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The Health Seeking Behaviours of Ageing Niuean Women in Central Auckland

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Abstract

This qualitative study encompasses several features in its design. It is exploratory, emergent and the realms of discovery and description are informed by Max van Manen's (1990) human science approach. Van Manen's approach has enabled analysis of the data. Human science is comprised of phenomenology, hermeneutics and language and when coupled with the data collection method of focus groups makes for interesting outcomes. Time is needed to develop the narrative texts as phenomenological interpretation is never complete. There will always be levels of understanding waiting to be discovered. As a New Zealand born Niuean woman, I have provided a preliminary account of the health seeking behaviours of ageing Niuean women (Matua fifine) in Auckland. The context of health seeking behaviour cannot be realized until there is an understanding of the participant's perceptions of health and illness.

Understanding peoples perceptions of health and illness may give insights into the reasons for the decisions that the Matua fifine make when choosing to engage or not engage primary and or secondary health services. This also includes traditional medicine and complementary therapies. The assumption is that people make a direct move to seek a healthcare provider when well and unwell. What is not appreciated are the choices that are also available such as self management or a wait and see approach. Equally important is the role of spirituality, which encompasses Christian beliefs and traditional beliefs.

Background information of history and the Niuean way of life, sets the context for this study. Consultation within the Niuean community is an ethical consideration that has paved the way for support for this study. This study will enable the voice of the Matua fifine Niue to be heard so that health services will be able to respond to and preserve their dignity and individuality which are foundational for good health and positive ageing.

Glossary

Field text is composed of the data collected from the focus group meetings.

Narrative text is my analysis and interpretation.

Rather than use the term participant in the narrative text, the term *Matua fifine* is used as it recognizes and values the contribution that is being made.

“**Ethnic specific**” is the term used to acknowledge that Pacific people are comprised of people from different island groups. E.g. Niue Island.

I use the term **ageing** because mature women participate with older women in the groups in Auckland. To specifically ask for participants and then set an age limit to exclude some, seems disrespectful to those who wish to participate. Flexibility is crucial to this study as it allows room to manoeuvre to accommodate intending participants.

Agafaka motu Niue Niue way of life.

Ai malolo. Illness.

Ai fakahanoa. Do not display any disrespect.

Aitu. Ghost. I take the term to mean a spirit.

Fakaalofa. The definition within the Niue Language Dictionary (1997) gives multiple meanings for the term fakaalofa. These meanings are love, pity, greetings, gift and compassion (p. 63). In this study context, it means a gift. It is not a payment. Neither is it accepted as payment for information. To perceive it as payment is to undermine and under value the giving and receiving that has transpired between two people.

Fakahohoko e manava. To satisfy a craving for food.

Fakalilifu. To respect.

Fakapokia. To be hit by a spirit.

Fakatau au. To walk together arm in arm.

Fifine. Woman.

Fotafota. Massage.

Fuafua. Test or examine. (This is the Matua fifine’s understanding of the term fuafua).

Fakatonuaga. Proof.

Gagao. To be sick. Gagao pikitia. Contagious disease. Gagao matima. A salt related disease (Sperlich, 1997 p.94).

Higoa haau ne fia kai. What do you want to eat?

Lagamatai. To help.

Magafaoa. Family.

Malolo. To be strong, to be healthy.

Masemase kelea. Misfortune.

Mataola. To be healthy looking.

Matua. Parent.

Mamatua. Parent.

Matua fifine. I use the term to mean a mature woman or older woman and as a respectful way of addressing the participants. There is no equivalent Niuean word for participant.

Momotua Elder. I understand it to mean a respectful term for an older person.

Nane. A Niuean dish made from arrowroot and young coconut meat.

Palagi is the term used by Niuean people when referring to mainstream people of New Zealand.

Patuiki. King or Monarch.

Taulaatua. Practitioner of traditional medicine.

Tatalu. A mild illness (Sperlich, 1997 p. 300).

Toafeka. To be in perfect health

Tuafu. To feed with a rich protein (Sperlich, 1997 p.328). A special food for a sick person.

Tunu paku. To cook food on hot embers.

Uka feke. Very difficult.

Vai lakau. Herbal medicine.

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FIGURE ONE
MAP OF NIUE

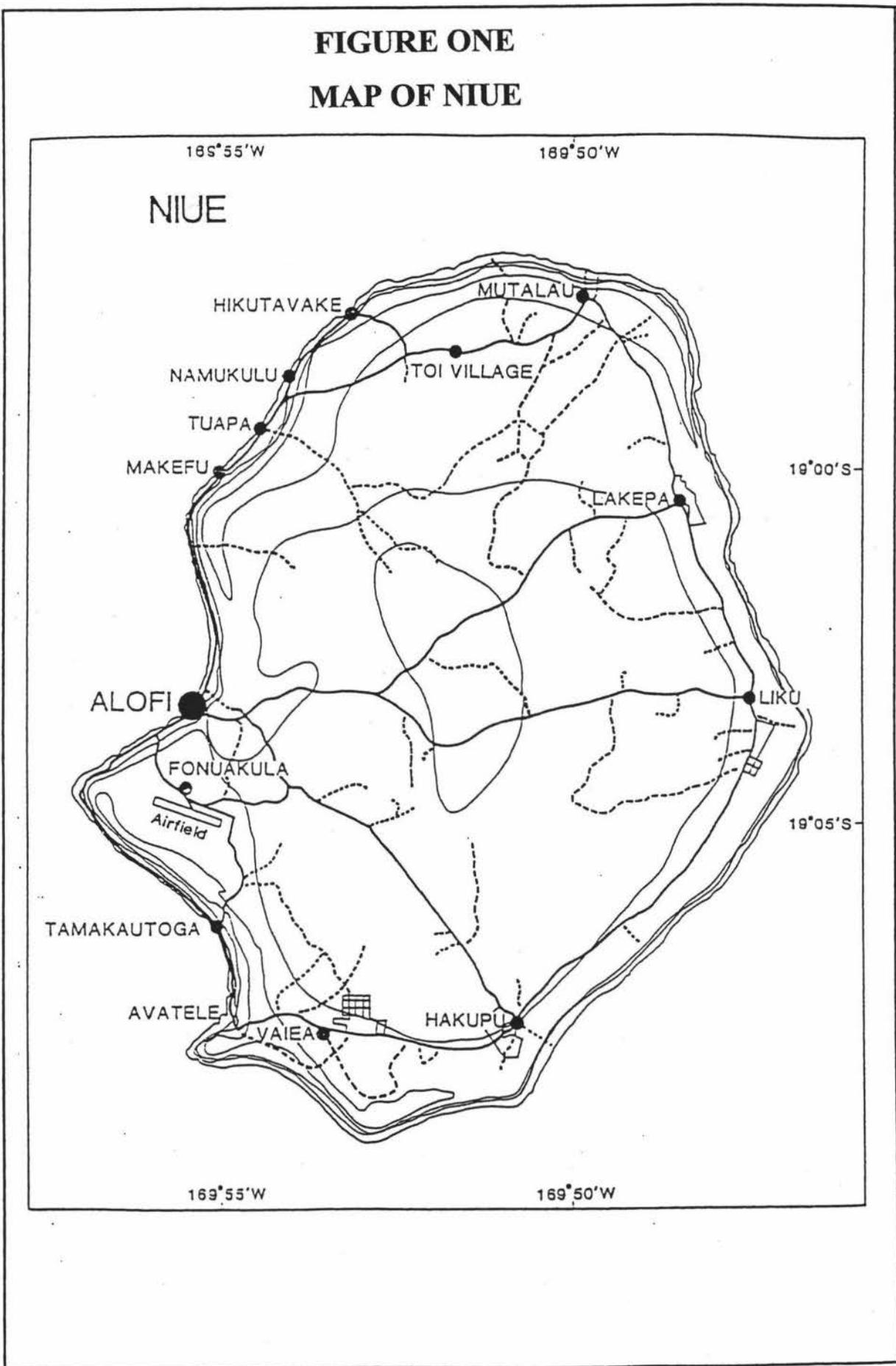
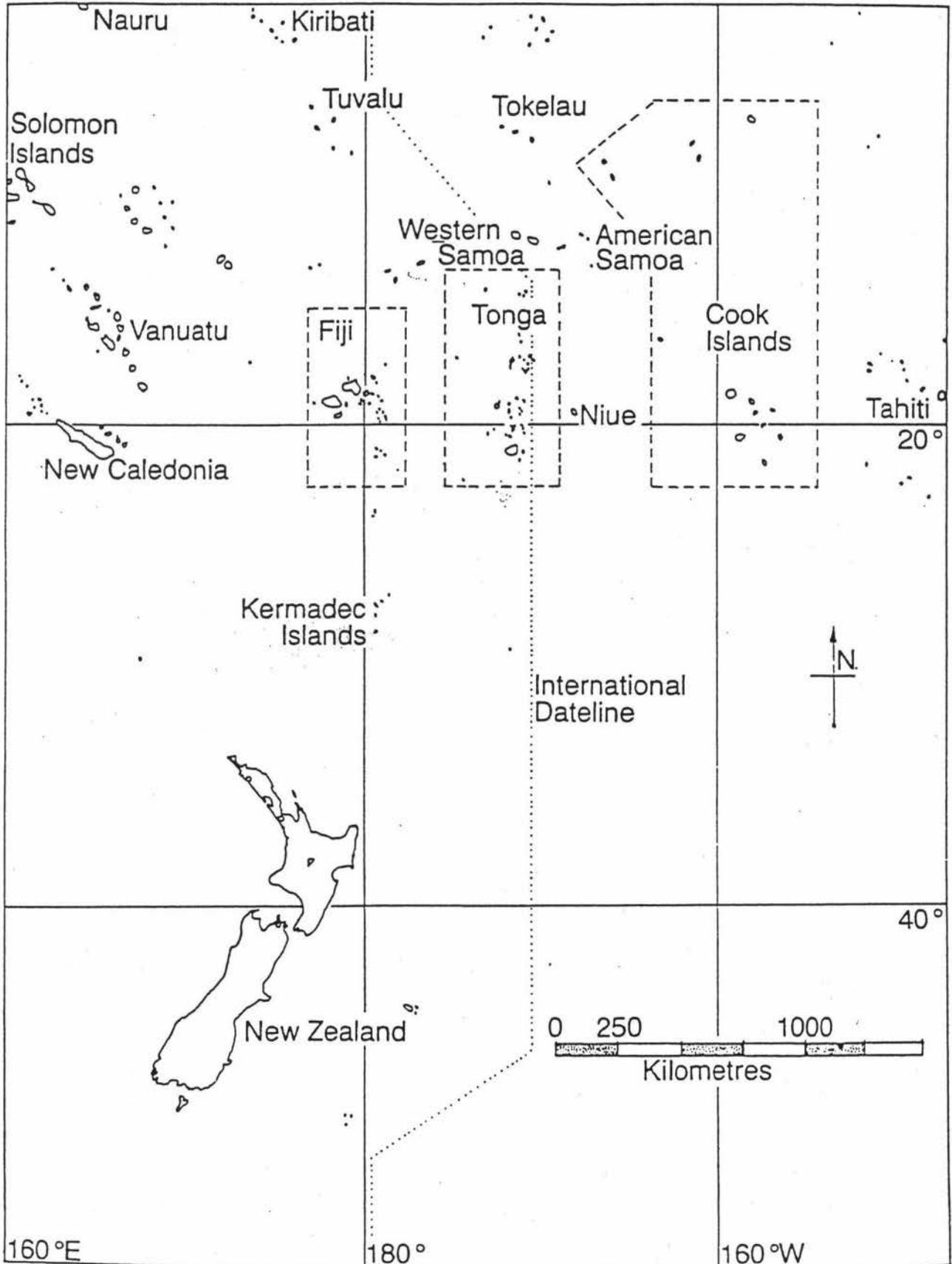


FIGURE TWO
MAP OF THE SOUTH PACIFIC



CHAPTER ONE

Introduction

This qualitative study, is exploratory in design. The exploratory nature has progressed into the realms of discovery and description as informed by Max van Manen's (1990) human science research approach. Van Manen's (1990) approach has enabled analysis of the data or field texts. Human science research seeks to understand the meaning of how people exist in the world (van Manen, 1990). As van Manen (1990) points out, human science is comprised of phenomenology, hermeneutics and language. Phenomenology describes lived experience, whilst hermeneutics interprets the field texts and language provides the vehicle for reflecting on the meaning and significance of the phenomena of interest. Thoughtfulness characterizes phenomenology (van Manen, 1990) and in doing so, it appears to bring about a sense of caring about people whose lived experiences are the focus of interest.

Exploratory studies are useful to research an area of interest when there is a paucity of data, as well as for describing and investigating the full nature of the phenomenon and related factors (Polit & Hungler, 1999). Polit & Hungler (1999) consider flexibility within qualitative designs enables adjustments to be made to meet the issues that arise as data is gathered. This is not a descriptive study whereby observing, counting, describing and classifying are the objective (Polit & Hungler, 1999). Description within this study is about describing the human science approach as espoused by van Manen (1990). This study is also emergent in design. The design can only be described as eclectic. This has been a journey of discovery in many ways, not only within the research study but also within the journey of the "self".

The research question

Nurses are drawn to phenomenology as a method of inquiry because nurses are asking different questions and seeking to know the world differently (Lawler, 1998). What is interesting is that phenomenology is a means to explore the meaning of everyday experiences and therefore, asks meaning questions (van Manen, 1990). Meaning questions are "what " questions or "how " questions. Therefore, the research question is

“What are the healthseeking behaviours of Matua fifine (ageing Niuean women) in central Auckland?”

Gadamer’s (1975 cited in van Manen 1990, p. 43) reference to the essence of the question demands an “opening up and keeping open of possibilities” and epitomizes the quest to question the phenomenon of concern. More importantly, for this study it means not only understanding the meaning of ageing Niuean women’s healthseeking behaviour in Auckland but in also understanding the abstract concepts that are used. ...“Keeping open of possibilities” has also meant understanding the concept of illness.

The research aims

This qualitative research study aims firstly; to explore, discover and describe the healthseeking behaviours of ageing Niuean women resident in central Auckland, and secondly; to describe the perceptions of health and illness.

The research interest

My original interest was in the issues of access and the factors that influence access to healthcare. This interest stems from personal interest, a passion for Pacific health issues and a commitment to the care of older people, as well as my participation in numerous consultation meetings over the past decade where the issues of access to healthcare have been raised. As a gerontology nurse, I was concerned that older Pacific peoples health needs were not being addressed. More importantly, it is the under-representation of older Pacific people in older people’s services that has generated interest (Richmond, Baskett, Bonita, & Melding, 1996). Older Pacific people were conspicuous by their absence not only in older people’s services but equally conspicuous in their absence from the New Zealand health literature. Older Niuean people, in particular, have said at community meetings (for example, North Health community forum: North Health Regional Authority, 1993) that there was the need for improved access to information.

Initially, time and energy were devoted to grappling with the issues of access because until recently there was a lack of clarity concerning the concept of access in the New Zealand health documents. (For example Ministry of Health 1997; Ministry of Health

1999). The release in December 2000, of “The New Zealand Health Strategy” (King, 2000) defined access as the

“ Ability of people to reach or use healthcare services. Barriers to healthcare can be (1) a person’s locality, income, or knowledge of services available; or (2) by the acceptability or availability of existing services (p. 48)”.

Nevertheless, before Pacific people and, in this case, Matua fifine can access health services, they need knowledge and information of the health services that exist and are available for older people. Healthcare providers also need to understand the meaning of health from a consumer or layperson’s perspective. Before, I undertook an exploration of the issues of access to healthcare it seemed pertinent to understand the meaning of health seeking for Matua fifine and this became the motivation for this study.

Health seeking behaviours

Health related behaviours have a number of different names such as health behaviour, illness behaviour, utilization behaviour, preventative health behaviour to name a few. The terms can be confusing but health behaviours, which have health related issues like health seeking behaviours are considered by Melnyk (1988) to come under an umbrella known as “health related behaviours”. Melnyk (1988 cites Kasl and Cobb (1966) who state health behaviour is “... any activity undertaken by a person believing himself to be healthy, for the purpose of preventing disease or detecting it in an asymptomatic stage” (p.196).

Melnyk (1988, cites Kasl and Cobb, 1966), considers illness behaviour as “...activity undertaken by a person who feels ill, for the purpose of defining the state of his health and of discovering a suitable remedy” (p.196). Illness behaviour is also considered to be helpseeking. Help seeking as defined by Dunning and Martin (1998) “Refers to patient initiated consultation with a health professional. The terms may be different for illness behaviour and help seeking but the meanings are the same whereby assistance is required from a provider.

Some studies that use the word “healthseeking” such as Nyamathi (1989) do not give a definition of the term. Healthseeking behaviours are defined by Carpenito (1992) as “ The state in which an individual in stable health actively seeks to alter personal health habits and or the environment in order to move towards a higher level of wellness ”(p. 470). The meaning of healthseeking for the Matua fifine participants will emerge from the data. This study will not address the theories of health related behaviours as description and the principles of phenomenology that has informed this study does not focus on theories but on being. The literature which informs this study will be discussed in Chapter Three.

I take health seeking behaviours to mean a collective or an individual move to attain, maintain, and or improve wellbeing. Decisions for health seeking behaviours can encompass a symptomatic or asymptomatic phase and do not necessarily mean a direct move to a provider.

It would appear that in relation to health seeking, more is known about the name of the phenomena than about the phenomena itself (Miller & Dzurec, 1993). Miller & Dzurec (1993) assert that within phenomenological tradition the names of the phenomena are not defined by the literature, but the participants and the researcher enable the uncovering of the characteristics of the phenomenon. The multiple meanings are inherent in the words that are used by the participants to name the phenomena (Miller & Dzurec, 1993).

Overview of the study

Health seeking is about seeking out health information and health providers when well. However, when a person is unwell the assumption is that the first move is to a primary provider such as a doctor or a secondary provider as in hospital care. The reasons that Matua fifine choose to seek out and use or not use health information and health services, traditional medicine, contemporary therapists are the focus of this study. The decision to include health seeking when in a symptomatic phase was made during the formation of questions. The Niuean women (hereafter referred to as Matua fifine but the term is also used to mean participant) in this study portray the attributes of strength and fortitude to make decisions that will meet their health needs.

This study is also about sharing the meaning of the cultural identity of Niuean people. Strength is drawn from the belief in prayer, family and the island lifestyle that has engendered the values of maintaining wellbeing in another country. More importantly, it will enable the voice of ageing women to be heard. The essence of their experience is shared so that it is not only valued but preserves their dignity and integrity, these being foundational to good health and positive ageing.

Qualitative research methods such as focus groups, with its hallmark of interaction are capable of revealing the greatest depth of description of the phenomenon under investigation (Morgan, 1997). On the other hand, phenomenology with its focus on the search for the essence of a “lived experience” (van Manen, 1990) provides the thread, which anchors the analysis of the phenomenon under investigation.

Significance of the research

Information gathered from this study will not only inform the practice of nurses and health caregivers, it also has the potential to add to the body of nursing knowledge. The availability of ethnic specific knowledge will also assist in planning and delivery of culturally appropriate healthcare and disability services for Niuean women.

How can health services be provided for Pacific people and in particular ageing women of specific ethnicity when there is little documented information on health and illness beliefs? Any debate on health issues needs to be based on data not only from a biomedical perspective but also on meanings that health consumers give to health issues. Without this data, health services fail to resolve the health issues which impact on those who use them. Pacific people call for improved access to healthcare and the Ministry of Health (1997) document “Making a difference: Strategic initiatives for the health of Pacific people” has identified accessibility and availability of health services as major issues. The current Government’s stand within The New Zealand Health Strategy (King, 2000) is to reduce inequities in health with the injection of extra funding for projects such as the Pacific Health and Disability Plan. This plan includes a number of components such as improved specialist services for diabetes, asthma, and mental health. However, services will continue to be inappropriate as long as providers see people from a problem perspective.

Understanding the people who use the services may pave the way for increased participation. Although, Cowles (1996) study was about cultural perspectives of grief, the same sentiments apply to this study in the following comment

To observe and describe human experiences without attention to the context both from which the person has drawn previous experience and in which the current experience occurs, is to ignore the foundation on which the life is built and the structures which help to maintain that life (p. 287).

What compounds the situation further is the lack of understanding of culture as a determinant of health (National Health Committee, 1998). Although the authors of the National Health Committee (1998) document and acknowledge the importance of culture, they point out that it should be included on its own and not included with social determinants. Culture, with its many attributes anchors the identity of Pacific people and in this situation, the influences on health and illness. These ideas and perspectives are discussed briefly in Chapter Two.

The significance of this research is that it also addresses the need for information on ethnic specific Pacific groups in New Zealand. In this case ageing Niuean women. What is also apparent is the invisibility of older Pacific women and their health needs in the health literature. These issues are discussed in Chapter Three.

The researcher's position within the study

I am undertaking this study as a New Zealand born Niuean woman, as a nurse of thirty years clinical experience and as a researcher. All three aspects impact on my understanding of the healthseeking behaviours of Matua fife in central Auckland. In this study I position myself within both the emic (insider) and etic (outsider) roles. Positioning myself enables the emic and the etic perspectives to address my understanding of health and illness. In an in-between role I interpret and mediate between both roles. I was also within these roles individually as well as simultaneously. What was not anticipated was the many tensions within the study, which would impact on my being. At the beginning of the research project I was employed as a gerontology

nurse in an assessment and rehabilitation ward in a large urban hospital. Part way through the project I chose to terminate my employment and care for ageing parents. The change in circumstances meant a change in thinking as I was now more community focused, because I was no longer in clinical practice. This had an impact on my decision to opt for a non nurse (van Manen, 1990) to direct my methodological outline within phenomenology, rather than to follow a respected nurse researcher. The reasons for opting for a non-nurse are discussed in Chapter Four.

When I was positioned within the insider or emic role I was aware that non-Western beliefs were not valued by mainstream (Pelto & Pelto, 1997) and when I was in the outsider role or etic role I was aware that Western tools and methodologies could assist me as the researcher to gain insights into and understanding of the phenomenon under investigation. As a result I was never completely an insider with the Matua *fifine* as I am New Zealand born, younger than the Matua *fifine* and conversely I was never completely an outsider as I could trace my descent back to a common Niuean ancestor and had been brought up within a small but growing Niuean community, in an urban suburb in Auckland.

Positioning also demands that the research process is culturally safe for the participants and the researcher. What this means for the participants is that ethical considerations will ensure that they come to no harm. If they enjoy the process then that is a bonus. As to the cultural safety of the researcher this is attained through the consultation process with the community, support from health professional colleagues, and supervision from the nurse research supervisor. Anae (1997) cautions any researcher who is researching in their own community to be very clear as to the positioning within the emic and etic role so that they can write meaningfully about their people. The issues of utilizing a culturally safe methodology have plagued this study as the responsibility has weighed heavily upon me, as the researcher, to ensure that the entrusted information would be honoured in a theoretical framework that was not of Pacific origin. It is easy to say that Western methodologies do not bode well for Pacific people but a balanced argument must be offered to offset this, whilst Pacific research methodologies remain in an embryonic phase. Until such time as we develop Pacific methodologies that are valued and accepted as academically viable we are reliant upon Western research tools. As a non-Western nurse researcher I feel that I am in a vulnerable position. However, if there

is to be any understanding to the meaning of healthseeking behaviours then western research tools need to be used to show that they are of value in generating understanding. On the other hand if Western research tools do not value cultural norms and values, give insight, or are inappropriate then there is a responsibility to document this. Phenomenology provides the opportunity to see with fresh eyes what we have taken for granted (Crotty, 1998). The phenomenological cry of 'back to the things themselves,' implies a return to the level of experiences that people know and understand (Crotty, 1996 p. 48). My journal reflections (August 2000) give some insight as to my positioning and the decision to opt for a Western methodology. The words cited by Willis (no date, accessed on the internet 6/10/00) in <http://truserve.com/~jwillis580Qual/Qual4.htm>. (p11 of 14) in the discussion on interpretative research seemed relevant to my discussion at the time.

Do research within your own paradigm but remain open to methods and results from other paradigms. Make an effort to understand what other people are saying and be willing to change your paradigm, or even give it up for another if proponents of opposing views can convince you that they have merit.

These words prompted the decision to accept van Manen's (1990) human science approach.

The structure of the thesis

Chapter one has introduced the research study. The aims and question that have guided the research process are identified and are very broad in order to allow flexibility in exploring this topic of interest. Locating my position within this study will explain the reasons for the decisions that were made. The significance of the study explains the need for information on ethnic specific Pacific older people such as ageing Niuean women to not only inform the practice of nurses but add to the body of nursing knowledge.

Chapter two is in two sections. The first section seeks to briefly define health and illness as we seem to know more about the words that are used rather than what they actually mean. The second section provides a background informing the reader of the

geographical, historical, traditional, and political background for the people of Niue in their island homeland. The background information continues with older Niueans in Niue, Niueans as Pacific people in New Zealand and then as Niuean people in (Auckland) New Zealand. A brief discussion continues with culture or the *aga fakamotu Niue* or as it is also known, as the “*Moui faka Niue!* The Niue way of life.

Chapter Three considers the literature that informs the study in terms of the socio political context. An extensive literature of health seeking behaviours is not within the bounds of this thesis as the term health seeking as a health related behaviour is unclear.

Chapter Four introduces the methodology for human science research as espoused by van Manen (1990), which also provides the perspective to analyse the data.

Chapter Five is composed of the design and method. The emergent design enabled management of issues that were not recognized or understood at the beginning of the study. Focus groups as the method of data collection is discussed. Community consultation, the ethical considerations that were of importance to this study are also included.

Chapter Six begins the first of three data chapters by considering a number of issues, such as Munhall's (1994) “portal of entry” which would enable understanding of the meaning of health, illness and health beliefs. The Matua fifine's search for health information when in a state of wellbeing comes to the fore. What also becomes apparent is the choices that the Matua fifine have in the decisions to seek healthcare.

Chapter Seven considers spirituality, which embraces both prayer and other traditional beliefs. The use of western medicine and traditional medicine in a complementary manner is shared in the narrative text.

Chapter Eight presents the last theme, which is the cost of health seeking. The cost of health seeking for traditional or complementary therapies is not a concern. Issues of cost other than finance are considered. Costs are incurred when seeking help.

Chapter Nine draws together the discussion and the importance of understanding a lay perspective of health and illness. The importance of the hermeneutic circle of inquiry is reinforced as it has uncovered and given meaning to the researcher's interpretations. The implications for nursing, limitations of the study, the tensions endured and sometimes resolved within the study.

Conclusion

The research topic is not only one of interest but it will also potentially assist in informing the practice of nurses and other healthcare providers and also provide data for service planners. To effectively care for people as nurses we must not only respect and be sensitive to the values of others but also have an understanding of the needs of ageing adults from ethnic minorities. The next chapter begins the journey of exploration and discovery by setting the context for the study.

CHAPTER TWO

Health and illness

Introduction

This chapter is presented in two sections. The first section begins with peeling away and unpacking the meanings of health and illness and disease. The term health means different things to different people at different times and in doing so, creates the situation whereby the term cannot be defined absolutely (Finau, 1994; Ministry of Health, 1997). In Radley's (1993) view, health and illness inform each other and therefore cannot be separated. The latter half of this chapter will focus on the geographical, historical traditional political background for the people of Niue in their island homeland, as older Niuean's in Niue, Niuean's as Pacific people in (Auckland) New Zealand and as Niuean people in (Auckland) New Zealand. A brief discussion continues with culture or the *aga fakamotu Niue* or as it is also known, as the *Moui faka Niue*, the Niue way of life. Culture provides an anchor for ageing Niuean women's lives. In line with van Manen, (1990) phenomenological inquiry will unearth that which has been taken for granted and also reveal what is buried within the colonial administrators reports. Before, one can progress forward there is a need to understand the past and how this can impact on the present and therefore influence the future. Crotty (1996) explains that a "return to the things themselves" (p.3) is the call of phenomenological inquiry.

The concept of health

The often quoted definition of health from the World Health Organization (1947 cited in Ministry of Health, 1997, p.5) is "A state of physical, mental and social well being not merely the absence of disease" As spirituality is recognized as a crucial aspect of Pacific life, the term is added to the definition. The definition was modified by the Ministry of Health to become "A state of physical, mental social and spiritual wellbeing not merely the absence of disease" (Ministry of Health, 1997 p.5).

The definition is still not complete because it omits such issues as culture and family, which are equally important to Pacific people. It appears unlikely that any definition of health will be universally accepted (Seedhouse, 1995). Definitions abound, but as

Seedhouse (1995) explains “ Definitions provide a foothold for understanding” (p. 20). To understand health is to also consider the cultural and specific situations. Academic definitions of health are abstract and difficult for lay people to understand and as Spector (1993) states there is little understanding of the term “health” from a layman’s perspective of health which is holistic.

What does the term health mean to Niuean people? According to the Niue Language Dictionary (Sperlich 1997), health has several meanings “To be healthy looking, *mataola*, to be in perfect health, *toafeka*, to be strong, to be healthy, *malolo* (1997, p. 452 English translations). The Niuean term for health *malolo* has multiple meanings such as “strong, victorious, unyielding, hard, stiff, taunt, healthy ”(1997, p.204). Seedhouse (2001) considers one of the many meanings of health debated by scholars, as “health is a *reserve of strength* that helps us adapt to changing circumstances” (p.5 italics as used by the author). This discussion will continue in Chapter Six when the Matua fife share their understanding of health. The English translations pertain to wellbeing whilst the Niuean term *malolo* imparts multiple meanings, all of which have positive connotations. (Throughout this study the Niuean term *malolo* is used to mean health and strength).

Lack of clarity continues if we take the meaning for granted. We know more about the word health, than what we know about its meaning. Health is an elusive concept which means many things to different people. For one Matua fife: “ *malolo* refers to a person who is not sick” (Matua fife (4) focus group 3.1. p.1). But this was the perspective of one Matua fife and cannot be generalised to all Matua fife.

According to Holland & Hogg (2001), the term health is broad and complex. Furthermore, the perception of health changes over time (Holland & Hogg, 2001). This becomes apparent when the Matua fife speak of health in their youth and health and illness in their ageing years, especially in New Zealand.

Family

Family plays a large part in any decisions on health in the lives of Niuean people. Health seeking within the island environment is not an individual enterprise but is very much a family affair. Within the Niuean concept of family, it is the older members of the

family who influence the health seeking behaviours of the family as to who will be consulted and the dietary requirements for the sick person (Tukuitonga, 1990). In the island environment, family uphold the individual during times of wellbeing and or ill health. Mind and body are not separated for Pacific people and this has a bearing on their health belief systems.

Health belief systems

Holland and Hogg (2001) identify three categories of health belief systems. These are biomedical, personalistic, and naturalistic. Biomedicine also known as Western medicine requires identification of the organization responsible for the disease so that it can be treated. Treatment is carried out by a trained health professional. Within a personalistic health belief system, ill health is beyond an individual's control. A naturalistic health belief is explained by the elements of hot and cold. Any imbalance causes illness. Jackson (1993) states that naturalistic and Western science co-exist in such countries as China.

Within the Pacific, Finau (1994) declares that there is a "mutually beneficial co existence " between traditional medicine and Western scientific medicine (p.14), so that health belief systems need not be accessed on their own but can co exist side by side.

When a health professional takes the time to understand health beliefs and a patient senses this understanding then a patient doctor relationship develops which is beneficial to both concerned. As McAllister and Farquhar (1992) explain, "the uptake of preventative health programmes are related to people's underlying motivations, attitudes and beliefs of health and illness"(p.1447).

Illness and disease

Illness and disease are differentiated. Illness is defined by the Ministry of Health (1997) as " A physical, mental, and spiritual state that society and the individual agree will adversely affect life, relationships and the performance of duty" (p.5). Illness is referred to by many names, such as "*gagao*", "*tatalu*", or "*ai malolo*" by the Matua fifine. The term "*gagao*" means to be sick, or ill (Sperlich, 1997). One needs to

seek assistance to identify, treat and cope with the illness. The term “*ai malolo*” is used mainly throughout the text to mean illness.

Freund and McGuire (1995) consider the interpretation of illness is an ongoing process and that illness can be reinterpreted at different times. Interpretation is from the individual’s perspective, from the family’s perspective and from society’s perspective. When illness is experienced there is the wait and see stance (Freund and McGuire, 1995).

“Disease is defined as a state of physical, social, mental and spiritual abnormality as defined by the medical profession” (Ministry of Health, 1997, p. 5).

For Niuean people, the term disease is difficult to define as the term is used in the context of specific illness, such as infectious disease *gagao pikitia* or related to the symptoms of the disease such as *gagao matima* meaning a salt related disease (Sperlich, 1997 p. 94). Often there is no word within the Niuean vocabulary to fit the disease terminology as used by the medical profession and explanations are given rather than a medical term. Health, illness and disease have been defined but what are health seeking behaviours?

To conclude this section, health and illness are not separated in discussion as each informs the other. The Matua fifine share their views and experiences of health and illness in Chapter Six. The latter half of the chapter continues with the Niue way of life.

Moui faka Niue, also known as the Aga fakamotu Niue: The Niue way of life.

The journey of exploration begins this chapter with a description of the geographical, historical, traditional and political background for the people of Niue in their island homeland, as Niuean people in New Zealand and as Pacific people in New Zealand. A brief discussion continues with culture or the “*aga fakamotu Niue*” or as it is also known, as the “*moui faka Niue*” (The Niue way of life). Culture anchors ageing Niuean women’s lived experience so that hermeneutical phenomenological inquiry will unearth what which has been taken for granted and also reveal what is buried within the colonial

administrators reports. Before, one can progress forward there is a need to understand the past and how this can impact on the present and influence the future. Hence, the comments from Plager (1994, p 101) are also pertinent to this chapter when she states, "Understanding is historical and must be understood historically". Knowledge of the historical context of Niuean people will enable an understanding of how this background impacts on their lifestyle health experiences and determines the essence within their health seeking behaviours within New Zealand.

Geography

Niue (Figure 1) is situated in the southwest Pacific, 480 kilometres east of Tonga, 660 kilometres away from Samoa and 930 kilometres from Rarotonga (Figure 2). Positioned on the Pacific rim, Niue experiences hurricanes and is occasionally subjected to torrential rain and heavy winds. The rocky coral, has indigenous forest and no rivers and streams, which makes a subsistence economy that has developed a hardy breed of people. Without natural water resources, fresh water was obtained from the chasm and within the trunks of trees that acted as minor reservoirs. The island was therefore subjected to periods of drought. In the past century water, was obtained from artesian bores (Nosa, 1995). Surviving in this rugged environment meant planting crops in a slash and burn method as there were limited areas of fertile soil. Without lagoons, fishing was an important supplement for food from the abundant ocean. Increasing contact with the outside world has enabled the importation of food and goods such as sugar, salt and flour. This was to influence a change in dietary habits. In later years this would have an impact on Niuean people's wellbeing with the increase in diseases of modern living such as asthma and diabetes .

History

Traditional Niuean history seeps back into the depths of time in its myths and legends. Kunitau and Hekau (1982) portray early settlement around 1500 years ago as carbon dating pinpointing the years 900-1300 can be incorrect due to Niue's high radioactivity. Before European contact, Niue chose self-isolation from the surrounding island groups for fear of contracting sickness. Ryan (1977) suggests that a previous encounter with outside island groups had introduced sickness and this had generated fear of outsiders. Contact was avoided with the outside world until 1774 when Captain Cook placed the island of Niue on the map of the world. His legacy to the people was to name their island,

Savage Island. It has taken the Niuean people many years to reclaim the rightful name of Niue Island. *Nukututaha*, which means “the island that stands alone” is an ancient name that rightly describes this island, which is the largest coral island in the Pacific. In recent times, the people of Niue Island affectionately refer to their island homeland as the “The Rock”. Ryan (1975) presents an account of contact with those from neighbouring islands such as Tonga, Samoa and Pukapuka and then the increasing contact with those from the outside world such as early seafarers, missionaries and traders. A full account of Niue history cannot be accommodated here and the reader is referred to Ryan’s (1977) “Prehistoric Niue, An Egalitarian Polynesian Society”, and the (1982) Government of Niue and institute of the Pacific Studies of the University of the South Pacific “Niue, A History of the Island”.

Contact with the outside world

Early descriptions of Niuean people are found within primary historical sources. Primary historical sources attest to the hardworking lifestyle and nature of Niuean people at the turn of the 20th century (Smith, 1902). An ability to work along side a spouse is valued. This industrious nature is an important aspect of Niuean life. As a Matua fifine (Focus group 2.1. p.2) stated “ Our bodies are strong. In Niue we work until we die”.

Traditional political system

Niue differs from its island neighbours in that it did not have the hereditary chiefs of Samoa or the aristocracy as practiced by the Tongans. Instead Niue developed a system whereby strength, individual talents and a strong work ethic (Ryan, 1977) enabled any man to aspire to leadership as the *Patuiki* (warleader) or influence and practice as a *taulaatua* (with skills and knowledge of traditional ways of healing). It is suggested by Vilitama (1982) that Niueans had their own power structure. Ryan (1977) recognized this unique characteristic and titled his thesis “Prehistoric Niue : An egalitarian Polynesian society”.

Traditional concepts of health

Traditionally, Niuean people worshipped ancient Gods to ensure their wellbeing (Etuata & Tanaki, 1982). Living in harmony with one’s environment maintained wellbeing

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(Tukuitonga, 1990). Any disruption of this harmony would create misfortune for the unfortunate individual. Etuata and Tanaki (1982) consider the Niuean people to be superstitious by nature and that activities of life were guided by a tapu system. Tapu has many meanings such as sacred, forbidden, prohibited and any disrespect in obeying protocols meant an 'unnatural death' (Sperlich, 1997 p. 299). Therefore, Niueans fiercely protected their wellbeing.

Traditional medicine

Traditional medicine is a fundamental aspect of Pacific people's life (Finau, 1994). While some educated Pacific people from different walks of life have tended to view traditional medicine with disfavour (Finau, 1994) Niuean people in New Zealand have continued to use traditional medicine. In recent times, there has been a call from New Zealand health providers (Richmond et al, 1996) for improved understanding of traditional medicine. The topic of traditional medicine is interwoven throughout this thesis.

Traditional practitioner

Within Niue, the local "*taulaatua*" held many roles. One role was as a practitioner to dispense traditional medicine. The role of the "*taulaatua*" is complicated and demands a section of its own and the reader is referred to the Niuean literature to glean this fascinating topic (Loeb, 1971). However, the role of the *taulaatua* has continued through to the present day and it is in the administration of traditional medicine that this person is sought.

Health seeking

Any description of health seeking within the early literature pertains mainly to the avoidance of strangers for fear of contracting disease (Loeb, 1924; Etuata and Tanaki 1982). McDowell (1961) asserts that any objects that were brought off boats were left in the bush for weeks demonstrating a fear of introduced diseases. The other reason for health seeking was during the time of famine. Climatic conditions such as prolonged drought (personal communication H. Douglas 12th February, 2002) and limited agricultural opportunities often created famine conditions. Health seeking during times of famine was the search for plants that would sustain life. Smith (1902) states that

sustenance was gained by eating the Fa or pandanus *drupes*. Another plant, the *ti* (*Cordyline terminalis*) could be prepared and consumed at famine and other times. The Nonu berries were also considered a famine food (Loeb, 1971).

Missionary influence

Since Missionary contact and the introduction of Christianity, the church has played an important role in the lives of the people. With the church as a focal point, missionary influence also extended to the formation of thirteen villages around the coast of the island. Niue's isolation was broken with the people embracing Christianity; this led to the vulnerability of being kidnapped by the notorious blackbirders (kidnappers). Loeb (1971) considered self-imposed isolation from the world had previously protected Niuean people from marauding blackbirders.

Securing the services of a medical officer

Within the combined reports from Niue and the Cook Islands, reference is made to the need for a medical officer for Niue (Appendix to the Journal House of Representatives, 1908). Assistance was obtained from a medical officer from Tonga. Smith (1902) in his reports to the New Zealand Government stated that there was no malaria and that the climate was conducive for any European to work in (p. 55). A report to New Zealand revealed the introduction of leprosy into Niue and the death of six Niuean people. Isolation precautions were implemented for those who had come in contact with the contagious individuals. There was no explanation as to how this was achieved.

The first reference to health seeking in early colonial documentation, referred to the declining population with the comment that there was: "No particular reason other than the well tendency of aboriginal races to decline when brought into contact with civilization" (Maxwell, 1907-1908 p. 52). Niue's geographic isolation had given protection before European contact. The secondment of a medical officer from New Zealand in 1910, was to respond to the increasing health needs of the Niuean people. The skills of the traditional practitioner could not combat the ravages of introduced and infectious diseases.

Colonial administration

New Zealand annexed Niue in 1903 and has continued to support Niue to a political position of self-government in free association with New Zealand. The construction of the first hospital was completed in 1922. Developing a workforce meant identifying capable young Niuean people to be sent to other island nations. In 1936, three young Niuean women were identified and sent to Samoa to train as nurses. Niue has a health service, which has continued to be largely funded by New Zealand.

The health of ageing Niueans in Niue

Ageing can have positive and negative attributes throughout an individual's lifetime and as Ebersole and Hess (1998) point out, is tied to history and culture. The health of ageing Niueans drew interest from an American anthropologist, who conducted several studies in Niue during the latter 1980's (Barker 1988). The health of older people in the Pacific had received little interest due to the small numbers (Barker, 1988). The health needs of infants and young children were also an issue of concern. Barker (1994) identified a number of concepts of ageing in her study of older people on Niue. These concepts are chronological age, age inflation, older age as a social group and intergenerational family groups.

Firstly, age can be a problematic concept for a number of reasons (Barker, 1994). Niuean people born before the registration of births were often unable to give accurate chronological age (Barker, 1994). Remembering and comparing life events could offer an estimate of age. Pickering and Thompson (1998) consider chronology to be a concept, which measures the value of the person's life in terms of the number of years the person has lived. This is a continuous event and cannot be interrupted. Bonita (1993) would add that chronological age is not a good indicator of health, attitudes and behaviours as there is such diversity amongst older people. But it does give some guidelines that assist in decision making for health care.

Barker (1994) discovered and articulated another interesting point, namely that social groups were based on gender and village affiliations. This is in complete contrast with New Zealand where social groups can be based on age. The formation of distinct older adult groups is a foreign concept in Niue, according to Barker (1994).

Niuean Health Services for older people

There is little current information on the Niuean health system (Barker, 1988, 1994). The Niuean government provides free health services for the people. This may influence expectations in a new country. The Niuean Government provides a pension but does not provide pensioner housing in the present day (Personal communication H. Douglas 12th February 2002). Health services for Niuean people are provided by a 20-bed hospital in the main village of Alofi. A mobile medical service, staffed by a doctor and a nurse, visited each of the villages four times a week (Barker, 1994). The mobile service no longer exists and in the present day, people who are in need of medical services are expected to attend the local hospital (Personal communication H. Douglas 12th February 2002). An ambulance service is available for those who are seriously ill. Older peoples health services are comprised of a ward for those in need of ongoing care. Within the community, a monthly health visit by the public health nurse follows up those frail and elderly who are still being cared for at home. Barker (1988) points out that there are no alternatives to hospitalisation. Although ideas for a rest home have been raised, there has been no support from Government or private enterprise.

Niueans as Pacific people in New Zealand

The heterogeneous composition of the people who make up the group Pacific Island people in New Zealand come from the main island groups of Samoa, Tonga, Cook Islands, Niue, Fiji, Tokelau and Tuvalu islands. Other island groups included in the makeup of Pacific people in New Zealand are those from the countries of Papua New Guinea, Vanuatu and the Solomon islands in Melanesia, with smaller numbers emerging from the country states within Micronesia. The island countries have their own distinct language, customs, culture and citizenship. Harmonious relations are recognized and acknowledged within and amongst the diversity of Pacific people within New Zealand (Karepa & Douthett, 1998).

Niuean people were accorded New Zealand citizenship through its political annexation in 1903. Not all Pacific people in New Zealand have the rights and privileges accorded to New Zealand citizens. For some Pacific people, such as Niueans, Cook Islanders and Tokelauans New Zealand citizenship is enjoyed. For the others who hail from independent island countries, immigration laws determine immigration status. In 1976,

Niue attained the political status of self-government in free association with New Zealand.

Migration from the Pacific to New Zealand has occurred since the end of the 1800's. Niuean people, Cook Islanders and later, Tokelauan people, have had rights of access to New Zealand. The influx of Pacific Island people from other island homelands did not eventuate until around the time of World War 11 and has continued into the present day. Settlement patterns have tended to favour Auckland with its claim to being the largest Polynesian city in the world. Other cities like Wellington, Christchurch, Tokoroa, were also favoured although smaller numbers of people headed for Hamilton, Hawkes Bay, Dunedin and rural areas as well.

This movement of Pacific people into New Zealand has seen a population increase to 202,000 people at the 1996 census (Ministry of Health, 1997). The Pacific Island population is comprised of a younger age group, which means that the youth of today will be the ageing population of the future.

Characteristics of older Niuean people in New Zealand

Older Niuean people, like older Pacific people in New Zealand, are under represented in the elderly age group (Statistics New Zealand, 1998b). The Pacific Island Profiles of Niue People In New Zealand (Statistics New Zealand, 1998a) identifies the following population trends. New Zealand's Niuean population has grown by almost 50% during the years 1986-1996. The increase is from 12,498 to 18,477 people. This increase is due to an excess of births over deaths.

Niuean people in New Zealand over the age of 65 years who were born overseas (Niue) make up 99% whilst 1% are New Zealand born. This trend will reverse as the New Zealand born will outnumber Island born and services will need to be developed to cater for this group.

Geographical trends show more Niueans settling in Auckland and lesser numbers moving south to Wellington. The first wave of Niueans who arrived pre World War II favoured Central Auckland. Parnell was an especially popular suburb for settlement with

increasing numbers moving to Ponsonby and Grey Lynn. In the past two or three decades, the trend has been to move to South Auckland or over to West Auckland.

In the 1996 census, (Statistics New Zealand, 1998a) Niuean women born in Niue were more likely to be speaking in the Niuean language in comparison with New Zealand born Niuean women. Religion was of significance to those over the age of 65. Influenced by the church in the island homeland these religious beliefs were transferred and practiced in the New Zealand environment. Family households tended to be three generational or more. There was the tendency to live with ageing adult children and their adult children (Statistics New Zealand, 1998a p.35). Niuean men and women over the age of 65 received a New Zealand pension of less than \$10,000 (p. 43). This has an impact on healthcare costs and other financial responsibilities of living in a western society.

Culture or Moui faka Niue or Aga Fakamotu. The Niue way of life

Culture is a *palagi* (Western) concept that has many meanings, such as the customs civilization and achievements of a particular time and place, nutrient material to support the growth of micro organisms, feeling disoriented in another culture, (The Reader's Digest Oxford Complete Wordfinder, 1993). Albeit brief, culture is the anchor for the Matua fifine in this study and reference to it will continue to be made throughout this study.

Language, village, descent from a common ancestor, values, belief in the power of prayer, spirituality and relationships to all aspects of life anchor an older Niuean person's identity to the culture or *aga fakamotu*. *Aga fakamotu* culture is exemplified by the multiplicity of relationships with God, the sea, the land, family, nature and the person themselves (personal communication, M. Erick, April 2000). This means living in a state of harmony and respect with all that surrounds you. The values that have been inculcated in childhood stand the Niuean in good stead throughout their lifetime. It does not matter if there is a move abroad; these values uphold the Niuean to maintain harmony within the self and the environment. Health seeking behaviours, which maintained a state of "*malolo*" wellbeing within the island environment, are continued in the new immigrant environment.

There is no equivalent word in the Niuean dictionary to define culture (Sperlich, 1997). The depth of meaning is difficult for a Niuean to explain but when Niueans speak with passion about their island homeland a fellow Niuean recognizes the essence and the 'phenomenological nod' unites two people with a common bond of understanding and there is an instant recognition of an essence in an experience that is being shared. Mainstream English words do not always portray the depth of being that a Niuean word can inspire. However, there are experiences, which are universal and are recognized by those who have experienced them. Such experiences as grief and love are a few examples that women can share and which strike a chord of recognition.

Conclusion

To conclude, the journey has described older Niuean people in their island homeland in the varying geographical, historical, political, social and traditional contexts, as Niuean people in their island homeland, as Pacific people in New Zealand as well as being older Niuean people in New Zealand. In doing so, it prepares the reader for the journey ahead. As stated, culture is important as it is evolving and is not static. If the health seeking behaviours of ageing Niuean women in Auckland is to be understood then the next part of the journey is to consider the literature that informs the study and the pearls of wisdom that it has to offer.

CHAPTER THREE

The sociopolitical context

Introduction

There is a lack of literature and research on older Pacific women resident in New Zealand and in particular ethnic specific data on health seeking behaviours. The literature search is to identify the literature, which would best inform the study. I do not seek to debate the theories of health behaviours. What I endeavour to do is to surface the many and varying issues which impact on health seeking behaviours.

As already stated in the introductory chapter statistical evidence reveals a youthful Pacific population as well as an ageing population in New Zealand (Statistics New Zealand, 1998a) This ageing population has health needs that are not being addressed by mainstream providers. Access to healthcare is not only a major concern for health policy it is just as much a concern for providers, funders and more importantly those who are unable to access services for whatever reason.

The omission of women in historical accounts

Early Pacific Island historical accounts omit mention of women. This is recognized in the Journals of Captain James Cook in his voyages of Discovery in 1774 during his first voyage to Niue. This is also noted in later historical documents (Ryan, 1984). The mention of older Pacific women as a group does not appear to be a consideration in the early literature. Early anthropological studies did not consider the aged were worthy of a study in their own right and were included in general studies as 'exotic curiosities' (Ebersole and Hess, 1998). The sources of general information for anthropologists were usually aged men (Holmes and Holmes, 1995). This perspective has gradually changed over time.

Women's health

A trend seen in more recent times is the growing international interest in women's health. Within New Zealand, the establishment of Ministries such as the Ministry of Women's Affairs in 1986 and the Ministry for Senior Citizens in 1990, recognized the needs of

older women (Bonita, 1993). Politicians are acknowledged as recognizing the important place of women and the elderly in society. However, the political view tends to emphasize what will benefit the majority omitting the specific and or special individual of those in most need. In doing so, all women are treated the same regardless of colour, culture or ethnic identity. Within Pacific women's health issues, maternal, sexual health and child health dominate interest.

When older Pacific women are considered as a group they are clumped together, implying homogeneity. The focus on Pacific women as a homogenous entity has clouded the heterogenous makeup of each island group, therefore denying an accurate picture of the realities for people accessing health information and health services. Research that clumps together people from different ethnic groups creates confusion, as it does not recognize language, culture and custom. All of which will impact on how health is defined and ultimately on health seeking behaviours of the people involved. Sorofman (1986) asserts that any investigation or research of ethnic diversity demands clarification of the ethnic population so as to avoid confusion.

Richmond et al, (1996) calls for ethnic specific data in the report to the Ministry of Health on "Older People in New Zealand". There were few responses from Pacific people to the call for submissions when the document was circulated (Personal communication from the chairperson, L. Jones, National Health Committee, 4th August 1995). Tukuitonga and Finau (1997) espouse the view that there is a need for ethnic specific health information whereby understanding of people enables appropriate services to be developed, which can then be monitored and evaluated. What is noted in the literature on Pacific people in New Zealand is that the focus seems to be on one island group and on one health specialty. Anae (1999) in her bibliography on The Mental Health of Pacific people in New Zealand notes that in recent years, any ethnic specific research has tended to focus mainly on Samoan people in mental health.

Worthy of note is the point made by the National Health Committee (1998) that the cultural determinants of health are not well developed. The focus to date has highlighted the socio economic factors and there is a call for cultural research that answers the reasons for poor health status. The issues of culture were briefly discussed in the latter half of chapter two and will not be repeated here.

Paucity of information on older Pacific people in New Zealand

Another explanation for the paucity of information on older Pacific people is the low participation of Pacific people in aged care services such as home healthcare and health services for the elderly (Walker and Armstrong, 1998). General explanations that are offered are that services are available but not accessible (Richmond et al, 1996). There is equitable provision of services (Ministry of Health, 1997). One explanation offered by Statistics New Zealand (1998b) is that Pacific people are under represented in the elder age group. This is consistent with the youthful Pacific population in New Zealand at this point in time.

However, scant data on the social and health needs of elder Pacific people in New Zealand indicates a need for data on healthcare utilization (Richmond et al, 1996). When Pacific people do not respond to the call for submissions on health issues then this also adds to the dearth of data. Consultation with key informants is crucial. Added to this, is the fact that reliable key informants who are aware of tight government time frames are invaluable during the gathering of submissions.

Confusion due to the different roles within the health sector

Tukuitonga (1990) suggests that the problems experienced by Pacific people could be explained by the confusion that is experienced when they are confronted by the many and different roles of health professionals and health workers. Living and working in Auckland has shown me that Pacific people lack knowledge of the structure and function of the New Zealand health system. It is also possible that the bureaucratic nature of hospitals and complexity of the health system deters access for Pacific people (Lurch, 1989).

There is a healthcare utilization study still in progress, which is being conducted by Pacific people in Auckland (Health Research Council, 1995). My study will complement the Tukuitonga study as my focus is on ageing Niuean women and their health seeking behaviours.

A different approach to determine the reasons for the inability to access primary healthcare was offered by Ma'ai'i (1986). As a respected Samoan doctor in the Samoan community, Ma'ai'i recognized the need for a holistic approach that may well challenge the traditional biomedical approach to health and illness. Descriptions of as much detail as possible of the history, religion, politics, economy, and culture of a social group add to a holistic view (Fetterman, 1998).

What is recognized within the literature is that "Many Pacific Island people do not regard health as a high priority because of other socio economic considerations" (Tukuitonga, 1990 p. 960). This may lead to a delay in seeking healthcare, and the consequences of the delay mean prolonged ill health and increased costs for health providers for conditions that could have been prevented with prompt attention. What providers have not always appreciated are the reasons for the delay. Some answers are provided within the socio economic determinants which impact on the wellbeing of Pacific people in New Zealand. Unemployment and low incomes create poverty and are exacerbated by poor housing and over crowding. An inability to access healthcare because of cost, transport and language difficulties, if intertwined with medical difficulties adds, to the decline of the individuals wellbeing. The biomedical conditions which impact on older people are mainly, asthma, coronary heart disease, pneumonia and diabetes (Bathgate et al. 1994).

Self denigration of old age

It has been acknowledged within the literature that the lack of holistic care includes self-denigration of old age (Campbell, 1993). There is a desire not to disturb the busy doctor. My observation over the years is that some elderly Pacific people do behave in this manner. What is revealed in the 1996/1997 New Zealand Health Survey, is the issue of unmet health need when older people in the survey did not wish to disturb a busy doctor. Another reason for the shortage of information is that older people often do not distinguish between ageing and illness, which leads to under reporting of symptoms (Charter, 1999). This in turns leads to lack of information for health professionals seeking to understand the lived experience of elderly Pacific people,

Undervaluing of cultural beliefs

Finally, frustration is expressed by anthropologists who consider decision makers within health, do not give any importance to the understanding of cultural beliefs and knowledge of consumers of health services (Pelto & Pelto, 1997). This could be explained by the different approaches to the knowledge and health beliefs. Health professionals perceive knowledge and cultural beliefs as two contrasting terms (Pelto & Pelto, 1997) whereas anthropologists give value to the terms of knowledge and cultural beliefs without making judgements on them.

Conclusion

This chapter has highlighted the literature that will inform this study. Pacific women, and in particular ethnic specific ageing women are invisible within the historical literature and the situation has continued into the present day. Health seeking behaviours and issues of access are not clearly defined and this compounds the issue. Seeking to uncover the reasons for this situation adds a level of understanding towards the health seeking behaviours of ageing Niuean women. The reasons for the shortage of information about Pacific women have overlapped over the last three chapters but were drawn further in this chapter. The next chapter continues the journey into the methodology that will inform this study.

CHAPTER FOUR

The research methodology

Introduction

From the socio political literature, which informs this study, the journey moves into the depths of theory to explain the thinking, which informs the perspective of analysing the data. Phenomenology is a useful methodology for knowledge generation as it enables exploring, describing and understanding what the subjective meaning of a phenomenon is to an individual. This in turn enables the researcher to interpret the “life experience” of human beings as it is revealed within the text (van Manen, 1990). This chapter of the thesis considers methodology in the research design, phenomenology as understood by the researcher, and then provides an explanation of phenomenology before leading onto a brief historical background. The section continues with a description and the use of phenomenology, which embraces van Manen (1990) interpretation of phenomenology.

Methodology

Within the research process, Crotty (1998) recognized the lack of clarity in the use of the terms method and methodology. More so it is how the methods and methodology relate to theory. In Crotty’s (1998) view, research methods pertain to the techniques or procedures to be used, whereas methodology was the research design, which would link the method to the desired outcome. Seeking an appropriate methodology that would clarify the philosophical underpinnings of human research and influence interpretation was important for a research study of this size. Within the research methodology of phenomenology, it is the participant’s perspective that is valued. It is seeing and understanding the world through their eyes but it is the researcher’s interpretation that brings to the fore the multiple realities within the study. The chosen methodology enables the philosophical stance to be described and in doing so enables the assumptions that I have as the researcher to be identified (described in Chapter Five). Phenomenology, which is the chosen methodology for this study, uses both description and interpretation (van Manen, 1990). The former seeks to describe, “how things appear” whilst the latter considers how “lived experiences are captured in language” (van Manen, p.180).

Phenomenology

Van Manen (1990, p.183) states "Phenomenology is the science of phenomena". Furthermore... "phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience" (van Manen, 1990 p.10). It is the study of the life world, which comes from the foundational philosophical work of Husserl (van Manen, 1990) that has subsequently been developed by other noted philosophers. This process enables the exploration and description of one's interest and understanding of a phenomenon but more importantly helps the researcher to discover the essence of the phenomenon under study.

Phenomenology is about putting on paper those understandings of an experience that we take for granted. As Heidegger (1925 cited in Smythe, 1997 p.16) explains "Phenomenology is about 'the laying open and letting be seen' that which is 'taken for granted' in our every day world". As Crotty (1998) expounds, phenomenology is a methodology that enables the researcher to return to the experience at many points along the way. This returning to the phenomenon enables reflection and further discussion with the participant(s).

The researcher who uses phenomenology is seeking to capture an essence within the stories and experiences that are shared. Extracting or articulating this essence enables the search for the interpretation within the data or field text. Van Manen (1990) states that reflective grasping provides the opportunity to consider what is significant in describing what it is that the researcher is exploring.

Variations of phenomenology

Phenomenology as a research methodology has evolved into a number of variations from differing interpretations of phenomenological philosophy. One of these variations is hermeneutics. Hermeneutics is considered to be the science of interpretation (Fjelland & Gjengedal, 1994). Koch (1995) points out that the terms phenomenology and hermeneutics have been used interchangeably even though both terms have different philosophical ideas. Cohen (1987) explains that phenomenology

has many meanings as it is used in different disciplines such as religion, philosophy and physics. The philosophical origins are interpreted by the different disciplines and interpretations are bound to differ. This may cause uncertainty (Carpenter, 1995).

In his earlier work van Manen (1990) claimed that phenomenology was not a method but was a tradition. In a later work, "From meaning to method", van Manen (1997) articulated the reason for the focus on the term method was to point out that there is no one method or way of ascertaining the true meaning of something.

The hermeneutic circle

The 'hermeneutic circle' (Welch, 1999) explains the moving back and forth between the parts and the whole. This could explain why there are new understandings and insights emerging within this study that were not previously understood.

Historical background

In an endeavour to understand the philosophy and use of phenomenology, it is important to begin with an historical background. Although phenomenology has its roots in philosophy (Lo Biondo-Woods & Haber, 1994) it is also associated with the scientific efforts of Immanuel Kant (Cohen, 1987 cites Spiegelberg). Phenomenology as a philosophical movement can be traced through the development of three distinct phases (Cohen, 1987). The three phases are: preparatory, German and French. Another phase emerges to distinguish itself from the three European phases and that is the American phase (Caelli, 2000).

The first phase, which is the preparatory phase, is associated with Bretano (1838-1917) and the concept of "intentionality" (Carpenter, 1995). Husserl added to the development of intentionality (Welch, 1999) and in doing so, Cohen (1987) considers intentionality was to become an important concept in the analysis in later phenomenological studies. But what does intentionality mean? In van Manen's (1990) view "The term intentionality indicates the inseparable connectedness of the human being to the world" (p.181). Koch's (1995) explanation of intentionality means, "the mind is directed towards an object" (p. 828).

Phase two, which is also known as the German phase, is dominated by the works of the noted philosophers Edmund Husserl (1857-1938) and Martin Heidegger (1887-1976). Husserl's line of inquiry continued to develop the concepts of essences, intuiting, and phenomenological reduction.

"The term "essence" derives from the Greek "*ousia*", which means the inner essential nature of a being, the true being of a thing" (van Manen, 1990, p. 177). It is this essential nature that is recognized and given a common understanding. In Carpenter's (1995) view, "Essences are concepts that give common understanding to the phenomenon under investigation" (p. 32). When the concept of essence is recognized in a phenomenological description, there is no need to explain, the listener recognizes the essence and connects with the experience.

Smythe (1997) offers the view that the "phenomenological nod" indicates that there is recognition of an essence in a good phenomenological description and that there is no need to explain. The term "phenomenological nod", attributed to the Dutch scholar, Buytendijk (van Manen, 1990) is equal to the voiced "aha" that a person makes when recognizing an essence. In this study there may be a need to explain the essence, as Niueans will recognize reference to the concepts that are part and parcel of their worldview but for others this may not readily be the case.

As to the second concept of "intuiting", Spiegelberg (cited in Cohen, 1987) considers that the interpretation from German to English makes the meaning of the term "intuiting" difficult. Intuiting does not appear to be discussed by Van Manen in his 1990 work. However, Polit & Hungler (1999) consider 'intuiting' to mean being open to the meanings of the phenomenon under study. In doing so, intuiting also requires the researcher to be immersed in the phenomenon being studied.

Husserl's third concept is "phenomenological reduction" which seeks to put aside one's assumptions, beliefs and bias of the phenomenon under study. In doing so the term bracketing was coined (van Manen, 1990). Van Manen (1990) does not use this term but instead refers to "the explication of assumptions and pre understandings" (p. 46).

Attention is now given to the third phase of phenomenological development: the French phase. Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905-1980), and Maurice Merleau-Ponty (1908-1961) developed the concept of embodiment and continued to develop further “being in the world” as espoused by Heidegger (1927/1962).

These three phases form the European tradition that anchors the philosophical underpinnings, and are crucial to any understanding of phenomenologically based nursing research.

The American tradition

Caelli (2000) declares that the American approach to phenomenology diverges from the European tradition in two areas. American phenomenology does not seek prereflective experiences but includes the thoughts and interpretations in the data collection and analysis. Secondly, the focus is on describing the lived experience within the context of the culture (Caelli, 2000). It is the focus and acknowledgment of culture that draws my attention. More so, it is the work of Van Manen within the American tradition of phenomenology that draws my interest because of the practical manner in which he applies phenomenology to the generation of knowledge.

The work of van Manen

Van Manen’s (1984) methodological activities quoted in Streubert and Carpenter (1995) chapter on phenomenology motivated my initial interest. But it was van Manen’s (1990) methodological themes, which confirmed the decision for me to embrace phenomenology. Although the methodological themes are listed in a particular order it does not mean that they are to be used in that order. Neither does it mean that this is a fixed set of procedures. Instead, the themes are intended to guide the research.

Van Manen’s (1990) methodological themes of hermeneutic phenomenology are:

“(1). Turning to a phenomenon which seriously interests us and commits us to the world.

- (2). Investigating experience as we live it rather than as we conceptualise;
 - (3). Reflecting on the essential themes which characterize the phenomenon;
 - (4). Describing the phenomenon through the art of writing and rewriting;
 - (5). Maintaining a strong and oriented pedagogical relation to the phenomenon
 - (6). Balancing the research context by considering the parts and the whole”
- (p 30-31).

Turning to a phenomenon which seriously interests us and commits us to the world

The first methodological theme involves thoughtfulness and a questioning of the phenomenon of interest. Commitment drives phenomenological inquiry (van Manen, 1990). This can be likened to my commitment to Pacific health issues and how the question of access and health seeking has plagued my thoughts so as to understand ‘what is going on’.

Other aspects for consideration in this theme are orienting to the phenomenon. Formulating the research question was another aspect, which was discussed in chapter one. Explicating assumptions and preunderstandings was another essential aspect for consideration and these are discussed in Chapter Five. This particular aspect was of interest in regard to knowing more about the phenomena. What van Manen (1990) is saying is that we have begun to interpret the phenomenon before we have understood the phenomenological question.

Investigating experience as we live it rather than as we conceptualise

This involves the experience as we live it and pertains to the collection of data (as discussed in chapter five). A number of aspects make up the methodological theme. Using personal experiences can be a starting point. Van Manen (1990) recognized that the researcher’s experiences are likely to be the experiences of others. Tracing etymological sources refers to the phenomena that may have lost some of their original meanings. The example that comes to mind is the term *faihoani*, which is described in Chapter Six. Some of the Niuean words used by the Matua fifine have lost their significance and were not included in the latest edition of the Niue Language Dictionary (Sperlich 1997). The Niue Language Dictionary (Sperlich 1997) does not carry the word *faihoani* in the particular context that it is used, instead, the word is

interpreted in the modern way of reference to “company: *kamupani*. club, company, co operative, company board: *kautaha kau*. However, for ageing Niuean women when the word *faihoani* is used an essence is retained and understood for the context for which it was used.

Searching for idiomatic phrases, forms another aspect of this section and these phrases abound within the study for example: ‘I go to look for my health’, ‘we work until we die.’ Borrowing other people’s experiences enables a deeper understanding of the meaning of experiences. (van Manen, 1990). The phenomenological literature is also a source for descriptive and or interpretive accounts.

Reflecting on the essential themes which characterize the phenomenon

Reflecting on the essential themes was to gain meaning of the phenomenon. Phenomenology is retrospective and not introspective (van Manen, 1990).

Van Manen identifies four fundamental existential themes, which may apply in any cultural, historical or social situation. The four existentials, which may guide the research process, are: “*lived space* (spatiality), *lived body* (corporality), *lived time* (temporality), and *lived human relation* (relationality or community)” (van Manen, 1990, p.101). Worthy of note is van Manen’s (1990) comment that the four existentials can be differentiated but cannot be separated.

Firstly, when Van Manen (1990) speaks of lived space (spatiality) he makes reference to “felt space” as in the examples of the feelings that are experienced when standing in the large space of a national museum or the wide-open spaces of the countryside. Different spaces conjure up different feelings. The Niuean person experiencing the health and hospital system in a New Zealand city for the first time may feel vulnerable and lost. Accustomed to a one-stop facility there is a feeling of awe at the sheer size and complexity within the health and hospital system.

The second existential of lived body (corporality) means that we are bodily in the world. What this means is that it is the bodily presence that is first encountered when two people meet (Van Manen 1990). It can also relate to the experience that a body is

subjected to when not having funds to pay for a medical consultation. That is, feeling scared which is an embodied experience.

Van Manen (1990) considers the lived other (relationality) is “the lived relation we maintain with others in the interpersonal spaces that we share with them” (p.104). This could be likened to relationships with others in the way that we greet them or the impressions that we form when one presents oneself to others. For Niueans the relationships of family, friendship and introduction are rekindled with a kiss of greeting and a kiss for family and friends when departing. It is also within the role of the family to assist during times of illness. For the Matua *fifine* relationality plays a large role in the lived experience of home help, which is discussed on page 120.

Lastly, lived time (temporality) is subjective time in comparison to clock time, which is objective time in van Manen’s (1990) view. The reference that Pacific people make to island time is definitely not clock time but is indicated by the position of the sun when invitations are extended or meetings are arranged in the island environment. Lived time can be interpreted by the older person in the memories of the past, whilst the younger person interprets time as being filled with activities in the present and the future. The Niuean person considers lived time to mean not wasting time and reference will be made to this throughout Chapters Six, Seven and Eight.

Describing the phenomenon through the art of writing and rewriting

The phenomenon is described through the art of writing. For van Manen (1990) this means writing and rewriting. Before this can happen, the skills of listening are crucial so as to pick out the subtleties in the language. Van Manen describes several ways in which to give flavour to the text through the use of silence, anecdote, narratives and examples. In doing so, the flavour permeates the text and brings to life that which has been obscure or hidden. Van Manen (1990) considers that periods of silence are equally important for they seek to highlight the limits and power of language and identifies three types of silence. Literal silence when there is no speaking, epistemological silence when there is situation where the words cannot be found to express how one is feeling. The third form of silence is ontological silence when there is a return to silence after an enlightening moment of speech, reading or experience.

It is interesting to note, that phenomenology cannot be conducted in an oral society (van Manen, 1990). Phenomenology demands the use of writing to record reflections. Words are used in a certain way of thinking, demand literacy, and writing and as van Manen (1990) states “Writing fixes thought to paper” (p.125). I understand van Manen’s quest in this chapter is to bring to the fore that which has waited to be shared and committed to paper. In doing so, the experience that has lain dormant, within, is revealed.

Maintaining a strong and oriented pedagogical relation to the phenomenon

In van Manen’s (1990) view, the text needs to be oriented, strong, rich and deep. Added to this view is that phenomenology is a critically oriented research. An oriented text does not separate theory from life. Van Manen (1990) calls for strength within the interpretation of the phenomenon. Richness within the text comes from anecdotes and stories, which are unique, particular and irreplaceable. Depth within the text comes from being open, to search for the rich description.

Balancing the research context by considering the parts and the whole

Lastly, van Manen (1990) calls for the research context to be balanced by being aware of the parts and the whole. Openness enables exploration and decision making for issues that were unforeseen at the beginning of the study. Planning is crucial. It is the recognition of using creativity to meet the unique needs of the study that has inspired confidence. Although van Manen comments pertain to children, he does point out that approaches may need to be innovative to meet unique needs of the study.

This study of the health seeking behaviours of ageing Niuean women takes its shape from van Manen’s (1990) methodological themes. As Caelli (2000) suggests American phenomenology allows for the exploration of experience per se and this is one of the reasons that the methodology as described by van Manen has been chosen. Exploration within this study enables an understanding and a clarification of issues, which impact on decisions whether to use or not use services, traditional medicine, complementary therapies or other sources of healthcare.

Conclusion

If any depth of understanding is to emerge, then van Manen's description of human science research provides methodological themes to guide interpretation of the data. But it is the existential themes themselves, which will provide the lever to analysis. In the next chapter, the research design and the data collection method of focus groups is discussed.

CHAPTER FIVE

Design and Method

Introduction

The previous chapter provided a description of human science as informed by van Manen which will be the approach to analyse data collected from focus groups. Focus groups are acknowledged as a qualitative research method that is exploratory in nature (Krueger, 1994). This chapter is presented in two sections. The first section informs the reader of the research design and the way that I use and interpret phenomenology, and the second section will discuss focus groups as the method of data collection.

Modifications to the original project

My original intention was to use an ethnographic approach. However, it became clear that participant observation was not suitable for this study. I amended my proposal to exclude ethnography. Ethics approval was gained for a change of data collection method to focus groups with individual interviews if required. The inclusion of individual interviews was added for two reasons: the first reason was to follow up perspectives that were briefly discussed within the focus groups and the second reason was to avoid “slippage” (Roe & Webb, 1998) in access for data collection. My past experience with Pacific people is that family, cultural, village, church and community responsibility take priority over the researcher’s project. Even rainy weather can deter participants from attending research meetings. Even if transport is supplied! Tukuitonga (1990) has stated that Pacific women need to see the benefits of agreeing to participate in such health programmes for example cervical screening. This also applies to research. Participants need to see that there is some personal benefit, before they will attend research meetings. Otherwise, the old Niuean adage applies that it is “*moumou magoaho*” or a waste of time if there are no benefits to the individual.

The research design

This qualitative research was exploratory as well as being emergent in design. That is, decisions were made as the study progressed and as Lincoln & Guba (1985) acknowledge, this is not due to the fault of the researcher but was intended to manage the

emerging perspectives that were not understood and or recognized at the beginning of the study.

A qualitative research design that encompasses an emergent design is based on “a network of assumptions” (Morgan 1983 p, 77). An assumption articulated by Lincoln & Guba (1985) is that the researcher’s values will influence the study. This is reflected in the design of the study, which seeks to respect and honour the values of the Matua fifine and allow their voices to be heard.

Qualitative research methods such as focus groups are capable of revealing depth of description of the phenomenon under investigation. On the other hand, phenomenology with its focus on the search for the essence of a “lived experience” (van Manen, 1990) provides the thread, which anchors the analysis of the phenomenon under investigation.

The interpretations that I bring to phenomenology

The interpretations that are brought to the thesis are partly constructed through the lens of an upbringing within the Niuean community. Other interpretations are clarified by the Matua fifine themselves. Cohen, Kahn & Steeves (2000) point out that the researcher may have a vague idea of the whole of the data but it is the moving back and forth within the parts that gives meaning. The hermeneutic circle drives the analysis at different levels (Cohen, Kahn, & Steeves, 2000). This means that even the smallest statements must be understood in the cultural context. The interpretations have taken time to develop and these are explained throughout the data chapters.

My approach to phenomenology

Trying to uncover the embedded meaning within the experiences has meant movement back and forth within the hermeneutic circle of inquiry, looking at the parts and trying to figure out the whole. Benner (1994) talks about “false starts” and the benefits to be accrued in writing up what has been taken for granted. The false starts could be likened to the different attempts to uncover meaning within the data. On the other hand van Manen (1990) encourages working the text so that... “the structure in its decisive form emerges as one textually progresses with the work ” (p.167). Munhall (1994) enabled the journey to continue when she used the term “portals of entry” as being any place to start (p.59). For Munhall (1994) naming the experience was an example. The portal of entry for this

study was in the understanding of health and illness as *malolo* and *ai malolo* and a return to the research question. All three points of view were important in enabling a way forward that would enable the use of van Manen existential lifeworld themes.

The researcher's assumptions

The researcher can only articulate assumptions when they become aware of what they are (Streubert & Carpenter, 1995). What I did not recognize or realize was that I had been documenting my assumptions throughout my journal. Morgan (1983) presents the view that qualitative research designs demand an emergent design that is based on a "network of assumptions" which is connected with naturalism or interpretivism (p.83). A number of beliefs are identified and Lincoln and Guba, (1985) aid my understanding by pointing out that:

"(a) reality is complex, constructive and ultimately subjective, (b) the research act is an interactive process in which the inquirer is ultimately inseparable. The paradigm for this research is "interpretative" from the subject of inquiry, and truth is best achieved by initiating the encounter with subjects of inquiry in their natural environments naively, or without prior theorizing" (p.77).

My assumptions are summarized to give meaning and understanding to the study.

- My initial assumption was that the right questions had not been asked. However, what are the right questions? Anecdotal comments from the Niuean community since arriving in the country is that "The same questions are always being asked". No one is listening.
- One of my assumptions was that there was a direct move to medical care when unwell. Medical emergencies were the exception..
- Another assumption was that mature and older Niuean women did not wish to disturb a busy doctor. This assumption was not supported.

- Another assumption was that a non-Niuean would have limited knowledge of the issues that I was raising. As a result I have to describe as much as possible so as the reader would understand my interpretations.
- One other assumption was that my ability to speak and transcribe the Niuean language was limited. This too was not supported as each of the groups encouraged and supported my ability to speak and to transcribe the tapes.
- An assumption is that all women's issues are the same. The needs of older Pacific women differ from younger Pacific women.
- There is also the assumption that health services be designed so that a one size fits all, without taking into consideration the many and varying needs of the people who make up New Zealand society and in particular those from ethnic minorities. The issues for women are currently being developed in the New Zealand Women's Health Strategy (Ministry of Women's Affairs, 2001).

Focus groups as the method of data collection

The literature gives many definitions of focus groups (Gibbs, 1997). According to Krueger (1994), who is a social researcher, a focus group is a ...“carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment” (p.6).

On the other hand, Robinson (1999) provides a definition from a nursing perspective and states

A focus group can be defined as an in depth, open-ended group discussion of 1-2 hours duration, explores a specific set of issues on a predetermined and limited topic. Such groups consist typically of between 5-8 participants and are convened under the guidance of a facilitator (p. 905) .

The former definition is a general statement whilst the latter appears to be more precise by spelling out specifics such as the type of questions used, the duration of the focus

groups, the number of participants and the use of a facilitator. The definitions of focus groups are not precise (Carey, 1994). The reason could be that the focus group method is used in marketing research, evaluation research, health research and social science research.

Justification for focus groups

Krueger (1994) makes this pertinent comment

“It is important to keep in mind that the intent of focus groups is not to infer but to understand, not to generalize but to determine the range, not to make statements about the population but to provide insights about how people perceive a situation. As a result focus groups require a flexible research design...” (p.87).

The strategies embedded within a qualitative research method such as focus groups, enables the exploration of insights and understanding of phenomena that are not well known (Krueger, 1994; Gray-Vickery, 1993; Steward and Shamdasani, (1990). Another reason for using focus groups is that it enables the voice of those who have been silent within the literature to be heard (Morgan, 1997). As Morgan (1995) points out the hallmark of focus groups is the group interaction that produces data and insights. More importantly, the goal of focus groups is to understand reality (Krueger, 1994).

The interaction within focus groups “enhances the depth of the conversation” (Cote-Arsenault & Morrison Beedy, 1999) and in doing so, prompts thoughts and ideas and ongoing discussion within a group. It is the sharing and comparing of ideas and experiences amongst participants that creates the moments of hilarity and humour that is not often found in studies. On the other hand, if care is not taken in the selection of participants then the focus group interaction may fall flat, as participants withhold their interaction for whatever reason. Such examples are, not feeling confident in the group (Sim, 1998) and contributions may be withheld if a participant feels censured (Carey, 1994). Focus groups are not aiming at a group consensus (Carey, 1994) that is finding an answer that participants agree on but to generate interaction that allows the flow of stories, opinions and ideas as stated earlier.

Focus groups are a natural forum for Pacific people

For Pacific people focus groups are a natural forum for dialogue (Tamasese, Peteru and Waldegrave, 1997). And it is this very forum where women who know each other can release those thoughts and feelings that may not necessarily emerge in individual interviews. Focus groups when coupled with interpretive inquiry are able to generate data, which enables the emergence of the essence within the lived experience of the Matua fifine.

Cultural Aspects of Focus Groups

Little is written on the cultural aspects of focus groups (Strickland, 1999) but there are a small number of overseas nursing studies. Examples are from the work of Twinn (1998) and her work on cervical screening with Chinese populations in Hong Kong. Cowles (1996) studied the cultural perspectives of grief in Wisconsin, USA, with six different ethnic groups whilst Strickland (1999) conducted her study with Washington State Native American tribes. There does not appear to be a cultural, nursing focus group study within New Zealand, but the health research from Tamasese, Peteru and Waldegrave (1997) has generated much interest in the mental health of Samoan people in Wellington. Tamasese et al. (1997) considered focus groups to be a natural forum for collective and open discussion that would enable the collection of in-depth information.

Focus groups are acknowledged as being a culturally appropriate method (Carey, 1994). Carey (1994) does not give any explanation and we have tended to unquestioningly accept her comments. What is interesting is the comment from Yelland & Gifford (1995) who argues that focus groups were constructed for Anglo-Celtic populations and that it may not be an appropriate data collection method in cross-cultural studies because of the difficulties encountered in their study about beliefs about sudden death syndrome.

Uses of focus groups

Morgan (1997) considers that social science research utilizes focus groups in three different ways. Firstly as a self-contained method in its own right as a source of data collection as seen in the Samoan mental health investigative study by Tamasese, Peteru, and Waldegrave (1997). Secondly, focus groups can be used as a supplementary method in quantitative studies prior to a study, as well as a follow up, to enhance the primary method. A third use is in multimethod studies and adds to the primary data collection

method (Morgan, 1997). Flexibility enables further exploration of the unexpected issues that arise within the study (Krueger, 1994).

The use of focus groups within the nursing profession

Within the nursing profession it is only within the past decade that focus groups as a method has gained acceptance and increasing popularity (Sim, 1998). This is apparent with the growing number of published nursing studies. Focus groups are suitable within gerontology as anxiety levels are lowered within homogenous group sampling and the small number within the group allows time to share points of view and stories (Gray-Vickery, 1993). Gray-Vickery (1993) also demonstrated the use of focus groups as a method of data collection within phenomenology could generate rich data. Unfortunately, there are very few studies in gerontology that use the data collection method of focus groups and phenomenology.

Advantages and limitations of focus groups

Krueger (1994) points out that the advantages of using focus groups is in the flexibility of the method which allows the researcher to probe. Other advantages are the high face validity, and being in a homogenous group enables people to relax so that they are likely to open up and share leading to richer data. As to the limitations of focus groups, Krueger (1994) considers the exploratory nature of focus groups is not suitable for projection to the population because the small sample does not allow for generalization to the population, (for example Niuean women in New Zealand). Other limitations identified by Krueger (1994) can be group members influencing the course of discussion indicating that the facilitator may be losing control of the focus group. Therefore, skilled interviewers are crucial for focus groups. The assumption is that focus groups are a quick and easy option for research but the reality is that planning is crucial and time consuming.

Limitations that are specific to this study include the use of an interpreter/prompt and translation of the questions. Within the interpretation from English to Niuean the nuance and the significance of the word(s) may be lost as there is no Niuean equivalent for some English words. In addition the researcher can be confident and prepared when walking into the room but can be easily overwhelmed by trying to facilitate a focus group that is bilingual. Lastly, data can be more difficult to analyse, as it must be interpreted within that context.

The second part of the chapter, will consider focus groups as the method of data collection, which will give explanations for decision making throughout the study.

Focus groups as the method of data collection

Planning

My planning of the study is integrated throughout this section. Morgan (1997) considers the planning of focus groups requires particular attention in such areas as ethics, budget and time. These aspects are discussed later in the section but what are considered important considerations for this study are consultation with the community concerned, interpreters for focus group meetings, identifying competent and reliable translators and or transcribers, gifting, and ensuring that the sample has participants who promote group dynamics and interaction, rather than stifle it.

Consultation

The qualitative research design that is exploratory and flexible in nature begins with consultation to ensure that the research practices are appropriate and acceptable, and more importantly, that the outcomes will benefit the people concerned. Although the Ministry of Pacific Islands Affairs document Pacific Analysis Framework (1998), (hereafter referred to as PAF) offers guidelines for policy, these guidelines are also relevant for research within and amongst the Pacific communities in New Zealand. Consultation is considered an investment in terms of time given to gain rapport and trust amongst participants within a study (PAF 1998). Consultation is not only a common courtesy but it also acknowledges and recognizes the people concerned. Ongoing communication will be maintained by the reporting back to the participants and to the groups on completion of the study. Consultation included prominent Niuean key informants, the Niue Advisory Council, Niuean health professionals, and older Niuean women's groups.

The multitude of information on how to conduct focus groups was quite overwhelming at times as each author shared their process. It is interesting to note that Morgan (1997) provides his rules of thumb:

- (a) “Homogenous strangers as participants.
- (b) Relatively structured interviews and high moderator involvement.
- (c) Have 6-10 participants.
- (d) Have a total of 3-5 groups per project (p. 34)”.

As the researcher of this study I was mindful of these suggestions from Morgan (1997). There was a need to allow flexibility in this process to pursue the levels of data collection that have provided insights and understanding. More importantly, it has enabled me to conduct these focus groups in a culturally sensitive manner. The interviews have been more semi-structured to accommodate the use of both Niuean and the English language. The departure from Morgan’s rules of thumb, begins with the selection of participants.

Obtaining research participants

In this study several issues in the selection of the participants required attention. Participant selection was both convenience and purposive. Convenience sampling was undertaken for the access to groups and availability of participants. Purposive sampling (Cote-Arsenault & Morrison Reedy, 1999) requires participants who are not only knowledgeable of the phenomenon being studied but who are also willing to participate.

The participants were all Niuean born women over the age of 45, not 60 as planned. Participants were self selecting from two groups who attend women’s fortnightly meetings. The researcher did not consider it good form to refuse Matua fifine who wished to participate because they were part of the women’s fortnightly meetings. The Matua fifine from the originally planned third group were unable to participate. A fourth group was approached but unforeseen circumstances prevented their participation. A group of Matua fifine from a central Auckland community were invited to a meeting, organized by a Matua fifine from within this community. Most had withdrawn from an established group and were interested in finding out what the meeting was about. Self selection enabled four women to form what would become the third focus group. I needed the third group to ensure that I had reached saturation.

Morgan (1997) considers the ability of participants to talk freely to each other and to feel comfortable about the topic to be crucial to the success of the discussion. Homogeneity in background not attitude is an important factor for Morgan (1997). This was achieved in

the formation of the groups and the ability to talk about sensitive topics without embarrassment. Morgan (1997) argues that screening participants alerts them to the topic. If participants are not familiar with the topic then more exposure to the issues gives them time to think them through and respond accordingly. This was the reason for having two group meetings to introduce the study and canvas potential participants and two focus group sessions with second session being used for clarification purposes.

Another issue requiring attention was the issue of strangers versus acquaintances. Krueger (1995) asserts that there are many communities whereby it is difficult to find strangers. Within this study it would have been virtually impossible to get Niueans who are strangers to each other as the population of Niue is small and Niueans know of each other or can trace descent back to a common ancestor. Added to this the numbers of older Niuean females is small in Auckland.

Morgan's (1997) recommendation regarding the number of participants is determined by two factors; that the group is small enough to be free to express their thoughts but big enough for the diversity of opinion (Krueger, 1994). Researchers give varying numbers but the usual size seems to be 4- 12 (Krueger 1994). If the group size is smaller than 5 or larger than 12, then these numbers may constrain discussion. Namathi and Schuler (1990) regard 7-10 participants as ideal. Focus groups one and two each had six participants and focus group three had four participants in the first focus group meeting and for the second focus group meeting, numbers remained the same in the first two groups but the third group had two participants.

Planning and gaining access involved a considerable investment of time. Access to three groups was arranged at the beginning of the project with the co-ordinators of the established groups. As stated, I had two group meetings. The first meeting was to consult the group about my intentions to conduct the research study in the community as well as to seek support and potential participants. The second group meeting was to inform the groups of ethics approval, pretest the questions and begin participant selection.

Pretesting of the questions was done in the second group meeting of focus group one and two. (Group meetings were for consultation, gain participants and pretest questions for the study). The purpose of pretesting within the groups was not only to check the

understanding of the questions but also to whet the appetite and curiosity of potential participants. The questions were also pretested with individual women from the Niuean community. The questions were accepted, and no changes were made.

I could not assume that I had access whenever it suited me. Negotiation and renegotiation with groups was ongoing (Burgess 1984). Negotiation with the co-ordinators required patience as they were busy and fitting in my need to discuss the project often needed an innovative approach for one particular co co-ordinator, as she was never available. I identified the community meetings that she would be attending and attended them myself. This paid off and access was arranged. The group co-ordinators informed me when it was convenient to attend. Participants were more likely to be available in a non-pension week as group activities were usually organized in the pension pay week.

Budget

This was an important aspect of planning, as I needed to fund the study. Costs would be incurred with venue, refreshments, transport, *fakalofa* (gift) and other incidentals that would be required such as a tape recorder, batteries etc. An application was made to the Health Research Council and to Massey University for funding. The applications were successful.

Translators and transcriptions

Planning also included identifying a reliable translator. My experience of the availability of translators in Auckland was that professional translators were too expensive and too busy. Arrangements were made to send the tapes to Niue for transcription. Before the tapes were sent, a confidentiality form was signed and mailed back by the transcriber in Niue. (See Appendix G) In order to ensure safety and confidentiality of the tapes, permission was gained from the Administrator of the Niue Consular's office to send the tapes via the Government diplomatic bag. Only, the tapes from the first focus group were sent to and from the island in the diplomatic bag.

Group meetings

At the first of the group meetings I waited to be invited to speak and then I explained the study and invited members to participate in a focus group discussion on how, when,

where and why ageing Niuean women choose to use or not use health services, traditional medicine and complementary therapies. I was seeking 4-6 participants from each group to participate. I gave people who expressed interest, an information sheet to take home to consider their participation. The issues concerning consent were included in the information sheet and so I did not give the consent form to take home. I read out the Niuean information sheet. I also read through the consent form pointing out that confidentiality and anonymity could not be guaranteed, as I had no control over what participants said once they left the group. Participants would be asked to respect what was said in the group and to not repeat it outside the group. The participants identified themselves in the second group meeting.

The venue had to be confirmed the day before the event. Contacting participants the night before to confirm attendance was crucial to ensure that transport as well as a driver was available. All equipment was checked. Most important to this whole enterprise was the question guide. The development and translation of the research questions is worthy of a study all of its own.

The role of the moderator

As the researcher I undertook the role of moderator, which is facilitator to stimulate discussion within the group. As moderator I followed new topics as they arose and endeavoured not to ask questions that had been covered (Morgan,1997). This made aspects of the analysis difficult. As well as moderating the interview, I was also responsible for tape recording. Other aspects such as transport and refreshments were left to another person.

The role of the assistant

The role of the assistant within the focus group discussion in this study is really one of assisting with prompting, clarifying in the areas where participants are unsure of language. The assistant could not be called a co facilitator as the role differs to that which is described in the literature by Krueger (1994) and Morgan (1997). The role of the co-facilitator/co moderator is to take notes, note the group dynamics and body language, monitor the recording devices and in general support the moderator facilitator and does not participate in the group. The one area where there is common ground is in the debriefing and discussion post focus group meeting. Group one assistant was a group

member, group two assistant was the group co ordinator and group three assistant was a Niuean health professional.

Another departure in the focus group was that the assistants were informed of their role as assisting with interpreting. The group synergy drew them in and they participated. It was too late to get in another interpreter prompt. On the other hand, to bring in an interpreter from outside the group would affect the group dynamics. Trust is paramount. As stated the participants were aware that I was becoming fluent and I was encouraged to use the first language. The interpreter non disclosure form is enclosed (Appendix F) but was not used as, as the main questions had been translated.

Structure of the focus group discussion

Preparation for the discussion demanded serious consideration of the research questions. Krueger's (1994) discussion on the benefits of using either a topic or question format assisted in making a decision. Preference was for a format guide, but I lacked the ability to spontaneously phrase the questions in the Niuean language. The decision was made to use a question guide to ensure that the translated questions would be consistent across all groups (Appendix H). A major concern was that a different interpreter in each group might ask questions differently. This difference in interpreting would be another problem in analysis.

I had probing questions but needed questions that would stimulate discussion. Kingry, Tiedje & Friedman (1990) suggest that the questions should be open ended and based on the literature review and purpose of the study. This generated the question on knowledge of older people's health services. As the purpose of the study was to also elicit the perceptions of health and illness, questions were also formulated around this area well before entering the field.

Nyamathi & Schuler (1990) recommend that "why" questions should be avoided as they may be perceived as threatening. Stewart and Shamdasani (1990) assert that asking "why" questions may generate too rapid a response. Why questions were unintentionally asked on several occasions within focus group one but were asked in a way that was more inquiring rather than threatening. The Ethics committee requested an amendment be

made to my questions with the inclusion of the question "Is there anyone else that you would not go to and why?"

The Matua fine themselves asked questions. Within phenomenology many questions or prompts are asked to tease out the lived experience (van Manen, 1990) which helped me to understand why I had so many questions. The issue of the number of questions arose for Morgan (1997) who advocates no more than twelve questions, as there is insufficient time to respond to them all. If the topics arise within the interview, then the relevant question pertaining to the topic may not be asked. The second interview in each group provided the opportunity to probe and clarify issues of which I was unsure.

Venue

Venues were according to the participant's preference. This must be a safe environment but also one that is conducive to the participants wellbeing (Gray-Vickery, 1993). Venues are discussed in the section on the implementation of focus groups. Group one chose to use one of the community rooms where they met fortnightly. A small cost was paid to hire the room for two hours. Group two opted to use one of the rooms next to the church hall. In New Zealand, Pacific Island church buildings are used as community gathering places and people feel comfortable using them. This contradicts Cote-Arsenault & Morrison Beedy (1999) who considered participants would be uncomfortable holding their meeting in such a respected place. Group three agreed to the use of a clinic room in a local community centre.

Moderating the group

Within each focus group meeting, participants were welcomed and each meeting commenced with prayer. Each group required a different level of moderation or facilitation varying from high to low. Within group one there was high level of facilitation to engage the group to begin with and it then progressed to the group interacting and responding. Group two was different as there tended to be a lot of leading from the co-ordinator but this was also to engage the participants initially and then settle to an interaction amongst the group. I sensed that I had low facilitation in this group. This could also be interpreted as respect for the group process. The members of this group have been meeting for over ten years and are accustomed to interacting. Concerned that

the group two co-ordinator might be influencing the discussion I rang and asked her if she would allow the participants time to share more of their experiences. Added to this, my recorders failed me and some of the questions needed to be clarified or repeated. The second focus group meeting flowed unproblematically. In focus group three, facilitation was high to begin with but settled to a medium level as participants shared. This was the best focus group discussion as I had settled into my role and was feeling confident with facilitating because there were only four participants. Morgan (1997) states that there are no right or wrong answers. This point was emphasized in order to engage participants.

Ground rules in terms of group behaviour, were not set as I did not think as a younger Niuean woman that it was my place to tell older Niuean women how to behave in a group meeting. This could be perceived as insulting. Niuean people have their protocols in meetings and these are adhered to. Respect for others to speak without interruption is an unvoiced expectation. Although the assistant could ask for participants to speak one at a time in excitable moments. What was emphasized, was to respect what was said in the group and not to repeat anything outside.

Winding down

Morgan (1997) calls for an indication that the session is winding down. Group one wound down when I noticed that as we had started late, time had moved quickly so that lunch for diabetics was late. The call was made inviting last minute comment but as there was none, the session ended. Fruit was on the table and members had nibbled throughout the discussion so there was no risk of (diabetics in the group) having a hypoglycaemic episode. A prayer was shared and participants moved to another room for lunch. Krueger (1994) advocates a summary on completion of the session. This was not done as time had been given to attending to everything else. Participants were given a list of themes at the next meeting.

When the participants of focus group two started to get fidgety as observed by clock watching and a member was getting up to put on the jug, this provided the cue to wind down and stop. The closing question "Is there anything else" was called. As there was no response the meeting ended with a prayer.

Winding down for group three occurred when I noticed that we had been in progress for an hour and a half and the call for any further questions did not initiate a response. I decided in this group to give a verbal summary to see what effect it would have. The response was yes, I had captured the topics that we had spoken about but it did not generate any further questions. Once each session was over a departing prayer was said. Participants were thanked for their contribution to the meeting. Some stayed for refreshments whilst others went on their way.

Fakalofa

As stated, the spirit of gifting as espoused by Tamasese et al (1997) was in the giving and receiving of gifts. It is the issue of reciprocity. A small sum of money was bestowed on each participant as they departed. This was greeted with some surprise in all groups, as they did not expect anything. Their previous experiences with researchers was that researchers take, but do not honour the tradition of reciprocity.

Dialogue before and after the focus group session

The dialogue that takes place before and after the focus group meeting does not appear to be an issue within the literature as the studies are guided by the format as espoused by researchers who are considered authorities on the method of focus groups. Krueger (1994 p, 155) provides enlightenment for information arriving after the focus group meeting. Three options are given, such as to use the information like the focus group data, or address it as information post-data collection and lastly, not to use the data in the analysis.

In recommending this process, Krueger has enabled the inclusion of post- focus group data, which will be acknowledged as such. But what about pre focus group information? From the point of view of the participants who talk and share whilst waiting for the meeting to start, this is socializing. This occurred at each of the focus group meetings. Does the researcher remain detached throughout the whole process as suggested by Stewart and Shamdasani (1990)? If the advice of Stewart and Shamdasani is followed then this creates alienation and a loss of rapport. By mingling with the participants one is able to respond briefly if issues are raised and ask that they be raised again within the group or used to engage the group if there is any hesitancy in getting started.

Problems encountered

I encountered different problems within each group. As each problem arose it was a matter of dealing with it. Problem one was group one starting an hour late and one participant was omitted as the driver got the wrong address. Time was given to addressing the understanding of the information sheet and gaining consent and signatures. Therefore, the initial question was not asked and the interview commenced with the topic of eyes (See p.103) in order to engage the participants and continue the discussion into the areas that would generate knowledge of the research topic.

Problem number two emerged within focus group two in the first interview with the failure of both recording devices to catch the entire interview. This was counteracted by the notes that I had scribbled throughout. The notes were verified by the focus group assistant (who is also the group co-ordinator) and the themes were returned to the participants who agreed that it was a correct account of the discussion.

Problem number three materialized in focus group three in the second meeting when only two participants turned up. The decision was made by the two participants to continue as they had taken the time to attend. This would counteract the Niuean concept of "*ai moumou magaaho*" which means not to waste time but to put the time to good use. This was to my advantage as it was the opportunity to probe further and clarify issues as well as delve into the issues of older Niuean women's health beliefs. Out of this encounter came some of the richest data and an understanding of my own taken for granted beliefs about food for a sick person. Declaring these problems and the impact that they had on the study is linked to the trustworthiness and credibility of the study.

Ethical Considerations

Formal approval for this study was gained from the Massey University Human Ethics Committee. Although ethical considerations permeate this study it was decided to confine the discussion to this section.

Respect

Respect for the rights of the participant are an important consideration in research. Smith (1999 p, 120) strikes a chord of recognition when she states, "Through respect the place of everyone and everything in the universe is kept in balance and harmony. Respect is a reciprocal, shared, constantly interchanging principle which is expressed through all aspects of social conduct". An essential element is the respect for the participant's time. Researcher's unrealistic timeframes are a source of frustration for Pacific communities. Respect for the unexpected family, religious and cultural obligations are an unvoiced expectation that will take priority over any research. This respect for the Matua Ffine is demonstrated in being Niuean and having the same point of reference. As stated, it is in the negotiation and renegotiation to meet at times that are suitable to the Matua ffine and the deference in respect to age and values that this is demonstrated.

Confidentiality

Although participants were asked to respect what was said in the session and to not repeat discussion outside the room, there were no guarantees that participants would respect confidentiality. This respect of what participants say and "to leave it within the group" was emphasized. The information sheet and consent form state that the anonymity and confidentiality cannot be guaranteed. As Smith (1995) explained, the researcher has no control over what a participant says once they leave the group. To preserve the confidentiality of the group, the transcriber and assistant (interpreter) were asked to sign a non-disclosure form. Confidentiality also extended to the tapes being sent to Niue for transcription.

Anonymity

Polit and Hungler (1999) define anonymity as "Protection of participants in a study such that even the researcher cannot link the individuals with the information provided" (p. 695). Within the study anonymity cannot be guaranteed. I did not use any personal identifiers for either the group or individual participants. Discussions have taken place as to how the participants wished to be addressed within the research, as pseudonyms were not considered appropriate but no definite answer has been given by the Matua ffine.

The participants as Matua fifine

An issue, which needed to be addressed, was in how to address the participants in the narrative text. For example: Each quote that is used will be referenced by use of the term Matua fifine for participant. An initial in brackets, indicates the particular Matua fifine. A number, followed by a dot indicates which of the three focus groups the quote originated from. Another number followed by a dot, will indicate whether it was the first or second focus group meeting, followed by a page number. Follow up sessions will be identified by the abbreviation F/U. Example. Matua fifine (3) 1.1. p.5 or Matua fifine (3) 3.F/U followed by a page number.

Informed consent

Informed consent ensures that the participants know and understand what they are signing when they consent to participate in a research study. When the consent form is presented in both the Niuean and English languages then it should be understandable in lay terms. There is an obligation to ensure that the research is carefully explained as too often older Niuean people sign forms without understanding the consequences. Signatures were obtained on the Niuean consent form. I anticipated family members contacting me to discuss their Mother's participation but this issue did not arise.

An interesting aspect of focus groups is that Carey (1994) appears to be the only one to mention that written consent is not required, as agreeing to participate is considered consent. Tamasese et al. (1997) acknowledge that the participant who has agreed to participate has given verbal consent. Within the community it seems that if you have given your word to something then that should be enough. Explaining again and then getting the Matua fifine to sign the consent forms raised a few eyebrows even though this had been explained at the group meeting and again prior to the first focus meeting. Signing a consent form was a requirement from the Ethics Committee. Copies of the information sheet (Appendix B and C) and consent form (Appendix D and E) in both the English and the Niuean language are included.

Withdrawal

Withdrawal is possible up to the end of the focus group interview but is not possible after the tapes are transcribed. Information cannot be withdrawn if the participant decides to withdraw. This is an issue that does not seem to be addressed within the ethics of focus

groups. The greatest concern seems to be over disclosure (Smith 1995) and the safety and wellbeing of the participant.

Other ethical considerations

An ethical consideration that was requested from the ethics committee was that I produce written confirmation from groups that permission had been given to attend and seek participants for my study. The group co-ordinators were perturbed at this request as it meant more of their time writing and this raised the issue of trust. Wasn't their word good enough? I offered to write the letters and the co-ordinators agreed. The letters were signed with a copy being left for each co-ordinator.

Another issue to arise was disclosure. How was I going to deal with disclosure if it arose? Niueans do not usually go to counsellors. A person's issues are usually dealt with in the group. The assistant supports and assists where able.

Referral to the Massey University, Human Ethics Committee, multi ethnic committee was not possible as this committee had disbanded. The role of this committee had been to assess research proposals with a cultural component where participants had English as a second language. Ethical issues are not taken lightly by Niueans. When a Niuean entrusts information to you, the unvoiced expectation is that you will do no harm.

The Treaty of Waitangi is New Zealand's founding document. Although this study is Pacific focussed, reference has been made to Maori authors and the researcher recognizes and acknowledges partnership relationships.

Trustworthiness of the study

Honesty and trustworthiness are crucial elements of qualitative research and this can be attained in the use of an audit trail. Koch (1994) prefers to use the term decision trail. The use of a decision trail to record reflections was extremely useful as it was my personal record for decision-making and why I opted for one decision rather than another. This was most reassuring when I thought that I had not documented my assumptions, only to find that I had written them and had not recognized their significance in the study.

Trustworthiness demands transparency and this was an important part of my research. Transparency demands an honest portrayal of the participant's contribution. Although the literature abounds with examples on the focus group method, I found an eclectic approach best to meet my needs, as there is little information available on Pacific cultural perspectives regarding the use of focus groups.

The flexibility of the focus group method enabled me to meet the differing needs as they arose, for example the problems already mentioned. Transcribing my own tapes meant that I was becoming familiar with the data. Translating the research questions was to ensure that I had continuity and consistency amongst all three groups and to avoid problems or inconsistencies. Twinn (1998) describes her concerns of having different translators giving different interpretations in her study on cervical screening in Hong Kong.

The themes were returned to the group participants and they agreed that these were correct. Unfortunately, there was no time to get anyone to translate the transcripts into Niuean but the Matua fifine said that they understood English and that it was not a problem. "Member checking" seeks validity within the research study. Sandelowski (1993) asserts "Member checking has been hailed as a way of enhancing the rigor of qualitative work by specifying a set of auditable practices and by the virtue of its congruence with the quantitative goal of representing experience from the actor's point of view" (p. 4).

Burrows and Kendall (1997) state that participants can change their point of view over a period of time. Points of view remained consistent within all three groups as demonstrated by reference to points within the discussions. For example, the Matua fifine who shared her story in Focus Group 1.1. repeated aspects again in the second session.

Koch (1994, citing Lincoln & Guba 1989) refers to credibility, transferability and dependability as depicting reliability and validity in a study. Credibility refers to "confidence in the truth of the data" (Polit & Hungler, 1999 p.427). In seeking to determine credibility, Koch (1994) states that the researcher should reveal any research experience and be able to document any issues that have impacted on the study. Focus

groups are considered to have “high face validity due to the credibility of comments from the participants” (Nyamathi and Schuler, 1990 p. 1284).

Koch (1994) refers mainly to the credibility of data. The credibility of the researcher is of paramount importance to the Pacific community if she is to gain support and access to intending participants. Confidence in the researcher can also give weight to the validity of research findings (Polit & Hungler, 1999). Credibility, is also the anchor for the “self as instrument” (Sandelowski 1986).

Koch (1994) uses the term transferability to mean fittingness and how this is recognized by readers and transferred across the text. Dependability refers to auditing the process. When all three elements of credibility, transferability, and dependability are established then confirmability is achieved.

Confirmability relates to the objectivity of the data (Polit & Hungler, 1999) and this is verified by the decision trail. Polit & Hungler (1999) point to a systematic collection of six types of documentation that enables an independent auditor to come to conclusions about the data. The documentation includes transcripts, preliminary data reduction notes, themes returned for member checking, reflections, memos and drafts of final reports. The audit can either support or refute the findings.

Self, as the research tool

Within qualitative research the bid for the accurate collection of data demands that the researcher serve as the instrument for data collection (Rew, Bechtel & Sapp, 1999). The use of self can create a dilemma for the researcher. Focus groups were developed in industrial societies but when used amongst participants from non-western societies the dilemma for the researcher is in following the rules (Khan & Manderson, 1992). Morgan provides some of the reasons for the departure from the rules and these were briefly discussed earlier in this chapter.

Method of Analysis

The use of a single method of analysis that is capable of analysing all manner of data is not possible as different forms of research demand different forms of analysis (Burnard,

Method of Analysis

The use of a single method of analysis that is capable of analysing all manner of data is not possible as different forms of research demand different forms of analysis (Burnard, 1991). Quantitative research methods seek statistical responses whilst qualitative research seeks responses that promote understanding. In this study, data collection and analysis were simultaneous. On completion of each focus group meeting, the tapes were rewound and listened to, to ensure that the recording device was effective. The tapes were labelled and stored securely until they were transcribed. Reflections on the preparation, the actual interview, outcome and my own thoughts were documented. Only the first tape was sent to Niue for transcribing. I also transcribed tapes myself to check consistency of interpretation. As the transcriptions from Niue were not word for word or as close as possible to what the Matua fifine had shared, then the decision was made to transcribe the tapes myself. A particular benefit to the researcher was a deeper understanding and familiarity with the data. Journal entries were made post data collection.

Transcription was time consuming but the listening and re-listening to the tapes, enabled the transcripts to be sorted into themes. Themes were returned to the participants. Although the themes were not translated back in to Niuean because of time, finance and availability of a competent transcriber, my interpretation of the themes were accepted. At an earlier focus group meeting a Matua fifine (Focus group1, 1) had stated that the responsibility was mine to "scratch out" what was not deemed correct. This places a big responsibility on the researcher as the unvoiced expectation is that the researcher will do no harm. The themes were accepted as an account of the discussion.

Ely, Vinz, Anzul, Downing, (1997) state that thematic analysis takes time to develop. A preliminary analysis, working across all three groups produced a mass of themes in a mind map which was unworkable. Trying to work the data horizontally also did not reveal the hidden meanings. The third attempt, using Thomas's (2000) general inductive method produced themes and descriptions but not the depth of analysis, which I required.

The introduction to Van Manen work (1984, 1990) paved the way forward. Van Manen (1990) considered three forms of isolating thematic statement. These are sententious, highlighting and line-by-line approaches. A sententious approach seeks a phrase, which

encapsulates the significance of the text as a whole. Within the highlighting approach, those phrases or sentences are identified which give an essential or revealing aspect of the phenomenon being described. Highlighting also includes either underlining and or circling of the essential or revealing phrases or sentences. The third approach requires detailed reading of every sentence in search of the experience being described.

Smythe's (2001) method of analysis presented a way of unearthing the meanings that were embedded within the experience by describing, interpreting and reinterpreting. The meaning of the theme was recognized and the interaction depicted the experience, which was then described and interpreted. I did not reinterpret due to the large number of words that would be generated. Smythe's method of analysis was time consuming but it gave me the insight that I was searching for not only within the shared experiences but also within the research process. In the process I realized I had originally been problem focused in my analysis and this could explain why the embedded meanings did not reveal themselves. Once I moved to a phenomenological form of analysis beginning with Smythe's (2001) way of describing an experience and then van Manen's (1990) use of the existential themes, I was able to continue. Analysis and interpretation work together to create meaning (Ely et al, 1997) and for me this major insight did not occur until after several attempts at rewriting the data chapters.

Group interactions are not always documented in focus group reports and this deficit is highlighted by Kitzinger (1994). Reference is usually one speaker. Gray Vickery's (1993) transcription examples demonstrate the multiple difficulties experienced by people caring for a loved one with Alzheimers Disease. The shared experiences bring to the fore meaningful experiences in the combination of focus groups and phenomenology. I have used the interactions to highlight the themes which explain the Matua fifine's experiences.

Difficulties in analysis arise when questions have not been specifically asked across all groups as Carey (1995) considers it is inappropriate to then seek comparisons across all groups. Comparisons were not sought.

Conclusion

This chapter has considered the research design in the first section and discussed in great length the research data collection method of focus groups in the second section. The reasons for planning and conducting the focus group discussions differently were to acknowledge and respect the Matua fifine's contributions. Such differences are the consultation process, beginning and ending the sessions with prayer, the use of an assistant to aid interpreting, transcribing tapes from the first language into English and the implications and issues that arose. Although data collection and data analysis were simultaneous, difficulties were encountered, as the depth of meaning that I was searching for was not revealed until I embraced the interpretive methodology of phenomenology. The next chapter will portray the Matua fifine's meaning of health seeking within their shared experiences, starting with an understanding of health and illness.

Chapter Six

Understanding health and illness

Introduction

The journey continues as the flexibility within the research method of focus groups has enabled the discovery of experiences that are descriptive in nature. Understanding becomes apparent as analysis, and interpretation come together to give meaning to the data (Ely et al, 1997). Van Manen's (1990) existential lifeworld themes of lived time, lived body, lived space and lived other, assist in interpreting the stories and interactions regarding the issues of health and illness that are shared in this chapter. Radley (1993) declared that health and illness could not be separated "as each informed the other" (p6).

In this chapter the discussion will consider, understanding health and illness as the first of three categories. The subcategories are: keeping well in New Zealand; maintaining health beliefs in New Zealand; searching for health information when well; finding health services; attaining well being; explaining *ai malolo* illness; understanding *ai malolo* illness; and, being prepared when living alone. Pacific health is complex and any understanding of health seeking behaviours, cannot be understood in isolation and must begin with an understanding of the meaning of health for ethnic specific groups such as the Matua fifine.

Keeping *malolo* health in New Zealand

For the Matua fifine health is upheld by the foundation of strength. The term *malolo* will be used interchangeably to mean health and strength. When the Matua fifine were asked the meaning of health, the following themes emerged.

Matua fifine (X) *Malolo* or health refers to a person who is not sick.

Matua fifine (Z) The body is well when you are young. When you are getting old you get sick.

Matua fifine (Y) As soon as you come to New Zealand you get sick. The body is old. Some people are old but they are well.

Matua fifine (Z) Some people get sicknesses on top of old age. The *malolo* of a Niuean woman comes with looking after herself. She keeps her health by looking

after what she eats, moving around and working until old age. *Malolo*, comes from Niue and lasts in New Zealand. You must look after yourself. You must not drink and smoke (Focus group 3.1.p.1).

Description

Health is synonymous with strength and is the thread which is embedded throughout the existential elements. Youth equates with health and in the Matua *fifine*'s opinion old age brings sickness. Coming to New Zealand has brought ill health. If you are healthy when you come to New Zealand then ongoing care of self will ensure continued wellbeing. Being mindful of the food that is eaten and being active are important in maintaining the strength of the Matua *fifine*. Abstinence from alcohol and cigarettes assists well being.

Interpretation

Malolo comes from strength, harmony and a balance in life. Health is related to a person who is not sick. Within the existential element of lived time, van Manen (1990, p.104) adds meaning when he states "Whatever I have encountered in my past now sticks to me as memories or as (near) forgotten experiences that somehow leave their trace on my being". Time has marched on and the days of youth and wellbeing are long gone and for some Matua *fifine* old age brings with it sickness. Although, it is recognized that there are those who are well in old age.

Lived space and lived body call forth memories of being healthy during times of youth. *Malolo* is developed and nurtured in Niue and will last in New Zealand if care and consideration are continued in terms of nutrition and activity. As to the fourth existential element, the lived other refers to relationships. Relationships are not only with people but include the relationship with nature as it is described in the next experience.

The following experience uncovers further layers of the meaning of health.

Matua *fifine* (A). When women get old they become concerned [in New Zealand]. There are feelings of uncertainty when they become sick but if they are well there is no concern. I do not feel concern because I know that I am in health but there is one thing that I hold onto and that is prayer when I am well and unwell.

Matua fifine (B). Women are very healthy in Niue. They work hard. They go to the bush and work. They husk coconut and chop and carry firewood. There is no family doctor on Niue. When they come to New Zealand there is a change in the body. When people come to New Zealand and when they are unwell they go to the family doctor. That is my understanding of older women. When a woman gets old in Niue it is different to New Zealand. In New Zealand we have noticed the changes in the body of the young and the old. When we get old we get a pension in New Zealand but not in Niue. Our bodies are strong in Niue. In Niue we work until we die.

Matua fifine (D). Old people work in Niue and they crawl if they can't walk. They collect plants and if they are bent over they are still active. Their eyesight is good and they don't need glasses (focus group 2.1.p.1).

Description

Niuean people are healthy in their island environment but notice changes in health when they come and live in New Zealand. In New Zealand, old age brings with it the potential for ill health and this is a time of concern. Mention is made of moving directly to a doctor when unwell. Prayer upholds a person in sickness and in health. Women are healthy in Niue because they work hard. There is no family doctor in Niue. Old age pensions were not collected in Niue (at the time that the Matua fifine makes reference to) but a superannuation pension is collected in New Zealand. Niueans are a strong people and work until they die. Even if they are stooped, they continue to work and they crawl if they can't walk.

Interpretation.

In the above narrative, reference is made to physical wellbeing with the inclusion of spiritual wellbeing. Niueans are a hard working people. They have to be fit and healthy, in order to survive in the harsh island environment. Health is taken for granted in the natural environment because of the lifestyle, which demands self reliance. Women work. There is no lack of activity. As stated previously, health services are provided by a free one-stop facility. Pensions are now being paid in Niue (personal communication L. Takelesi 11/4/2001) but were unheard of during the time that the Matua fifine were living on the island. For old Niuean people, involvement in activities is important to their well

being. Inactivity leans towards illness. There is usually some form of work around the house or garden.

Van Manen's (1990) existential elements of lived space, lived other, lived body and lived time give meaning to the Matua fifine's life experience in the island homeland. Again, it is pointed out that "Understanding is historical and must be understood historically" (Benner, 1994 p.101). The lifeworld of Niue is revered for the *malolo* that it has given. The existential element of lived space means that the Matua fifine can be independent within her home and environment and this affects the way she feels. She is not reliant upon others for her well being. The activities of daily life are performed because of her own strength and endurance to move within the different dimensions of lived space as in the freedom of walking to and from the bush and the seashore. Her experience is one of being at ease. The Matua fifine in Niue has a sense of belonging and she is aware of the boundaries for this lived space as the landmarks of trees, gardens and homes determine the boundaries. There is a bond with the environment and there is no concern, as an individual's *malolo* strength will determine survival. As van Manen (1990, p.102) states "Home is where we can be what we are".

When the Matua fifine becomes stooped and unable to travel far, she continues to make her contribution to the family by weeding around the home. Being active is not by choice. All members of the family are expected to contribute to the home. The relationship with the family remains as she is still demonstrating her *malolo* and ability to be active. Lived time is given meaning when reference is made to "Our bodies are strong in Niue. In Niue we work until we die" (focus group 2.2.1.p.1). Van Manen, (1990) talks about subjective time, which is not clock time. Survival depends upon the subjective use of time and is determined by the Matua fifine. An expression of fatalism means that lived time is a time of work and continues up until the time of death.

Being active is not leisure but an activity, which benefits the individual or the family. The dimensions of time, in terms of the past, present and future each feature in the Matua fifine's experience as she shares her thoughts This is demonstrated in her experience and the movement of thought back and forth in time from the past to the present and from the island, to life in New Zealand. Although she does not articulate her specific concern it lies with care in old age and especially if she is unwell.

Reference is made to the pension and its ability to assist the Matua fifine in New Zealand. Again, the issues of the pension and cost are discussed in Chapter Eight. Another reference is made to the relationship with God. Praying whether in a state of health or illness is important to the Matua fifine. The power of prayer is a dominating theme to emerge amongst all three groups and as it overlaps into most themes it is discussed in some detail in Chapter Seven. Just as it was important to anchor the meaning of health so too is it important to consider the health beliefs that are shared by the Matua fifine.

Maintaining health beliefs

According to Holland & Hogg (2001), 'health beliefs' refer to the beliefs and practices that are upheld by people of different cultures (p.15). The health beliefs that have kept ageing Niuean women healthy in New Zealand are many and varied but this discussion is confined to company and the importance of food, as they are included in the dominant themes related to health seeking behaviours.

***Faihoani* - Company - It's the talking that is missed**

Company is defined from a Niuean perspective. Within the Niuean context, company or *faihoani* is an important health belief that ageing Niuean women have continued, or tried to continue in New Zealand. When there is a sickness or bereavement within the family then one of the many roles of the older Matua fifine is to visit and to provide comfort as demonstrated in the following experience.

Matua fifine (W) Support. Care. *Faihoani* Company. They come and they stay for days. That's a gap in New Zealand.

Matua fifine (X). They talk

Matua fifine (U) Yes.

Matua fifine (X) They sing. Do their handcraft (focus group 3.2.p.5)

Matua fifine (X) When a person is sick they want to be touched or massaged (*Ke hau e malolo*) so that they will get back their strength and health back.

Matua fifine (W) When two women walk arm in arm that is called *faka tau o* That is being friendly.

Matua fifine (X) *Takape* is the word for widows.

Matua fifine (U) They keep company. When they come to New Zealand it is hard as there is no transport. It's the talking that is missed. If one lives in Otaru, who takes the other one up there?

Matua fifine (X) They sleep over and go home in the morning. Some bring these beliefs to New Zealand.

Matua fifine (U) Some women are frightened to be on their own.

Matua fifine (X) I went to stay with my relation and she didn't want me to go home.

Matua fifine (W) You are OK. I'm on my own. I went to my relation and I had to grab my sheet and go home. I told her that she is well enough now to stay on her own. (Focus group 3. 2. p.6).

Description

Keeping company in the traditional sense for the Matua fifine has two meanings. The first meaning relates to the companionship that two people enjoy. It is a time of sharing and catching up as friends tend to do. Another meaning of company is used when there is illness or bereavement and the company is one of support and caring and staying over which is valued. It is a time of sharing. A source of concern is transport, within the New Zealand environment and how to get to the home of someone who you care about. When reference is made to a gap in New Zealand, it is in recognizing the importance of *faihoani* as meaning company and comfort in the health seeking behaviours of the Matua fifine. The transference of this belief and practice is becoming difficult, as there is no transport to the home of the person or family in need.

Interpretation

Van Manen's (1990) existential element of lived space evokes the thought of distance that is to be travelled. Within New Zealand, there is the feeling that there is an emptiness of space, where there is no one to keep company and prompts feelings of loneliness. Temporality as the existential element for lived time (van Manen, 1990) brings forth the meaning of time in New Zealand where the Matua fifine are reliant upon the benefit and transport to visit a person/ relative in need. The Matua fifine cannot always respond immediately to the unvoiced need for support, comfort and company. When the Matua

fifine do visit it is also about knowing when it is time to leave to attend to one's own responsibilities.

The term *faihoani* carries with it the camaraderie and friendship that two people share when walking arm in arm. The lived relationship maintains the harmony that two people have established. The unvoiced expectation is that the Matua fifine will visit during times of need. Van Manen (1990) states that we are always "bodily in the world". For the Matua fifine it is the physical presence and of seeing a person's face that is important. It is not what you can bring. Lived time brings the opportunity to share and offload all that has been waiting to be said to someone who cares. It is also a time to gather strength for the days ahead when they are alone. It is also a time to massage and share thoughts.

In Niue the use of the Niuean language is taken for granted but in New Zealand older people may be isolated by distance but when they are together then the use of the Niuean language is comforting. In New Zealand, this aspect of company is important as the Matua fifine may be living alone and may be feeling fearful when unwell. The holistic aspects of social cultural and family well being of health emerge in this interpretation to add to the overall meaning of health. In a sense the Matua fifine could be likened to the layperson that Finau (1994) relates to in his explanation of providers within the healthcare systems. Different but complex, *faihoani* is a health seeking behaviour which is slowly losing its meaning.

The importance of food. Kai ke moui. Eat to live

Another Niuean health belief to emerge is in the importance of food and this also plays a part in health seeking.

Matua fifine (U). You cook to give to a sick person. (*Tunu paku* is to cook food on hot embers). The family goes out of their way to look for food for the sick person. It doesn't matter how rough the sea is the family do their best. They also ring Niue to get food that the person is craving for.

Matua fifine (X). There is a word. *Fakahohoko e manava*. (To satisfy a craving for food) Cook a *nane* (arrowroot and coconut dish). Try to get the person to eat a bit more. *Papa e mena kai*. Wrap food up and put it on hot embers.

Matua fifine (U). *Tuafu*. That is to get the sick person or child something special to eat.

Matua fifine (X). It's like *hohoko e manava ke moui*. The stomach is satisfied and there is life.

Matua fifine (U). To give food for life.

Researcher. You recognize that this is a special time.

Matua fifine (U). You start to come back to life. Offer a little bit at a time. That's what we always do in the islands. The first food after a person has been sick. (*Pause/ silence.*) Eat to give life. *Kai ke moui*. Eat to live. *We fotafota* massage. Look at the eyes and ask. *Higoa a haau nei fia kai?* What do you want to eat? (Focus group 3. 2. p.5).

Description

Tuafu (Special food for a sick person) is an essence of the life of the Matua fifine. The search for special food also encompasses communication with the island homeland. Different ways of cooking are suggested. This is a special time as it will be the first food that a sick person requests after a time of illness.

Interpretation

Munhall (1994) talks about the tension between the parts and the whole. This becomes apparent in this interaction as the thoughts that are shared move back and forth from the island homeland to New Zealand. The Matua fifine bring to the fore, the experience of *tuafu* and the nature of the lived body, lived relation lived time and lived space (van Manen, 1990). The lived body responds to massage and the direct gaze. The sick person is asked to identify a special or desired food. Then, when eyes meet, a verbal response from the sick person begins the family search for the special food. The networks of family, church and community relationships are enhanced during a time of sickness. Time is given to search for this particular food. If it is not available in New Zealand then contact is made with Niue. Modern communication and transport speed up time of delivery, so that distance is not a major issue.

When a Niuean says "*kai ke moui*" ("eat to live") to a sick person, then it is meaningful but when the interpretation in the English language is used then the essence and the power of the words are lost. The deeper meaning of the words "*kai ke moui*" is to

encourage the sick person to accept the food in the spirit with which it is offered so that it nourishes not only the body but also the spirit and soul. The unvoiced understanding that passes between the two people is a connection with the spirit to fight the illness and to begin the journey to regain strength. The food itself is usually a particular type of fish. It is prepared with the utmost consideration to ensure that it is tempting and appetizing in presentation. Food is offered to tickle and refreshen the taste buds to revive the memories of the sharing of food in another time and place. The concept of food as a health seeking behaviour is equally as important to the Matua fifine as health seeking for a doctor's consultation, traditional and complementary medicine.

Health seeking is not only confined to one specific approach. Just as seeking the meaning of health to anchor this chapter was important, so too is it important to consider the search for health information when well.

Searching for health information when well

The search for the meaning of health has ventured far and wide and has only been briefly addressed. Niueans do not give a detailed explanation in one session but return time and time again to add to the story. When consideration is given to the question of searching for health information when the Matua fifine is well there is a call to set up a group. Some of the Matua fifine in focus group three had withdrawn from an established women's weaving group.

Matua fifine (U) They want me to set up a group. There's a gap.

Matua fifine (X) We want a group. Someone who will come and tell us what is going on. The women come and hang around the shopping centre as there is nothing to do.

Matua fifine (U) It needs a base. *(Name withdrawn)* runs a group out here.

Matua fifine (X) You are right. I left her group.

Description and Interpretation

Within the existential element of lived space there is the openness of space within the shopping centre but at the same time a space for the Matua fifine to congregate. Lived time brings with it the feeling of inactivity and there is the unvoiced desire for time to be

spent constructively as in group activities. There is the awareness of a gap in the Matua fifines' lives. Physical presence when meeting in the shopping centre is not enough for the Matua fifine, the desire is to learn and to find out. The Matua fifine would like to have someone come and share what is going on in the world away from the space that they are in. The existential element of lived other, emphasizes the relationships that the Matua fifine share. As a Matua fifine points out, she has been approached to set up a new group. Setting up a group was one way of getting information but there were also a variety of other ways. Other questions were asked to engage the Matua fifine and identify the sources of health information and healthcare systems. The Matua fifine are interested in being informed when they are well and it is realized that this topic requires a study all of its own.

Finding health services

The question that was asked to engage the Matua fifine was "Can you please tell me of any health services for old people in Auckland. How did you find out?", generated a long discussion. It also notes a change in the way terms are used and that is away from health seeking to help seeking.

Matua fifine (A). There are lots of different types of help (*lagomatai*) to help old women. There are Chinese, Indian, and other palagi to help

Researcher. Can you tell me what sort of help does he give you?

Matua fifine (D). What sort of help does he give you?

Matua fifine (A). I go to the Chinese like the one we went to years ago.

Researcher Is that a doctor? What sort of help does he give you?

Matua fifine (A). He is not a doctor. He is like a herbal (*sentence unfinished*).....

Matua fifine (D). He gives herbs.

Researcher. You mean he's like a herbalist

Matua fifine (A). Yes. He gave me medicines and tablets to help me sleep. He gave me all sorts of tablets to help me with my health.

Researcher. Did you go as a group or on your own?

Matua fifine (A). I went on my own.

Researcher. How did you find out?

Matua fifine (A). We found out through friends.

Matua fifine (B). Friends.

Researcher. Is there anyone else?

Matua fifine (B). I went to the same doctor. In my case he didn't give me tablets. He told me to cook the mussels and drink the juice but don't eat the mussels. Just drink the juice.

Matua fifine (A). Wasn't it sour? *Giggling.*

Researcher. I'm really interested in how you found out.

Matua fifine (B). I'm not allowed to eat the mussel. Just drink the juice.

Researcher. Do you know what it was for?

Matua fifine (B). No. I have forgotten because it was such a long time ago. I went to lie on the bed while he *fuafua* (test) me. And then he told me what I had to do.

Researcher. What did he test you with?

Matua fifine (B). He just use his hand.

Matua fifine (D). Look at the hand not with the scope.

Researcher. So he did not use a stethoscope. So he's not like palagi doctor. He just looked at your hand. Where is this doctor?

Matua fifine (D). He's in the Market. He moved out.

Researcher I'm really interested to know how you found out.

Matua fifine (A). I found out through my friends.

Matua fifine (D). They found out through friends.

Matua fifine (B). My stepfather was sick.

Matua fifine (D). We found out through the handcraft. We were selling in the market.

Researcher. So that's how you found out. (Focus group 2. 2. p.1).

Description

The question was trying to find out the Matua fifine's knowledge of health services for older people in Auckland. There are lots of different types of help for old women. A few ethnic groups are mentioned rather than the profession. On-going questioning seeks to identify the type of help that is given. This is soon clarified as being a herbalist. Tablets were given to help the Matua fifine sleep and to help maintain her health. The Matua fifine find out about the different forms of help through their friends. Further probing, resulted in finding out that information was gained through the connections made when selling of handcraft in the market.

Interpretation

The endeavour is to identify the ways of seeking knowledge and information. What is becoming apparent is the change in the use of terms in that it is the Matua fifine who are now referring to the term "help". Different forms of help are identified. However, it is not the professional role that is given, but more the ethnic identity of the person who is providing the help. The ethnic identity is usually associated with the medical profession but in this case probing seeks to find out exactly what occurs when seeing the Chinese herbalist. Different treatments are given and a comment on drinking mussel juice is strange, when the flesh of the shellfish is usually eaten. Humour is always lurking beneath the surface of the ongoing interaction. Finding out was through the usual manner of friends sharing information. Further probing reveals that another way that the Matua fifine found out was when the group was selling their craft in the market.

Although I did not realize it at the time this focus group interview is also likened to a hermeneutic interview in that the attempt was to keep the question open and to keep on asking questions (van Manen 1990). The purpose of the question was to identify knowledge of services for older people and what transpired was what I had not expected to uncover. We take it for granted that people just get information but we do not take the time to delve and find out from whom or when this information comes.

How can van Manen's (1990) lifeworld existentials be applied to peel back the layers of meaning? Briefly, the concept of lived space as felt space is experienced in seeking health in the local Market. The space does not seem to be important, what is important is seeking whatever will maintain wellbeing. The move has shifted from health seeking to help seeking. The existential element of lived other brings with it the ability to communicate with the herbalist as both have English as the language in common. Lived body or corporeality is conveyed when the Matua fifine sits on the bed and allows the herbalist to use his hands to examine her hand. There is an acceptance of his way of finding out what is the matter with her. He is actually conducting an examination. As to the existential of lived time the Matua fifine reflect on the experience, which took place years ago and says she has not forgotten, because it has helped her maintain her wellbeing. What is important is an examination and a prescription for treatment. What is

interesting is that the above example demonstrates how complex healthcare systems can be, in that a provider can provide a service in almost any space where people congregate.

Knowledge of older people's services

Knowledge of older people's services generated limited discussion as the Matua fifine expressed satisfaction with their family doctor. The response was

Matua fifine (A) We have just spoken about the Chinese (The doctor). What else is there?

Researcher. Can you name any services for older people?

Matua fifine (B). I don't know them.

Matua fifine (A). We don't understand.

Matua fifine (T). Most of us only know the family doctor and the Chinese. And the Indian (Focus group 2.2.p.4).

Description and Interpretation

Lived time in New Zealand brings with it, knowledge of the familiar sources of health care. Lived relationships have been established with the family doctor and the Indian who were both medical professionals. The Chinese is a herbalist. It is acknowledged that there is no understanding of the services for older people. The Matua fifine's lived experiences differed, with the family doctor and the Chinese.

Attaining wellbeing

The Matua fifine attest to the many ways of maintaining and attaining well being in New Zealand. The following experience reveals the concurrent use of health seeking as in self management and the use of prayer, as well as the medical consultation, and traditional methods.

Prayer. Chorus of agreement.

Matua fifine (G). Pray to bring well being to your family.

Researcher. Are there other ways?

Matua fifine (G). There are many ways.

Matua fifine (A). Going to the doctor. You only get well being when you clean around the house. Massage your body. Believe in your heart that when you take the

pills that they are going to work. If I take them without believing then they won't work.

Matua fifine (D) You know that when you wake up in your heart you feel different.

Matua fifine (A). You know that when you have no money you worry and then you pray and when you wake you feel better. It doesn't happen straight away.

Matua fifine (B). It's the same with me. I don't know the name of the plant but I can find this plant and crush it to take to the hospital. Its not for drinking its to wipe on the body.

Matua fifine (A). Can you share this? (*Giggling*)

Matua fifine(D). Do you know the name of the plant?

Matua fifine (B). I don't know the name of the plant but I know it when I see it. It has a nice smell when it is crushed.

Matua fifine (A). What if I come with you one day and the two of us go and look for the plant? (*Giggling*)

Matua fifine (B). It grows by the roadside.

Researcher. So you pick it, and take it home.

Matua fifine (B) I go home and put the leaves in a cloth and crush them. I put in a little water and I put it in a bottle.

Matua fifine (G). You are allowed to take that sort of help into the hospital.

Matua fifine (B) I massage and then I tell her to apply it after I have gone. I have done my part to help.

Researcher. How often do you use it?

Matua fifine (B) Only when you are sick.

Researcher. Would you recommend this to anyone else?

Matua fifine (B). No I only keep this to myself.

Matua fifine (A). That's not fair. You have to share.

Matua fifine (B). I already share the oil. (*Laughing in the group as they are trying to get the Matua fifine to share her knowledge.*) (Focus group 2.2. p.2)

Description

The above example shares the ebb and flow of life as the discussion is not confined to one topic but flows into the many ways of health seeking. These become apparent in the above example in the use of the belief in the power of prayer, medication and traditional

methods of the application of crushed plants to promote well being. Attending the doctor when unwell helps. Household activity also maintains well being. Praying and giving over to God, concerns about money are a source of comfort. Believing in the effectiveness and power of whatever is used to promote health and well being is vital. Without this belief, there will be no effect. The issue of “taking that kind of help into hospital” is picked up and a Matua fífine shares her experience of taking prepared plants. Another Matua fífine seeks information of the plants and offers to go and help pick them. The offer is refused. The name of the plant is not known but can be recognized by its distinctive fragrance when crushed. The sick person is massaged and then told to apply the bottled preparation. Again the Matua fífine is asked to share her knowledge and wisdom of this plant, but there is unwillingness as she shares the herbs but not the knowledge. In the Matua fífine’s view, the group have already benefited from the blessed oil.

Interpretation.

Belief is an essential theme for ageing Niuean women, as it is an essence of the Niuean lifeworld. Without belief there is nothing. Van Manen (1990) considers the lived experience can produce idiomatic phrases such as the comment from a Matua fífine “Believe in your heart that when you take the pills that they are going to work. If you take them without believing, then they won’t work” (Matua fífine (1). Focus group 2.2. p.2). Belief as in the power of prayer is further discussed in Chapter Seven.

Van Manen (1990) words strike a chord when he states “ Hermeneutic phenomenological research is a search for the fullness of living, for the ways that a woman possibly can experience the world as a woman, for what it is to be a woman (p.12) ” In saying so, van Manen (1990) articulates the aim of fulfilling our human nature. For Niuean women it is the use of that wisdom in preparing a plant to take to a sick person in hospital to aid healing and a return to health. For those who do not have the knowledge then it is knowing who to ask, for the wisdom that will help care for a sick person.

Within the existential of lived space, the Matua fífine explains where the plant can be found. The experience of lived space becomes apparent within the different types of lived space. It is not only in the distance to travel but it is also in an open space of searching for

the plant by the roadside. It is also being in a closed space of a transport system and or being in the closed space of home.

The existential element of lived other is not only with people it also includes nature. This relationship with nature is confirmed with reference to the recognition of plants that have medicinal or therapeutic value. When the plant is found it is then crushed and in its prepared form is taken to the person in hospital. Instructions are given and the responsibility then rests with the person concerned. The hospital is no longer a place that denies the use of traditional medicine but there is now the feeling of acceptance of another system of healthcare.

Temporality or lived time brings with it subjective time as in decision making as to when to go and gather the plants. Linear time occurs when planning to take the prepared plants to the hospital and this must fit in with the availability of transport and hospital visiting hours. Corporeality as in the element of the lived body is realized when the Matua fifine has completed massaging and leaves instructions for the application of the prepared plants. Self-responsibility becomes the issue if well being is desired by the person concerned.

Just as *malolo* was embodied in strength and feeling right, then *ai malolo* emerged when the Matua fifine was feeling unwell and experiencing symptoms of illness.

Understanding Illness or *ai malolo*

Just as it is important to have an understanding of *malolo* health so too is it important to have an understanding of illness *ai malolo*. In Radley's (1993) view, the interest in illness has prompted the general understanding of health and illness. The terms ill, illness, sick, sickness, unwell, unhealthy are used interchangeably to mean *ai malolo*. So too are the Niuean terms *gagao*, *tatalu* mean ill health. Just as the meaning of health is broad and complex so too is the meaning of illness. When the question "What is the meaning of *ai malolo* illness?" was asked, a response from one Matua fifine (A) was :

I said I feel cold. I feel dizzy. That's *ai malolo*. *Malolo* is when I wake in the morning and I feel right and my body is right. All is well. (focus group 2.2. p,5).

Reasons given by another **Matua fifine** (B) to explain illness

I know that when I am unwell, its because I was late in taking my pills. When I take my pills I feel better straight away (focus group 2.2.p. 5).

No description is required as the meaning seems straight forward. An interpretation of both these comments is that illness is of a minor nature. The meaning embedded within is one of lived time. Time, for the former Matua fifine is one of wait and see, as in sleeping and waking to a body that is feeling right in the morning. As for the latter Matua fifine, self management resolves the feeling of being unwell. The body responds promptly to the ingestion of medication. Lived time has given the Matua fifine the knowledge that symptoms will arise if she delays taking her medication, just as taking the medication gives speedy relief. However, this is not the case for everyone.

Ai malolo or feeling unwell

Even if they do know what to do and who to contact when unwell, the Matua fifine acknowledge that they have to be very sick before they will be admitted to hospital. As a Matua fifine acknowledged:

At this point in time *momatua* (respectful title for old women) it is very hard to get admitted to hospital and it is very difficult if we don't have any proof or paper (*fakatonuaga*) from the family doctor. That is why it is important to get the family doctor before you call the ambulance (Matua fifine (J) Focus group 1.1.p.4).

Description and interpretation

The existential element of lived time is born out by the Matua fifine who realizes that at this point in time, in order to be admitted to hospital she requires proof from her doctor to legitimise her illness. Lived time, brings with it knowledge of a health system that demands a piece of paper for hospital care. Lived space and relationships brings with it an order of things. The family doctor is the first point of contact and then the ambulance. To reverse this order would make life difficult for the Matua fifine in terms of delay in assessment and treatment. Even if the move is to seek a doctor's consultation to

legitimise illness and admission to hospital there is no guarantee that the Matua fifine will be admitted.

How to cope when living alone can also be an issue in relation to managing both health and illness.

Being prepared when living alone

Worthy of note is the issue of illness when living alone, especially when health seeking at night. Being prepared is an issue. Again there is an overlapping or ebb and flow of life within the themes.

Matua fifine (A). When I am sick at night I don't wake the family. I wait until the morning. Then I ask the kids to ring the ambulance. (*The Matua fifine lives on her own in a flat on the same property as her adult children*)

Matua fifine (B). Yes I wait, as I might feel better in the morning.

Matua fifine (A). My life since I have lived on my own is good. Everything is quiet. One night I feel very sick and I throw everything out of the wardrobe and I rush to tidy up my house in case something happen to me and people come to my home and that is when I realize that living on your own is hard.

Matua fifine (D). Living on your own is hard.

Matua fifine (A). Yes it is true it can be hard during the time of *mase mase kelea*/misfortune. The kids are in their house and when illness strikes and I die well I die!

Matua fifine (D). What made you think you were going to die?

Matua fifine (A). I think about the people who are found dead in the morning. I made a promise with my son. Dear. You must ring me at night before you go to sleep and ring again before you go to work in the morning. Plenty of parents are found dead when the children come to visit. And that is why I say it can be difficult living on your own.

Matua fifine (D). Frightened that if you are die who is going to find you.

Matua fifine (A). I must be prepared so that if anybody comes my house is tidy.

I will be honest. I must tidy my house first. I wear my nightie so that if I sleep (*meaning if I die*) that's it. (Focus group 2.2.p.6). *Silence*

Description

When the Matua *fifine* suddenly get sick at night, there is the preference to wait until the morning before calling the family to ring the ambulance. Just in case there is an improvement overnight. An experience of suddenly becoming ill at night is shared. It is not so much the illness but the fear of not being prepared and the house being found untidy. There is the realization that living on your own is hard. Thoughts turn to people who are found dead in the morning. Arrangements are made for the son to contact his mother each morning and night. For this Matua *fifine* it is important to be prepared and to have her house tidy and be dressed in her night attire so that if she dies in her sleep that's it. Being responsible and prepared for any eventuality is an important aspect of the Matua *fifine* strength.

Interpretation

Within the element of lived body emerges the *malolo* strength and resolve. Self-reliance, comes to the fore in health seeking. Being prepared is important to this Matua *fifine* and her fatalistic attitude is that she must be prepared and properly attired so that if this is her moment for her everlasting sleep, then she is ready for it. There are many stories within this piece of group interaction. Although it may seem as if they are the only two in the group, the others listen to the exchange and it is the silence that is interesting and the body language, which indicates a recognition of what is being shared. Van Manen's (1990) explanation of ontological silence is the return to silence. Is it the silence of life itself or is there another explanation? There is the respectful silence of listening and recognizing your own vulnerability if you live on your own. Lived time as in the use of time is also revealed in this account. Time to attend to those tasks in preparation for the unexpected, is the uppermost thought in mind. Van Manen (1990,p.102) comment of "... we become the space we are in" is a potent reminder of lived space, especially when living on your own. For the Matua *fifine* it is hard as there is no one to help maintain the standards that she has been accustomed to especially as she feels a sense of impending doom. The element of lived other as in lived relationships emerges when the Matua *fifine* arranges with her son to ring twice a day, as she is aware of her vulnerability. So that even though she is living alone there is still the relationship with family and consideration that she espouses in her wait and see approach by waiting until the morning, before calling them for assistance.

Conclusion

The Matua fifine in this study consider (*malolo*) health as strength and it is synonymous with wellbeing. *Malolo* cannot, however exist in isolation and the holistic aspects of health are illustrated in the narratives that were shared. It is in the circular manner of moving back and forth within differing narratives, which enable meanings to be uncovered.

The Matua fifine give meaning to the term health and this paves the way to understand the reasons for choosing to engage in health seeking when well and unwell. Seeking information and engaging in health seeking then begins the decision making as to whether to self manage, wait and see or move to see a healthcare provider when illness arises. What is also becoming apparent is the Matua fifine's use of more than one health care system and brief mention was made to healthcare pluralism. "Understanding health beliefs is fundamental to nursing practice if we are to care for people holistically" (Holland & Hogg, 2001, p.17). A part of holistic nursing practice is attending to spiritual needs. The following chapter explores the issues of religion and spirituality as a dominant aspect of the Matua fifine's life and health.

CHAPTER SEVEN

Spirituality and traditional beliefs

Introduction

The previous chapter identified understanding health and illness as being the portal of entry (Munhall, 1994), into the data. This has enabled the journey to continue into the important theme of spirituality. Spirituality is an aspect of holistic nursing care that should be provided by nurses. If nurses are to meet the spiritual needs of ageing Niuean women then there is a need to understand the clients' concept of spirituality. Spirituality is a lifeline to the lived world of ageing Niuean women whether in Niue or in New Zealand. As a term spirituality encompasses both religious/Christian beliefs and traditional beliefs. This chapter will discuss the second category of health seeking behaviours, which is spirituality and traditional beliefs. The subcategories discussed are: the power of prayer; the used of blessed oil; caring for yourself enhances your prayers; thanking God for his blessings and traditional beliefs.

This chapter is separated into two parts, the former will consider religious Christian beliefs as in the importance of praying whilst the latter will consider spirituality within traditional beliefs as in spirits otherwise known in Niue as *aitu* which is the spirit of a dead person (Sperlich, 1997 p.46).

Definition of spirituality

Spirituality is a term that lacks clear definition within the nursing literature. This lack of clarity in part arises from the acceptance of the view that spirituality as a concept is both subjective and personal (McSherry, 1995). The Matua fifine are clear as to their meaning of spirituality. Some nursing theorists omit spirituality whilst for other nursing theorists spirituality is a central concept. There appears to be a paucity of information in nursing literature on the meaning of spirituality as it is encompassed within traditional beliefs. Leininger (1991) a nursing theorist is one of the few to embed spirituality into her theory of "Culture care diversity and universality: a theory of nursing". Leininger's (1991) theory includes not only a holistic perspective it also encompasses spiritual beliefs, which would reflect the influences, which impact on health and illness (p.23).

Spirituality is not only applicable to religion and traditional spiritual beliefs but also includes reference to “ Incorporating spirituality into the caring dimension [which] requires a sensitivity to the many ways in which spirituality may be experienced and thus expressed” (Dyson et al 1997).

The Matua fifine’s understanding and use of the term as they know and understand the term, which is the practical use of spirituality in daily life rather than a theoretical understanding. The Matua fifine frequently refer to spirituality, as in prayer, indicating its importance in their lives.

The Matua fifine made reference to prayer across all three groups. The Niuean transition to embracing the principles of Christianity was possible, as Niueans believed that their (*malolo*) strength came from God. The principles of (*fakalofa*) love, (*fakalilifu*) respect, and (*fakamagalo*) forgiveness uphold Niuean people (personal communication M.Erick 11/8/01). Prayer is paramount to the wellbeing of the Matua fifine.

The power of prayer

The following interaction reveals the power of prayer and the search for wellbeing and indicates an area of health seeking which can be one of self management, encompass a wait and see approach or it may be included as a fourth provider within healthcare systems alongside, the medical profession, traditional medicine and complementary systems.

Matua fifine (D). There is only one thing that helps me and that is the power of prayer. When I go to sleep I think about all things and turn them over to God and I ask God to give me strength. Living together [with your husband] is good sometimes, sometimes it isn’t.

Matua fifine (A). You can’t be happy all the time.

Matua fifine (D). When I feel unhappy I pray and I sleep and I know that God will help.

Matua fifine (B). That’s true I believe that.

Matua fifine (D). I believe (Focus group 2. 2. p.8).

Description

A Matua fifine shares her belief in the power of prayer. By turning things over to God, she asks for strength to carry on. God is perceived as a provider of health care. When there are feelings of unhappiness, prayer brings peace and an ability for peaceful /restful sleep as there is the belief that God will help.

Interpretation.

Belief in the power of prayer is an essential theme in the health seeking behaviours of ageing Niuean women. What does the power of prayer mean? It means faith in God. Prayer sustains the older person and problems are given over to God. The lived relationship (van Manen, 1990) with God is that there is trust and faith that will bring peace and restful sleep. Lived time, brings the morning whereby prayer will bring strength to face the day. The philosophical comment is made that you cannot be happy all the time. When unhappiness is experienced, praying and giving over the cause of unhappiness to God is the unvoiced expectation that God will help. Van Manen's (1990) existential of lived other brings with it the lived relationship that a Matua fifine maintains with God.

Health seeking behaviours and the use of blessed oil

The following example explains the use of oil that a Matua fifine has blessed and how a delay in taking medication created ill health. The immediate ingestion of the medication brought about relief. Self management has brought about an effect.

Matua fifine (B). I know that when I am unwell it's because I was late in taking my pills. I take my pills and I feel better straight away. Last night I got pins and needles in the side of my head and I felt uncomfortable and I got my oil, which I keep at the side of my bed and I massaged around my ears and head and when I wake this morning it is gone. The needle like feeling has gone.

Researcher. This oil that you talk about is this the oil that is blessed? *Matua fifine (B) brings her bottle of oil out of her bag.*

Matua fifine (B). This is the oil that we have been talking about.

Researcher. And it has been blessed?

Matua fifine (A). Yes.

Matua fifine (D). But you must not let go right down. You must keep it full. You must keep it full with the blessing.

Researcher. What happens if you allow it to empty?

Matua fifine (A). It is hard for you to go back and ask the Matua to give you another one.

Researcher. Is it hard for you to ask for another one or is that she won't give you another one.

Matua fifine (A). The Matua fifine warned me about [keeping the bottle full].

Researcher. Is that to maintain the belief?

Matua fifine(B). Yes

There is a chorus of agreement.

Researcher. Have you had any blessed oil Matua fifine?

Matua fifine (G). No. I only use coconut oil.

Matua fifine (A). When I had an accident, I put my leg up on the chair and I massage my leg. And while I am massaging I believe that it is because of the oil that I am well. (Focus group 2.2. p.5.)

Description

Again there are several stories within the field text. The delay in taking medication has had a negative effect. Relief came as soon as the medication was taken for a medical condition. Oil that is blessed by the Matua fifine must be maintained in its full capacity and the bottle must always be full. If you allow it to become empty then the blessing is gone. Believing in the power of the oil that is blessed whilst you are massaging, enhances its effects. Some prefer to seek out and use coconut oil. Different treatments are used for different symptoms

Interpretation.

Faith, beliefs and values are an important part of the Matua fifine's life. This reminds me of Van Manen (1990) comment about " Hermeneutic phenomenological research is a search for the fullness of living, for the ways a woman experience the world as a woman, for what it is to be woman" (p. 12.) The use of "blessed oil" appears to be an individual Matua fifine's way of healing in another country and is also shared with others in the group. The oil is a symbol, which signifies a belief and faith in healing

an ailment. This use of baby oil (which is a commercial product) is a practice that is not traditional Niuean. The belief is that whilst the bottle of blessed oil is kept full then the power of healing remains. If it is allowed to empty then the blessing is gone and it is hard to regain that blessing again. Topping up the bottle of oil with Baby oil maintains a full bottle. Van Manen's (1990) element of lived relation is evident in the relationship between the Matua fífine who has blessed the oil for the believer who has faith in the oil. The belief in the use of oil continues in the lived space whether home is in Niue or New Zealand. In New Zealand, it is not the type of oil that is important but a Niuean belief that a Niuean who has the traditional skills and knowledge of the ways of being and knowing continues to help others maintain levels of wellbeing away from the island homeland. The complementary existence of blessed oil and prayer can only be effective if the person has practised a healthy way of living.

Caring for yourself enhances your prayers

The importance of self management for healthcare emerges when the Matua fífine talk about the ineffectiveness of prayer if healthy behaviours are not practised. The following example highlights this situation:

Matua fífine (W). A Matua fífine is responsible for keeping herself well. Health and wellbeing are only maintained if you look after yourself. Don't hide your sickness.

Matua fífine (Z). Yes.

Matua fífine (W). What about prayer? Prayer is important.

Matua fífine (Z). That's what we know. Prayer comes over and above. We pray. Prayer is first and foremost. If the body is not kept in good health it doesn't matter if you go to church and pray, you'll still be sick if you don't look after your body.

Matua fífine (W). If you look after yourself, pray and seek the doctor's help then you'll be okay.

Matua fífine (U). Years ago [my friend] told her mother that if she goes to church in the rain that when she comes back she will be sick .

Matua fífine (W). You'll get sick. You go to pray for health and long life but it doesn't work, if you don't look after yourself.

Matua fifine (Z). Pray before you go to sleep.

Matua fifine (W). Praying all the time doesn't help if you don't look after yourself. *Ai fakahanoa* that means don't put yourself at risk.

Matua fifine (U). Everything must go together. (Focus group 3.3.p.2).

Description

Again there are many levels of meaning within this theme of self management. Health and wellbeing can only be maintained if the Matua fifine takes care of herself. Don't hide your sickness is in reference to not being shy to show or tell a doctor if you have an ailment affecting a private part of your body. All the prayers in the world cannot help if you are too shy to inform your doctor of your ailments. Prayer surrounds all aspects of life and upholds the Matua fifine. Going to church and praying is ineffective if there is no personal self management as each complements the other.

Interpretation

Prayer is the lifeline of the island Matua fifine and features in all aspects of life. Statistics New Zealand (1998) reveals older island born Niueans were likely to be members of a religious group. Van Manen (1990) existential element of lived space means that a prayer can be conducted in any space or place. Lived time within the island environment has a different meaning as the church is within the village and within walking distance of the home, whereas within New Zealand, lived time means travelling a distance to church. If the weather conditions mean rain, then the existential of the lived relationship emerges with adult children expressing concern that the parent is at risk of getting sick if she ventures out in the rain because of the different climatic conditions. There is a threefold overlap with, the lived relationship which pertains in the desire to be amongst other Niuean speaking worshippers, the lived body in being in the bodily presence in church and is also the lived space of worship.

What does this all mean for the Matua fifine? In a way, a lived body can only be a healthy body if it is respected and cared for in a way which God intended. What the Matua fifine could be saying is that the body is a holy temple, God has created and given people a gift which they should not defile, neglect, or treat disrespectfully by abusing it with too much food, alcohol and substances which are harmful and create

illness. As the Matua fifine stated prayer is “over and above”, and “first and foremost”. The connection is with self, God and others (Dyson et al, 1997) and life is in harmony. Harmony is not taken for granted and God is thanked for his blessings.

Thanking God for his blessings

For one Matua fifine there is an acceptance that God cannot grant a 100% cure but that an ability to be mobile and to continue life as best one can is sufficient.

Matua fifine (N). When I first came to New Zealand I was sick. It was my stomach and I could not eat chop suey and *ota* (marinated fish). The doctor gave me a list of food to eat and I was not allowed to eat any fatty food. I have continued with this diet and I look after myself. The doctor used to look after me. Now I look after myself. I do not need to go and see the doctor all the time. I watch my diet and that is the way that I am. My problem now is arthritis. I am not being smart. I thank God for his blessings. I am not a 100%. I have pain in my hip but I know how to get relief (Focus group1.2. p.15).

Description

The Matua fifine came to New Zealand to seek treatment for a stomach ailment. The doctor gave dietary instructions as part of her treatment. Adhering to a diet, she has maintained a state of being which makes the Matua fifine state that she is not being smart. By following the doctor’s instructions, she no longer has regular visits to his surgery. She is able to care for herself. Arthritis is the main problem now. She knows how to care for herself. Irrespective of the pain, she is grateful for the level of wellbeing that she has. Despite not being a 100% well, she feels blessed.

Interpretation

Again, the question is asked what does this all mean for the Matua fifine? The importance of maintaining a diet has been beneficial for this Matua fifine and this is reflected in the lived body and the ability to manage. Lived time brings with it, the ravages of time and age which have led to causing pain in the hip but the Matua fifine is philosophical as she knows how to relieve the pain. A lived relationship, as in a spiritual relationship with God has given her strength to be self-caring.

The discussion has followed the importance of religion in health seeking behaviours as in praying and the power of prayer, praying to promote a safe environment, the dual existence of blessed oil and prayer, effectiveness of blessed oil, and the ineffectiveness of prayers if healthy behaviours are not practiced. It is the move to the doctor which has brought about the opportunity for self management.

The next section leads onto spirituality within traditional beliefs.

Traditional spiritual beliefs

The ways of knowing and being a Niuean person impact on the behaviours that we observe and demonstrate when confronted by traditional spiritual beliefs. As these traditional spiritual beliefs are not documented by Niueans, they are handed on verbally through the generations although anthropologists have documented a few (Loeb, 1971). New Zealand born Niueans do not usually ascribe to traditional beliefs but there is a respect for and an understanding that there are those who adhere to such beliefs. The power behind traditional spirituality sanctions the tapu that is imposed on land or sea so that any transgression results in ill health in the island homeland (personal communication M. Erick). The beliefs of tapu as practiced in Niue do not appear to have been continued in New Zealand.

This study did not begin with the intention of asking questions about spirituality, information emerged spontaneously. Spirituality from the Niuean perspective encompasses a number of aspects such as spirits *aitu*. In this section examples are given of traditional spiritual beliefs.

The existence of traditional spiritual beliefs and western medical beliefs co exist so that when an emergency arises the health seeking behaviours are immediate in order to respond to the situation, as is seen in the response to the following question:

Researcher. If you are unwell who do you seek help from, first? (*This question was clarified in Niuean*)

Matua fifine (Z). It's the doctor first. Family doctor. And then we seek the plants (traditional medicine).

Matua fifine (X). We know that the body is not well.

Matua fifine (U). I don't touch those things. (traditional medicine)

Matua fifine (Z). One day I went to town on the bus. I was well. I had something to eat before I went. When I went on the bus I started to feel sick. As soon as I got to my daughter's house I was sick! I asked one of the people there to push my back. When my daughter came I asked her to take me to the hospital. I was white and sweaty. She rang the ambulance and then ran outside and picked the plants and put them in a cloth and crushed them and applied them to my face. The ambulance people came and they asked "What's wrong with Mum?" My face was all green from the plants. I got sick so quick and then I got better quickly when they put the crushed plants on me. My kids said I was visited by my dead brother. They took me to hospital. They tested me and put the things on the chest and took my blood and didn't find anything. My kids were quick and clever to help me. (*Faka po kia. Hit by a bad spirit*).

Matua fifine (X). You had physical symptoms.

Researcher. So how did your daughter know how to get the plants?

Matua fifine (Z). She went out and got any plants.

Researcher. You believed in the power of the plants to heal.

Matua fifine (Z). Of course. Straight away the sickness [and the sweat] went. They treated me in the hospital and I have no diabetes.

Matua fifine (X). They test you in the hospital and find nothing wrong. And when you ask there is no answer. So you go home and get the plants.

Matua fifine (W). It's the spirits. *Faka po kia*. [I was] hit by a bad spirit but not possessed.

Matua fifine (W). [You were affected] Just for a short time (Focus Group 3.1.p.6).

(This discussion continued in the second focus group meeting).

Matua fifine (U). That's why I said there are plenty of plants to be used. Spirit possession is often cured with plants.

Matua fifine (Z). They (my children) were going to squeeze my face to make me talk. My kids said my face was like my brother's face. How can you explain these things to a doctor? He has no understanding. Why did the spirit come?

Brief silence.

Matua fifine (X). Use any leaves as it comes back to belief.

Matua fifine (U). The kids are young. They have seen it (Their parents use of plants). They will carry it on. It's hard to explain. You know it works, especially when everything else has failed (Focus group 3.2.p.6).

Description

There are many layers of meaning within this story. The family doctor is the first point of contact during times of medical emergency followed by the use of plants (traditional medicine). However, during an emergency the ambulance is contacted for transportation to the hospital. A Matua fifine's sudden bout of sickness alerts the daughter and she responds immediately to call the ambulance and then darts outside to grab any plants to crush and apply to her mother's face. The ambulance personnel are perturbed as to why the client's face is green and accept the explanation when the daughter informs them that their mother's speedy recovery is due to the plants. Hospital care does not reveal a cause for the sudden episode of sickness. The Matua fifine thinks that she was "hit by a bad spirit" but the speedy actions of her daughter averted a major problem. Belief in the power of the plants assisted greatly. When there is no medical explanation given then the Matua fifine acknowledges the beneficial powers of the plants.

Interpretation.

The many layers of meaning begin with the peeling back to acknowledge that Western medicine is the first point of contact in this situation. During an emergency, knowing how to contact an ambulance is crucial. Healthcare pluralism (Helman, 1994), which is the use of two or more systems of healthcare, becomes apparent in this example. Lived time, reveals the swiftness with which illness can strike. The power of the *aitu* spirit hits and is countered by the equally swift actions by the daughter, in her application of the crushed plants. The lived body responds promptly to the traditional ways of being with an immediate improvement. Peeling back another level of meaning reveals the use of massage (pushing her back), which is a traditional form of care. Massage connects and

supports the one who is afflicted by sickness and eases the tension within the muscles. The sick person knows and feels that they are not alone.

Another level of meaning is in the treatment instigated within Western medical care. Western medical assessment tools will not reveal the cause, as there is a different understanding of illness. Nursing will not fare any better as there are different worldviews and one can only treat what one knows and understands. The “mutually beneficial co existence” of the Western medicine and traditional medicine (Finau, 1994, p. 14) has averted a potential problem. As to the nature of lived space this attests to the ability of the spirit to strike in any space. The lived relationship between the mother and daughter is one of respect for the Matua fifine’s beliefs as demonstrated by the application of plants.

Another lived relationship is one that exists between health services such as the ambulance responding to a call out from those in need. Communication skills and the art of asking and listening reassure the family and pave the way for on going medical care. The Matua fifine did not express dissatisfaction with the ambulance service as a first point of contact with the health care system. Misdiagnosis at this early stage may have lead to dire consequences for the Matua fifine with a referral to a psychiatric unit. That this did not happen and the Matua fifine was able to freely share this experience attests to what could be considered as a positive outcome.

Another level of meaning is in the daughter’s way of knowing. How did she know to use the plants? The Niuean ways of knowing emerge during the times of need as knowledge is not always verbalized but is demonstrated by example and children watch, learn and listen as they grow up and respond when the need arises. There is a quiet pride in the mother’s voice as she acknowledges her daughter’s speedy actions. The question as to the why did the spirit come, remains unanswered.

As is shown in the transcript, not every Matua fifine uses traditional medicine. The mutual co existence of the western medicine and traditional medicine has averted a potential problem. However, nursing colleagues must remain vigilant and document the concurrent use of traditional medicine and western medicine if the former is brought in

for the hospitalised patient. As Whittaker (2001) explains herbal and conventional medicines have the potential to cause toxic reactions.

Conclusion

For most of the Matua fifine in the study, reference is made to spirituality in both its religious and traditional forms and this co exists in a complementary manner. The essence of spirituality flows throughout the Matua fifine's lives to bring *malolo*. Prayer is important as is evidenced in the interactions that are shared as it also demonstrates self management in health seeking. But what also becomes apparent is a wait and see approach as in the handing over issues to God in the belief that he will bring peace of mind after a night of rest. In emergencies, the doctor is called first and then traditional medicine is applied. If nurses are to deliver nursing care in a holistic manner then consideration must be given to understanding what the complementary co existence means to the Matua fifine. It also means being responsible and documenting the use of traditional medicine. Spirituality has been the focus for this chapter; the next chapter will consider the costs of health seeking behaviours.

CHAPTER EIGHT

Differing costs

Introduction

The journey of exploration has traversed the meaning of health and illness, ventured into the realms of spirituality in both its religious and traditional forms and has made its way to the theme of costs in health seeking. Financial cost for healthcare was not an issue for the Matua fifine in Niue. Medical consultation, prescriptions, and the mobile health service there are free. If hospitalisation is required then the transport to and from the hospital, as well as health care is at no financial cost to the patient. Patients with a medical emergency requiring expert treatment are referred to New Zealand. As there was little on the issues of cost within Niue, this chapter will address the issues of cost in New Zealand.

This chapter will discuss the third category of health seeking behaviours which are the differing costs. The subcategories are: looking for treatment, getting something for my health; paying for primary care, doctors certificates, transport, dental costs; paying for traditional and complimentary medicine; delaying payment, being prepared, emotional cost and wasting time. The issues of cost were raised in all three groups and it was not only confined to financial cost but revealed other aspects of cost in the matua fifine's health seeking behaviour. Financial cost with the variation in consultation fees was a major source of concern.

Cost

What is the meaning of cost? According to Thompson (1995 p.302) cost is defined as

“ 1 What a thing costs; the price paid or to be paid. 2. a loss or sacrifice; an expenditure of, etc time, effort. 3. legal expenses, esp. those allowed in favour of the winning party or against the losing party in a suit”.

The first two examples of cost in the above definition impact in different ways in New Zealand and the analysis and my interpretation begin with the theme cost and how this may influence decisions for health seeking.

I went to look for treatments

The topic of eyes was raised by the researcher in order to engage the Matua fifine in the first focus group meeting as they were late in attending. Attending an eye clinic was a source of concern and the inconsistent cost of transport may explain the reasons why people do not attend clinics.

Matua fifine (J) I have a sickness with my eyes. I have been to the doctor and I put drops in my eyes. He said that I missed the treatments for my eyes and now I find that my eyes are not very good.

Researcher. I heard you say that you missed the treatments. What did you mean?

Matua fifine (J) The treatments were done at (name withheld). I think I went there three times. When I had the treatments I was blind for half an hour but this was alright as the people took me home in a car. After that I complained. Why did they take me home in a car the first time? Why didn't I get a lift like before. I come in my own transport. I had no money. I come in the bus. I didn't know where to go. And my treatments I didn't do it. I went to look for treatments and the doctor gave me pills and *vai* drops to put in my eyes and that's how I survived.

Researcher. So did you go back?

Matua fifine (J). No.

Long pause.

Researcher. So, are you waiting for an appointment?

Matua fifine (J). I made an arrangement with my family doctor. When I come back from overseas I will go and get my eyes fixed.

Researcher. So it's up to you when to decide.

Matua fifine (J) Yes (Focus group 1.1. p. 2).

Description

There are several meanings embedded within this experience but the main one seems to be the inconsistent supply of transport after clinic appointments when eye drops have temporarily blinded the Matua fifine. Not having any money to pay for bus fare is a source of concern. But worse still is not knowing where the clinic is situated. Frustration pushes the Matua fifine to not attend the clinic, which results in increasing deterioration in eyesight. This motivates the Matua fifine to look for treatments and satisfaction appears when a medical consultation results in pills and eye drops. The Matua fifine negotiates with her family doctor to let her make an appointment on return to the country.

Interpretation

All four existential elements impact on the well being of the Matua fifine. It has been the combined effects on her body, which has prompted the Matua fifine to express her concerns. Lived time, is one of living a life with deteriorating eyesight and worrying about money and transport. This has prompted attendance at an eye clinic. However, lived time is also one of reflection as to the inconsistency in the provision of transport for clinic patients. Both patient and health professional need to agree as to what is the problem, otherwise there is no compliance with treatment (Spector, 1991). Lived space brings with it the frustration of not knowing the situation of the clinic and this results in the decision to delay further appointments until the return from overseas. The relationship with the family doctor is cordial as she feels confident to negotiate her plans and a medical consultation satisfies her needs to resume instilling the eyedrops. The hidden costs of transport remain an ongoing issue for Niuean and Pacific people in New Zealand (Tukuitonga, 1999). Costs are not only borne by the Matua fifine but are also borne by the family.

Getting me something for my health

The family become the provider of healthcare and bear the cost of healthcare. Health seeking takes on another meaning when the search is outside New Zealand and cost in transport is not mentioned, when Matua fifine (J) shares her story of feeling unwell after major surgery.

When I went for a check up they said to me to come for another operation and I

said “No”. “No more”. Its my body and if I feel sick then OK. I feel well so don't make me sick. I had choice do I stay [and have more surgery] or do I go on holiday. Was this a nice thing to do? I thought is this the last time for me to live. Am I going to say goodbye to my family. When I got there I cried. I thought that this was the last time that I would see my family. They go to get something for my health. And when I had that nonu I felt better. When I had that nonu I felt my health coming back to me. I could walk. I could stand up, I could dance, I could do all those things. They bought two bottles for me. And when I came home I am going to live again. That's what they did for me.

(Focus group 1.1.p.8).

Description

The Matua reflects on her decision to cancel her surgery or visit her family for a holiday. She seeks reassurance from the group. She ponders, was this a trip to bid farewell to her family? She expresses emotion and the family respond by searching for treatment and purchasing nonu for the Matua fifine. A positive effect is experienced with the ability to stand and walk and dance. On return to New Zealand there is the belief that her life has been returned to her.

Interpretation

There is much overlapping within the issues. Lived time is crucial as the Matua fifine reflects on her decision to cancel major surgery for a holiday which may very well be her last opportunity to see her family. It is the importance of the lived relationships, which prompt the Matua fifine to seek out her family. She feels the need to experience the feeling of connectedness with family again. Lived space has been one of being alone. Space which is empty of others (J. Clark. Personal communication 4/2/02) . The Matua fifine is wondering if she is nearing the end of her time. Responding to the Matua fifine's emotion, the family seek out a traditional medicine, which has been commercialised, and purchase several bottles for her Nonu brings about a miraculous recovery. Her body responds and she experiences a resurgence of activity, which enables walking and dancing which give meaning to life. There now seems a sense of control in her life, which enables the Matua fifine to refuse further surgery and to assert “I am well don't make me sick”. Senior and Vivesh (1998 p.288) assert that “clinical iatrogenesis” is illness which is caused by surgery. The Matua fifine has regained her independence and there is no way

that she is going to lose it again, whilst she is well. The family as a provider have paid for her nonu but what about paying for the doctor.

Paying for primary medical care

Medical consultations need to be paid for. Rather than having family pay for the consultation, the Matua fífine needs to pay this fee. The varying costs for consultation and prescription fees were a source of concern. The following interaction attests to the sharing of views.

Matua fífine (J). I stay with the same doctor because it's cheap. It's five dollars.

Matua fífine (K). Sometimes I pay two dollars. I pay for my medicines.

Matua fífine (N). How much do you pay for your medicines? Three dollars for each medicine.

Matua fífine (Q) Mine's the same

Matua fífine (P). What is the cost of the doctors in town?

Matua fífine (N). Just the same. I pay \$25-\$27 when I owe \$20 and when I pay for my medicines I pay \$3 and when I need a repeat I pay thirty cent

Matua fífine (Q). Now there is a \$3 cost and it should not cost thirty cent for repeat. You need to return to your doctor and tell him why is it different. Why are some chemists free?

Matua fífine (N). Everyone is different. It's like she said, it's \$5 for her and when I am very sick and I only owe \$20.

Matua fífine (Q). You should only pay \$5.

Matua fífine (N). Oh leave it like that.

Matua fífine (Q). Fight for your life lady. Change your doctor.

Matua fífine (P). I have a good doctor.

Matua fífine (N). I am grateful because you have clarified everything for me. You understand and can clarify everything for us. Why [is there a difference in cost].

Matua fífine (Q). Every doctor is different because they want the money. You never argue with them. You never talk to them (Focus group 1.1.p.12).

Description

The interaction involves not only consultation and prescription costs, but also is encouraging a Matua fifine to find out why there are differences in cost. If there is no satisfactory explanation then she is advised to fight for her rights and change her doctor. Not all the Matua fifine question costs as one is satisfied with her doctor. The doctor patient relationship arises here, as this requires a trust relationship and rapport to be able to ask the question of variation in cost. Another issue to emerge is the extra cost for delayed payment when the original fee was \$20. No one asks for an explanation as to the five dollar consultation fee. The five dollar consultation fee was charged at a community ethnic clinic in an Auckland suburb.

Interpretation

There are several stories within this interaction and the issues that arise for the Matua fifine are the varying costs in doctors' consultation fees. Although the Matua fifine is encouraged to ask her doctor to explain, there seems to be a quiet acceptance of this state of affairs. The nature of Van Manen "lived relationship" reveals the passivity in attitude towards doctors as there is respect for this esteemed profession. Older Niuean people do not challenge those in authority. It is an age old value handed down over the years and could be likened to the traditional healers who were respected for their skills and knowledge. As stated, the Matua fifine do not argue or talk to doctors so how will they ever find out? Van Manen's (1990) existential element of lived other, appears to generate a feeling of cynicism from one Matua fifine, when she calls to leave things as they are.

Paying the full price for a doctor's letter

Costs are incurred in attaining a doctor's certificate to prove that there is a medical reason for applying to social welfare (now known as WINZ, Work and Income New Zealand) for extra funds for example, for dental care or for changing the benefit. The costs are for writing out the supporting letter. Mixed feelings are expressed.

Matua fifine (N) Some doctors are good. Some want the money.

Matua fifine (J). Some only want the money. They scratch the letter. When you need the doctor's letter for social welfare you have to pay the full price. More

money. That's the main thing. We pay. Especially when you need to change the benefit (Focus group 1.1. p8).

Description

Cynicism reigns as the Matua fífine consider some doctors only want the money but there is also the realization that there are good doctors. The doctor's letter provides proof that there is a medical condition or that there is a need for extra funds. It seems unfair that the doctor's letter costs the full price of a consultation.

Interpretation

Spatiality and relationality bring with it, time and distance to travel to a doctor to get a letter that will legitimise the need for extra funds. Then there is travel to the Department of Work and Income Support to process the application. Having to pay the full consultation costs for a letter creates mixed feelings. It would be different if there had been a medical consultation to justify the cost. After all, they are applying for funds and are not expecting to pay out. This is just another cost in a long line of costs which motivated the application to start with. Legitimising the need for a benefit changes also extends onto legitimising illness as discussed in Chapter Six.

No money to travel on the bus

The expense of travelling across town for a consultation creates an issue for a Matua fífine. When there are insufficient funds to pay for transport costs then the consequence is to change doctors. As **Matua fífine (Z)** stated:

I have shifted to the doctor downstairs from the meeting room as there is no money to travel on the bus. (Focus group 3. 1. p.5).

Description and Interpretation

The Matua fífine's comment reveals the reason for changing doctors. "Lived space" means the open space between home and the doctor's surgery is no longer so large and the space to travel is now in close proximity to home (and in this case, downstairs from the meeting room). The space to be negotiated no longer involves financial costs. Lived

time is now one of less time to travel. The need for funds becomes an issue when other health costs must be met. But how to achieve this involves a variety of responses.

Dental Costs

Financial costs usually focus on medical consultations but dental care also requires consideration. The discussion on dental costs continued with the following interaction:

Researcher. Some people have trouble with their teeth and then what?

Matua fifine (N) Go to the social welfare.

Matua fifine (P) Go to the doctor

Matua fifine (Q) I go to the dentist.

Matua fifine (P) But me I go to the doctor to get the letter before I go to the social welfare. And then I go the doctor. It's too dear. They said go to the hospital . Matua fifine (1) tried that hospital.

Matua fifine (J) The reason is the money. If I had the money I would go there. It cost \$40 forty dollars. I went home. And I know that three teeth is going to cost me one hundred and twenty dollars. If I had the money I would go and get them taken out. I go to social welfare and they turn me back. I try to ask where has all the money gone. There is no money to buy the bread. Social welfare ask me where is the family? Does anyone work? That is the problem (Focus group 1.2. p.3) .

Description

We take it for granted that when we have dental problems that we automatically go to the dentist. For the older Niuean who has the finance, this is not a problem but for some ageing Niuean women it is a problem. The problem is not only the imposed physical discomfort but also the financial discomfort that is imposed in having to find the money to pay for dental care. The experience for the ageing Niuean woman is that she needs to legitimise her claim with a visit to the doctor to get a medical certificate indicating the need for dental care. Time is taken to travel to the nearest social welfare department to gain the authority which then enables dental treatment. There is no guarantee that assistance will be granted. The assumption made by social welfare is that any family members who are working will contribute to the cost of dental care, without realizing that

often the Matua fifine is living alone. If family do reside at the same address then the assumption is that there will be a contribution to dental care forgetting that there may a minimal wage being paid to the family member. For the Matua fifine who chooses to use the hospital system there is still a small cost to be incurred.

Interpretation

The existential of 'lived time' is a time of concern for the Matua Niue. Forty dollars is a lot of money and when there are three teeth to be extracted, and where to find \$120 is worrying. "Clock time" plays a part now as the onus is on waiting for pension day so that payment can be made. Fjelland & Gjengedal's (1994) comments on distance strike a chord when they talk about the 'distance' for old people because the distances in life are different. The distances in life are different for ageing Niuean women because dental care in New Zealand is costly and in the island environment they were accustomed to a free, one stop facility. There was also no need to legitimise a need for dental care in Niue.

The Matua fifine's question of "Where has all the money gone to?" falls on deaf ears as she is in turn asked where are her family to assist in this time of need. The lived relationship with family is one of need as the Matua fifine points out that there is no money to buy the bread. Buying food takes priority over dental care.

The Matua fifine's comment on "Where has all the money gone?" is a question that asks about Government funding. The Matua fifine is asking in terms of "lived time" her time, when she is in need, where is the money to help pay for her dental fees.

Delaying payment

Delaying payment for consultation requires an ability to communicate clearly the intention to pay for the consultation at another time and day. This is usually on pension day. Delayed payment is demonstrated in the following example:

Matua fifine (Z). It's OK now as the doctor will help as he will wait and be paid later. There is help for people with no money (Focus group 3.1. p.5).

Description and Interpretation

To avoid repetition, description and interpretation are combined. Lived time and lived space is one of knowing that delaying going to the doctor is no longer an issue for a Matua fifine. She knows that she can negotiate to pay the doctor at a later date. A rapport has been developed with the doctor and this becomes evident in the lived doctor-patient relationship. There is knowledge that when a pension is paid out, the doctor will be paid. On the other hand, money can be saved to pay for consultations.

Being prepared. I put money away in case I get sick

Cost is not always perceived as a worry. For one Matua fifine being prepared was crucial to her wellbeing as she states:

Matua fifine (W). It is my way to put money away, in case I get sick (Focus group 3.1. p.5).

Description and Interpretation

Again description and interpretation are combined to avoid repetition. Although there is brevity in the above statement, the statement is potent. Financial costs for healthcare have been an issue for the Matua fifine throughout this study. Lived time for one Matua fifine means putting money aside in preparation for any unexpected illness. As a widow it is important that she be prepared. Within the existential of "lived human relations" there is no reliance on anyone else. She is on her own. She has transferred her spirit of independence and self reliance from Niue to New Zealand.

Being prepared, also entails remembering to name your medical conditions as is explained by **Matua fifine (J)**

I have to prepare first before I get sick. [I have to remember] my sicknesses like high blood pressure, asthma, gout, kidney [problems] and all those kinds of things.

When I go to the doctor then they know what sort of sickness I have and they know how to treat me. That is how I feel. Instead of getting sick, sick, sick, and no body knows anything about me (Focus group 1.2. p.6).

Description

The Matua fifine feels that she must be prepared as in remembering all her different illnesses. By being prepared to answer questions at the medical consultation, health professionals will know how to treat her. By being prepared she will not endure on going delay as she has given her health information.

Interpretation

Albeit brief, the experience shared by the Matua fifine is an essential theme. Van Manen (1990) asks a question “What renders this or that particular experience its special significance” (p.32). It is bringing to the fore something that has been unnoticed. In doing so, it enables a closer scrutiny and hopefully a better understanding. The Matua fifine’s lived experience has been one of lived time and lived space where she has been “sick, sick, sick”. Feeling as she does, she expresses her need to be prepared. It is within her experience of the relationships with health professionals that the realization comes that if health professionals are aware of her medical history then treatment should be not be delayed. The existential element of lived body reveals itself in the feelings of frustrating when health professionals do not have a full medical history or as the Matua fifine so eloquently states, “Nobody knows anything about me”. Even when health professionals do have a medical history there can be differences in interpreting what constitutes illness.

Emotional cost when I know that I am sick

Emotional cost also emerges within the patient doctor relationship especially when both have different ideas about illness.

Matua fifine (W). I stand in the queue and wait. I have no appointment and I wait my turn. That’s why they said change my doctor.

Researcher. You said that they didn’t listen to you.

Matua fifine (X). *repeats what I have said.* You said that you went to hospital and they didn’t listen to you.

Matua fifine (W). I know that I am sick. I tried to go to the hospital. He said no you wait until someone comes from the clinic. Why do I have to wait? I

went to the hospital by myself. I rang the night doctor he was expensive. I showed my illness. "Red in the urine"

Matua fifine (X). It is getting worse.

Matua fifine (W). My doctor said that I am not sick.

Matua fifine (X). You would be worried living by yourself.

Matua fifine (W). I went to the hospital. They tested me and I went home. Four times I went . Long queue. I sit and I wait. I had no letter. That night I rang the night doctor and he sent me to the hospital and when I went home I was told to change my doctor (Focus group 3.2.p.8).

(Before the meeting I spoke to the Matua fifine and she told me that she overheard her doctor ring the hospital and tell them that she was not sick).

Description

Problems arise when the patient and the doctor have different perceptions of illness (Senior & Vivesh, 1998). The emotional cost to the Matua fifine is that the doctor does not believe that she is sick. She does not understand why she can't go the hospital and why she has to wait for someone from the clinic to come and see her. Self referral on three occasions to hospital is unsuccessful as she has no doctor's letter of referral. On the fourth occasion she contacted the night doctor who referred her to hospital. She had shown him her sickness, which was blood in the urine. Successfully treated she was advised to change her doctor on discharge from hospital.

Interpretation.

"Doing interpretive research is not an easy option in research" (Koch 1998). I agree. This story has many hidden issues and one of them is emotional cost within the doctor patient relationship. Van Manen (1990) existentials come into play in this experience. Lived time and lived body bring with it the patience to not only "wait my turn" but also to attend a hospital four times to show your illness. The Matua fifine overhears her doctor ring the hospital to inform them that there is no illness. This does not inspire confidence and she feels that she is not being taken seriously. The existential lived other, reveals itself in the ringing for the night doctor to legitimise her illness (to show her illness) and arrange hospitalisation. This 'relationality' brings with it a positive outcome in that she is hospitalised, treated and advised on discharge to change her doctor. Finding a lady doctor pleases the Matua fifine as she feels cared

for and there is consideration for her as a pensioner in the prescribing of repeat prescriptions. But what happens if assistance is needed on discharge from hospital?

Homehelp as wasting time

Support services to assist the Matua fífine in the home are not always understood by those who use them. Costs as in wasting time warrant discussion.

Matua fífine (5). Do you remember the Matua fífine saying that after she had an operation they sent someone home to help her with cleaning and to do any washing.

Matua fífine (J). Homehelp. They come to my house and sit down and we talk. It's no use because it's only for a short time. They replied to my letter and said that I was not entitled for ongoing care. I know one of the mamas in Mangere she wanted help 2-3 days a week for 2-3 hours a day and that this would cost \$200.

Matua fífine (K). Yes I looked after my mother at home. But she is changed like a baby and I don't want to put her in a rest home. I ask the doctor to help me look after my mother at home until she died.

Researcher. So you relied on the doctor to help you at home.

Matua fífine (K). At the moment there is a woman who helps.

Matua fífine (N). That kind of help is lazy and I make up my mind that I must do it myself. My sister had a homehelp for a week. Some are lazy. They sit down until it is time to go home. You must complain to the co ordinator.

Researcher. It is important that they come at a time that suits the client.

Matua fífine (J). *Maumau maga aho.* Waste of time (Focus group1.2.p.4).

Description

As the Matua fífine do not have much knowledge of the role of the homehelp they are perceived in a negative light. If the homehelp is of the same ethnic group and could therefore converse in the first language then they are also providing a little companionship. Lots of questions are raised. The role of the homehelp is short term and is there until the person can reclaim their independence. To ask for help from strangers is

not the Niuean way of doing things. It is the role of the family to help in the times of ill health.

Interpretation

Lived time and lived space bring with it responsibilities for the family to come and assist the recuperating individual. It is not within the Niuean value system to bring a stranger into the home to attend to such tasks as housekeeping. Lived space is one of family and the dynamics within this space have been culturally defined. So that, being in this space is one of familiarity amongst family or friends. Van Manen's (1990) existential concept of lived other uncovers the taken for granted thoughts that we have of home help. Why does a homehelp just sit until its time to go? There are different perceptions as to what is necessary. The Matua fifine is seeking assistance in the home whilst the home help considers talking to be of some benefit. The relationship is tenuous as the Matua fifine would prefer to develop the trust relationship outside the home. If the home help was of the same ethnic group and conversant in the first language then maybe the situation would be different. The cost is in waste of time, which is *maumau magoaho*.

Cost is encountered in all aspects of life and the discussion returns to the issue of financial cost. Tukuitonga (1999) points out that Pacific providers are aware of Pacific people in New Zealand using traditional medicines, which are brought from the islands. The New Zealand health literature does not appear to show any interest in the financial cost of traditional medicine as a commercial preparation. The Matua fifine in the study purchase the commercial preparation of nonu as well as consume the nonu seeds.

Cost of traditional medicine

The financial cost of purchasing traditional medicine such as nonu (*mirinda citrifolia*, Loeb, 1926) which is a tropical plant is worthy of discussion

Matua fifine (Z). We drink the nonu it is good.

Matua fifine (X). It keeps you well.

Matua fifine (S) Who drinks it?

Matua fifine (Z) I drink it.

Matua fifine (X) It's dear.

Matua fifine (Z) Twenty five dollars. I used to have the seeds now I have the drink.

Matua fifine (W) It's fifty dollars. It's dilute.

Matua fifine (X) (name with held) talked about it. It's dilute.

Matua fifine (Z) I'm still drinking the twenty five dollar bottle. It doesn't matter. My daughter bought the bottle.

Matua fifine (W) [Some people eat the] nonu seeds.

Matua fifine (Z) I left the seeds and [I now} drink the juice.

Matua fifine (W) People eat the seeds in Niue.

Matua fifine (Z) 10mls is measured in the small measuring glass. (The matua fifine holds up her finger to indicate the amount). It's strong (Focus group 3.1. p.8).

Description

The purchasing cost of the traditional medicine in New Zealand does not seem to be an issue to the Matua fifine. The fact that it is a traditional medicine and is known to have healing properties prompts its purchase. The effects of drinking nonu attest to the Matua fifine keeping well. It does not matter whether it is the seeds or juice, both are consumed. Only a small measured amount is consumed as demonstrated by one of the Matua fifine as the nonu is strong and may need to be diluted.

Interpretation

The lived world of the Matua fifine is one of using traditional medicines in New Zealand. Regular consumption of nonu, leaves its imprint on the Matua fifine as they attest to its value on their bodily well being. The consumption of nonu in the New Zealand lived space, brings with it a discussion on the purchasing cost of the traditional plant in its prepared form. Whether the plant is in its prepared form or in berries the comment is that the flavour is strong. For one Matua fifine the lived relationship with family attest to the cost as being born by a family member so that expense is not a problem. Continued use of the nonu whether it is in New Zealand or Niue attests to its medicinal value and therefore its continued use. Just as there is use of traditional medicines so too is there use of complementary herbal medicines.

Cost of complementary or herbal medicine

Reference is made to herbal products which are purchased across the counter (Whittaker, 2001. Yoon & Horne 2000). Complementary medicine such as the purchase of Chinese pills and potions to attain, maintain wellbeing are an expense that is accepted. An example is shared.

Matua fifine (W). The pills from the Chinese are expensive. They are expensive but I still buy them. It doesn't matter.

Researcher. What is this Chinese that you talk about?

Matua fifine (Z) [They use to sell] herbs [in the shop].

Matua fifine (U) The shop use to be over here [but it has now closed]. They use to sell herbs and tea.

Matua fifine (X) It works for her but it is expensive.

Researcher. You believe in it.

Matua fifine (W) I notice that my body feels well now. The Chinese told me that it would not work straight away. It's true I drink the Chinese tea. [I haven't been back to see him as] I'm feeling so much better. I still drink the tea and that is why I do not go back.

Researcher. But you still go to the family doctor.

Matua fifine (W). Yea. I still go to the family doctor (Focus group 3.1. p.3).

Description

The purchase of Chinese herbs and tea has worked to the Matua fifine's advantage. She has been informed that the herbs and tea take a while to be effective and now she no longer needs to make regular visits to buy the herbs and the teas. The ingestion of herbal teas and consultations with visits to her family doctor continue.

Interpretation

The belief in the effectiveness of Chinese herbs and tea has brought about bodily wellbeing for the Matua fifine. The expense is not an issue. The nature of lived time manifests itself in the notion of bodily wellbeing. The Matua fifine has been informed that it takes time before there will be any effect. Regular consumption of the Chinese tea has maintained wellbeing and there has been no reason to return to the Chinese herbalist. For

the Matua fifine “lived space” is expressed as felt space as she states that the shop where she purchased her supplies has closed. Although the Matua fifine states that as she is feeling well there is no need to return. There is the unvoiced reality, that space in terms of distance may also play a part if she ever needs future supplies. The existential element of lived other brings with it the relationship that the Matua fifine has with the concurrent use of herbal medicine and consultations with the family doctor.

Conclusion

To conclude, cost is not always confined to financial cost as is seen by the narratives in this chapter. Issues of cost have been wide and varied. Payment for medical care is considered an expense but when traditional and complementary medicines, herbs and tea are purchased this does not seem to be an issue and is accepted. Health seeking behaviours has included exploration, description and discovery to reveal the ways that ageing Niuean women attain, sustain and improve their level of health, function and productivity. What it has also revealed is the financial cost of consultation with a provider of health. What this may suggest is that the loss of *malolo* warrants help. Help costs. The Matua fifine is reliant upon her own *malolo* strength to maintain wellbeing as in the self management and the wait and see approach. If the Matua fifine needs to consult a healthcare provider then the shift is away from health seeking to help seeking. It is outside the scope of this thesis to begin any discussion on help seeking but point out that this topic is worthy of further study or to revisit the data to uncover another level of meaning. The next chapter paves the way to discussion about a journey that has explored and discovered the health seeking behaviours of the Matua fifine, implications to nursing, limitations of the study and the tensions encountered.

CHAPTER NINE

Discussion and conclusion

Introduction

The journey is nearing completion. The previous three chapters have analysed the data which has brought the thesis to the stage of discussing the researcher's interpretations of the experiences that were shared. Van Manen (1990) advocates searching for signposts that would enable the move forward, whereas Koch & Harrington (1998) call for the identification of the signposts that will support the rigor of the study but it is Munhall (1994) who advocates the search for "the portal of entry". The portal of entry to the analysis and therefore the discussion was in the naming of the experience of health and illness and understanding the structures that make up the experience. "Phenomenological themes are the structures of experience" (Van Manen, 1990, p.59). Therefore the seeking of *malolo* (health) and *ai malolo* (ill health) are such structures. Although the health seeking behaviours are many and varied what has become apparent is that there is more than one way of engaging an approach to use or not use healthcare. The approaches have included, self management, a wait and see approach, going directly to a doctor, layperson (which includes herbalists and the Niuean ways of health seeking, and lastly, traditional medicine. What has become apparent and is included is the use of more than one healthcare system and is referred to as "healthcare pluralism" (Holland & Hogg, 2001; Helman, 1994)). These approaches are determined by the Matua fífine, in their own way and in their own time. The issues are complex and when cultural perspectives are added then this compounds the issues. Crucial to any nursing research study is connecting the findings and interpretations of the narratives to the growing body of nursing and health literature. This chapter begins with the search for the holistic meaning of health *malolo* as strength.

A major insight arose to explain the search for the portal of entry. The movement back and forth within the hermeneutic circle of inquiry in search of the meaning of the whole study arose, after numerous returns to van Manen (1990) text. As this was the text which informed the study, the following pertinent comments suddenly made sense "...the interview process needs to be disciplined by the fundamental question

that prompted the need for the interview in the first place” (van Manen 1990, p. 67). Preoccupation with the data collection method of focus groups meant that the question got buried. In hindsight I can see now why van Manen (1990) cautions the researcher to guide against the method overshadowing the question and this is exactly what happened.

The meaning of health is complex. A salient insight is provided by Kahn (2000 p.63) when he states that the use of concepts such as health (and in this study, health seeking) may be of interest to the researcher but may be an “abstract construct” to the participants in a study. What is advocated is to remain close to the level of experience and to frame the question in such a way as to get close to the life experience. This is a preliminary study and exploration in uncovering the Matua fifine’s ways of knowing and the ways of being an ageing Niuean woman in another country when seeking healthcare.

Health research studies have tended to exclude the lived experience of people in health research (Plager, 1994). In doing so, as Pacific people we have been relegated to the margins of society where we are visible only within the negative health statistics. What is a likely explanation for the exclusion of people’s life experience from research studies and their definitions of health?

Plager (1994) offers an explanation for the exclusion of the individual’s life experience in health research. Plager’s (1994) explanation stems from the use of health and health promotion research on family and nurse practitioner practice. Within these ideas Plager (1994) depicted health and health promotion as concepts and variables that will fit into the theories of health. The individual’s perspective and context of the health experience are excluded (Plager, 1994). When providers and funders perceive health in an objective manner, it is for the purposes of measurement and evaluation so as to arrange the allocation of funding and services. Health becomes a commodity (Radley, 1993). On the other hand, the Matua fifine as the consumer of services approaches health from a subjective stance as in the every day way of life. It is at this point that understanding the meaning of this interface from the Matua fifine’s perspective is crucial. Equally important is the interface that the Matua fifine has with other ways of health seeking such as the engagement with complementary and or traditional medicine.

***Malolo* - Health as strength**

Seedhouse (2001) recognizes many meanings of health that are debated by scholars but the one pertinent to this study is "...*health is a reserve of strength*" (author's *italics*, p.5). This meaning fits within the Niuean understanding of health. The meaning of health for the Matua fifine is the reality of living life itself. It is drawing from the strength within the individual. Self management or self reliance epitomizes the term *malolo*. Beliefs about illness are dispersed throughout the three data chapters and the threads that have given insight to me as the researcher are linked to health belief systems (Holland & Hogg, 2001) and healthcare pluralism. But what has this all meant to the Matua fifine?

Strength is upheld by an ability to work and to maintain independence and to remain active. *Malolo* is brought from Niue but maintaining it in New Zealand is difficult for some Matua fifine. For the Matua fifine in this study being active was important. Being active implied physical activity as in working around the home. Being active is crucial to maintain *malolo*. As one Matua fifine stated "We work until we die" (focus group 2.1.p1). The Ministry of Health's 1996/ 1997 Health Survey (1999, p.41) in New Zealand attests to the benefits of "regular moderate physical activity can improve health and wellbeing". The 1996/1997-health survey portrays Pacific people in New Zealand as leading a sedentary life and did not ask questions about work around the home. This may be true of the participants in the survey but for the Matua fifine in this study activity was important.

According to Senior & Vivesh (1998) there is no consensus on the definition of illness. Maybe as Madjar & Walton (1999) suggest one reason is because no one is listening to what people have to say about illness. For the Matua fifine health is depicted as a state of being *malolo* not being sick whereas *ai malolo* is a state of being unwell or losing strength. The latter, if left alone will pass on and there is a return to wellness. Rest may relieve this feeling and this is in line with Dunning & Martin's (1998) wait and see stance. Illness can be an ongoing process and can be interpreted differently at different times (Freund & McQuire, 1995).

Finau (1994) makes a stand and offers the view that decisions to seek healthcare are determined by several different options within the healthcare system. The options are not doing anything, otherwise known as wait and see, self management, and or seeking care from people or services such as western medicine, traditional medicine and lay people. I take lay people to mean providers of alternative medicine such as herbalists.

As Niuean people embrace Christianity, God is considered a provider of healthcare and forms the fourth in the quartet of healthcare providers. This is not considered by Finau (1994) but is crucial in the options of health seeking for the *Matua fifine*.

What is not acknowledged is that if the *Matua fifine's* self management and the wait and see approach have not begun the journey to *malolo* (that is an improvement in wellbeing or strength) then the approach is for consultation with a health provider. If the consultation does not give the healing and satisfaction that is sought, then seeking assistance from different doctors or other sources begins. If the journey to *malolo* health is still evasive then consideration is given to seek out alternative and or traditional medicines or Niuean ways of health seeking. It can be seen then that the first move to seek healthcare is not the taken for granted move of going to a provider or the use of western medicine but can incorporate a number of choices.

Health seeking as being a movement to a higher level of wellness

Carpenito (1992) asserts health seeking as being a move from stable wellbeing to a higher level of wellness. Carpenito's (1992) examples of care are from a health professional who provides dietary instructions on how to lower cholesterol levels or avoid heart disease. The client or individual's point of view is not acknowledged. The assumption is that the first move is towards Western medical care. Carpenito (1992) talks of a move to a higher level of wellbeing and this implies the implementation of biomedicine as in primary and secondary care but omits traditional and complementary therapies. Holland & Hogg (2001) proclaim that in general, Western medicine is considered as being the superior system of healthcare.

Mention was made of professional health providers but what about the other two providers as identified by Finau (1994), the layperson and the dispenser of traditional medicine. Laypeople include the herbalists. Herbalists are referred to in the text as the “Chinese” and their contribution to wellbeing is appreciated even if it is expensive. Traditional medicine is an integral part of Niuean people’s lives. Derived from plants and herbs it is defined as “*vai lakau*” herbal medicine (Sperlich, 1997 p.481). Traditional medicine and Western medicine cater for different demands (Finau, 1994). In doing so they meet different needs. However, when both are used Finau (1994) refers to a “mutually beneficial co existence” (p.14) or as stated by Holland & Hogg (2001) “pluralistic healthcare” (p. 33). Herbal medicine is now accepted in hospitals (Matua fifine focus Group 2.2. p.2). However, the use of traditional medicine implies natural herbs are harmless but when taken in conjunction with conventional medicines then caution is advocated as interactions have been reported by Yoon & Horne (2000), Whittaker, (2001). Richmond et al (1996) acknowledges the use of traditional medicine but calls for further research so that there is safe use. But what are the other systems of healthcare that the Matua fifine consider if the first move is not directly to a health provider?

Self management

Bayne-Smith & McBarnette (1996) assert that movement from illness to medical care is not always a direct move, but there is an attempt at self management. This was apparent within the data with the examples and interpretations that were given. Improvement indicates that self management was the right decision for that point in time. If self management did not work there was the wait and see approach.

Wait and see approach

This ‘wait and see’ approach generates effectiveness on one hand but on the other hand can be ineffective for the older aged person. The Matua fifine in this study, asserted that the wait and see approach was due to minor ailments. In a sense there was some control over the situation and the wait and see approach was the right decision for that point in time. However, the wait and see approach may not always be as effective as “Aging related physiological changes alter the way specific diseases behave both in symptom

manifestation and in response to treatment” (Levanthel & Crouch 1998, p.79). Age can impact on ill health and vice versa.

Being prepared

What does not appear to be addressed within the literature is the issue of being prepared. The Matua fifine raised this issue across the three groups. Included within this aspect of being prepared is knowing how to contact medical assistance at night. Also important is ensuring that there is a logic and order in notifying medical authorities that there is illness and this has been legitimised with a medical certificate. The Pacific literature on health Bathgate et al, (1994); Ministry of Health (1997), describe the poor health of Pacific people in general, pointing out that Pacific people are sicker when they are admitted to hospital. In this study, the reason is that the Matua fifines know they have to be very sick before they will be admitted to hospital.

Another aspect of being prepared is in putting aside funds to pay for unexpected medical consultations. What is interesting is the being prepared for death. This is a Niuean aspect of being *malolo* strong. Everything must be in order so that if an unexpected occurrence results in death then preparations have been made. Health seeking is not only about being prepared financially it is also ensuring that the home environment is tidy and that the individual is washed and dressed so that when discovered by the family, everything is in harmony.

Self management begins with spiritual guidance

Movement to a higher level of wellness was not always a direct move to a health provider for the Matua fifine in this study but was considered by some Matua fifine to begin with prayer. The Matua fifine within the study disclose the first move towards health seeking is not always to seek out the medical doctor but to first seek out healing from God. Praying begins the way to well being for some Matua fifine, as religious spirituality permeates the lifeworld of the ageing Niuean women.

Spirituality and praying as experiences of health seeking

The inclusion of spirituality in the Pacific definition of health in New Zealand brings with it an acknowledgement of the importance of the religious side of spirituality. Hence,

the data provided by the Matua fifine reinforce the importance of the power of prayer evoked the scripture of Mark 12 :24. "Therefore I say unto you, what things soever ye desire, when ye pray, believe that ye shall receive them, and ye shall have them" (Holy Bible, no date, p.822). A belief in God has healing for the Matua fifine who prays. Strength comes from prayer and flows into all areas of life such as the physical, mental, social and spiritual family and cultural realms. Reference to healthy behaviours enhances the power of prayer. But what is the connection between spirituality and praying to the nursing profession.

As stated, spiritual care is a nursing responsibility when patients are in the care of nurses (McSherry, 1998). But this can only be acknowledged and developed when the nurse or caregiver has an understanding of the patient's health beliefs. Leetun (1996) has developed an assessment tool for use in the clinical setting but this can only be effective if nursing colleagues include a spiritual assessment in the planning of care. Another point made by Leetun (1996) is that for effective interventions with older people consideration must be given to cultural factors. Reference to the development of care plans and goals that did not include the cultural beliefs of the client (Leetun, 1996). When cultural beliefs are identified and acknowledged by both parties concerned then, the client may feel empowered that their religious beliefs, be they religious or traditional spiritual beliefs, have been valued. Moreover, Ross (1994) explains that if the nurses are expected to provide spiritual care in a holistic manner then a framework must be available.

The level of wellbeing reflects the integration of mind, body, spirit, which is also linked to culture and family. This leads onto the portrayal of a human being within the nursing literature as being a "biophysosocial" entity, and so the omission of spirituality becomes apparent (Oldnall, 1995 p. 417). Within recent times, the spiritual component of a human being has been included and now a human is portrayed as being comprised of four domains which are biological, physiological, sociological and spiritual (Oldnall, 1995).

Another point offered by Oldnall (1995) is that the exclusion of spirituality from care planning which incorporates the nursing diagnosis of assessing, planning, implementing and evaluating means that care planning may not have been correctly attended to. And in doing so, people presenting with symptoms that are not understood by mainstream health professionals may be misdiagnosed. The example of being hit by a spirit (Focus group

3.2.) demonstrates a situation that may have been misinterpreted if the children had not explained the presence of green plant stains on their Mother's face. Having children who are able to explain the symptoms and spiritual needs and beliefs at the time, enable a positive outcome for the patient. The negative side would have been an inappropriate diagnosis with referral onto a psychiatry unit (Oldnall, 1995).

Oldnall (1995) also advocates the development of nursing theories by nurses in clinical practice, as they are in contact with clients and may be aware of the client's spiritual needs. Spiritual practices, both religious and traditional play an important part in the wellbeing of ageing Niuean women and were a driving force in this study. The Matua fífine were very firm in their beliefs and convictions. And it is only by acquiring an understanding of these beliefs that a health provider can begin to meet the needs of the individual Matua fífine.

Traditional Medicine

While some educated Pacific people from different walks of life have tended to view traditional medicine with disfavour (Finau, 1994), in recent times, there has been a call from New Zealand health providers (Richmond et al, 1996) for improved understanding of traditional medicine.

Issues of health seeking and the Matua fífine's experiences of cost

The literature attests to the over representation of Pacific people in secondary care and the under representation in primary care (Tukuitonga, 1990). The Matua fífine in this study attest to a number of issues which impact on cost and whilst Tukuitonga's (1990) comments were in general about Pacific people, the Matua fífine's experiences and the difficulties of cost in attending a general practitioner service also point out that there are other factors for consideration.

Information from the 1996/1997 New Zealand Health Survey (Ministry of Health, 1999) which was conducted in the mid North Island, generated older participants responses to a question of unmet health need. Reasons for Pacific people choosing to consult or not consult a doctor in the 1996/1997 New Zealand Health Survey (MOH 1999), stated cost was a major factor. Older people in the survey considered that they did not want to make

a fuss or could not be bothered when it was presumed that the illness was of a minor nature. The Matua fifine in this study, did not talk about not wanting to make a fuss, instead showed great fortitude to be able to make decisions about consulting a doctor when the need arose.

Within the New Zealand health literature, cost can be a barrier to primary healthcare services as described by Gribben (1996) but that it may not necessarily mean "decreased utilization" (p.455). Malcolm (1996) and Young (1997) point to the positioning of Pacific people within the lower socio-economic bracket, as having a bearing on the under utilization of primary care and the over utilization of tertiary care services. Emergency departments have borne the brunt of over utilization of secondary care services (Garret, Mulder & Wong Toi, 1989). The Matua fifine in this study point out the need for legitimisation of their illness otherwise they will not be admitted to hospital. Strategies were developed by some Matua fifine to cope with doctor's cost. Such an example is in making arrangements to pay the consultation fee at another time. What is interesting is that the Matua fifine across the three groups did not mention health insurance.

Hidden costs

The general hidden costs for health care as articulated by Tukuitonga (1999) are transport and childcare. These comments were made in general about Pacific people. The Matua fifine in the study attest to other issues that could be considered hidden costs. Such hidden costs as paying for medical documentation for Work and Income Support to legitimise the purchase of dentures and glasses. Paying the full cost of a consultation fee when all that was required was a letter, annoyed one Matua fifine. The perception is that healthcare is free but the dental costs even from within the hospital service are considered expensive. For the Matua fifine, the reasons for the varying costs of primary healthcare remain largely, unexplained. However, for healthcare providers of primary and secondary care, Tukuitonga (1999) provides reasons for healthcare funding such as fee for service, capitation (that is amount per head paid by government paid to a registered provider). These reasons are of concern to providers but are of no interest to the Matua fifine. What is important to the Matua fifine is that the reason for costs, such as prescription costs are explained to them (Public Health Commission, consultation meeting Auckland, 11th May 1993).

The family

Reference was made to the role of the family in health seeking within the island and in the New Zealand environment. What is noticeable is the Matua fifine living alone and having to make decisions that are not always determined by family members. This will have future implications for the frail Matua fifine living alone as decisions may need to be made regarding resthome care.

Implications for the nursing profession

A number of implications for nursing become apparent as a result of this study into the health seeking behaviours of ageing Niuean women. Firstly, within nursing education, teaching cultural awareness and an understanding of the health beliefs of the ethnic specific groups, which make up the Pacific population in New Zealand is crucial. This will demonstrate a respect for the different ethnic identity of a people. This also paves the way towards providing a culturally safe service.

Defining and understanding the terms that we as health professionals use is crucial so that in any interaction with the community we use terms that have shared meaning. Until such time as we define words like health then we will not make a difference for those whose needs are not being met at the present time.

Discharge planning within gerontological nursing, demands careful consideration, especially when considering homehelp for a Pacific client. Taking the time to explain the role of homehelp and the short term benefits to be accrued will ensure a positive outcome especially if the client agrees to a home help from the same ethnic group. Homecare services delivered for and by Pacific providers have demonstrated positive comments from Pacific elders who have used the service. (Personal communication Dahlia Naepi , Co ordinator Pacific Services, Wesley Homecare March 1999). If the client refuses homehelp, then this request should be respected.

For the Matua fifine in this study, two issues become apparent around seeking secondary care. Firstly, beliefs around having to be very sick before seeking consultation and then calling an ambulance stem from the knowledge that they need to legitimise their illness.

As the Matua fifine believe that they have to be very sick before being admitted to hospital then, it requires nursing colleagues to take heed and respond accordingly. Secondly, if hospital records show two or more admissions to Accident and Emergency department without a doctors letter, then serious consideration should be given to assessment and identifying the patients perception of illness and the general practioner's perception of illness. If there is unvoiced disagreement with the doctor then the Matua fifine seeks consultation elsewhere. If nurses recognize that that the patient and the doctor have different perceptions of illness then a thorough assessment may avoid repeated admissions to hospital.

As to the spiritual needs of the Matua fifine, nursing assessment should take into consideration not only the importance of prayer but also the importance of traditional medicine. Healthcare pluralism (Holland & Hogg, 2001) or the concurrent use of modern medical treatment and traditional methods is becoming acceptable within the secondary sector as well as in the community. How nursing colleagues react and or accept traditional methods within the secondary sector will determine the openness with which Niuean people use and declare these methods. If nursing colleagues are to meet the health needs of the Matua fifine Niue, who are admitted to hospital then understanding of cultural beliefs of health and illness are paramount. Tukuitonga's (1990) recognition of Pacific people as placing cultural obligations ahead of healthcare may have been relevant at the point in time that the comment was made but the Matua fifine in this study do not articulate cultural obligations instead give very practical reasons for choosing to engage in using / not using healthcare.

There are several implications for nursing research. Rather than focus on one ethnic specific Pacific group such as Samoans (Anae, 1999) generate interest in other ethnic specific groups. The information will add to the body of nursing knowledge. Colleagues who are interested in conducting research within Pacific communities will need to identify and consult with the appropriate communities to gain support as well as participants.

What is pointed out is that the community can support a research project and assist with participants but at the same time can with hold its support.

Lastly, time is needed for analysis to uncover the essence within life experiences. Experiences that are translated from the first language into English lose significance in the translation .

Tensions

Tensions existed throughout the development of this study and they had a major impact on the decision-making process, such as wanting to develop a descriptive study as there was a paucity of information to support my findings. I can now appreciate the benefits of the inclusion of a perspective for analysis. The use of description and interpretation has generated numerous insights. But in accepting this advice, it created tensions in using Western philosophical underpinnings, which seemed inappropriate as the assumption is that only Western models of understanding will suffice. However, whilst Pacific research method and methodologies are in their infancy, the ideas from Western science are useful. Persistence with resolving the tension resulted in numerous returns to van Manen's text. Van Manen's (1990) existential elements are acknowledged as providing the lever to uncovering meaning and for this I thank him. It gave me the insight that I was searching.

Tensions, that have also had an impact on this study, are in the insider–outsider positioning within the study. When I was positioned in an emic or insider role, focus groups as the method of data collection seemed appropriate but did not provide the perspective to analyse data. However, when I was positioned in the etic or outsider role on completion of data collection, I was troubled by the trilogy of methodology, theoretical framework and epistemology as they are based on Western traditional thought. I was uncertain as to whether to proceed without a theoretical framework or unquestioningly accept a framework which would provide knowledge for the nursing profession and not make a difference for the *Matua fifine* or to opt to continue to explore other possibilities. I opted for the latter when the internet provided an interesting comment about understanding what others have to say about methodology and van Manen provided an opportunity with his approach to human research. This seemed to fit in with the search for meaning. The reality for me as the researcher has been one of constant thinking and reflecting about this tension. The thoughts move back and forth as if I have my own personal “hermeneutical circle of understanding” taking place along

side the “hermeneutical circle of inquiry” within the narrative text. Each is important for an understanding of the whole of the study. When I began the study I was aware of my position as being in the insider outsider role individually and simultaneously. I did not realize that this intense battle would take place within my thinking. At times I felt as if I always had one foot off the ground and was never quite getting my balance. This tension is worthy of further discussion in another paper.

Limitations of the study

The small sample means that the study cannot be used to generalize to the Niuean population within New Zealand.

As the study was for the Matua fífine, all participants were Niuean born and length of time in New Zealand would determine their experiences and responses. Chronological age of sixty five plus was not a criteria.

There are two issues worthy of further consideration and they are perceptions of health and illness and information needs for Pacific people in New Zealand. All the planning and preparation did not prepare me for the encounters of research. However, this is a preliminary study and did not set out to provide all the answers but to pave the way forward to further discussion and research. As a preliminary study, the experience was invaluable for the insights and understanding that it brought to light.

Future research that is needed

Finau and Tukuitonga (1999) call for ethnic specific research. Ethnic specific research is required to assess, plan evaluate and monitor the provision of health services. More importantly, Finau and Tukuitonga (1997) call for “Pacifícentric analysis” (p.65). These need to be developed.

The experiences shared in this study raise more questions. Future research needs to address the need for Pacific research methods, methodologies and analysis especially from a nursing perspective. By using mainstream methodologies that are European in origin, it creates tensions in reconciling Western philosophies and cultural beliefs and ways of being. In terms of research topics, future research will need to address the issues of self management as well as the wait and see approaches to healthcare from ethnic

specific perspectives. Another area that needs to be addressed is research with older Pacific men.

Equally important is a research study on the health information needs of Pacific people in New Zealand. What this study has highlighted is the different ways that people get health information. The formation of groups will assist in the dissemination of information. The Matua fifine cannot ask questions if they do not know the questions to ask.

The themes of fatalism, massage, the patient-doctor relationship, the role of the traditional healer and the use of remedies used at home, were not developed and will need to be addressed in another study. More research needs to address the health consumers' perspective of health and illness as until such time as this is attended to health policies will continue to reflect the perspective of health professionals and there will not be any major changes to the health status of Pacific people in New Zealand. What also needs to be addressed is funding, which is earmarked specifically for Pacific nursing research in New Zealand if any difference is to be made to the wellbeing of the people concerned. Lastly, cultural research supervision within the nursing department would greatly reduce the tensions experienced within a study. If I have another opportunity to follow up this study I will have a fluent Niuean speaking co researcher and have less questions which will be unstructured. The methodology will be Niuean.

Conclusion

To conclude this chapter, discussion brings to the fore, the use of terms such as health and illness and their impact on health seeking behaviour, spirituality and traditional beliefs, the many varying costs that affect the decisions that people make about seeking healthcare, implications for the nursing profession, limitations of the study, tensions and further research that is needed. Therefore, the next section brings the thesis to its final conclusion.

Conclusion to the thesis

The journey started as a search to understand the meaning of the health seeking behaviours of ageing Niuean women. In doing so, my preparation, consultation and commitment did not reckon on the intense complexity, tensions, uncertainty, and challenges that this journey would bring. Recognition of the theoretical framework embedded within the study helped to provide a perspective to analyse data. Time to work through the data was valued. As Rice & Izzy (1999) pointed out often the researcher is using a framework but is unaware of this. Flexibility and an emergent design enabled decisions to be made and allow the journey to progress.

This study revealed to me the *malolo* strength that the Matua fífine have embedded in their being. *Malolo*, which is both health and strength, which was brought from Niue, was valued and attempts were made to uphold it within the New Zealand lifestyle. Despite the rigors of the New Zealand lifeworld, the Matua fífine have adapted and formed groups to continue the ways of being that were instilled in the island homeland. For those who live alone, reliance is on their own *malolo*.

The issue of seeking health information when the Matua fífine is well is complex. When the issue of older people's services was raised there was no understanding of this service as recognition was of the family doctor and the homehelp. The issue of cost dominates the study and yes this is an issue for some but what is also realized is that choice is also a factor in the decision to engage or not engage a health provider. What has come to the fore is God is considered as a provider of health and so are lay people such as the Matua fífine themselves.

One of the sobering conclusions is that the Matua fífine do not see or talk about themselves as being a problem, it is the information put out by epidemiologists who categorize Pacific people within statistical data as having health problems. Therefore this thesis forms one level of analysis as I now believe that on revisiting the field text there will always be another level of understanding. I could continue uncovering deeper levels of understanding because of the wealth of information, which gives multiple realities, but phenomenological interpretation is never complete.

The overall conclusion is that health seeking to maintain well being when well and or unwell is not a direct move to providers but that the Matua fífine have choices except in emergencies and common sense prevails. Decisions are made after considering self management, and or a wait and see approach. To access healthcare providers, the Matua fífine need information and financial resources. There is a shift in the terms used as health seeking is one of seeking to regain strength or health whereas help seeking is the treatment of a significant change in wellbeing. The decision to use any or use all of the providers is as one Matua fífine (Focus group2.2.) stated "*Fia moui vave*" I want to get better quickly.

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Appendices

- Appendix A Human ethics approval
- Appendix B Information sheet in English
- Appendix C Information sheet in Niuean
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- Appendix E Consent form in Niuean
- Appendix F Interpreter non disclosure of information
- Appendix G Non disclosure of information transcriber/translator
- Appendix H Questions

APPENDIX A

Massey University

7 March 2000

Doreen Arapai
C/O Gillian White
School of Health Sciences
Massey University
Albany

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Massey University
Albany Campus
Private Bag 102 904,
North Shore MSC,
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Principal: 64 9 443 9799 ext 9517
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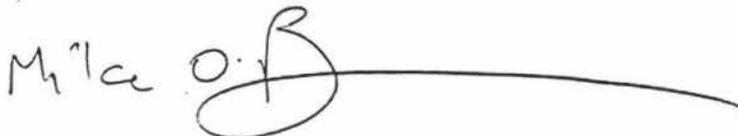
Dear Doreen

**HUMAN ETHICS APPROVAL APPLICATION – MUAHEC 99/084
THE HEALTH SEEKING BEHAVIOURS OF AGEING NIUEAN WOMEN RESIDENT IN
CENTRAL AUCKLAND**

Thank you for your letter of 23rd February 2000. Your amended application details have been placed on our files.

The amendments you have made now meet the requirements of the Massey University, Albany Campus, Human Ethics Committee and the ethics of your application, therefore, are approved.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Mike O'Brien', with a long horizontal line extending to the right.

Dr Mike O'Brien
CHAIRPERSON,
MASSEY UNIVERSITY, ALBANY CAMPUS
HUMAN ETHICS COMMITTEE

cc. Dr Gillian White, School of Health Sciences, Massey University, Albany

APPENDIX B

Massey University

COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences -
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RESEARCH INTO THE HEALTH SEEKING BEHAVIOURS OF AGEING
NIUEAN WOMEN RESIDENT IN CENTRAL AUCKLAND.

INFORMATION SHEET

focus groups

Fakalofa lahi atu and greetings.

My name is Doreen Arapai and I am a New Zealand born Niuean woman. I am a Master of Philosophy student at Massey University and I am currently enrolled in the School of Health Sciences at Albany campus. As an older woman and a nurse I am aware of the health needs of Pacific Island people and in particular, ageing Niuean women in Auckland. What I am interested in finding out is if ageing Niuean women seek health information and services, when they are well to maintain their wellbeing. I am also interested in finding out why they seek to use or not use traditional and/or mainstream health services when they are unwell. Understanding ageing Niuean women's perceptions of health and illness is also an important part this study. I am concerned that if we do not find out from our ageing women what they think and feel about health care services then appropriate health services will never be developed to meet their needs.

The information from this research study will enable my completion of a degree but more importantly it will enable the voice of ageing Niuean women to be heard. What is important is that the information from this study will inform the practice of nurses and other health professionals through health journal publications and presentations at nurses conferences.

With the permission of the group, I will visit to listen and be a part of the group. I will wait until I am invited to speak then I will ask for 4-8 women to be a part of a focus

Te Kunenga ki Pūrehuroa

group to talk about how older Niuean women seek health care. I will meet with the focus group for up to two hours on two occasions in a private place of the group's choice. With your permission the focus group meeting will be taped and then a written account of what you said will be made. Each person will be sent or given a copy of the account for comment or change. At the end of the research the tapes will be erased and the raw data retained for 3 years in a locked cabinet in my home. I will also return to tell you about the findings before I write up the thesis and I will send you a summary on completion of the study.

I will not use any personal identifiers and every care and consideration will be taken to ensure anonymity and confidentiality but this cannot be guaranteed. Participants will be asked to respect what is said in the group and not repeat it outside.

You do not have to answer any questions that you feel uncomfortable with.

If you agree to take part, you can withdraw from the research up to the closure of the group interview and that withdrawal after the tapes have been transcribed is not possible.

If you agree to participate then you will be asked to sign a consent form.

The consent form will be in the Niuean and the English language.

Transcription and translation of the Niuean tapes will be done by Lisa Takelesi of Niue Island. The tapes will be sent airmail via the diplomatic bag. The transcriber will sign a non disclosure form to respect the confidentiality of the information. I will transcribe the tapes that are conducted in the English language. Your name or any information that will identify you will not appear in the final report.

If you are unsure or want more information about any part of the research, please contact my supervisors: Dr Gill White or Dr Antoinette McCallin.

phone. [REDACTED]

I can be contacted by phone [REDACTED]

Thank you for taking the time to help me with my research study. Fakaue lahi mahaki.

APPENDIX C

Massey University

COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences

Albany

Private Bag 102 904,

North Shore Mail Centre,

Auckland, New Zealand

Telephone: 64 9 443 9700

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Kumikumiaga kehe malolo tino moe tau mahani he mamatua fifine Niue momotua I loto uho Okalana.

Koe tau matakupu (Information sheet)
Matakau Kumikumi (focus groups)

Fakalofa lahi atu.

Koe higoa haaku ko Doreen Arapai. Ko au koe fifine Niue, ne fanau au i Niu Silani.

Fano au he aoga koe university i Massey. Lali au ke moua e fakamailoga koe

“Master of Philosophy.” Koe magaaho nei kua hu atu tuai au kehe faahi he aoga koe

School of Health Sciences i Albany. Ko au foki koe nosi, si maama kia au e tau tatalu he tau sino he tau fifine Niue kua momotua. Manako foki au ke iloa, koe fēfē e tau manamanatuaga he tau fifine Niue momotua, he vaha malolo moe magaaho tatalu? Fia iloa nakai a lautolu ha tala kehe tau malolo sino pese ni kua malolo ha lautolu a tau sino.

Fia iloa foki au koe fakaaoga, poke nakai fakaaoga, e lautolu e tau puhala lagomatai tuai faka motu kaeke ke tatalu e sino? Koe mena aoga lahi kehe kumikumiaga nei ke maama moe iloa e tau manamanatuaga he tau matua fifine Niue momotua, hagai kehe tau puhala lagomatai kaeke ke gagao e sino. Kua hokulo lahi e haaku a manamanatuaga ke he tau mena nei. Kaeke ke nakai hūhū a tautolu kehe tau mamatua

fifine Niue momotua si nakai iloa e tautolu ha lautolu a tau manamanataga hokulo si nakai maeke a lautolu ne tause e tau lagomataiaga moe tau lagatau ke lata moe tau matua fifine momotua pehe nei he vaha nei. Koe tau matakupu kakano ka moua mai he kumikumiaga nei, to maeke ia au ke fakaaoga he fakaosiaga he haaku a tau fakaakoaga ke moua ai foki taha fakamailoga koe (degree). Koe kakano uho he kumikumiaga nei ke maeke ke iloa e tau manamanatuaga he tau mamatua fifine Niue momotua. To maeke foki ke fakaaoga e tau manatu nei mo fakaakoaga ke lata moe tau Nosi pihia foki mo lautolu kua fakaako he faahi gahua leveki sino. Ke maeke ke lolomi ai he tau tohi fakaako ke lata moe tau fakaakoaga ha lautolu.

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

Kaeke ke fakaata mai he matakau nei to maeke ia au ke hu atu ke fanogonogo kehe tau fakatulalaaga he matakau. To fakatali atu foki au kia lautolu ke fakaata au ke maeke ke vagahau moe ole atu ke moua, fa (4) poke valu (8), fifine ke eke mo matakau taha haggao ke he tau kumikumiaga lagomatai he tau fifine Niue momotua. To maeke ia mautolu ke fono ai moe faka tutala kehe ua (2) e matahola kehe ha matakavi kua talia k  ai. Kaeke ke talia e mutolu to maeke he matakau ke tapaki e tau matakupu he (tape) moe tohi fakamau e tau kupu ne vagahau e mautolu. To fakafano atu kia mutolu taki tokotaha e laupepa ke hiki ha kupu kua nakai lata moe haau a totouaga.

Koe fakaosiaga he fekau nei to maeke ke uta kehe osi e tau leo vagahau moe tau kopu vagahau hahai ai kehe (tape). To tuku e tau fakamauaga osi he puha ki he kaina haaku ke gata mai he tolu (3) e tau tau. To maeke foki ia au ke fakailoa atu kia mautolu e maopoopoaga to maeke ke tohi e au e tala ke lata moe haaku a pepa moe fakaakoaga.

To fakafano atu e au kia mautolu katoatoa he kumikuimiaga nei.

To nakai fakakise fakahanoa e au e tau higoa ha mutolu kehe ha tagata.

To nakai maeke foki ia lautolu ne gahua fakalataha he matakau nei ke tutala fakahanoa ki tua ha valatala haggao kehe tau mena nei.

Kaeke ke talia e koe ke gahua fakalataha kehe fekau nei to ole atu kia koe ke fakamooli haau a higoa. Koe pepa fakamooli to lolomi kehe vagahau Niue moe vagahau Peletania koe fakaliliuaga he tau (tapes) faka Niue to fakaliliu ai e Lisa Takelesi i Niue.

To fakafano atu e tau (tapes) na he taga meli he Fakatufono. To fakamooli   ia haana higoa ke nakai maeke ke tutala fakahanoa ha tala ka logona e ia kehe (tape). Ka koe (tape) he vagahau Peletania, to fakaliliu e au e tau (tape) ia.

To nakai tohia ha higoa ha motolu he fakaotiaga he kumikumiaga nei. Kaeke ke tuaha akoe moe nakai talia kehe fakamaama nei si kumikumi atu kehe haaku a tau pule gahua ko Doctor Gill White mo Doctor Antoinette McCallin.

Koe telefoni [REDACTED]

Koe telefoni haaku, numela [REDACTED]

Fakaaue lahi ke he tau lagomatai ke lata moe haaku a kumikumiaga. Oue tulutulou

APPENDIX D

RESEARCH INTO THE HEALTH SEEKING BEHAVIOURS OF AGEING NIUEAN WOMEN RESIDENT IN CENTRAL AUCKLAND

CONSENT FORM

focus groups

- (1) I have read the Information sheet and I have had the details of the study explained to me. My questions have been answered to my satisfaction, and I may ask further questions at any time.
- (2) I understand that I have the right to withdraw up to the closure of the group interview and that withdrawal after the tapes have been transcribed is not possible. I also understand that I can decline to answer any particular questions.
- (3) I agree to provide information to the researcher on the understanding that my name will not be used without my permission.
- (4) I understand that anonymity and confidentiality of my participation in the research cannot be guaranteed.
- (5) I agree/ do not agree to the interview being taped.
- (6) I also understand that I have the right to ask for the audio tape to be turned off at any time during the focus group meeting.
- (7) I agree to the researcher using the information for presentation at nurses conferences and publication in refereed health journals.
- (8) I agree to participate in this study under the conditions set out in the Information sheet.

SIGNED:

NAME:

DATE :

APPENDIX E

KUMIKUMIAGA KEHE MALOLO TINO MOE TAU MAHANI HE TAU MAMATUA FIFINE NIUE MOMOTUA HA LOTO UHO OKALANA

PEPA TALIA. (CONSENT FORM).

MATAKAU FAKATUTALA. (FOCUS GROUPS).

- (1) Kua totou e au e matakupu he pepa nei, si kua maama e au e kakano. Kua tali mai foki haaku a tau huhu? Iloa foki e au koe maekeia au ke fai huhu atu he ha magaahohe fakatutalaaga.
- (2) Kua maama foki e au koe maeke ia au ke uta kehe ha matakupu ka osi e tau huhu nei. Iloa foki e au koe maeke ia au ke nakai tali falu huhu.
- (3) Talia e au ke tali falu fakatuala ka huhu mai kia au kaeke ke nakai fakaaoga pule noa haaku a higoa.
- (4) Kua iloa e au, pehe, koe nakai fai fakamooliaga, to nakai tokutoku e higoa haaku, kehe tohiaga he tau tala nei.
- (5) Talia e au / nakai e talia e au ke tapaki he (tape) e fakatutalaaga nei.
- (6) Iloa foki e au koe maeke au ke ole atu ke taofi e tapakiaga he (tape) ka manako au ke ai.
- (7) Talia e au ke maeke a ia nei ne manako ke fakamau e tau matakupu ke maeke ke fakaoga poke fakamau ai he tau fonoaga he tau nosi moe tau tohi fakamau kupu.
- (8) Talia e au ke kau fakalataha moe kumikumiaga nei kaeke ke miutua atu kehe tau matakupu puipuiaga kua fakamau ai he pepa nei.

FAKAMOOLI.

HIGOA.

AHO.

APPENDIX F

INTERPRETER NON DISCLOSURE OF INFORMATION

I.....agree not to disclose, the name of, or any other information that would lead to the identification of, the participant in the research study being undertaken by Doreen Arapai.

NAME.

SIGNATURE.

DATE.

APPENDIX G

NON DISCLOSURE OF INFORMATION TRANSCRIBER/TRANSLATER

I.....agree not to disclose, the name of, or any other information that would lead to the identification of, the participant in the research study being undertaken by Doreen Arapai. The audio tapes, transcriptions and computer discs will be not be made available to any other person but the researcher or her supervisor, and will be kept securely while in my possession. I will not retain any copies of the audio tapes, discs or transcriptions.

NAME.

SIGNATURE.

DATE.

APPENDIX H

QUESTIONS

The following questions were used in the focus groups.

Can we talk about your experience of health and illness in New Zealand?

- (1) How and when do you seek help when you are feeling unwell?
- (2) What kind of remedies do you take at home? (This question was not asked as the Matua *fifine* gave examples of remedies during the interview).
- (3) What kind of island remedies do you take at home and how do you get them?
- (4) Who makes the decision to seek healthcare when you are unwell?
- (5) Who would you most likely go to and why?
- (6) Is there anyone you would not go to and why? (Amendment requested by the Ethics Committee).
- (7) Do you seek health information when you are well?
- (8) What is the meaning of the word health/ *malolo*?
- (9) What is the meaning of the word illness/ *ai malolo*?
- (10) What did you know about the New Zealand health system before you arrived?
- (11) What are the health beliefs that have kept you well in New Zealand?
- (12) Can you name any health services for older people in New Zealand?

APPENDIX G

NON DISCLOSURE OF INFORMATION

TRANSCRIBER/TRANSLATER

I.....agree not to disclose, the name of, or any other information that would lead to the identification of, the participant in the research study being undertaken by Doreen Arapai. The audio tapes, transcriptions and computer discs will be not be made available to any other person but the researcher or her supervisor, and will be kept securely while in my possession. I will not retain any copies of the audio tapes, discs or transcriptions.

NAME.

SIGNATURE.

DATE.

APPENDIX H

QUESTIONS

The following questions were used in the focus groups.

Can we talk about your experience of health and illness in New Zealand?

- (1) How and when do you seek help when you are feeling unwell?
- (2) What kind of remedies do you take at home? (This question was not asked as the Matua fifine gave examples of remedies during the interview).
- (3) What kind of island remedies do you take at home and how do you get them?
- (4) Who makes the decision to seek healthcare when you are unwell?
- (5) Who would you most likely go to and why?
- (6) Is there anyone you would not go to and why? (Amendment requested by the Ethics Committee).
- (7) Do you seek health information when you are well?
- (8) What is the meaning of the word health/ *malolo*?
- (9) What is the meaning of the word illness/ *ai malolo*?
- (10) What did you know about the New Zealand health system before you arrived?
- (11) What are the health beliefs that have kept you well in New Zealand?
- (12) Can you name any health services for older people in New Zealand?