20% of NZ's population that fall under the "big bubble", as our participant MW2EM noted, this outlook is less than satisfactory.

Limitations

We recognise the limitations of our study. Although our sample of practitioners is small, our subsequent dissemination of emergent findings with larger audiences at the consultative workshops confirm theme saturation. Our sample were mostly recruited from public hospitals and speak to their experiences with a particular migrant clientele. Although the interviews were about ethnic women in general, in most cases, the practitioners tended to provide responses focused on Indian women, perhaps because they represent the patient profile in public health-care institutions.

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Notes

1. The term "ethnic", as used here, refers to people from regions in Asia, Africa, Latin America and Africa. Ethnic migrant presence, particularly from China and India, has been documented as present in the country since the 18th century, but the vast numbers migrated post-1990s and today make up almost 17% of the total population. Non-ethnic in this context refers to majority populations. Māori and Pasifika are highlighted as distinct groups.
2. Pākehā is a Māori language term used to describe New Zealanders of European descent.

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