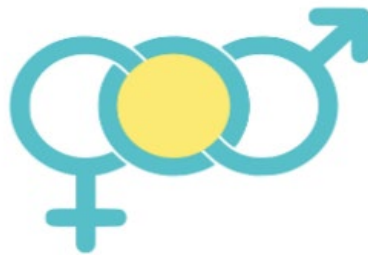


Women, Reproductive Health and Cultural Diversity in Aotearoa, New Zealand:

Report of Symposium, 8th July, 2022
University of Auckland



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MEDICAL AND
HEALTH SCIENCES





Introduction

The one-day 'Women, Reproductive Health and Cultural Diversity in Aotearoa, NZ' symposium was held to engage diverse stakeholders in conversations relating to reproductive health and ethnic and migrant women. The symposium was hosted by the Gender Bias in Ethnic Communities research team at the School of Population Health, the University of Auckland on 8th July 2022.

The aim of the Symposium was to disseminate and consult on the key findings from the 'Gender Bias among Ethnic communities in Aotearoa New Zealand' research project. The Gender Bias research is a Health Research Council funded project (Explorer Grant no. 19/730) that explores cultural values of son preference and practices of sex selection among Asian, ethnic and migrant communities.

The project, comprising distinct quantitative and qualitative data analyses phases, explores potential male-favouring sex ratios at birth (SRB) trends and underpinning cultural and gender values among New Zealand Asian communities, widely documented in other multi-ethnic western countries with concentrations of migrant Asian populations. Findings from the quantitative component of the research have been previously appeared in academic journals and general media publications noting absence of male-favouring sex ratios, and potentially, lack of evidence for sex-selective abortions (Simon-Kumar, Paynter et al., 2021; Simon-Kumar and Paynter, 2021).

The symposium was a forum to share findings from the qualitative phases of the research which were undertaken with reproductive and maternal care practitioners, and parents from Asian communities with young children.

Structure of the Day

The Symposium participants included 40 participants (excluding the research team) including workers, community representatives, clinicians, policymakers, students and academics. Attendees at the symposium identified with a range of ethnicities, religions, gender and migrant background, and represented diverse regional locations in New Zealand including Christchurch, Wellington, and Hamilton. For many, there was an overlap in their personal and professional experiences of migration, pregnancy, ethnicity and gender when reflecting on the research presented.

The hui was organised into 3 separate sessions as follows:

- Session 1: Community Values
- Session 2: Policy Concerns
- Session 3: Data Issues

Each session began with a presentation from a member of the research team summarising key findings from each specified theme. The presentation was followed by a facilitated discussion based on pre-selected leading questions (listed in Appendix A). Attendees were separated into different discussion groups depending on professional background and sector. Participants generated information based on their group discussions which were recorded on post-it notes and flipchart



sheets. In addition, three independent note-takers also collated key points from the discussion throughout the day. This report reflects these discussions.

In addition to the sessions, Dr. Susitha Wanigaratne, Social Epidemiologist & Senior Research Associate Edwin S.H. Leong Centre for Healthy Children at The Hospital for Sick Children Research Institute, who was the invited international speaker, delivered a keynote address on parallel work on son preference and sex selection being undertaken in the Canadian context among minority South Asian communities. Details of her lecture will not be included in this report.

The day ended with a summary session presented by a member of the team, and a final open discussion on potential actions forward.

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Session 1: Community Values

The opening speaker presented findings on from the qualitative phases of the study highlighting, firstly, values and practices within ethnic communities around pregnancy and maternal care and, secondly, the constructions of ethnic women clients by health practitioners, and, thirdly, the implications for maternal healthcare. The presentation highlighted that cultural values are not practiced in isolation and must be understood as intersecting with migration (including language, lack of family support) and socio-economic factors (low-paid and multiple jobs with added care responsibilities). While cultural values are to be recognised and acknowledged in the provision of maternal care, the presentation noted the limitations when culture was essentialised and ethnic women stereotyped.

In the discussion that followed, attendees were split into four separate groups based on occupation: health practitioners; researchers; government and the public sector; and NGOs and community. To kickstart discussion, we asked participants how they saw cultural practices and/or stereotypes impacting on the way reproductive and maternal healthcare is delivered to, and received by, ethnic and migrant women. There was a general agreement that reproductive healthcare reflected mainstream/dominant Pākehā values, are imposed *on* ethnic women, and often differ from the values that are held *within* the community. Participants noted the following points:

- **Judgemental attitudes** – There are often judgemental and negative attitudes that are reflected by health practitioners as they interact with ethnic and migrant women clients. This often comes as a result of preconceived ideas of what outcomes should look like during pregnancy versus the reality for many ethnic women. These judgemental attitudes can also impact on the level of health care that an ethnic woman receives compared to her European and non-ethnic counterparts.

“Be your own advocate”

- **Cultural conflict** often comes about due to tensions for women who have certain understandings for what health service delivery should look like from information passed down from generations and family. There can also be clashes with cultural practices from ethnic women’s home country. It is not uncommon in non-western contexts to follow advice from clinicians without question whereas there is a vastness of choice that in the New Zealand health system that can be confusing. For women who come from patriarchal backgrounds, there are challenges when asked to make independent decisions about their health because they often socially conditioned not to do so or because they have been discouraged by family from making these decisions. Therefore, they are often new to making their independent choices around pregnancy care, which conflicts with the Westernised system of healthcare that is focused on women readily doing so.



“Stereotypes can be debilitating”

- **Model minority as representation of all minorities:** Participants also noted that ‘model minority’ ethnic groups, i.e., educated, professional, English-speaking, affluent migrants, were often used in much of the current research and key findings as though they represented the needs of all minorities. This had the potential of invisibilising women who are not from these groups. The group expressed concerns that the voices of minorities among minorities were not being heard.
- **Misunderstandings in the health system** were identified as a key issue for the relationship between clinicians and pregnant ethnic women. There is a clear disjoint between how the former understands that health care should be delivered and the way that the latter expects to receive health care. These misunderstandings show that ethnic women are placed into a system that does not understand the cultural expression of Asian women, to both outwardly and inwardly expressions of pain. For example, expressions of pain, which are associated with ethnic pregnant women, does not equate to powerlessness or lack of pain tolerance, as the health system widely understands it. Similarly, accumulation of misunderstandings and misconstructions feed into an overall distrust of health systems by ethnic migrant pregnant women seeking care.
- **Distrust in the health system** – In part as a consequence of the misunderstandings ingrained in everyday care, and in part because of explicit discrimination, there was a distrust among ethnic women clients for the health system. Attendees recognised that there is awareness of the shortcomings of the health system in New Zealand, such as the inability to account for ethnic differences in terms of values or health care. One participant spoke of their experiences of observing first hand racism against pregnant ethnic women, all which contribute to the overall distrust of the health system.

Cultural environments are significant to the care that is sought and received. For some ethnic communities, they seek a particular healthcare service that is delivered only by members of their own community as there is more trust built in shared ethnicity. Cultural environments can often also create tension with the Westernised health care setting; given the collectivist culture of ethnic communities families expect to have greater involvement along with greater subscription to cultural and religious values in the care of the pregnant woman whereas maternity care in NZ is focused on the individual woman with a focus on bio-medical outcomes. For many, there is competing advice between the community and the healthcare practitioner, which impacts on what information the pregnant woman must follow.



- **Translation and communication** of medical advice and language capabilities was viewed as a double-edged sword in the context of ethnic and migrant pregnant women where translators were commonly resorted to. Translators could be either professionals assigned to a case or informal, where English-speaking family members step in to assist in conveying information between the women and the medical practitioners. Attendees acknowledged the importance of health information translated in languages that patients understand, however there are chances that translations can be potentially skewed. Medical practitioners are continually concerned about mistranslations, especially with family members, but are apprehensive to intervene lest they be seen as imposing themselves into a culturally sensitive space. The group discussed the possibilities of options being misrepresented 'when families potentially mistranslate health information to women. This overall lack of confidence in current practices of communication reflects issues on how information is being disseminated between the patient and the health care practitioners, including systems of support for the woman.
- **One size does not fit all** – Attendees spoke of the difficulties that arise when navigating the healthcare system. Issues include lack of support, the confused role of the mother and child during birth, and mental health systems that are not set up to support ethnic women. Health systems have made significant strides in addressing cultural needs of Māori and Pasifika communities. However, participants highlighted that the societal needs of population groups differ between Māori needs (as mana whenua) and Asian (as those who have migrated to a new land). The participants raised questions around whether: what is good for Māori is necessarily also what is good for everyone? or are the needs of these population groups too different to be reconciled with a one-size-fits-all approach.

“Disempowering – by calling post-natal women ‘queens’. It dismisses what the community is doing”.

- **Racist overtones in healthcare delivery** – The final theme raised in this session related to racism. The quality of healthcare that is delivered and received is dependant specific practitioner’s framing of certain issues and cultural competences. For example, attendees noted that in some cultures, practitioners have a responsibility to answer patient questions no matter how ‘frivolous or tedious’ they may seem. In NZ, on the other hand, there is a negative attitude toward ethnic patients who ask too many questions where patients are ordinarily expected to research and ‘google’ their own symptoms in addition to consulting the doctor. This expectation of own-care creates confusion for ethnic women who, in their own country, are actively discouraged from undertaking any form of own-care. Overall, these differing expectations create further confusion on where to get support, help or answers.



Session 2: Policy Concerns

The Policy session focused on the 2020 Abortion reform and its implications for ethnic and migrant communities, particularly around sex selection. The main presentation highlighted areas where there is lack of clarity around the implementation of reproductive rights granted in law. Among the post-reform issues raised included the following: (a) operational uncertainties for practitioners in the absence of structured processes; (b) changing relationships between women and practitioners as an outcome of the law; (c) and the impact of concurrent commercialisation of reproductive technologies. The implications for ethnic women and particularly around issues of sex selection were discussed.

Participants were split into four groups based on the following skillsets: research, advocacy, one to one client work and policy. Participants selected a group based on their own assessments of their most relevant skillsets for this discussion. We asked our attendees to reflect on the implications of the latest abortion reform in New Zealand and consider what research questions need to be thought of as these open the way forward to new avenues of enquiry into health issues.

The key themes from each group are listed below:

(a) Research

- Participants noted that it is important to understand the scale of the problem (of sex selection), including specific forms it might take, such as whether sex selection happens during abortion or assisted reproduction.
- Understand the views of various groups in relation to sex selection including:
 - Women using maternal healthcare services

“Speak to youth to get their views. [We need] a good representation of diverse youth

- Youth (young women and men) and prospective ethnic mothers
- Multiple generations and the changing values to gender status over time
- Immigrants, migrants, people who have lived here for a longer period of time

Participants were also interested to know whether the change in the abortion law has impacted uptake in abortion usage of sex selection, and especially if there is any increase of abortions between 10 and 20 weeks by ethnicity as this would assist in seeing where efforts should be directed.

(b) Advocacy

Given that international students are implicated in abortion statistics among Asian communities, more data is required to understand assumptions around their access to healthcare services especially the use of abortion as a contraceptive and on contraceptive education.

- An exploration of the potential services available to women seeking abortions and compulsory nature of counselling as a form of support.



- An exploration of the consequences of late-term abortions on clients and practitioners.

(c) One-to-one client work

Participants in this group identified the following key themes:

“[There is] a need for research and data, as anecdotes otherwise get amplified”

- There is a lack of availability of prevalence data on the uptake of non-invasive pregnancy screening test (NIPT), including reasons why families choose to have them. Anecdotally, the reasons can include seeking fertility assistance, or the pressure/social norms of having one child so the parents want to ensure the child is healthy and the mother is not blamed for abnormalities in the child, using IVF to select sex,

There needs to be exploration of socioeconomic status, on the usage of abortion services.

There was also some open-ended discussion on the risks around early-stage abortion including the complications at 13-14 weeks and the challenges of raising these without seeming as if providers are against abortion generally.

(d) Policy

The Policy group reported back the following points of discussion:

- Are Asian women requesting sex selection more after the reform?
 - Is there evidence of it in the first place?
 - What are the parameters for legality?
- The group also queried the standards for counselling in regard to the new abortion law reform.
 - Is there a new standard to be released and reflect the new reform?
- There was also discussion regarding the rights of the women vs rights of the baby
 - For example, there are implications if a woman is carrying a child with the wrong gender, such as family violence occurring to the woman during pregnancy, and to the child after it is born.

“What are the implications of not getting a child with the ‘right’ gender?”



Session 3: Data Issues

The final session of the day explored the issues that arose in the data during the research period. The opening presentation for the session noted the challenges of collecting information about gender bias and sex selection. Among the issues of data included the amorphous nature of gender bias that it is often not discernible and even when detectable, the numbers might be too small to produce significant results. The session concluded that even if gender bias may be occurring, it is too infrequent to distinguish statistical evidence from chance.

The facilitated session that followed focused on three questions:

1. What are other data sources we can use?
2. What is the appropriate balance between data needs and privacy?
3. What other ways could we detect and measure gender bias?

(a) Question 1

In response to Q. 1, participants identified the pros and cons of a range of data sources.

- *New Zealand Attitudes and Values Survey*: as a place to get a feel for the gender bias attitudes, however the method of collection for ethnicity data poses limitations on determining which ethnics hold biases towards whom.
- *NIPT data*: While data on who accesses NIPT would be useful uptake of testing is not uniform across the population. NIPT data currently is privately owned by a commercial entity which presents privacy issues and creates challenges for accessing this data for research
- *General Practice (GP)/Primary care data*: Accessing data where Chinese or Indian patients are the majority patient population group, though given the private model most primary services in New Zealand makes accessing this data a challenge.
- *IDI*: There is potential of linking the travel of women with record of pregnancy and a subsequent outbound travel to regions in India where gender bias is prevalent. However, this linkage has the potential to be highly identifying, raising confidentiality issues,

The group expressed concerns that any data access has the potential to be misused. There was also an overall sway that abortion reforms and subsequent legislation move towards a more conservative direction. There was also a call for more data on the prevalence of post 20 weeks abortions occurring in New Zealand.

“Why would ethnic women tell us? For the woman, what is the investment?”

(b) Question 2:

The participants who focused on Q. 2 identified the following problems in balancing data collection on abortion and maintaining privacy.



There was a concern for those who considered it illegal to be discussing abortions. For some women particularly, there is a risk of deportation or legal troubles in a new/foreign country when considering abortions. Additionally, there is the potential of stigma reflected onto ethnic communities, pointing to the gap between older migrant groups and new and younger ethnic populations. The potential of stigma can extend beyond communities and can become politicised, creating denigratory stereotypes for certain population groups from associations with 'negative' statistics, such as for example, high rates of abortion.

Attendees spoke of the importance of having such data available as the scope of the problem is still under-researched. If policy decisions are to be made, there needs to be accurate prevalence that reflects these issues. However, gaining quality data can be difficult in itself, as there are questions of whether the data is true or misleading. Many women may give deceptive responses due to embarrassment, fear of community or wanting to fit into New Zealand society amongst other reasons. Other issues also arise such as translation, where English may be a second language for many population groups, leading to words and meanings being lost in data collection.

Another problem identified is that the population group needing to be researched may be hard to reach due to factors outside of our control such as those living with their in-laws.

Finally, there are the questions of who owns the data overall. There are cultural implications around who collects, uses and owns data as articulated by Māori scholars in relation to data sovereignty. Similar issues are relevant in the context of the Asian/ethnic minority community as well. On the other hand, there was also the counterpoint of not collecting or using data (in the name of cultural group sovereignty) especially if that data points to inconvenient evidence of the oppression of women.

“Who owns the data?”

In response to the concerns raised above, the following solutions were identified and shared among the group.

Attendees spoke of the need for more partnership between communities and researchers. Participants need to see the investment on the information that they are disclosing, and to see the results of what has been shared. By building on this trust between the communities and researchers, there becomes a greater potential for more research to be done on those who are considered hard to reach. Communities have a role to play in recommending their members to participate in research, but this is possible only if there is an underlying trust. In doing so, it gives the researchers more opportunities to find the 'right' group of ethnic women needed for studies, such as those who are recent migrants.

The cultural and religious values of women and their communities must also be taken into account, ensuring that each woman is heard and respected in ways that validate her own experience and values.



Question 3:

In response to Q.3, the group listed the following ways in which gender bias among ethnic communities could be detected and measured.

- Noting the age of marriage for women and girls, including forced and arranged marriage and grooming.
- Education levels of women and girls.
- Detecting financial ownership in relationships including:
 - Land ownership.
 - Monetary accounts.
- Relationship dynamics including events such as unexpected pregnancies early in the relationship.
- Immigration status of couples and this effect on residency status of women.
- Gender-based violence.
- Gender data of 'terminated babies'.
- Considering the use of feminist or health equity research tools to structure and ground the research on ethnic women and pregnancies/abortions:
 - This may help eliminate misunderstandings of central concepts such as gender/equity.
 - Utilisation of such frameworks would allow the high-quality outputs of gender/ethnic knowledge.
- Examining the status and position of males/men and their representation in various spheres of society.

“[There is] more chance of data if we are engaged with specific communities”



What needs to happen?

This section covers what our attendees decided what needs to happen to ensure safe and quality maternal health care given to ethnic and migrant women. The responses are included below and are split into various subheadings, however many of these responses cover a range of issues.

Health professionals

There was a great emphasis on better, even mandatory, education and training resources for health professionals in terms of implicit bias, cultural safety, cultural norms and practices, dialogue with patients and cultural competency for health service delivery.

“Have an attitude of ‘cultural humility’ among healthcare professionals”

There was a request for more diverse health practitioners as well as for an attitude of ‘cultural humility’ (i.e., willingness to appreciate cultural values different from their own) among existing health practitioners. The intake of diverse health practitioners is tied to specific focus during recruitment and targeted advertisements for diversity in the various health professional roles of the health sector.

There was a recognition that health service providers have good intentions, however, there is a need for better service delivery, that is not solely based in the medical model.

Cultural safety and competence

Cultural safety and competency needs to be embedded into practitioner education and training, with the possibility of renewal required. However, it was recognised that there is a tension between improving cultural competency whilst being aware of not homogenising ethnic communities.

“To create safe and inclusive spaces that ethnic women can ‘be’”.

Education

Education is a highly regarded tool that needs to be more culturally and linguistically appropriate, particularly in areas such as sexual education for youth, or in the antenatal – post-natal period.

For those who are interacting with ethnic communities, there needs to be more education, not only in cultural competency but also in culturally appropriate actions that are taken to engage the community. There needs to be an understanding of diversity, cultural values and practices that are held in ethnic communities, because in doing so, more resources, classes and education tools can be developed.

Finally, specific resources are needed that introduce the maternity care structure with explanations targeted at both a local and national level.



Community and awareness

Alongside an increased visibility of the A/EM communities, there is a need for greater awareness of cultural practices, values and norms, with sustained engagement and connection with communities to ensure that the voices of ethnic people are informing the work of practitioners.

Connections are also vital within groups of ethnicities to come together to discuss issues and learn from each other.

“Increased visibility of A/EM communities”

Accessibility

There is a greater need for language accessibility, including having information written in different versions for new mothers entering the maternal health system. There is also a need to improve access to the Asian Women’s Maternal Health service.

Support

Support is needed for ethnic women, both pregnant and new mothers, to be empowered in their understandings and decision-making skills regarding sexual and reproductive health. This can include things such as antenatal classes tailored for Indian women, more health literacy programmes for new migrants, classes/lessons for pregnant women and new mothers and Asian cultural support at public hospitals.

There needs to be better education on where to find support. This can be done by bettering community outreach, and clearly showing options that are available which enhance perinatal mental health for women.

“Share these findings”

Research

Research needs better data, a place to continue with differences of practices between ethnic practitioners and Pākehā practitioners observed and noted.

Other

Other answers to ensure safe and quality maternal care for ethnic and migrant women included dismantling eurocentrism, engaging with RANZCOG (Royal Australian and New Zealand College of Obstetricians and Gynaecologists) in their diversity initiative, the shift from bi-cultural to multicultural society, ethnic women overcoming their own internalised racism and finally, prioritising and listening to ethnic and migrant women.



Final words

This document is a compilation of the minutes from the one-day symposium held at the University of Auckland, titled 'Women, Reproductive Health and Cultural Diversity in Aotearoa, NZ.' For any further questions or comments, please contact our principal investigators: Rachel Simon-Kumar or Janine Paynter at genderbiasresearch@auckland.ac.nz.

We are grateful to Bex Fraser for facilitating this symposium with respect for the safety for all our attendees and for ethnic women more widely. We also acknowledge Sujean In, Celesti Tan and Jacinda Yee, our student volunteers who supported the Symposium. Thanks to Chris from Christen Your Room for candles that meaningfully shine the messages of our hui.

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The Gender Bias team comprises Rachel Simon-Kumar, Janine Paynter, Vartika Sharma, Annie Chiang, and Nikki Singh.



Appendix A:

Session One:

1. Does this resonate?
2. (Focus on ONE of these)
 - How do you see cultural practices impacting the way healthcare is received?
 - How do you see cultural stereotypes impacting on the way healthcare is delivered?
3. What needs to happen?

Session Two:

Thinking about the implications of this in your own work, what are the research questions we still need to think about?

Session Three:

Gather around one of the following questions:

- What are other data sources we could use?
- What is the appropriate balance between data needs and privacy?
- What other ways could we detect and measure gender bias?

Stay in touch:
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