Kia Mau, Kia Ū

Supporting the breastfeeding journey of Māori women and their whānau in Taranaki

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Karanga - Karakia – Mihimihi

He Karanga

Whakatau mai rā me te ūkaipōtanga eee!

He Karakia[1]

Ko Rangi,
Ko Papa
Ka puta - ko Rongo,
ko Tāne Māhuta,
ko Tangaroa,
ko Tūmatauenga,
ko Haumiatiketike,
ko Tāwhirimātea
Tokona te rangi ki runga,
ko Papa ki raro
Ka puta te ira tangata
ki te whai ao, ki te ao mārama
E Rongo whakairia ake ki runga
kia tina - Tina!
Hui e! Tāiki e!

He Mihi

Tēnei te mihi kia rātou kua whetūrangitia, hoki atu ki te moenga roa. Huri noa ki a tātou te hunga ora, ngā mihi maioha. Ka mihi hoki kia tātou e mahi ana ki te hāpai i te hauora o tātou te iwi Māori, tēnā tātou katoa!

He mokopuna ahau o te maunga tītōhea. Ko Ngāti Mutunga te iwi.

Ko Marnie Reinfelds ahau.

Tihei Mouri Ora!

[1] This Karakia is titled Tātai Whakapapa, and is our creation story. It acknowledges our sky-father Ranginui and our earth-mother, our ūkaipō - Papatūanuku, and their children of whom we are descendants.

Abstract

The benefits of breastfeeding for maternal and infant health are well known to Māori. Yet inequities in breastfeeding rates between Māori and non-Māori exist. To understand some of the causes of these inequities, this qualitative study was designed to investigate some of the barriers to breastfeeding for wāhine Māori. It is grounded in Kaupapa Māori and Mana Wāhine research methodologies as a way of ensuring that the experiences of Māori women were prioritised and to provide transformative outcomes for whānau, hapū and iwi. The aims were to:

(1) Identify the barriers to full and exclusive breastfeeding for the recommended six months for wāhine Māori in Taranaki;
(2) Identify ways to reduce these barriers; and
(3) Understand how a breastfeeding culture can be enhanced within whānau Māori.

Semi-structured interviews were conducted with 11 Māori women and two whānau Māori living in Taranaki. Thematic analysis identified several intervention points to support breastfeeding: (1) access to high quality breastfeeding information (*Filling the kete*); (2) a compassionate and culturally-safe maternity healthcare workforce (*Health service support*); (3) active whānau involvement (*Whānau support*); (4) greater acceptance of breastfeeding by the wider community (*Hapori – supportive communities*); and (5) access to breastfeeding role models (*Role-modelling breastfeeding*). Partners and whānau provide important emotional and practical support to breastfeeding women (*The breastfeeding support role*) however the significance of this role needs to be acknowledged and encouraged (*Supporting the supporters*). Building whānau capacity and capabilities related to breastfeeding support must begin in the antenatal period (*Access to information*).

This thesis presents a Kaupapa Māori breastfeeding support framework that highlights two areas of action. *Tiakina Te Ūkaipō* describes the relationship between whānau and maternity providers and the ways in which they can protect the mother/infant dyad. It also offers a pathway for supporting Māori women in their breastfeeding aspirations. *Hāpai Te Tikanga Ūkaipō* describes the responsibilities of Government, the healthcare sector and the wider community to protect tikanga ūkaipō. Māori women aspire to breastfeed our babies, just as our tūpuna did. As this thesis clearly shows, achieving these aspirations will require a commitment and reorientation of the maternity healthcare system towards whānau ora.

Preface

My thesis has been a personal journey as well as an academic one. My interest in the kaupapa (topic) of my research began when I entered the realm of motherhood. My experiences of breastfeeding my first two children, my sons Ngāmotu Rongomai (born 2006) and Tiki Ngārangi (born 2007), did not meet my expectations.

As a Māori woman I felt it was important to breastfeed, to give our tamariki (children) the best start in life. I had always planned to breastfeed my own children. The 'breast is best' message had been well received and my goal when I was hapū with my first child was to breastfeed until at least 12 months. In the pre-natal period, formula feeding was never a consideration for me.

While breastfeeding initiation was successful with both my sons, my breastfeeding journey ended when my sons were six months old and five months old respectively. Breastfeeding my first child was interrupted with being pregnant with my second child. Sadly, the breastfeeding experience of my second child was greatly impacted on by the untimely death of my mother, my own ūkaipō (mother). Her passing was at a time when I needed her more than I felt I had needed her in the past, and the impact that had on me, my breastfeeding and mothering journey has been profound.

Motherhood for me time of huge transition and change. Dealing with the changes to my body and feelings about my body had an effect on my trust in it to sustain and nourish life. Ultimately, I made decisions on feeding my children based on the information I had at the time – unfortunately the information was not inclusive of the risks of not breastfeeding.

I had a three-year gap between the birth of my second and third child. During that time, I re-entered the paid workforce working for the Taranaki District Health Board's Public Health Unit as a Health Promoter. As part of my professional development I enrolled in Massey University's Post Graduate Diploma in Public Health.

Perhaps the guilt of not breastfeeding to the Ministry of Health's[2] recommendations, or my desire to learn more about breastfeeding to "get it right" for my next child, saw me undertake my major assignment and subsequent research paper on breastfeeding. Suffice to say the research into breastfeeding has certainly influenced my approach and attitude to infant feeding. My daughters Parekaiuru Tūturu o Te Atiawa (born 2010) and Te Waiaurere Mahinekura (born 2012) too have benefitted.

Learning about the importance of breastfeeding, the barriers women face (in particular Māori women) and the facilitators that enable a successful breastfeeding journey, has been empowering. In addition, looking at breastfeeding through a Kaupapa Māori and Mana Wāhine lens has highlighted the particular challenges we face as a people in upholding our tikanga.

Consequently, through this learning I not only had a more positive breastfeeding experience with my daughters, I have felt more value and therefore empowered in my ūkaipō role as a mother and as a nurturer. The connection to Papatūānuku has been strengthened as I have placed trust my body to sustain life beyond the womb and now view my body as powerful for having done that.

It is my hope that my research and thesis will influence policy and funding streams and subsequently practice so that Māori women like myself, can be supported in their own breastfeeding journeys. That said, the stories shared by the participants of this research project are the real taonga of this mahi. They are inspirational and I hope that the stories create change at a systemic level and provide motivation at a personal level, for all of those who read this thesis.

[2] The Ministry of Health (2008) recommends exclusive breastfeeding until infants are around six months, and continuing breastfeeding for at least the first year of the infant's life, or beyond.

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Mā tini, mā mano ka rapa te whai

By many, by thousands, the work will be accomplished.

This whakataukī encapsulates my thesis journey. I could not have done it without the many who have contributed to this work with their support and guidance. It is not possible to fully express the gratitude for the manaaki and tiaki that has been extended over the last couple of years during this journey. I am indebted to the many that have assisted in getting me to the finishing line.

Firstly, I must pay tribute to my tūpuna, to my ancestors whose deeds and actions have meant that I, their uri, can stand today. I feel my thesis is a continuation of their work, to challenge the status quo, to enable a better, more prosperous and just future for my future mokopuna. I also thank my mother, my own ūkaipō whose untimely passing has impacted on me in ways that I'm continuing to discover as I walk along this huarahi that is life. It was her research journey she undertook shortly before her passing that deepened my interest and sent me on this journey.

To the wāhine Māori and whānau Māori participants, I cannot thank you enough. It was an honour and a privilege to hear your kōrero. I marvel at being able to bear witness to the challenges you faced and to gain insight to the strength it takes to be Māori in a society that often trivializes haputanga and te ūkaipō. It is your stories that are the wero.

To my supervisor, Dr. Sarah-Jane Paine, ngā mihi maioha. Your commitment to seeing me finish this thesis has been beyond amazing. In amongst your own professional and whānau commitments you have continued to be a constant pou ārahi and pou tautoko. The long distance nature of our working relationship has come with its own challenges, but you have remained steadfast, always positive, responsive, critical when needed and you are just a genuinely awesome, caring, compassionate, Māori woman. Ka nui te aroha ki a koe, me tōu whānau hoki.

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framework of Kaupapa Māori and Mana Wāhine theory, which explores the many, varied and diverse realities of Māori women. I am honoured to be a part of this movement.

Lastly and by no means least I thank my whānau. The saying "it takes a village" has become somewhat cliché, but it really ***does*** take a village. To my friends and whānau who have supported me along the way, who've opened their homes to me, who've looked after my babies, who've been genuinely interested in my mahi, kei te mihi. Thank you to the whānau of Te Kopae Piripono, for providing a safe place for my babies to flourish. To my darling children, Ngāmotu Rongomai, Tiki Ngārangi, Parekaiuru Tūturu o Te Atiawa and Te Waiaurere Mahinekura - mama loves you. You are my motivation. Thank you for accepting my absence as I've focused myself on the mammoth task of writing. Glen, taku tau pūmau, I could not have done it without your support. Thank you for stepping up and being the mama/papa while I've done what I have needed to do. Ka nui te aroha.

Kia Mau, Kia Ū, Kia Ora!

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Glossary of Māori Language

A

Amorangi – Leader

Ao – World

Aroha – To love, feel concern for, feel compassion, empathise

Ara – Pathway

Atu – Away

Atua – God, supernatural being, ancestor with continuing influence

H

Hāpai – To lift up, rise, elevate

Hapū – Pregnant, kinship group and the primary political unit in traditional Maori society

Hapūtanga – Pregnancy

Hauora – Health

Huarahi – Road

Hui – Meeting

Hutia – To pull out

I

I – A particle used before verbs and statives to indicate past

Iwi – Extended kinship group

K

Ka – A particle used before verbs indicate future

Kai – Food

Kaikaranga – Caller, the role of the making the ceremonial call the karanga

Kaikōrero – Speaker

Kaimahi – Worker, staff

Kanohi – Face

Karakia – Prayer, incantation

Kaupapa – Topic, policy, plan, purpose, agenda, proposal, theme

Kaua – Don't

Kete – Flax basket

Kete Aronui – Basket of knowledge of aroha, peace, and the arts and crafts which will benefit the Earth and all living things

Kete Tūātea – Basket of ancestral knowledge of mākutu and evil

Kete Tūāuri – Basket of sacred knowledge

Ki – To, into, towards

Kī – To say, speak, call, mention

Kia – To

Kitea – To see

Koha – Offering, contribution, acknowledgement

Kohia – Gather

Kō – To sing (of birds)

Kōmako – Bellbird

Kopae – A Taranaki specific terms for Kōhanga

Kore – Nothing

Kōrero – Talk, narrative, story, account

Kura – School

M

Mā – By way of

Mai – This way, from, since

Māhaki – Be inoffensive

Mahi – Work

Māku – For me

Mana – Prestige, authority, control, power

Manaaki(tanga) – Hospitality, kindness, support

Mānuka – Tea-tree

Māori – Indigenous peoples of Aotearoa/New Zealand

Māramatanga – Understanding, enlightenment

Mātauranga – Knowledge, information

Mau – To take up, carry, lay hold of

Mea – Thing

Mihimihi – Introduction, greeting

Mua – The front, in front of

Muri – The rear, behind, at the back of

N

Ngā – The (plural)

Nui – Big, large, important

O

O/ō – Of, belongs to, from, attached to

Ora – Well-being, health

Oti – Complete, finish

P

Pā Harakeke – Flax bush

Pango – Black

Papatūānuku – Earth mother

Parihaka – A community established in Taranaki in the late 1800s by Te Whiti o Rongamai and Tohu Kakahi is resistance to Crown oppression.

Pēpi – Baby

Pō – Night

Pou – Post, pillar, support

R

Rangahau – Research

Rangatira – Leader, chief

Reo – Language

Ringawera – Cooks, caterers

Rito – Centre/heart of the flax bush

Rourou – Food basket

Ruia – Cast away, throw away

T

Taitea – Whitewood, sapwood (in the context of "ruia te taitea" it can mean cast off the rusbbish)

Takahia – Stamp, trample

Takoto – To lie down, to lay down

Taku – Mine

Tamaiti – Child

Tamariki – Children

TamaWāhine - Women

Tāne – Man, men/Atua of the forests and birds and for some iwi humans

Tāne-mahuta – Atua of the forests and birds and for some iwi humans

Tangata – Person

Tāngata – People

Taonga – Treasure

Tau - Your

Tautoko – To support

Te – The (singular)

Teina – Younger sibling of the same sex

Te Kohanga Reo – Early childhood immersion language movement

Tiaki – To look after, nurse, care, protect

Tika - Right

Tikanga – Custom, correct procedure

Titiro – Look

Tohunga – Expert, skilled person, healer

Tū – Stand

Tuakana – Elder sibling of the same sex

Tūpato – Be cautious, careful, wary

Tūpuna – Ancestor

Tōtika – Straight, correct, right

U

Ū – Breast (noun); to be firm, fixed, resolute, unyielding (verb)

Ūkaipō – Mother, source of sustenance, origin, real home

Ūkaipōtanga – Nurturing

W

Wā – Time

Waiata – Song

Wai ū – Breastmilk

Wāhine – Woman

Wānanga – Learning important knowledge or educational seminar, conference, forum

Wero – Challenge

Whaowhia – To fill

Whakarongo – Listen

Whakataukī – Proverb, saying

Whakawhānaungatanga – The process of establishing relationships

Whānau – Family

Whānaungatanga – Relationship, kinship, sense of family connection

Whāngai – To feed, nourish, nurture

Whea – Where

Whero – Red

Chapter One – Introduction

1.1 Introduction

Breast milk is an ideal food for infants[3] (Ministry of Health, 2008; National Breastfeeding Advisory Committee of New Zealand, 2009b; World Health Organization & UNICEF, 2003). Breastfeeding and human milk are 'the normative standard' for infant feeding and nutrition (American Academy of Paediatrics, 2012), and decades of research evidence has confirmed the important role of breastfeeding in protecting and promoting the health of both infants and their mothers (Ip et al., 2007; Ip, Chung, Raman, Trikalinos, & Lau, 2009; Ministry of Health, 2008; National Breastfeeding Advisory Committee of New Zealand, 2009b; World Health Organization & UNICEF, 2003). There is also strong evidence to show that breastfeeding contributes to the social and emotional wellbeing of infants, mothers and families (American Academy of Paediatrics, 2005, 2012; World Health Organization & UNICEF, 2003). The protection, promotion and support of breastfeeding are therefore fundamental to achieving optimum health for the nation (Ministry of Health, 1997; National Breastfeeding Advisory Committee of New Zealand, 2009b).

Despite the well documented relationship between breastfeeding and health, breastfeeding rates in New Zealand are far below the Ministry of Health targets[4]. Moreover, inequities[5] in breastfeeding rates between Māori and non-Māori exist (Glover, Manaea-Biddle, Waldon, & Cunningham, 2008; Hayes-Edwards, 2014; National Breastfeeding Advisory Committee of New Zealand, 2009b; Royal New Zealand Plunket Society, 2010). Māori breastfeeding rates are the lowest of any ethnic group in New Zealand and the long-term impact of this for Māori health outcomes are far reaching (Glover, Waldon, Manaena-Biddle, Holdaway, &

[3] For the purposes of this thesis the term infant will be used to refer to a baby/child, ranging in age from new-born to two years.

[4] The Ministry of Health breastfeeding targets established in 2002 were to increase exclusive breastfeeding rates at:

- six weeks to 74% by 2005 and 90% by 2010;
- three months to 57% by 2005 and 70% by 2010; and
- six months to 21% by 2005 and 27% by 2010.

Sadly, these targets are yet to be met at a national level.

[5] I have used the term inequities as opposed to inequalities throughout this thesis. While the term 'breastfeeding inequalities' describe differences in breastfeeding rates between Māori and non-Māori women, 'breastfeeding inequities' reflects differences in breastfeeding rates that are considered to be avoidable, unfair and unjust. Breastfeeding inequities are considered to result from the unfair distribution of the social determinants of health and include factors such as poor government policy and cultural exclusion (Global Health Europe, 2009). It is important to note that in Aotearoa ethnic inequities between Māori and non-Māori are the most consistent and compelling inequities in health (Reid & Robson, 2007).

Cunningham, 2009; Hayes-Edwards, 2014; Ministry of Health, 2008; National Breastfeeding Advisory Committee of New Zealand, 2009a, 2009b). As in other areas of health, eliminating ethnic inequities in breastfeeding will require targeted and specific action (Glover & Cunningham, 2011; Glover et al., 2008; Glover, Manaena-Biddle, & Waldon, 2007; Glover et al., 2009; Hayes-Edwards, 2014; Manaena-Biddle, Waldon, & Glover, 2007; National Breastfeeding Advisory Committee of New Zealand, 2009b).

1.2 Thesis Structure

This thesis presents a qualitative study, grounded in Kaupapa Māori research methodology, which was designed to develop a framework to support the breastfeeding journey of Māori women and their whānau. The thesis is comprised of six chapters;

Chapter One (Introduction) provides a detailed explanation of why breastfeeding is a significant public health and Māori health issue. It includes an overview of the Taranaki region and our breastfeeding rates and describes some of the historical and contemporary factors that have influenced Māori women and their breastfeeding journeys. Finally, the rationale, aims and objectives of the *Kia Mau, Kia Ū* study are given.

Chapter Two (Review of Literature) examines the international and national breastfeeding literature. A particular focus is given to identifying the barriers to breastfeeding and existing interventions to support breastfeeding amongst indigenous women.

Chapter Three (Huarahi Rangahau, Tikanga Rangahau – Research Design and Methods) describes the selection and application of the research methodologies and methods that have been utilised in this study. It begins with an exploration of Kaupapa Māori and Mana Wāhine research theories and their alignment with the goals of this project. This chapter also includes a detailed description of the data collection and analytical procedures that were used in this study.

Chapter Four (Findings) begins with an overview of the research participants. The remainder of this chapter is dedicated to a detailed presentation of the major themes that arose from the semi-structured interviews.

Chapter Five (Discussion) summarises the findings and then considers them in relation to the existing literature. Guided by the original aims and research questions a framework for supporting the breastfeeding journey of wāhine Māori in Taranaki is presented.

Chapter Six (Conclusion) explores the strengths and limitations of the *Kia Mau, Kia Ū* study. Some ethical considerations for conducting breastfeeding research are examined, as is the place of whānau ora within maternity healthcare. Finally, a series of recommendations for research, policy and health service delivery are presented.

1.3 What is Breastfeeding – Ūkaipō?

There is currently no generally accepted definition of breastfeeding. It is often thought of in the most literal terms: a woman providing an infant or child with breast milk (National Breastfeeding Advisory Committee of New Zealand, 2009a). However, the National Breastfeeding Advisory Committee (2009a) acknowledge that breastfeeding involves both a physiological act and a personal journey, and that it extends beyond the mother/child dyad:

> Breastfeeding is more than the physiological process of lactation and infant nutrition: it is a learned activity that involves a complex set of social, cultural and experiential factors. (p. 13)

The word commonly used by many iwi, including Taranaki iwi, to refer to breastfeeding is *ūkaipō*. The Te Aka online Māori dictionary defines ūkaipō as; "mother, source of sustenance, origin, real home" (Moorfield, 2003).

Rimene, Hassen, and Broughton (1998) state that:

> Ūkaipō refers to the nurturing of a person, literally to the place where a person is suckled. The word ūkaipō is an abbreviated form of the extended phrase: kai waiū i te po or suckling milk at mother's breast at night. (p. 26)

Murphy (2011) refers to ūkaipō as:

> …a beloved name for Papatūānuku, refers to the pre-dawn breastfeeding hours when a mother provides her baby physical, emotional, intellectual, and spiritual nourishment and sustenance through the milk. The use of the term in relation to Papatūānuku speaks

> to the divinity of the earth in its capacity to nurture and fulfil all the basic needs of humanity. (p. 34)

Dual meanings are common in te reo Māori, specifically in relation to reproduction, birth and lactation (Gabel, 2013; Simmonds, 2009, 2014). The multiple, but interrelated understandings of ūkaipō highlights the importance of pregnancy and the early postpartum period within Māori cultural understandings. We can see from the kōrero above that the concept of ūkaipō goes beyond the literal act of breastfeeding. Ūkaipō is a term that weaves physical nurturing with spiritual and emotional nurturing, and together these acts of love and caring eventually make the adult. Ūkaipō connects us to our humble beginning as a human being as well as our divine beginnings, and serves to remind us of our interconnectedness with our whānau and environment.

It is within my understanding of ūkaipō and the construct of breastfeeding proposed by the National Breastfeeding Advisory Committee (2009a, 2009b) that I have situated my research.

1.4 The Importance of Breastfeeding

Breast milk is the normal, natural food for infants, meeting the full nutritional requirements for infants up to six months of age (Kramer & Kakuma, 2004; Ministry of Health, 2008; World Health Organization, 2001; World Health Organization & UNICEF, 2003). For this reason, the World Health Organization (WHO) recommends that infants are breastfed exclusively[6] for the first six months of life, with no water, formula or other liquid or solid food given during this time. After this milestone the WHO recommends that breastfeeding continues, alongside appropriate complementary foods, up to two years of age (Kramer & Kakuma, 2004; Ministry of Health, 2007, 2008; National Breastfeeding Advisory Committee of New Zealand, 2009a; World Health Organization, 2001; World Health Organization & UNICEF, 2003). These recommendations are endorsed by New Zealand's Ministry of Health (MOH) (2008).

[6] 'Exclusive breastfeeding' is defined by the World Health Organisation, as no other food or drink, not even water, except breast milk (including milk expressed or from a wet nurse) for 6 months of life, but allows the infant to receive oral rehydration solutions, or drops and syrups (vitamins, minerals and medicines).

The World Health Organization and UNICEF (2003) also provide a hierarchy of infant feeding methods which emphasises the importance and value of breastfeeding and its position as the superior feeding choice:

1. Breastfeeding from the infant's mother;
2. Expressed breast milk from the infant's mother;
3. Breast milk from another woman (donor milk); and
4. Artificial feeding with powdered infant formula (least favoured).

1.4.1 Health Benefits

There is vast evidence that breastfeeding is an effective and important intervention for infant and maternal health (Ministry of Health, 2008; National Breastfeeding Advisory Committee of New Zealand, 2009a, 2009b; World Health Organization & UNICEF, 2003). The short-term benefits of breastfeeding for child health are clear and relate mainly to protection against morbidity and mortality from infectious diseases (World Health Organization, 2013b). Compared to formula-fed infants, breastfed babies are less likely to suffer from gastrointestinal tract infections (World Health Organization, 2013b), respiratory infections and ear infections (Ip et al., 2009), diarrheal illnesses (Creek et al., 2010; Duijts, Jaddoe, Hofman, & Moll, 2010; Ip et al., 2007; Ip et al., 2009), and they have a lower likelihood of developing asthma (Greer, Sicherer, & Burks, 2008). Breastfeeding is associated with a significant reduction in Sudden Infant Death Syndrome (SIDS) (Hauck, Thompson, Tanabe, Moon, & Vennemann, 2011; Ip et al., 2007). Nutritionally, breast milk contains many bioactive components which are beneficial for infant gut health and immunity and it is more easily digested than formula (Lawrence & Lawrence, 2005; Ministry of Health, 2008). An additional benefit is that breast milk, when sourced directly from the breast, is always fresh and immediately available; there is no preparation required and it is not at risk of spoiling (Ministry of Health, 2008).

Breastfeeding also has a number of long term health benefits. Infants who are breastfed are more likely to experience lower blood pressure (World Health Organization, 2007) and lower total cholesterol as adults compared with those who were not breastfed (G. Owen, Whincup, Odoki, Gilg, & Cook, 2002). Breastfed infants are also less likely to develop obesity (Ip et al., 2007; C. Owen, Martin, Whincup, Smith, & Cook, 2005) and both Type 1 and Type 2 diabetes

later in the life course (Pereira, Alfenas, & Araújo, 2014; Rosenbauer, Herzig, & Giani, 2008). Breastfeeding may also reduce the risk of asthma and cardiovascular disease in adulthood (American Academy of Paediatrics, 2005, 2012; Ministry of Health, 2007, 2008; World Health Organization, 2007, 2013a).

Interestingly it appears that there is a close relationship between breastfeeding and health, such that exclusive breastfeeding, with no added food or fluids for six months, provides the greatest health benefits (Renfrew et al., 2005). Complementary foods offered before six months of age tend to displace breast milk with no evidence to suggest that it confers any health advantage over exclusive breastfeeding.

Breastfeeding is an integral part of the reproductive process with important implications for maternal health (Ministry of Health, 2006; World Health Organization & UNICEF, 2003). Women who breastfeed have a reduced risk of developing breast cancer, ovarian cancer, osteoporosis, and hip fracture later in life (Godfrey & Meyers, 2009; World Health Organization, 2007, 2013a). Breastfeeding may help mothers with losing the weight gained during pregnancy. Breastfeeding has also been shown to protect against postpartum depression (Donaldson-Myles, 2012; Taveras et al., 2003).

It is noteworthy that Māori suffer disproportionately from all of these health problems (Ministry of Health, 2014c; Robson & Harris, 2007).

1.4.2 Social Benefits

Breastfeeding imparts a number of important social and emotional benefits for the mother and infant. For example, breastfeeding is associated with greater school performance and cognitive function in childhood and adolescence (Bartels, Beijsterveldt, & Boomsma, 2009; Fonseca, Albernaz, Kaufmann, Neves, & Figueiredo, 2013). Breastfeeding has been shown to have a positive impact on maternal mental health, enhancing mother/child bonding and increasing maternal emotional fulfilment (Donaldson-Myles, 2012; Hahn-Holbrook, Haselton, Schetter, & Glynn, 2013).

1.4.3 Economic Benefits

The economic benefits of breastfeeding for families and the wider community have also been highlighted in the literature (Cattaneo & Quintero, 2006; Craig, Anderson, & Jackson, 2008; National Breastfeeding Advisory Committee of New Zealand, 2009a, 2009b; Pugh, R., Frick, Spatz, & Bronner, 2002). Although more research is needed to determine an exact causal link, the existing evidence suggests that artificially-fed infants cost the health system more due to their greater risk of developing a range of childhood illnesses requiring treatment via primary care and/or hospital. Similarly, there may be health system costs incurred due to the possible link between artificial infant feeding methods and chronic health problems across the life course (American Academy of Paediatrics, 2012; World Health Organization, 2013a).

The National Breastfeeding Advisory Committee of New Zealand (2009b) highlights the financial liability of artificial feeding for families. Thus, there are important cost savings associated with breastfeeding, not only for families, but also for the healthcare system by potentially reducing the burden of disease.

1.4.4 Environmental Benefits

The sustainable nature of breastfeeding is also valued as an important environmental benefit. Unlike artificial feeding, breastfeeding does not have the environmental impact associated with dairy farming or the production, packaging and transport of artificial infant formula. The production and disposal of bottles, teats and other artificial feeding equipment may also have important implications for the environment, in addition to adding to the financial cost for families (National Breastfeeding Advisory Committee of New Zealand, 2009b)

1.5 Breastfeeding Rates

Despite the well documented relationship between breastfeeding and health, breastfeeding rates in New Zealand are far below the Ministry of Health targets which aimed to have 90% of women breastfeeding at six-weeks postpartum, 70% at three-months postpartum and 27% at six-months postpartum by the year 2010. However, data from the Royal Plunket Society of New Zealand (hereafter referred to as 'Plunket') indicate that for the period 2013-14, only 60% of Māori women and 67% of non-Māori women were breastfeeding at six-weeks postpartum. At three-months postpartum this rate had dropped to 44% for Māori and 58% for non-Māori,

and at six-months postpartum only 16% of Māori women were still breastfeeding versus 27% for non-Māori women (R. Evetts, personal communication, 13 February 2015).

Monitoring breastfeeding rates and how they change over time is critical for the development of effective breastfeeding policies and interventions. However, Renfrew et al. (2005) have noted a number of issues that should be considered when interpreting breastfeeding data:

- Representativeness of the data, in relation to ethnic, socioeconomic and regional variations within and between countries;

- The definitions of "breastfeeding" and "formula-feeding" used in data collection may not differentiate between exclusive breastfeeding and partial breastfeeding as per the definitions of the World Health Organisation;

- Reliance on data collection methods that require long-term recall and/or literacy skills or fluency in one specific language.

The collection of breastfeeding data in New Zealand is not immune to these issues (Thornley, Waa, & Ball, 2007). The national data for New Zealand are drawn from information from the Plunket database. Plunket have for a number of years collected information on breastfeeding for the Ministry of Health (Royal New Zealand Plunket Society, 2010) and they have been the only source of national breastfeeding data post-discharge from maternity facilities and Lead Maternity Carers. Although Plunket breastfeeding data suggests the existence of disparities in breastfeeding rates between Māori and non-Māori, a number of limitations must be mentioned. For example, although Plunket provides care for around 90% of babies in New Zealand, only 65% of Māori babies access their service (National Breastfeeding Advisory Committee of New Zealand, 2009a; Royal New Zealand Plunket Society, 2010). In comparison, Tamariki Ora[7] providers (generally Māori/iwi organisations) have a large proportion of Māori in their client base but they are not included in the national data because they are not Plunket clients. This

[7] Tamariki Ora services are generally contracted to Māori/Iwi organisations and are for tamariki/children aged zero to five years in age. Māori and Pacific people and those with a community services card are priority populations. Also whānau who meet high needs criteria can also access Tamariki Ora services. The Tamariki Ora service provider in Taranaki is Tui Ora Ltd. Plunket in Taranaki provides Well Child services to the remaining population.

privileging of Plunket services by the Government means that a significant proportion of Māori women and their children are missing from national and regional breastfeeding statistics.

Plunket has also been criticised in terms of how ethnicity data is collected, the quality of the data collected and the way that ethnicity data is manipulated to create the ethnic groupings presented in their reports (Royal New Zealand Plunket Society, 2010; Thornley et al., 2007) . Poor quality ethnicity data collection impedes our ability to identify inequities at a national or regional level and to monitor these inequities across time. This could be considered a breach of our tangata whenua rights to monitor the Crown under the Treaty of Waitangi (Robson & Reid, 2001).

1.6 The Kia Mau, Kia Ū Research Project

A call has been made for research that can increase our understanding of the contextual, personal, experiential, and cultural aspects of breastfeeding in New Zealand. In addition, there is an urgent need for research that seeks to identify the factors that hinder the initiation or maintenance of exclusive breastfeeding for different ethnic groups in New Zealand (Glover et al., 2009). Although prior research has identified important barriers to breastfeeding in Aotearoa, the factors influencing Māori women and their breastfeeding experiences may vary by region depending on the range of services and support mechanisms that are available within that locality. Within this call, I felt the need to look at Māori and breastfeeding within my own region, Taranaki.

The Taranaki District Health Board (DHB) delivers health services as far north as the Mokau area and as far south as the Waverly area (see Figure 1). The district covers more than 7,000 square kilometres. There are a few densely populated centres in Taranaki such as New Plymouth, Stratford and Hawera. The rest of the population is scattered in and around small rural centres (Taranaki District Health Board, 2014). There are eight iwi in the Taranaki DHB area and they are Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngāti Ruanui, Ngā Ruahinerangi and Ngā Rauru.

According to their 2013-14 Annual Report, the Taranaki DHB serves a population of just over 110,773 people, or 2.5% of the total New Zealand population (Taranaki District Health Board, 2014). The percentage of the population in Taranaki that identify as Māori is 17.4, (which is

slightly higher than the national average). The Maori population in Taranaki is youthful, with 45% being under the age of 20 years. There are approximately 1500 births in Taranaki per year.

Figure 1: *Map of the Taranaki District Health Board, 2014*[8]

Tables 1-3 below present the breastfeeding rates for Māori and non-Māori women who were resident within the Taranaki DHB region over the last three years. These data were collected by Plunket at the WellChild postpartum visits that are scheduled for six-weeks, three-months and six-months postpartum (R. Evetts, personal communication, 13 February 2015). Self-identified ethnicity is presented here comparing Māori (i.e. anyone who reported being Māori either alone or as one of many ethnic groups) to non-Māori women (i.e. everyone else). Breastfeeding status is also self-reported, with the data representing the proportion of women who were breastfeeding exclusively or fully at the time of the WellChild visit.

Breastfeeding rates in Taranaki are well below the targets set by the Ministry of Health[9]. Importantly, there is clear evidence of ethnic disparities in breastfeeding between Māori and

[8] Map sourced from http://www.health.govt.nz/system/files/documents/pages/taranaki.pdf
[9] The Ministry of Health breastfeeding targets established in 2002 were to increase exclusive breastfeeding rates at: six weeks to 74% by 2005 and 90% by 2010; three months to 57% by 2005 and 70% by 2010; and six months to 21% by 2005 and 27% by 2010.

non-Māori in the Taranaki DHB at each WellChild visit and across all time periods. Of particular note is the decline in the proportion of Māori and non-Māori women who report breastfeeding at six-weeks postpartum over the last three years. For Māori, the breastfeeding rate drops from 57% in 2011-12 to 53% in 2013-14. Overall these data suggest that the first six weeks for Māori women are integral in establishing and maintaining breastfeeding.

Table 1: *Taranaki DHB breastfeeding rates for Māori and non-Māori women at six weeks, three months and six months for the year 1 July 2011 – 30 June 2012*

Ethnicity	Six Weeks	Three Months	Six Months
Māori	57%	41%	10%
Non- Māori	69%	58%	23%
Total	66%	54%	20%

Table 2: *Taranaki DHB breastfeeding rates for Māori and non-Māori women at six weeks, three months and six months for the year 1 July 2012 – 30 June 2013*

Ethnicity	Six Weeks	Three Months	Six Months
Māori	54%	42%	11%
Non- Māori	67%	56%	23%
Total	64%	53%	20%

Table 3: *Taranaki DHB breastfeeding rates for Māori and non-Māori women at six weeks, three months and six months for the year 1 July 2013 – 30 June 2014*

Ethnicity	Six Weeks	Three Months	Six Months
Māori	53%	40%	11%
Non- Māori	65%	57%	24%
Total	62%	53%	21%

Despite legislation and policy to protect, promote and support breastfeeding, the international and New Zealand literature suggests that societal norms and attitudes, in addition to inconsistent access to adequate breastfeeding support have a significant impact on breastfeeding duration. Whilst data monitoring is critical to reducing ethnic inequities in breastfeeding rates, concerns about data collection processes in New Zealand limit our ability to use these data to develop strategies and interventions to improve Māori breastfeeding rates. Furthermore, quantitative datasets alone cannot fully capture the historical and contemporary

factors that influence Māori breastfeeding rates. Qualitative inquiry is therefore integral to answering questions about why ethnic disparities in breastfeeding exist and for identifying culturally-relevant interventions to promote successful breastfeeding relationships.

Therefore, the *Kia Mau, Kia Ū* research project was designed to explore the range of factors that influence the breastfeeding experience of Māori women living in Taranaki and to use this information to develop a breastfeeding support framework that reflected the realities and aspirations of Taranaki whānau. The *Kia Mau, Kia Ū* project grew from the following research questions:

- What do Māori women in Taranaki need to support their breastfeeding journey?
- What do whānau Māori in Taranaki need to provide support to Māori women to increase breastfeeding duration?

The objectives were to:

(1) Identify the barriers to exclusive breastfeeding for the recommended six months for Wāhine Māori (Māori women) in the Taranaki District Health Board (DHB) region;

(2) Identify ways to reduce these barriers; and

(3) Understand how a breastfeeding culture can be enhanced within whānau Māori.

1.7 Conclusion

This chapter has provided the rationale for the *Kia Mau, Kia Ū* study which is based on the premise that breastfeeding is a significant public health intervention. The overwhelming evidence suggests that breastfeeding is associated with a wide range of benefits, not just for the mother/infant dyad, but their whānau and wider society. Although these benefits are widely understood, current estimates indicate that breastfeeding rates in New Zealand are well below those recommended by the WHO. Furthermore, ethnic inequities in regional and national breastfeeding rates between Māori and non-Māori raises important questions about the ability of existing breastfeeding support services to meet the needs of Māori. Therefore, the *Kia Mau, Kia Ū* study has grown from a desire to reduce breastfeeding inequities by exploring the factors that influence the breastfeeding journey for Māori women and their whānau in Taranaki.

Chapter Two: Review of Literature

2.1 Introduction

A literature review represents an important first step in designing a high quality research project. Not only does it provide an opportunity to explore the existing evidence base, but it also allows the researcher to identify important knowledge gaps and entry points for new areas of enquiry. Therefore, this chapter presents a detailed description of the national and international literature related to low breastfeeding initiation and maintenance. One of my major hopes for the *Kia Mau, Kia Ū* study is that the findings will be used to develop and inform health policies and interventions. Therefore, this chapter also pays attention to the historical and contemporary factors that impact on breastfeeding for indigenous women.

The literature search was informed by the following questions:

- What are the barriers and facilitators to breastfeeding for Māori?
- What are the key issues and concerns for Māori with regard to breastfeeding education and support?

The initial search focussed on the Māori population, however because of the relative dearth of research that has focussed on our people, the search was expanded to include international studies that have focussed on indigenous peoples.

The literature search used combinations of the following terms:

> Breastfeeding; nursing; lactation; experience/attitude/behaviour; Māori/indigenous; ethnicity/race/racial; access/barrier/facilitator; support; initiative/intervention; life course/longitudinal/outcome.

The electronic databases that were used for searching on this topic were: PubMed, Scopus and Google Scholar. Relevant publications and grey literature were also identified through my knowledge of the health sector and stakeholders in breastfeeding protection, promotion and

support at international and national levels. I also searched bibliographies, conference proceedings, and the World Wide Web, with a particular emphasis on subject-related sites. Finally, I also consulted with key stakeholders in the Taranaki Whangai Ū Coalition as a way of identifying and accessing appropriate literature.

2.2 The Political Context for Breastfeeding

The existence of a broad literature suggesting the existence of significant health, economic and environmental benefits of breastfeeding has generated political support both nationally and internationally. A number of international documents and interventions, to which New Zealand are signatory to, provide guidance on how best to protect, promote and support breastfeeding. These include:

The International Code of Marketing of Breast-milk Substitutes (World Health Organization, 1981) is one of the first international documents that aimed to protect breastfeeding by controlling and monitoring the infant food industry. "The Code" encourages health workers to actively promote breastfeeding and restricts the marketing of artificial infant formula;

The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (UNICEF (1990); revised(2005)) is an international agreement that builds on the aims of the Code to enhance breastfeeding. In addition, it argues for the need to create environments appropriate to supporting breastfeeding. Advocacy, breastfeeding support and the development of breastfeeding policies are strategies endorsed as important for improving breastfeeding rates.

The Global Strategy on Infant and Young Child Feeding (World Health Organization & UNICEF, 2003) is mainly concerned with improving the nutritional status, growth, health and development of infants and young children through optimal feeding (National Breastfeeding Advisory Committee of New Zealand, 2009a). It also builds upon past international interventions, in particular the Innocenti Declaration and the Baby-friendly Hospital initiative. Although it addresses the needs of all children it has a specific focus on marginalised children, such as infants of mothers living with HIV, low-birth-weight infants and infants experiencing emergency situations (World Health

Organization, 2014). The strategy is intersectoral, in that it not only specifies the responsibilities of governments, but also international organisations, non-governmental organisations and other key stakeholders (World Health Organization, 2014).

Although these documents have provided a sound framework to address breastfeeding and appropriate infant feeding, it is important to note they are not legally binding. Each signatory country determines the ways in which the documents will be applied, measured and enforced. According to the National Breastfeeding Advisory Committee of New Zealand (2009a), New Zealand sits somewhere in the middle in terms of compliance as compared with countries of similar socio-economic, political and cultural histories.

New Zealand's legislative framework for protecting, promoting and supporting breastfeeding is covered in four key pieces of legislation:

- The Human Rights Act 1993;
- The Parental Leave and Employment and Employment Protection Act 1987 (amended in 2002 to include paid parental leave);
- Corrections Regulation Act 2005; and
- Employment Relations (Breaks, Infant Feeding and Other Matters) Amendment Act 2008 (National Breastfeeding Advisory Committee of New Zealand, 2009a, 2009b).

These legislations primarily focus on protecting a woman's ability to breastfeed while working and the right of a woman to feed in a public place. The Corrections Regulation Act 2005 specifically safeguards breastfeeding, by protecting the right of a woman who is imprisoned to breastfeed her infant for six months.

While the intent of legislation is to protect, promote and support breastfeeding, it is via policy that this intent is given practical effect. The development of the Ministry of Health's strategic policy document *Breastfeeding: A Guide to Action* (2002a) aimed to improve the initiation and maintenance of breastfeeding through seven key actions: (1) Establishment of a national breastfeeding committee; (2) implementation of the Baby Friendly Hospital Initiative; (3) active participation of Māori and Pacific to improve rates for these populations; (4) establishing consistent breastfeeding reporting and statistics; (5) increase in promotion and advocacy; (6)

increasing access to pre-natal education; and (7) ensuring quality and continuity of postpartum care.

Although some positive gains have been made as a result of this policy, the development of the *National Strategic Plan of Action for Breastfeeding 2008-2012* (National Breastfeeding Advisory Committee of New Zealand, 2009b) highlights the need for ongoing intersectoral commitment in order to improve breastfeeding rates. The National Strategic Plan concentrates on four key settings: government; family and community; health services; and workplace, childcare and early childhood education. For each setting, the National Strategic Plan recommends objectives and outcomes that together will support the cultural change that is needed in order to improve New Zealand's breastfeeding rates.

The broader relevance of breastfeeding for health and wellbeing is exemplified by the National Strategic Plan through the inclusion of other national policies. These include *He Korowai Oranga: The Māori Health Strategy* (Ministry of Health, 2002b, 2014a), the *Food and Nutrition Guidelines for Healthy Infants and Toddlers: A Background Paper* (Ministry of Health, 2008), *New Zealand's Agenda for Children* (Ministry of Social Development, 2000), and the *Baby Friendly Hospital Initiative* (New Zealand Breastfeeding Authority, 2007b). Te Tiriti o Waitangi (The Treaty of Waitangi) is also recognised as an important guiding document for the Strategic Plan. On this basis the Treaty principles of participation, protection and partnership are reflected throughout the Strategic Plan. It is also noted that improving breastfeeding rates for Māori will make a significant contribution to reducing the persistent health inequities experienced between Māori and non-Māori (National Breastfeeding Advisory Committee of New Zealand, 2009b).

Despite the numerous international and national legislative and policy mechanisms, their effectiveness in terms of improving breastfeeding rates has been variable. Although some of the objectives in the National Strategic Plan have been achieved, (e.g. all District Health Boards and most maternity services in New Zealand have achieved and maintained Baby Friendly Hospital Accreditation), most of the objectives remain a work in progress (Hayes-Edwards, 2014).

Legislation, policy and strategic frameworks can provide space for the protection and promotion of the breastfeeding process for both the mother and her infant in the hospital,

community, and workplace. However a study conducted by Smith-Gagen, Hollen, Walker, Cook, and Yang (2014) in the US found that breastfeeding legislation and policy influenced minority groups (African American and Hispanic) differently than the White population. The authors found that laws that were developed with the intention of supporting breastfeeding duration were significantly less helpful for African-American women relative to White women, but more helpful to Hispanic populations in comparison to White women. They concluded that cultural norms and societal attitudes strongly influence breastfeeding practices (Azulay-Chertok & Hoover, 2009; Smith-Gagen et al., 2014). Legislation, policy and government strategies, while important, cannot be fully effective if they are developed and implemented without consideration of the needs and expectations of those groups within society who are most at risk of not breastfeeding to the recommendations.

2.3 The Barriers to Breastfeeding

2.3.1 The Impact of Colonisation

Historical evidence tells us that breastfeeding was an integral part of our culture. In pre-colonial times, all Māori women breastfed their babies (Papakura, 1938). Breastfeeding was fundamental for all aspects of creating and sustaining a new human life (Glover & Cunningham, 2011). Elsdon Best (1929), a colonial ethnographer who studied Māori during the late 1800s and early 1900s, wrote that Māori women breastfeed for varying lengths of time, for example, until their baby could turn over without assistance, until teeth appeared, or for as long as the child chose to breastfeed. Papakura (1938) reported that breastfeeding was usually continued until the child was walking. Wet nursing was also commonly practiced in Māori society, generally when the biological mother could not breastfeed or was unavailable for breastfeeding, with the baby being breastfed by another woman in the whānau or hapū (Glover & Cunningham, 2011).

Traditionally Māori lived in tribal communities where the health and well-being of the infant and mother was the responsibility of the whole tribe (Best, 1929; Papakura, 1938; Schwimmer, 1966). Childbearing practices were vital for ensuring the survival of the people (Papakura, 1938) and breastfeeding was crucial in maintaining and sustaining a child's development and well-being. A healthy, well-fed baby was considered to reflect the health status of the whānau, hapū and iwi.

Māori in Taranaki had a particularly unforgiving experience of colonisation (Waitangi Tribunal, 1996). My tūpuna actively resisted colonisation through taking up arms which resulted in the land wars of the 1860s (Belich, 1986) and through the Parihaka movement in the late 1800s (Scott, 1981). The implication of their resistance resulted in harsh punishment from the Crown which included the confiscation of tribal lands, the invasion and destruction of Parihaka infrastructure and the imprisonment of Parihaka residents without trial over a 19-year period (Scott, 1981; Waitangi Tribunal, 1996). The early 1900s therefore saw a dramatic shift away from traditional structures of Māori communities in Taranaki.

The destruction of the Māori way of life and traditional health systems and practices of care was accelerated by the assimilation of colonial patriarchal medical practices and discriminatory legislation (Durie, 1998). For example, traditional Māori midwives were prevented from attending births through the Registration of Midwives Act 1904, which required midwives to be trained in colonial midwifery practice (Gabel, 2013; Simmonds, 2009, 2014). The Tohunga Suppression Act 1907 and the Native Health Act 1909, also contributed to the demise of traditional pregnancy, birth and breastfeeding practices (DeJoux, 2012; Gabel, 2013; Simmonds, 2009, 2014).

It is acknowledged that up until the 1930s Māori women retained some control over their birthing practices (Gabel, 2013; Simmonds, 2009). By 1936 over 80% of New Zealand's births had taken place within maternity hospitals and it is from this time that the Western medicalisation of childbirth took hold and Māori antenatal and postnatal practices were most dramatically transformed (McBride-Henry, 2010). Māori birthing shifted from the traditional birthing spaces within papakāinga (villages) to maternity units controlled by Western medical practitioners; a result of government policy that deemed birthing within a medical environment as more sanitised and safe (Kenney, 2011; Simmonds, 2009).

Despite these assertions, the medicalised maternity hospital units failed Māori women. By the 1960's Māori maternal mortality rates were three times that of non-Māori (Simmonds, 2009, 2011). The 1961 *Hunn Report*[10] shifted the focus away from hygiene and safety practice within

[10] J. K. Hunn's report on the Department of Māori Affairs was released to the public in 1961. It was strictly speaking a review of the Department, however it had far-reaching consequences which resulted in significant social reforms that disproportionately targeted the Māori (Meredith, 2012).

the hospitals and instead laid blame for ethnic disparities in mortality rates on Māori women themselves (Simmonds, 2009, 2011). In this report, Māori women were blamed for their poor antenatal care, unsatisfactory feeding of their infants and were labelled ignorant and apathetic (Simmonds, 2009, 2011). Although this sentiment is largely considered to reflect the attitude of the medical establishment towards Māori women at that time, these attitudes and beliefs continue to influence the level and quality of antenatal and postnatal care and support offered to Māori women.

2.3.2 The Shift to Artificial Feeding

At the same time as the *Hunn Report* fuelled negative and discriminatory attitudes towards Māori women, an emerging discourse arose mainly from the health sector that promoted artificial feeding as being equal to, if not better, than breast-milk in terms of producing healthy outcomes for infants (Bryder, 2009; McBride-Henry, 2010). In New Zealand this dominance of health professionals in infant feeding practices began in the 1940s and continued throughout the 1950s and 60s (Bryder, 2009; McBride-Henry, 2010). The artificial infant feeding industry was also in a growth period in New Zealand and their rigorous promotion of their products was highly influential. Biomedical language and health professionals dominated infant feeding discourse and as a consequence the belief that breastfeeding was by and large unattainable and of poorer quality took hold amongst the community (McBride-Henry, 2010). This had a significant impact on breastfeeding rates. The unrestricted marketing of artificial infant formula in New Zealand continued until the implementation of the International Code of Marketing of Breast-milk Substitutes in 1981. This action saw the end of the unobstructed promotion of often inappropriate and unnecessary infant feeding practices (J. Smith, 2004).

Despite the Code not being ratified by the World Health Organisation until 1981, the trend towards increasing breastfeeding rates began in the 1970's particularly in New Zealand and within other Westernised countries. As elsewhere, breastfeeding rates in New Zealand were particularly influenced by the Western feminist movements and the formation of La Leche League. Feminism and La Leche League movements saw a return to an ideology that empowered women and valued breastfeeding. The refocus on women-centred knowledge around pregnancy, birth, breastfeeding and motherhood occurred. Both movements were primarily driven by white middle-class women, thus although they swayed the discourse of breastfeeding in New Zealand, the entrenchment of anti-Māori and anti-breastfeeding

ideologies and policies within New Zealand at that time meant that ethnic inequalities in breastfeeding remained (Glover & Cunningham, 2011).

It is important also to acknowledge the efforts and influence of the Māori Women's Welfare League ("the League") on Māori child and maternal health. Established in September 1951, the vision of the League was to promote "activities that would improve the position of Māori, particularly women and children in the fields of health, education and welfare" (Maori Women's Welfare League, 2015). The founding president Dame Whina Cooper spoke of her personal efforts during her time with the League to promote breastfeeding to Māori women and their whānau (King, 1983).

Despite efforts of groups like the La Leche League and the Māori Women's Welfare League, the discriminatory attitudes and policies targeting Māori women during 1950s and 1960s in addition to the privileging and promotion of artificial feeding at this time has impacted on Māori women's infant feeding practices. The impact of these policies and practices across many generations has contributed to the current situation whereby three or four generations of Māori women within many whānau have not breastfed (Glover et al., 2007; Manaena-Biddle et al., 2007). A culture of artificial feeding dominates.

2.4 Causes and Consequences of Low Breastfeeding Rates

This section presents a high level review of the breastfeeding literature that was conducted to explore what is known about the causes and consequences of low breastfeeding rates amongst Māori, and to identify the knowledge gaps that need to be filled in order to create change. The primary goal was to identify the barriers to and facilitators of successful and sustained breastfeeding for Māori. A secondary goal was to consider potential issues regarding access to breastfeeding education and support services.

2.4.1 New Zealand Literature

There has been limited breastfeeding research conducted within New Zealand. Two studies that sought to describe the breastfeeding experiences of New Zealand mothers (Manhire, Hagan, & Floyd, 2007; McBride-Henry, 2010) suggest that despite the mothers' intent, the breastfeeding experience can be detrimentally affected by a number of internal and external factors. Physical discomfort and pain, inconsistent healthcare support and advice, perceptions

of others' attitudes and beliefs and limited access to breastfeeding support were all identified as having a negative influence on the breastfeeding relationship. Although these studies have made a significant contribution to our understanding of why women in New Zealand might wean their infants early they did not address disparities in breastfeeding between Māori and non-Māori populations.

Concern about ethnic inequities in breastfeeding rates has been apparent for the last two decades (Glover & Cunningham, 2011; Glover et al., 2009; Ministry of Health, 2002a; National Breastfeeding Advisory Committee of New Zealand, 2009b). Despite acknowledgement of the challenges that Māori women face when breastfeeding, the Government has shown a lack of political will and provided limited resourcing for the purposes of improving Māori breastfeeding rates. Such inaction has motivated Māori academics and communities to take the matter into their own hands (National Breastfeeding Advisory Committee of New Zealand, 2009b).

Te Whangai Ū - Te Reo o te Ara Tika: Māori Women and Breastfeeding (Glover, et al. 2008) is the most extensive research undertaken to date that has addressed Māori women and breastfeeding[11]. This qualitative research project sought to investigate the factors that influence Māori women's decision to breastfeed or not. Between 2004 and 2006 the researchers interviewed 59 women, aged 19- 49 years, who had cared for a newborn within the previous three years and 25 whānau members of some of the women who were interviewed. The participants lived in a number of geographic locations including Auckland, Palmerston North, Whakatāne, Whanganui and some surrounding rural areas. The authors concluded that Māori women had a strong desire to breastfeed and that Māori women acknowledge breastfeeding as the tika, or right, feeding choice and that breastfeeding is their preference. However, they also identified five dominant diverting factors that led Māori women to artificial feeding:

1. A breakdown in the breastfeeding norm within the whānau;
2. Early interruptions or difficulty establishing breastfeeding in the first six weeks;
3. Poor or insufficient professional maternity support for breastfeeding;

[11] Glover et al's (2008) report *Te Whangai Ū – Te Reo o te Aratika: Māori Women and Breastfeeding* presents the full results of the research undertaken to understand factors that influence Māori women and breastfeeding. Partial results have been disseminated in journal articles that I have also utilised for this thesis.

4. Lack of knowledge about how breastfeeding changes over time including the perception of inadequate milk supply; and
5. Having to return to work. (Glover et al., 2008)

Overall, the study highlighted the multiplicity and complexity of factors that exist within a woman's environment to impede the initiation and disrupt the duration of breastfeeding.

Using the same dataset Glover et al. (2009) also explored the perceptions of Māori women and their whānau towards the barriers to achieving best breastfeeding outcomes. This study found that the determination and desire of Māori women to breastfeed is extinguished primarily through the lack of support received at critical time points including when establishing breastfeeding and when life circumstances change. Factors which have had a significant impact on breastfeeding success for Māori women include the lack of timely, culturally relevant and comprehensible information around issues such as smoking while breastfeeding, the safety of bed-sharing, and perceived lack of acceptability of breastfeeding in public. The authors state that many of the barriers Māori women face relate to health services that are ill-equipped to meet their needs and expectations.

In their review, Glover and Cunningham (2011) suggest that the five diverting factors provide critical foci and points for intervention. For example, smoking is considered a significant barrier to breastfeeding for Māori women. Therefore, policies and interventions that address the determinants of health, as key drivers of health risk behaviours such as smoking, are likely to improve breastfeeding rates for Māori and reduce ethnic inequities. Similarly, establishing whānau inclusive approaches to breastfeeding promotion and protection strategies are likely to be important.

Although the factors that encourage and support Māori women to breastfeed have been previously explored (Glover et al., 2008), a more recent study by Hayes-Edwards (2014) has identified the critical aspects needed for a positive breastfeeding experience and provided a detailed explanation of how Māori women can achieve optimal breastfeeding. *Ūkaipōtanga: A grounded theory on optimising breastfeeding for Māori women and their whānau* involved interviews with eight women who self-identified as Māori, residing within the Eastern Bay of Plenty. The participants were aged between 19 and 36 years, and had breastfed within the past

10 years. A Kaupapa Māori health provider was also interviewed as part of the theoretical sampling. In that study, ūkaipōtanga (nurturing) was identified as important for achieving an ideal breastfeeding relationship and involved three important components (1) getting ready; (2) having an engaging midwife; and (3) having support systems. Hayes-Edwards (2014) noted that the Lead Maternity Carer, the partner and whānau have important roles within the ūkaipōtanga process. The author concluded that access to Kaupapa Māori antenatal education beginning in the second trimester of pregnancy, and supportive midwifery and well child/Tamariki Ora services after the baby is born are key for supporting Māori women to successfully breastfeed. The author also identified the broader environments of work, health services and community as important to successful breastfeeding and that they should be considered in policy and programme development.

2.4.2 International Literature

Non-Indigenous Literature

Most of the international breastfeeding literature has focused on identifying the factors that influence breastfeeding initiation and those that are associated with early cessation. For example, lack of confidence or knowledge, perceptions of others' attitudes and beliefs, breastfeeding problems, younger maternal age, lower education, lower income, smoking, giving babies infant formula in hospital, returning to work full time, maternal depressive symptoms, and high body mass index are implicated in a women's decision to stop breastfeeding early (Ertem, Votto, & Leventhal, 2001; Forster, McLachlan, & Lumley, 2006; Gerd, Bergman, Dahlgren, Roswall, & Alm, 2011; Kehler, Chaput, & Tough, 2009; Taveras et al., 2003). While it is important to understand the factors that can affect the breastfeeding journey, there is a growing focus on identifying interventions that can support breastfeeding initiation and duration.

A systematic review conducted by Renfrew et al. (2005) identified a number of practices and policies that were effective in enhancing breastfeeding duration, including preventing the inclusion of artificial feeding information and samples as part of hospital discharge packs; and proactively offering breastfeeding support to women. The authors also identified a range of policies and forms of care that were found to be ineffective or harmful, including restricting

timing and/or frequency of breastfeeding; and antenatal education delivered by paediatricians. Importantly, the review found that the timing of the intervention in relation to a woman's breastfeeding journey was critical. For example, group breastfeeding education sessions in the antenatal period and peer support in the postnatal period particularly in the first six-12 weeks, were highly effective interventions within a community setting. Additionally, the review recommended that a coordinated and well-supported national programme was pivotal to achieving real change in terms of breastfeeding culture and health provider practice. Specifically, the coordination of national and local policy and the ongoing monitoring of breastfeeding rates with agreed definitions and timing of data collection is needed. The authors acknowledged a significant knowledge gap with regards to disadvantaged and minority ethnic groups.

As breastfeeding is a learned experience, much of the international literature considers breastfeeding as a separate intervention rather than part of standard antenatal education programme (EU Project on Promoting Breastfeeding, 2004). The development of culture-specific education sessions in the antenatal period appear to be effective at increasing breastfeeding duration rates among different ethnic groups and those of lower socio-economic position (Renfrew et al., 2005). Peer support education and counselling in the antenatal period was also highlighted as a particularly effective strategy for increasing breastfeeding duration (Lumbiganon et al., 2011). There is clear evidence to suggest that providing women with written material alone does not increase breastfeeding duration. However, when written material is included amongst a range of education strategies then it can enhance verbal discussions and breastfeeding advice (Lumbiganon et al., 2011; Renfrew et al., 2005). Overall the literature suggests that successful antenatal breastfeeding education involves the following components:

- It consists of more than a one of lesson;
- The advice given is consistent and accurate;
- It is delivered by compassionate and knowledgeable individuals;
- It uses well designed information; and
- It is delivered more intensely to women who are not intending to breastfeed or who are undecided about what feeding method to follow. (EU Project on Promoting Breastfeeding, 2004)

McInnes and Chambers (2008) presented a qualitative synthesis of the experiences and perceptions of breastfeeding support held by mothers and healthcare professionals. The authors reviewed 59 papers that met the following criteria: they reported studies using qualitative methods to explore breastfeeding; they were published in English; and they were conducted in a Westernised country. They found that a lack of health professional support is experienced across a range of countries, not just those countries with poor breastfeeding rates. Despite advances in our knowledge and understanding of what constitutes good breastfeeding support practice, the review also found that conflicting and incorrect breastfeeding advice and intrusive assistance and understaffed postnatal wards/units were still commonplace. Interestingly, they found that mothers tended to rate social support as more important than professional support. However, a lack of breastfeeding knowledge or experience within the social group could compromise the breastfeeding relationship. McInnes and Chambers (2008) recommended that structural changes within health services were needed in order to address the needs of both mothers and staff. Such changes will require political will and appropriate funding of maternity services.

Although most mothers understand that breastfeeding is beneficial and expect to breastfeed their infants (Glover et al., 2008; Hayes-Edwards, 2014; Kornides & Kitsanta, 2013; Morton et al., 2010; National Breastfeeding Advisory Committee of New Zealand, 2009a; Nesbitt et al., 2012), many women cease breastfeeding early because they encounter problems that could be prevented with adequate care and support (Cattaneo & Quintero, 2006; Kervin, Kemp, & Pulver, 2010; National Breastfeeding Advisory Committee of New Zealand, 2009a). Ending breastfeeding early and not meeting personal expectations can present further problems including health issues for both mothers and their infants (Ladomenou, Kafatos, & Galanakis, 2007; Stuebe, 2009). Renfrew, McCormick, Wade, Quinn, and Dowswell (2012) analysed 52 randomised controlled studies from 21 countries as part of a review of breastfeeding support. The total number of women involved in the reviewed studies was more than 56,000. Renfrew et al. (2012) noted that the concept of support in the breastfeeding context is complex and layered; giving reassurance, praise, and information to women and providing the opportunity to discuss and to respond to a mothers' questions or needs. The authors found that these forms of support, when analysed, had a positive impact on breastfeeding duration. There also appeared to be a positive association between breastfeeding support and the delay of

introducing infants to solids or any other type of liquid. Renfrew et al. (2012) concluded that proactive breastfeeding support, rather than reactive support, was more likely to be effective. Support offered by either health professionals or lay/peer supporters were both effective. Moreover, their support was more effective if delivered face-to-face rather than by telephone or text message. The review also recommended that support is tailored to the specific needs of different population groups and their setting.

Indigenous Literature

Exploring the existing research on breastfeeding and indigenous women is important for me as a Māori researcher. We share many aspects of our breastfeeding history with our indigenous sisters, particularly in terms of our history of colonisation and our shared experiences of the oppression of our traditional pregnancy, birthing and breastfeeding practices. While the international literature exploring indigenous women's experiences of breastfeeding is somewhat limited, the discourse offered fills many of the evidence gaps that have been identified in the non-indigenous literature.

Two qualitative studies from Australia have explored the factors that influence indigenous women's breastfeeding experiences. W. Foley, Schubert, and Denaro (2013) examined the breastfeeding experience of urban Aboriginal and Torres Strait Islander women for the purposes of informing the development of breastfeeding support interventions. The authors conducted 20 semi-structured interviews with indigenous mothers of infants aged three to 12 months old, who were residing in urban Brisbane. While all the mothers in the study had initiated breastfeeding, 35% had ceased breastfeeding and 30% had introduced complementary artificial milk[12] by the time their infant was three months old.

The authors found that breastfeeding support was inconsistently available to those women who ceased breastfeeding early. Additionally, if healthcare support was unavailable or did not solve breastfeeding issues, then the mothers sought help from immediate and extended family. If the mothers or their family members could not resolve breastfeeding issues, then artificial feeding was introduced to address those problems (W. Foley et al., 2013).

Continuity of maternity healthcare, mother-centred support from sensitive health professionals and pro-breastfeeding sentiments and activities within the family were important for increasing

[12] Introducing complementary artificial milk means to formula feed an infant, in addition to continuing to breastfeed.

breastfeeding duration. W. Foley et al. (2013) recommended that the timing of interventions was pivotal to successfully supporting breastfeeding duration for indigenous women in Australia. In conclusion, the authors recommended that the research findings should be used to create an environment that was more conducive to breastfeeding for indigenous women and inclusive of family and their needs.

The second qualitative study from Australia explored the factors that influenced infant feeding choices in a rural indigenous community (Helps & Barclay, 2015). Semi-structured interviews, one during the antenatal period and one postnatally, were conducted with eight indigenous first time mothers. Although rural isolation of indigenous communities has been postulated to be protective of breastfeeding duration (Cromie, Shepherd, Zubrick, & Oddy, 2012), none of the participants were breastfeeding at the time of the postpartum interviews. Helps and Barclay (2015) acknowledge the complexities of the factors that influence infant feeding practices within indigenous communities and highlight that understanding the health benefits of breastfeeding can be outweighed by cultural, historical and socioeconomic factors. Specifically, they found that disruption of intergenerational breastfeeding knowledge, the persuasive presence of artificial milk formula and socio-economic issues such as housing and overcrowding are key barriers to breastfeeding within this community. Helps and Barclay (2015) recommend inclusion of partners, mothers and extended family members in antenatal breastfeeding interventions to widen the circle of support for pregnant mothers. Additionally, the normalisation of breastfeeding culture within the community setting is necessary given that the community can have a significant influence on health behaviour.

The ways in which the broader community can influence the breastfeeding experience was investigated amongst indigenous Hawaiian mothers (Oneha & Dodgson, 2009). This ethnographic study focused on disparities in breastfeeding rates from an ecological perspective. A total of 20 women of childbearing age, who self-identified as indigenous Hawaiian and lived within the Wai'anae community were recruited and interviewed for this study. The women had all weaned at the time of the interview. The findings highlighted the multifaceted and complex factors that influence the breastfeeding journey for indigenous women living in contemporary society.

The authors presented three overarching themes. Firstly, a range of resources considered helpful to the breastfeeding relationship were identified including; knowledge, prior

experience, motivation, support persons, equipment (breast pump), and empathy, particularly from health providers. Secondly, factors that made breastfeeding difficult included physical problems, time demands and lack of support. It was noted by Oneha and Dodgson (2009) that experiencing difficulty with breastfeeding and not having access to timely and appropriate support to problem solve, affected the duration of breastfeeding. The third theme described the challenges that can arise when a woman's breastfeeding experiences do not match their expectations. Oneha and Dodgson (2009) endorsed the creation of a supportive breastfeeding environment for indigenous Hawaiian mothers and believe this can be achieved by valuing and re-instating traditional Hawaiian practice and through the involvement of the *ohana* (family) in planning for and supporting the breastfeeding journey. Accessible and supportive health professionals were also important for indigenous Hawaiian mothers.

Culturally relevant interventions and the inclusion of broader social familial circles within breastfeeding support activities, have also been linked to increasing breastfeeding duration for indigenous women in mainland America (Dodgson, Duckett, Garwick, & Graham, 2002; Eckhardt et al., 2014; Horodynski, Calcatera, & Carpenter, 2012; Rhodes, Hellerstedt, Davey, Pirie, & Daly, 2008). This highlights the importance of social networks in the support of breastfeeding for indigenous women. Additionally, it indicates a need to include both immediate and extended family in interventions to promote and protect breastfeeding in indigenous communities.

2.5 Conclusion

Breastfeeding has received significant research attention for many years. However, there have been relatively few studies that have focussed on the issues of breastfeeding in the New Zealand context. The literature review identified a number of important themes that exist within the breastfeeding evidence base and highlighted the impact of colonisation and privileging of Western medical knowledge on Māori breastfeeding realities. It also described the complexities that are inherent in supporting, promoting and protecting breastfeeding for indigenous peoples. Although recent research by Glover et al. (2011; 2008; 2007; 2009; 2007) and Hayes-Edwards (2014) have made an important contribution to current breastfeeding knowledge, the Whānau Ora policy environment[13] requires locally-specific information in order to ensure that Māori health providers can support their own communities.

[13] Whānau Ora is an approach to health and wellbeing that puts families at the center of their own development. While it is not a new concept for Māori, the whänau ora philosophy became the foundation of Māori health policy in the early 2000's through the development of the Māori Health Strategy of 2002 (Boulton, Tamehana, & Brannelly, 2013). Whanau Ora was further entrenched in New Zealand's health and social services delivery sector in 2010 through the *Whänau Ora: Report of the Taskforce on Whänau- Centred Initiatives* (Taskforce on Whanau Centred Initiatives, 2010), and in 2015 remains a core government Māori health and wellbeing policy.

Chapter Three: Huarahi Rangahau, Tikanga Rangahau – Research Design and Methods

3.1 Introduction

This chapter will explore the range of factors that were taken into account when selecting the research methodology and methods for the *Kia Mau, Kia Ū* project. The location of the research within a Māori community setting and the focus on breastfeeding carried with it a responsibility to conduct the study in a manner that enhanced the mana of my participants and their stories. Details about the research design, including the sample, data collection, data analysis and ethical issues will also be outlined.

3.2 Indigenous Methodology

For many generations, since the European colonisation of Aotearoa, the Māori experience of Western research has not been positive. L.T. Smith (1999) highlights that the "research of Māori is marked by a history that has shaped the attitudes and feelings Māori people have held towards research" (p. 183). Further she states that research has privileged Western knowledge, while rejecting and undermining the legitimacy of Māori ways of being and doing.

The influence of the Western approach to research has been ongoing and significant. Research based in Western paradigms, not Māori knowledge or forms of inquiry, has influenced policy and shaped practices that impact on Māori communities. Therefore the proposition is that methodology itself inherently influences outcomes (Kovach, 2009). Indigenous scholars have argued that culturally-relevant research frameworks have the potential to improve the relevance of policy and practice within indigenous contexts (Kovach, 2009; Pihama, 2001; G. H. Smith, 1997; L. T. Smith, 1999). As indigenous researchers our ultimate responsibility is to apply our frameworks of knowledge "to identify the centrality of the [indigenous] voice and representation in research" (Kovach, 2009, p. 81). Additionally we have a responsibility to assist others to seek to know and understand our worldview in a respectful and responsible fashion (Kovach, 2009).

3.3 Kaupapa Māori - A Personal Experience

Kaupapa Māori is a term that I became familiar with as a teenager in the early 1990s. At the beginning of 1991 my family moved back to Taranaki for my Fifth Form year (Year 11) and my mother had begun working for Te Wānanga Māori (previously Taranaki Polytechnic, Western Institute of Technology). Taranaki at that time was seeing a resurgence of Te Ao Māori. Te Wānanga Māori was the hub of this resurgence, with te reo Māori programmes and other community building activities established under its auspices (Edwards & Ratima, 2010). These activities included the establishment of Kohanga Reo – Te Kopae Tamariki kia Ū te Reo (early childhood centres), Te Kura Kaupapa Māori o te Pihipihinga Kakano mai i Rangiātea (Māori immersion primary school), and the iwi Māori radio station Te Korimako o Taranaki. Kaupapa Māori was a term that was used frequently to describe the Māori community action that was taking place during this time. I was later able to apply this understanding of Kaupapa Māori in the health and social services domain with my familiarity of services available within the region.

My familiarity with the base intent of Kaupapa Māori action is also derived from my whakapapa. I am a descendent of 'challengers'. My ancestors actively resisted colonial oppression through taking up arms during the 1860s and later through the Parihaka movement. Some of my earliest childhood memories are of attending protests with my parents. Resisting the status quo, campaigning for social justice, for Māori rights, and for women's rights are activities my parents engaged in and the values aligned to those activities have influence me profoundly. It is therefore of no coincidence that I am engaged in a career path that seeks to challenge dominant views of the causes of health inequities through research. Kaupapa Māori approaches to research emerged as a way of challenging the Western frameworks that dominated research and policy in Aotearoa.

3.4 Kaupapa Māori – An Indigenous Research Methodology

Cram, McCreanor, Smith, Nairn, and Johnstone (2006) define methodology as the theoretical approach that defines the way research is undertaken, this includes, the researcher's relationship with participants and the communities to whom they are connected to. For research conducted with Māori communities, methodology is also prescribed in cultural terms, such that

the theoretical approach is one that makes moral and cultural sense (Lawton et al., 2013). Furthermore, it was important that the research methodology used in this study acknowledged and reflected my personal values and my goal to provide a strong voice for wāhine Māori.

As an aspiring Māori health researcher I am fortunate that Māori academics like Durie (1998, 2003, 2006a, 2006b), L. T. Smith (1999, 2005) and Pihama (2001, 2010) have pioneered academic discussion of the intersecting spaces between research and being Māori. One of the methodologies that has emerged from these discussions is Kaupapa Māori research (Pihama, 2010; G. H. Smith, 1997; L. T. Smith, 1999, 2005, 2006). Over the last twenty years the term Kaupapa Māori has been used to describe Māori community action across many domains, including education, justice and politics. As the Māori research community has grown, the theoretical and academic work around Kaupapa Māori has expanded from its roots in education out into psychology, health and increasingly into the basic sciences as well (Bishop, 2005). Kaupapa Māori theory and methodology is viewed as a robust approach to undertaking high-quality research and science in Aotearoa (Health Research Council of New Zealand, 2010).

Defining Kaupapa Māori research is not a simple exercise as there is no one definition. It has been argued that the need to define, discuss or explain its existence in itself serves as a reminder of the power of colonisation (Moewaka-Barnes, 2000). Nonetheless, in the present study Kaupapa Māori research is viewed as an approach to research that brings Māori from the margins to the centre, and views Māori as 'the norm' (Cram, 2009; Cram et al., 2006; Pihama, Cram, & Walker, 2002; L. T. Smith, 1999). Kaupapa Māori research locates Māori understandings of our environment and our relationships as central to the research design, process, analysis and intended outcomes (L. T. Smith, 1999). In the framework used for this research project, Kaupapa Māori focuses first on getting the approach right, and is not prescriptive with regard to the choice of methods that are used for any given type of research (L. T. Smith, 1999).

Further, a Kaupapa Māori research paradigm allows us to acknowledge that the research we undertake as Māori researchers has a different ontological (i.e., theory about the nature of reality) and epistemological (i.e., theory of knowledge) foundation than Western-oriented research (L. T. Smith, 1999). Kaupapa Māori Research is concerned with the views and opinions of Māori, and it seeks to validate Māori experiences and worldviews (Pihama, 2001;

L. T. Smith, 1999). Kaupapa Māori research also acknowledges and respects the use of tikanga Māori and te reo Māori within the research process (L. T. Smith, 1999).

L.T. Smith (1999) states "Kaupapa Māori approaches to research are based on the assumption that research that involves Māori people, as individuals or as communities, should set out to make a positive difference to the researched" (p. 191). Kaupapa Māori Research focuses on challenging the status quo. Its foundations are derived from organic community processes, such as Te Kōhanga Reo and Kura Kaupapa Māori, and provides Māori researchers with a theoretical process that ensures those struggles, and the inherent power relationships within those struggles, are a conscious part of our analysis (Pihama, 2001). Kaupapa Māori theory must be about challenging injustice, revealing inequalities, and seeking transformation (Pihama, 2001). Central to kaupapa Māori theory is the potential to create change through research and the production of knowledge (Murphy, 2011). A central facet of our commitment to Māori autonomy and the production of Māori-centred transformative research, is responsibility. This responsibility has been awe-inspiring and motivating throughout my research project.

3.5 Mana Wāhine Theory - An Extension of Kaupapa Māori Research Methodology

While Kaupapa Māori research provides a theoretical, practical and principled framework from which to develop a research project, the particular and significant focus of my research on Māori women could not be overlooked. Kaupapa Māori research inherently confirms and enhances mana Māori, and therefore implicitly confirms mana tāne and mana wāhine (Pihama, 2001). As my exploration of methodology evolved, the need to explore the space between being Māori and being female became apparent, and therefore Mana Wāhine theory was chosen as an integral influence in this study.

Mana Wāhine has been described by Pihama (2001) as a theoretical expression of Kaupapa Māori that challenges Western colonial patriarchy, which has impacted on Māori women and girls differently to Māori men and boys. Mana Wāhine is a theoretical framework that encompasses the complex realities of Māori women's lives (Pihama, 2001). Mana Wāhine extends Kaupapa Māori theory by explicitly exploring the intersection of being Māori and

female and all of the diverse and complex things being located in this interconnecting space can mean (Gabel, 2013; Pihama, 2001; Simmonds, 2009, 2011, 2014). At its base, Mana Wāhine is about making visible the narratives and experiences, in all of their diversity, of Māori women (Johnston & Pihama, 1995; Pihama, 2001; Simmonds, 2009).

Challenging the status quo and the transformation of Māori are implicit in a Mana Wāhine research approach. My own experience supports the view of Simmonds (2009) which suggests that health professionals working in maternity service provision label Māori women as the cause of their poor health outcomes. A Mana Wāhine analysis offers new ways to conceptualise discourses of blame and inadequacy of Māori mothers and whānau (Gabel, 2013; Simmonds, 2009, 2011, 2014) by critiquing structural causes of poor health and considering historical legacies and societal views of gender as powerful drivers of health inequities.

A Mana Wāhine research approach, as applied in the *Kia Mau, Kia Ū* study, extends the framework of Kaupapa Māori research by giving voice to the breastfeeding experiences of Māori women and their whānau in Taranaki. It validates the lived reality of the wāhine Māori participants and highlights the myriad of factors that influence their breastfeeding journey.

3.6 Research Ethics

The Health Research Council of New Zealand (2010) states "Māori ethical perspectives not only operate to ensure high quality research on Māori or Māori health, but also to ensure Māori participants, tikanga, and cultural concepts are protected" (p. 20). The incorporation of processes and practices that align with tikanga Māori is an important part of conducting research ethically with Māori communities. It is also central to a Kaupapa Māori methodological approach to research.

Table 4 presents the seven ethical principles for conducting research with Māori that were originally proposed by L. T. Smith (1999) and have been further elaborated on by Cram (2001a, 2009).

Table 4: *Ethical principles for conducting research with Māori*

Aroha ki te tangata	A respect for people
He kanohi kitea	The importance of being seen by the participants
Titiro, whakarongo, korero	The importance of looking and listening to the participants before settling into your position as a researcher
Manaaki ki te tangata	Taking a collaborative approach to the research
Kia tupato	Being cautious, politically astute and culturally safe
Kaua e takahia te mana o te tangata	Don't trample on the mana of the participants, keep the participants informed of the research progress
Kaua e mahaki	Be humble, don't flaunt your knowledge but instead share your knowledge and the research findings with the community

Tikanga Māori were an important aspect of the research process developed for this project. As the principal investigator, I invited participants to begin sessions with karakia and mihimihi. Participants had the option to conduct their interviews in te reo Māori or a combination of te reo Māori and English if they preferred. Manaakitanga was extended to participants through practices such as the provision of light refreshments and sharing of koha in the form of summary information about the study findings and $20 gift vouchers.

The study was reviewed and approved by the Massey University Human Ethics Committee (Southern A – 11/26). (Appendix A)

3.7 Kaupapa Māori Research Design

If methodology is considered to be the lens through which the research questions are determined, viewed and analysed, then the methods represent the processes and procedures through which the central questions of the research are addressed (L.T. Smith, 1999). Māori have a rich and significant history of oral traditions. Oral histories, story-telling, and the use of mediums such as waiata to explore perceptions held by Māori community members are rich sources of data within the research context (Kovach, 2009; L. T. Smith, 1999). Therefore, this study utilised qualitative methods to explore my research questions.

Qualitative methods and Kaupapa Māori research fit well together since they both focus on the importance of participation and partnership within the research process (L. T. Smith, 2005). For Māori, approaches to qualitative research such as narrative interviews, focus groups and in-depth individual interviews have enabled us to give voice to Māori realities and provided an opportunity to explain phenomenon from our own perspective (Pihama, Rautaki Ltd, & Ngā Pae o te Māramatanga). Cram, Pihama, and Philip (2000) suggest that qualitative methods are advantageous, and often preferred in Māori research because: (1) they allow the full expression of the participants interests and experiences in their own terms; (2) they allow for complexity and contradictions between participants; (3) researchers can look for meaning and patterns within the participants talk: (4) they highlight societal power structures, and (5) they allow for social change.

Kaupapa Māori research involves the "developing [of] approaches and ways of carrying out research which take into account, the legacies of previous research and the parameters of both previous and current approaches." (L. T. Smith, 1999, p. 183). Thus, to provide openings for participant story-telling, as well as accessing knowledge, the use of in-depth semi-structured interviews was deemed the most appropriate method for the *Kia Mau, Kia Ū* project. Although an interview may be viewed as incongruent with the fluidity of story-telling, the semi-structured nature of the *Kia Mau, Kia Ū* interview schedule was considered flexible enough to accommodate the diversity of the participants breastfeeding journey whilst also giving them the opportunity to share their stories on a specific aspect of their breastfeeding experience without being disrupted (Kovach, 2009). Additionally, the in-depth nature of the interviews allowed exploration of the complexity and nature of meaning within the kōrero. As a result, they were more like conversations than structured interviews (Rice & Ezzy, 1999).

The development of the interview schedules was important, and involved constant input by my supervisor and feedback from Māori colleagues from the local public health unit. Having formal supervision, or mentorship, from an experienced Māori researcher (not a researcher who happens to be Māori) has been integral to ensuring the research approach and subsequent research methods provided a forum for participants' stories to be heard. Additionally, support and ongoing conversations with Māori colleagues in the public health sector, as well as Māori health research practitioners have enabled formal and informal checks of the research process and methods employed. The schedules were also pre-tested with friends and family to gauge

the flow of questioning, the language I was using and to ensure the participants' voices would be heard.

The *Kia Mau, Kia Ū* study involved interviews with two main participant groups, wāhine Māori and whānau Māori[14] . The final version of the interview schedule for wāhine Māori focussed on the following issues:

- Pregnancy and birth experience;
- The kind of support the women received with their newborn;
- Their experiences of breastfeeding;
- The role of whānau in making decisions around infant feeding;
- Their ideas on supporting breastfeeding women and their whānau (see Appendix B).

The questions within the interview schedule for partners and whānau members focused on:

- The role they had in supporting a breastfeeding mother
- The experiences they had in the support role
- The breastfeeding information and support they received
- Their ideas on supporting breast-feeding women and their whānau (see Appendix C).

3.7.1 Wāhine Māori Sampling Strategy

The first stage of this project involved a series of in-depth key informant interviews with Māori women as they constituted the primary community of interest. Potential participants were initially identified using inclusion criteria that were chosen based on my study aims and were:

- Women who self-identify as Māori;
- Aged 16 years and over;
- Currently residing in Taranaki; and
- Have breastfed (partially or exclusively, regardless of duration) a baby in the previous 12 months.

[14] This research project defines whānau as those people who are closely linked to the mother and support her in her breastfeeding journey. Generally speaking, whānau is not limited toblood relatives.

Furthermore, existing evidence suggests that breastfeeding experiences may differ depending on the age of women. Therefore, my recruitment strategy was tailored to ensure that at least half of the participants were between 16 and 30 years of age.

3.7.2 Wāhine Māori Recruitment Strategy

The original recruitment strategy utilised purposeful sampling (Patton, 1990; Rice & Ezzy, 1999) whereby I used my community networks to identify women who met the study inclusion criteria. However, after four months it became apparent that this recruitment method was not suitable for identifying those women who had experienced difficulties with extended breastfeeding (i.e. beyond six months) and thus there was the potential that I would not capture the range of experiences required for a detailed analysis of the research questions. Therefore, it was decided that the recruitment strategy needed to be amended to better target this group of women.

Snowball sampling – also known as chain referral sampling – is a procedure whereby the researcher promotes the study via existing social networks (e.g. friends/family, contacts through marae, parenting groups) and word of mouth. Snowball sampling sits readily alongside Kaupapa Māori research approaches which support whanaungatanga, a tikanga Māori principle which embraces the importance of personal relationships. Snowball sampling is particularly useful when the participants of the study are well networked and difficult to approach directly. Further it is often used to access "hidden" populations (Rice & Ezzy, 1999).

Within a Kaupapa Māori research framework, the cultural principle of he kanohi kitea affirms the importance of meeting with people face to face. Therefore, my primary recruitment method was to approach all potential participants directly. However, use of email and text messaging was also employed to ensure efficiency and flexibility for the women.

The first three participants were connected to me through the Māori Immersion Early Childhood Centre that my children attend. During this first meeting I briefly explained the purpose of my study and provided them with information sheets (Appendix D) and consent forms (Appendix E) to consider in their own time. Each participant was followed-up, in person, to confirm their involvement within one week of the first invitation. Upon completion of the first three interviews, those participants were asked to further promote my study via their social networks and to pass on my contact details. This resulted in an enquiry from one potential

participant. The study documentation was supplied via email and the resultant interview was organised via text messaging.

I also utilised my networks within the maternity heath care sector, with two participants referred to my study through this avenue. I followed up these referrals with an email and a phone call to confirm interview times. Social media also played a useful role in connecting with participants with two women referred to me via a post on my personal Facebook page.

The nature of my study, and the close connection between my study populations allowed for referrals to be made between participant groups. For example, the staggered nature of data collection meant that one of my whānau participants was able to connect me with two wāhine participants. Finally, one participant was referred to me by an individual who had attended a presentation I gave at a training workshop.

A total of 11 interviews were conducted with individual wāhine Māori.

3.7.3 Wāhine Māori Interview Procedure

Each interview was 1.5-2hrs long and took place at the venue of the participants' choice; two interviews were held at the Māori Immersion Early Childhood Centre mentioned above, one interview was held in the participant's workplace, whilst eight were held in private homes.

Each interview began with karakia and mihimihi where emphasis was given to thank the participants for their support the kaupapa of the research and agreeing to share their story. Next, the research project was explained with particular attention paid to my obligations, as the researcher, for ensuring the confidentiality of their participation. Time was provided for the participants to ask any questions or raise concerns about the project. Written consent was provided before the interview began. The remainder of the meeting followed the interview schedule as described above.

Each interview was digitally recorded with permission and notes taken. During some interviews, space was required so participants could tend to their children, however most interviews were undertaken with no breaks. Questions from the participants were welcomed throughout the

interview. The semi-structured interview process employed in this study allowed for some flexibility to follow the participants own line of enquiry and to explore the issues they raised.

Sharing of kai and presentation of koha occurred at the end of the interviews in accordance with the tikanga Māori principles of manaakitanga, which is the process of showing support and respect.

3.7.4 Whānau Māori Sampling Strategy

Through my experiences as a health worker and active member of my community, I was aware that to fully understand the range of factors that influence a woman's breastfeeding journey, it was imperative that I capture the views and opinions of those people who provide support to the women, notably their whānau. I set out to undertake a series of focus groups with male partners of women who had breastfed in the previous 12 months (the "partner focus group") and whānau (i.e. parents/siblings/aunts/uncles/grand-parents). However, preliminary analysis of the one-on-one interviews with Māori women highlighted the central role of female whānau members and male partners in breastfeeding support. The sampling strategy and data collection methods were amended to pursue this line of enquiry.

The inclusion criteria for the male partner interviews were:

- Men who self-identify as Māori;
- Aged 16 years and over;
- Currently residing in Taranaki; and

They have had a partner who breastfed (partially or exclusively, regardless of duration) a baby in the previous 12 months. The inclusion criteria for the female whānau interviews were:

- Women who self-identify as Māori;
- Aged 16 years and over;
- Currently residing in Taranaki; and
- They have had a member of their whānau (immediate or distant relative) who breastfed (partially or exclusively, regardless of duration) a baby in the previous 12 months.

My decision to include partners and whānau members who self-identified as Māori was based on my desire to strengthen the Māori voice in my research. The Kaupapa Māori and Mana Wahine frameworks utilised in this project recognises that Māori women have diverse realities. For example, a number of my participants had non-Māori partners and whānau, and they acknowledged their non-Māori partners and whānau members as being supportive of the breastfeeding journey. However, the objective of this study was to explore Māori understandings and experiences of breastfeeding and thus I decided to limit the interviews to Māori. This decision was also supported by a growing literature which suggests that factors such as racial discrimination, bias and cultural competency underpin ethnic inequities in accessing and navigating health services in New Zealand (Cram, Smith, & Johnstone, 2003; Harris et al., 2006a, 2006b; Jansen, Bacal, & Crengle, 2008; Robson & Harris, 2007).

Potential participants were sampled using the snowballing technique. My intention was to interview two female whānau members and two male partners. However, despite a range of strategies and amendments to my study timeline, the recruitment of whānau participants, particularly male partners, proved challenging. Although many of the partners I approached were supportive of breastfeeding and interested in taking part in the study, finding a suitable time to conduct the interview was a major obstacle to their participation.

In the end, I conducted two semi-structured interviews with individuals who were recruited via a post on my personal Facebook page. One male partner was referred to my study by a friend from university, he was a shift worker so securing an interview time that suited us both was relatively straight forward. The whānau member participant (a sister of a breastfeeding woman) is a friend from secondary school.

Each participant was contacted by telephone and invited to participate in the study. Tailored information sheets (Appendix F and H) and consent forms (Appendix G and I) were emailed to these participants. A follow-up phone call confirmed their participation and was used to organise their individual interviews at a convenient time and location.

3.7.5 Whānau Māori Interview Procedure

Both whānau member interviews were conducted in their private homes and were 1.5-2hrs in duration. The procedure replicated that used in the wāhine Māori interviews, incorporating tikanga Māori (e.g. karakia, mihimihi and koha) and ethical research practice throughout (i.e. provision of written informed consent, assurances of confidentiality). The interviews were digitally-recorded (with permission) with discussions lead by the interview schedule developed for this participant group (see Appendix C).

Data collection for both participant groups was undertaken during 2011 and 2013[15].

3.8 Data Analysis and Interpretation

The analytical method used in this study was thematic analysis, which is primarily a descriptive strategy that facilitates the search for patterns of experiences within a qualitative set of data (Ayres, 2008). Thematic analysis aligns well to Kaupapa Māori methodology in that it provides opportunities for themes and patterns to emerge from participants' korero but also allows space within the analysis to address the aims of the study (Cram et al., 2006). As an analytical technique it provides for the sharing of power within the research experience such that the participants' voices and knowledge are honoured and valued as much as the research objectives. Thematic analysis also supports Mana Wāhine theory in that the importance of privileging the women's experience can occur through the analytical process. The application of thematic analysis within my Kaupapa Māori research framework has affirmed Māori women's authority as experts on feeding and caring for their infant and the authority of whānau to provide care and support to breastfeeding mothers. Thematic analysis is a recursive rather than a linear process. The researcher approaches the data in a flexible manner, searching back and forth over the data throughout all phases of analysis (Braun & Clarke, 2006). I had access to and had received training in the qualitative data analysis computer software package NVivo. However, given the relatively small data set, my research timeframes and my limited access to IT support as an extramural student I believed manual coding was the optimal approach for this research project (Basita, 2003). Manual coding is a reliable and robust approach to analysing qualitative data particularly when there are smaller sets of data. Manual coding enables the

[15] This study was suspended during 2012 whilst I was on maternity leave.

researcher to become familiar with the data and further, it supports the researcher to find meaning in the language used (Basita, 2003; O'Connor & Gibson, 2003). The analytical process used in this study was guided by the six phases of thematic analysis as described by Braun and Clarke (2006).

Phase one involved familiarising myself with the data. Each recorded interview was transcribed *verbatim*, with the transcript returned to those participants that requested an opportunity to make corrections and additions. I then spent time reading and re-reading each of the 13 transcripts, with ideas noted as I went along. The generating of initial codes was the second phase of analysis. At this point I worked systematically through each interview and identified patterns within the data. Each transcript was manually coded with sections of the participants talk highlighted and notes written on the text. The data was coded by labelling and categorising key words and phrases. Exemplary quotes were also noted. At this stage my interrogation of the transcribed interviews took both an inductive and deductive approach (Braun & Clarke, 2006; Cram et al., 2006). In other words, some codes arose from the transcripts without any preconceived ideas about the conversations meaning (inductive), whereas others evolved based on my prior reading and understandings of the issues (deductive). It also enabled me to identify key trends and commonalities that arose through the interviews. Once the coding had been completed for each individual interview, the coded data or text was extracted and collated together into each code grouping. This was done using Microsoft Word with the coded data copied from the original interview transcript and pasted into a new word document which was labelled with a "heading" which represented each code. It is important to note that the wāhine Māori and whānau Māori interviews were coded as two separate data sets. In other words, I synthesised the 11 wāhine Māori interviews as one data set and the two whānau Māori interviews as another.

During the third phase of the process, I examined the coded data for themes. Once again, the wāhine Māori and whānau Māori data were examined separately. This phase was essentially a re-analysis of the coded data with a focus on organising different codes into over-arching themes. Again, this phase was carried out manually, with coded data cut out of hard copies of the labelled word documents, and grouped and re-organised into broader themes. Through this process it became apparent that some emergent themes did not have enough data to support them, some codes were able to be combined and some codes stood alone. This process of re-

visiting the codes and reviewing the analysis of the data sets is an important stage of thematic analysis and thus time was taken to ensure that each theme was substantiated and robust.

The fourth phase involved refining and defining the themes. The analysis of each data set continued, with the data re-read, cross-referenced and categorised until five broad themes emerged from the wāhine Māori interviews and three broad themes emerged from the partner/whānau member interviews. Māori and Pākehā names were given to each theme.

The fifth, and final phase of the thematic analysis process, involved the selection of text which were used as exemplars during the write-up of the study findings.

3.9 Conclusion

Kaupapa Māori research is the methodology that underpins the *Kia Mau, Kia Ū* study. This chapter explored my own understanding of Kaupapa Māori and the ways in which Kaupapa Māori has been understood and applied within the research context. It also explained the need to align the *Kia Mau, Kia Ū* study with the principles of Mana Wāhine theory. This chapter described how this theoretical framework informed the conduct of the research and the overall study design. Importantly, the indigenous research approach ensured that the research participants were the kakano from which all decisions about 'the how's and the whys' of the research grew.

Chapter Four: Findings

4.1 Introduction

This chapter will summarise the main findings from the one-on-one interviews conducted with wāhine Māori and whānau Māori participants. I will begin with a description of the characteristics of the research participants, followed by detailed exploration of the themes that were identified during the thematic analysis of the interviews.

4.2 The Participants – Wāhine Māori

Table 5 presents the characteristics of the eleven wāhine Māori who were interviewed for this project. At the time of the interviews, the majority of the women lived in New Plymouth, the remaining women were based in Waitara, Bell Block, the Rahotu area, and Hawera. The age range of the participants was 18 to 38 years at the time of the interview. Five participants were under 30 years of age (the "under-30's") and the remaining six were 30 years or over (the "over 30's"). Six of the wāhine interviewed were first time mothers, three wāhine had two children and the remaining two wāhine had four children each. Two wāhine were solo parents, five were in de-facto relationships and four were married. Education and employment status varied across this group of wāhine. All but one participant had completed some form of tertiary study. Most wāhine had completed a certificate at a Polytechnic or similar institute. One participant had an undergraduate degree from a University. Six of the wāhine were full-time mothers at the time of the interview. Three wāhine had returned to paid employment.

The wāhine came from diverse backgrounds and had varied experiences in their breastfeeding journeys. Seven wāhine were still breastfeeding an infant at the time of the interview. All participants had breastfed their youngest child who was also their most recently child that was breastfed. All wāhine participants who had more than one child had breastfed their previous children.

All but one participant had whakapapa links to one or more of the eight Taranaki iwi. Most of the wāhine had strong cultural connections to their hapū and/or iwi, or were involved in cultural activities and/or engaged in kaupapa Māori services in their community.

Table 5: *Characteristics of the wāhine Māori participants in the* Kia Mau, Kia Ū *study*

Wāhine	**Age**	**Marital Status**	**Employment**	**Highest Level Education Achieved**	**Parity**	**Birth**	**Breastfeed at time of interview**	**Age of youngest child at time of interview**	**Age of youngest infant when ceased feeding**
WM01	>30	Married	Project Coordinator	Undergrad Diploma	1	Spontaneous labour Vaginal delivery	Yes	19 months	
WM02	<30	Solo parent	Fulltime Mum	Level 4 Certificate	1	Induced labour Vaginal delivery	No	12 months	Three months
WM03	>30	Defacto	Kaiawhina	Level 4 Certificate	4	Induced labour Vaginal delivery	No	Two years	18 months
WM04	<30	Solo parent	Fulltime Mum	Level 4 Certificate	1	Spontaneous labour Vaginal delivery	Yes	8 months	
WM05	>30	Married	Fulltime Mum	Undergrad Diploma	4	Spontaneous labour Vaginal delivery	No	Two years	Two years
WM06	>30	Married	Support Worker	Level 4 Certificate	1	Elective caesarean	Yes	15 months	
WM07	>30	Married	Project Coordinator	Undergrad Diploma	2	Spontaneous labour Emergency caesarean	Yes	11 months	
WM08	<30	Defacto	Fulltime Mum	Undergrad Diploma	2	Spontaneous labour Vaginal delivery	Yes	Five months	
WM09	<30	Defacto	Fulltime Mum	NCEA Level 2	1	Induced labour Emergency caesarean	No	10 months	Three weeks
WM10	<30	Defacto	Fulltime Mum	Level 5 Certificate	2	Spontaneous labour Vaginal delivery	Yes	12 months	
WM11	>30	Defacto	Fulltime Mum	Undergrad Degree	1	Emergency caesarean	Yes	Six months	

Additionally, the birth experiences for the wāhine were varied. Six women experienced spontaneous deliveries and three were induced. While most delivered "naturally", three wāhine had emergency caesareans and one had an elective caesarean. One wāhine was transferred to Waikato Hospital due to the complications she experienced during pregnancy and was delivered by emergency caesarean there. This baby was delivered pre-term at 29 weeks and six days gestation. All but one wāhine birthed full-term, and a total of nine participants birthed at the Taranaki Base Hospital. Only one wāhine had a home birth.

4.3 Ngā hua o ngā kōrero – Wāhine Māori

4.3.1 Theme 1: Filling the Kete

Accessing relevant information and understanding the types of support that are available for parents-to-be and parents of newborn infants is important. With knowledge and understanding comes an opportunity for growth and development. Furthermore, by knowing and understanding the breastfeeding process and the support services that are available to breastfeeding mothers and their whānau, the ability to advocate evolves.

Our creation stories talk about the atua Tāne-Mahuta (Tāne) filling his kete in his quest for knowledge. Tāne ascended from earth to the heavens and obtained the three kete of knowledge. When he returned to earth with the knowledge, he created humankind from the earth. Within this story is a wero to us, the descendants of Tāne, that in order to live an ideal life we must strive for knowledge, education and enlightenment[16].

The theme *Filling the Kete* in the context of *Kia Mau, Kia Ū,* is about wāhine Māori and their whānau having access to high quality and relevant information and resources to support the breastfeeding journey. It is important to note that Tāne collected three kete, te kete tūāuri - the kete of sacred knowledge, te kete tūātea – the kete of ancestral knowledge, and te kete aronui - the kete of observational knowledge, each containing different types of knowledge. Therefore, the importance of being able to access a range

[16] It is my understanding that for Taranaki iwi Tāne is the atua who obtained the kete of knowledge. I acknowledge that this kōrero can differ for other iwi.

of knowledge, not just Western medicalised knowledge, is highlighted as a key aspect of this theme.

Many of the women who participated in the *Kia Mau, Kia Ū* study had limited access to breastfeeding information from health professionals during the antenatal period. Limited access has several inferences - the amount of information that is provided; the context in which the information is provided; who it was provided by; and where it was provided. A number of women found that breastfeeding was not being talked about by any health providers during their pregnancy:

> "I didn't get any pamphlets from a professional because I don't ever remember conversations bringing up [sic] on how I was feeding my kids." (WM03)

Of those who discussed breastfeeding with their health care providers, many received only a minimal amount of breastfeeding information, for example being directed to a website or just being told it was best:

> "I think the only information I received was a website." (WM10)

> "She [midwife] just told me it [breastfeeding] was the best thing." (WM10)

Women who had more than one child often felt there were some assumptions made about them and their breastfeeding knowledge, and as a result they weren't given adequate information:

> "I did get some information from my midwife, but I did find sometimes because of my circumstances, and my history, a lot of the time they just presume." (WM07)

Many of the first time mothers relied heavily on female whānau members or friends who had experiences of breastfeeding as their key source of information during their pregnancy.

> *"So just thinking back to when you were pregnant do you think you received enough information about breastfeeding"?*[17]
> "If I wasn't, like if it wasn't in the situation I was with my mum, then no." (WM02)

> "From like the midwife? Yeah but not really, only because well, my sister and my mum was all the information I needed from them." (WM08)

Access to antenatal education programmes also appeared to be limited. Only four of the 11 wāhine participants attended an antenatal/childbirth education programme. There were some issues raised about the suitability of antenatal education programmes. For example, many of the wāhine stated that they would have preferred a Māori provider and/or a wānanga-style programme delivered in a marae environment as they felt that it would enable a more inviting, inclusive and participatory experience:

> "I find the environments not very relaxing in antenatal and things like that; they're always like boardroom…you're with a whole bunch of people that you don't even know at all." (WM07)

Additionally, the participants often felt uncomfortable in these programmes and that their experiences and knowledge were not validated within the formal antenatal education environment:

> "Like the practitioner, I don't know if that's the best approach. Sometimes they [health professionals], I don't know, you feel really forced when you're talked to like that." (WM10)

[17] Quotes in *italics* font represent my voice as the interviewer.

Of those who did attend an antenatal/childbirth education programme, there was mixed feedback about their quality and usefulness in terms of breastfeeding information. For example, there were reports that the breastfeeding content within these programmes was minimal:

> "We had an antenatal class at [Provider] and I just thought it was sub-standard and I didn't think it was worth it actually…. I don't think it was informative enough. I mean, a pamphlet's just not going to cut it." (WM01)

In contrast, another participant felt that she learned a lot about breastfeeding from her antenatal class, and that it prepared her well for the breastfeeding journey:

> "I did get a DVD with the antenatal classes. Those classes are really good for breastfeeding, and they really helped me a lot." (WM09)

Despite these mixed feelings, the wāhine generally agreed that learning about breastfeeding during the antenatal period was important:

> "I do encourage that they [health professionals] do [give breastfeeding information]. It doesn't matter how many children you have, you never know, and we should be encouraging it, and because we look at them as, they're supposed to be looking after us, and giving us every information that is useful for us to feed on to our babies as well." (WM03)

The participants felt that high quality information delivered in a manageable, accessible and non-threatening way during pregnancy would better prepare women for breastfeeding and would support breastfeeding duration:

> "I reckon if you have the right information and do the right things to prepare yourself for breastfeeding, it will work." (WM08)

> "I think if first time mums got the information of like what to expect from breastfeeding, like their baby as well to check for signs, I reckon if they got all that information they show you after you have your baby, before they have a baby, will make a difference." (WM03)

The participants identified some key points that should be shared with women during pregnancy as part of their preparation for breastfeeding:

(1) Breastfeeding positions:

> "Just the different ways you can have the baby. You can lay down; you could put them sideways. If you had twins they got to go opposite ways." (WM01)

(2) Managing tandem feeding and breastfeeding whilst caring for older children:

> "What if you got two kids and one's still on the breast and the other one's just arrived? All the issues that come up with stuff like that." (WM01)

(3) Exploring the full range of benefits for the infant and the mother:

> "Yeah and how important it is for our babies to have the breast milk, not just to breastfeed them but the interaction that they have as mother and baby." (WM03)

It was important for women to hear about the challenges associated with breastfeeding, such as the increased demand to feed during a growth spurt, the early signs of breast infections and breast care. However, some of the women felt that these issues were poorly addressed during the antenatal period:

> *"And you said earlier signs about when things go wrong, what to look out for?"*
>
> "Yeah what to look out for would definitely be one thing I really want to learn about. Obviously I just didn't know why I had a huge fever, I just started getting cold and then just the redness and stuff. I was going fine so I didn't know…." (WM09)

> "…see if I had have known that, you know, it [mastitis] wasn't bad for her or something like that I probably would have kept going." (WM02)

Similarly, several of the wāhine felt that more information about the 'reality' of breastfeeding was needed to ensure that women were fully-informed and prepared for these challenges. Understanding breastfeeding to be a learned activity could alleviate some of the anxiety that may be experienced by women when breastfeeding challenges arise:

> "Yeah, I just didn't hear enough stories about how hard it can actually be to get established and stuff…. I tell people my experience of it just so they go, it's not doves flying and the baby just latches on and does its thing. It's like, oh my God - it can actually be really hard and stuff like that." (WM06)

> "I don't think they tell the real story, that's a big issue. They say it's good for baby, the cost and all these benefits, but they don't tell you OK in this first you know, you're going to question yourself, it is going to be hard, you are going to be sore, your baby is going to cry, I don't think they give you the real picture. If you know that, that this is the way it's going to be, you won't be as desperate to think you're doing it all wrong, because this is very common." (WM07)

Physical preparation of the breasts was also highlighted as an important topic to cover. While methods such as scrubbing the nipple are generally not recommended by health practitioners today, the practice of gentle handling of one's breasts during pregnancy has become a common discourse for breastfeeding and lactation specialists (La Leche League, 2010; West & Marasco, 2009). Despite the potential benefits (i.e. preparation for milk expression by hand and developing a sense of comfort with that part of a woman's body) (La Leche League, 2010; West & Marasco, 2009), it appeared that the participants relied on the knowledge of their whānau rather than their antenatal educators to learn how to prepare themselves for breastfeeding:

> "…if my mum never told me to scrub my nipples, I don't think I could have done it. She made me scrub them with a dry flannel, scrub and squeeze them she said.

> I did that for about 3 months. I think if I had done it longer it would have been sweet as... Scrub your nipples, preparing before baby gets here, preparing the nipples and I reckon if they can." (WM08)

The participants felt that there was a need to address the concerns many women have around their baby getting enough milk and worries around breast-milk supply:

> "…you know when your baby is full, when they latch off and they finish. Questions like - are they having enough? are they having too much? - just all the little things really. That was the one thing that was worrying me when he first started feeding, was if he was getting enough…" (WM09)

> "You have to do it [breastfeeding] all the time. All that sort of stuff that to get your supply going is to get the baby on there, even if he's just lying asleep beside your breast sniffling you, being skin on skin. I think all that's really important for people to know." (WM06)

Although the participants wanted to know more about breastfeeding, they recognised that appropriate breastfeeding education and information during the antenatal period requires a careful balance of the challenges and benefits for the mother and child. One participant felt she heard too many horror stories during her pregnancy. From her perspective, normal and/or positive breastfeeding experiences weren't discussed, and despite her successful breastfeeding journey, her early breastfeeding days were marked with self-doubt:

> "I've heard the extreme and knowing that that could be something that can happen to you... I suppose the good stories you don't hear cos it's just normal, people just get on with life." (WM01)

It was suggested that one way to achieve a balanced presentation of breastfeeding information would be to highlight the fact that everyone's breastfeeding experience is different and that experiencing challenges is normal:

> "Not wanting to scare them but to let them know that it's not the most natural thing in the world…for people to click on to. It actually takes a bit of time and that." (WM06)

In addition to their suggestions around how to improve the content of breastfeeding education programmes, the wāhine Māori participants also provided some useful ideas that could improve access to breastfeeding information, particularly for younger women. For example, the participants articulated a desire to see breastfeeding education programmes shift away from formal classroom environments and narrow views of the breastfeeding experience, and instead take a broader approach that includes the use of different communication mediums and innovative methods for promoting the importance of breastfeeding across the Māori community:

> "I don't know if like an ad campaign on TV's going to do it or I think it's a range of different things aye... And just like how can we, it's like what perk can you give a young mum? To feed their baby, you know like is there a prize, or is there a, you know, like the prize is that the child is healthy. Like and so how can we prove that? You know prove that it works because we know that it works. So how can we, you know, give some really good facts, clear funky facts whether it's through an ad on radio, or I don't know like a thing you know to prove you've breastfed for 12 months, I don't know." (WM10)

Breastfeeding peer counselling/education or mother-to-mother breastfeeding support opportunities were also suggested as appropriate methods to promote and increase breastfeeding knowledge in the antenatal period:

> "I think like other mummies, you know like mummy groups and you know sharing stories on a real casual…you know supportive, whānau, coffee clubs, you know those sorts of things." (WM10)

The cultural significance of breastfeeding and the connection to one's ancestors was highlighted as an important consideration for breastfeeding promotion amongst Māori:

> "That is something, it's also I think the connection of being Māori and [breast]feeding. I don't speak the language, but there's certain aspects that I consider traditional Māori values, I'm talking about further back, that I can contribute [sic] almost to that., There's certain things that I did with my pregnancy that my nan told me, and whether I knew why or whatever, it's just that's what I did." (WM07).

Despite its importance, many participants spoke of a void within our people around our own cultural breastfeeding knowledge, such that it has become silent in conversations related to Māori mothering and parenting. As one participant noted, the loss of cultural breastfeeding knowledge is possibly implicated in low breastfeeding rates and early breastfeeding cessation amongst Māori:

> "I think that's something else that's missing is like the historical, you know like what did our people do? You know did our people formula feed their babies? … I don't think they did but you know that next generation they did and so what happened? There was something that happened there aye and that's continuing. We're missing some information or someone's not passing on the benefits." (WM10)

The idea of Kaupapa Māori antenatal breastfeeding education delivered in the form of wānanga was supported by participants. Wāhine expressed a desire to learn about our own breastfeeding cultural practices and understandings, as well as Western/Medical knowledge. Additionally, delivering the messages in a more active and participatory way with the inclusion of peer educators was also endorsed:

> "…maybe they [antenatal education providers] need to do a session on mirimiri for breastfeeding…" (WM07)

4.3.2 Theme 2: Health Service Support

Health providers, particularly the maternity healthcare workforce, have an important role to play in supporting women to initiate and sustain their breastfeeding journey (World

Health Organization & UNICEF, 1998, 2003). The Taranaki DHB is accredited with the Baby Friendly Hospital Initiative (World Health Organisation & UNICEF, 1991) and within this programme best practice for supporting breastfeeding is represented by *The Ten Steps to Successful Breastfeeding* (*The Ten Steps),* which were first published in *Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services* (World Health Organization & UNICEF, 1998). Many of the participants reported experiencing breastfeeding good practice from health professionals (as outlined in The Ten Steps) immediately after birth. For example, skin to skin (where the newborn baby is naked and lies on the naked skin of the mother) and bringing baby to the breast immediately after birth was suggested to the women by their healthcare providers:

> "*So how long after birth did baby have his first feed?"*
>
> "Straight after. It was skin to skin and he was hunting for breast so…straight on." (WM04)
>
> "…then she (midwife) put him straight on me and tried to get him to feed. She was quite proactive about that." (WM06)

However, inconsistent messages and breastfeeding advice from health professionals, particularly while staying on the postnatal ward, was commonly reported by the wāhine Māori participants. This inconsistency was often confusing for the women and impacted on how confident they felt about their ability to breastfeed and their confidence in the health professionals:

> "…yeah but there was a lot of conflicting information…and depending on the nurse you got, was dependent on the information you got." (WM07)
>
> "And they give contradiction. One nurse comes and says this and the next nurse comes in and says that and they next thing you're like, Oh, this is so confusing." (WM06)

Even though all of the participants experienced breastfeeding challenges, only some of these women received adequate information and support from health professionals during these times. The wāhine participants highlighted that it was the Lead Maternity Carer (LMC) midwives in particular that were attentive and proactive in their approach to addressing breastfeeding issues:

> "She [midwife] was really good in the fact that she would identify that something was going wrong and then she'd come every couple of days or every day as needed…" (WM06)

The wāhine Māori participants recalled that at the first sign of any issue with breastfeeding on the ward, artificial infant formula was automatically referred to as the only option for the women and their babies:

> "…they [health professionals] always offered the formula aye. It was, you know it was always like you know you can…you can always give [formula], you know if it doesn't work, which was nice but I don't know I would just go you must breastfeed your child." (WM06)

One wāhine felt formula was offered too quickly, before other options to overcome breastfeeding issues had been fully explored:

> "I think it was the second day they used the "f" word. One of them [ward staff] said "oh, we'd better get some formula coz [sic] the baby's not feeding enough." (WM06)

Advice from health professionals to introduce artificial infant formula, referred to by two participants as 'topping-up', seemed to be commonplace. Poor weight gain was one reason given for the introduction of artificial infant milk. However, the impact of this advice was evident when some of the participants continued this 'topping-up' practice for social rather than medical reasons. For example, one participant felt that introducing artificial infant milk meant her infant seemed more settled and had longer sleep periods which she felt was advantageous.

> "…he got to five months I was comping [sic] him to top him up. Every time I topped him up he would sleep longer, he was a happier baby. So for me I felt good because he was better…and the only reason why I know that is because he slept longer..." (WM08)

This practice of 'topping-up' however impacted the breastfeeding relationship of this wāhine:

> "I was breastfeeding and giving him the formula. After that he didn't want my tit [breast] and that hurt; I cried because I felt I was losing that bond between me and him.…" (WM08)

The majority of the wāhine Māori participants appreciated the practical breastfeeding support they received from their LMC midwife and/or staff in the postnatal ward. They felt respected when they were treated carefully and with patience:

> "…it was one of the hospital midwives, she was awesome, she was such a big help…a lovely lady she was so awesome, she taught me how to hold him. But like I said he latched on straight away; it was really good." (WM09)

> "I had a good midwife that showed me, and I prefer to be taught and explained to than reading a pamphlet." (WM03)

Unfortunately, rough treatment from staff was a common experience. Some participants felt that hospital staff encroached on their personal space, touching their breasts in a rough manner, often without asking and using unnecessary force on the baby's head:

> "…the nurses started to encourage him by firmly pushing him on my breast. Some were a little bit more rough…yeah they did prefer to just shove him on." (WM11)

> "He wouldn't latch on and I was panicking, and he was panicking, he was quite angry and I was stressed, and having to go and express then feed him through a tube off my finger... the midwives in hospital were awful, they'd just grab his head and grab me, and go shove, shove, shove and I was stressing and he was stressing…" (WM05)

One participant felt that the hospital staff were under pressure to get breastfeeding established quickly and that this came across as being pushy and impatient:

> "They'd come in and grab your breast and maybe trying to do it and yet at the time you're like, Yeah, I need help cos I want my baby to be fed, rather than just going okay and just take that little step back and let you explore it. Because they grab your breast and they've got two of them [staff] there and they're doing all the stuff and you're, oh, okay… But like I was saying it was all contradictive of each other and it was quite invasive and it seemed quite rushed or panicked." (WM07)

The handling of a woman's breasts in such a manner can have unfortunate consequences (Weimers, Svensson, Dumas, Naver, & Whalberg, 2006). Being touched in such a forceful way made the wāhine participants feel uncomfortable and portrayed the staff as being uncompassionate. It was apparent that rough treatment disempowered the women, by taking a 'do it to/for her' approach rather than giving verbal guidance, encouragement and support. When the healthcare professional 'rushed', it left the participants feeling personally invaded and worried for their infant.

Inappropriate practices and confusing advice from postnatal hospital staff impeded the participants' efforts to breastfeed and had a lasting impact on their confidence and breastfeeding journey:

> "Really hard. Yeah, flat nipples. Wouldn't latch. It was really hard, yeah. Apparently they said he was tongue-tied... And his tongue didn't come down far enough. And we had syringes to get him stimulating his sucking. We had little tubes, feeding tubes to try and get him to go. We had breast pumps going. Flat

> nipple - apparently I've got flat nipples so they were like, "Oh, you better use a nipple shield," which, big person, little baby… big breasts already and then you've gotta try and manipulate this plastic thing was really, really hard. And then my milk come in and it just drowned him. Yeah, so it was really hard." (WM06)
>
> "I couldn't tell the difference between a good latch and a bad latch, I felt that quite difficult. I ended up crying for hours because I felt I couldn't feed him properly, wasn't latching on properly…" (WM08)

All of the women who had caesarean sections reported significant challenges in establishing and/or maintaining a breastfeeding relationship. One participant believed having a caesarean section and experiencing poor practice from healthcare staff, including being separated from her infant, was a major contributor to her decision to stop breastfeeding early at three weeks postpartum:

> "I just had baby, just had a c-section, we just got out, then I had to stay in for 2 weeks but I couldn't have him. Even worse my boobs were so bad I couldn't really hold him, so I had to have somebody there because I couldn't look after him by myself, it was pretty dumb… So at the end of it they asked me, sorry a week into it they asked me if I still wanted to give it a go, after the mastitis had left and by then I was just really put off, and I just wanted the milk to stop…" (WM09)

In contrast, another participant used the challenges associated with her caesarean birth as motivation to succeed with breastfeeding. Her feelings of failure surrounding her birth experience made her determined to breastfeed:

> "Maybe it's perception of others, there's a lot of things I thought with the whole delivery of baby, I thought I failed, so it was almost like I'm not going to fail in this [breastfeeding] as well, I'm going to get something right with him." (WM07)

Two wāhine gave up breastfeeding before their infant was six months old. A lack of information and adequate support, in addition to unsupportive practices within the

hospital and community healthcare settings, were contributors to the cessation of breastfeeding before the Ministry of Health recommendation:

> *"So you talked about earlier that you had mastitis and that was the reason why you gave up? How old was baby when that happened?"*
> "She was just going on three and a half months yeah. And then that's when I stopped."
> *"So did you talk to anyone about that, any health professionals about that?"*
> "Just my mum. And then we went into the Plunket. Told her. And then yeah she just sort of said oh it's called something mastitis yeah. It's up to you whether to, you know what you want to do sort of thing. Just went to the doctors, got a prescription for [it]."
> *"Antibiotics?"*
> "Yeah, and after that I just pretty much stopped… And even when we went to the doctors, didn't really, it seemed like they didn't give us much information about it [mastitis] either. Yeah, so it was just oh you know take these antibiotics and see how you go." (WM02)

> "I went into A&E on the first night that I got out, they sent me home with pills. Then the second night I was home we had to go in again because it was just too painful. I couldn't feed at all; sorry one side it wasn't as painful as the other so I could do it off one side, but the other one was filling up so I couldn't just do one side. Anyway I went back to A&E and they didn't really know what to do, so they sent me to lay ward and they basically told me I have to stay in there. So I stayed in the labour ward…for about two weeks. I had to stay in for two weeks because it was just ridiculous. I felt like a freak show because every morning there'd be more doctors… Thing that sucked about that was that I couldn't have son to stay with me [in the same room]." (WM09)

The cultural competency of maternity healthcare staff was viewed as an important attribute by the wāhine participants. One of the wāhine participants had a Māori midwife and also had Māori ward staff attend to her after her caesarean birth. She felt this made

her recovery from surgery more positive and highlighted that the conscious planning of staff and patient compatibility was needed:

> "I know now just because I know the staff, it is [Māori nurse], I would be putting her with the young Māori mums. I would be looking at it, who's in and actually delegating some of the staff, knowing that you know she'll make a connection with them straight away, because she is younger, knowing she's Māori. I actually think they will take in more information coming from the likes of her." (WM07)

Many of the wāhine participants felt specialist breastfeeding clinicians and educators (i.e. Lactation Consultants or La Leche League members) needed to be more readily available to women with newborns. Although only a small number of wāhine accessed this type of breastfeeding support, they all found it useful:

> "I think some people don't have the confidence, and they want a little bit, maybe even how your midwife comes round regularly or whoever came round regularly after the baby is born, if there was someone specific to breastfeeding to come regularly after they are born. Even like I think back to [first child], if the La Leche League people hadn't supported me, I would have given up and I don't know if I would have breastfed the next three." (WM05)

Interestingly a number of the 'under 30' mothers did not know that Lactation Consultants were available or that such a professional existed. One of the 'under 30' mothers who stopped breastfeeding early felt access to this type of service might have made a difference to her breastfeeding duration:

> *"What about access to specialised, like people who are specialised in breastfeeding, like a lactation consultant?"*
>
> "Oh well, it would have been nice to even know about them. Yeah, yeah cause I probably would have, if you know if I was able to I probably would have gone to

> see them instead of [WellChild provider] ... Yeah it would have been nice to actually know about them [lactation consultant].” (WM02)

One of the ‘over 30’ mothers felt that the ability to navigate the health system and self-advocate were important skills for enhancing the breastfeeding experience. Interestingly, she noted that these skills were not shared with her by the health professionals involved in her care, but instead picked up from prior experiences with the health system:

> “I said be quite specific about what it is you want… Because the thing we’ve learnt about the health system is you don’t get if you don’t ask, if you don’t make requests and you don’t make a stink about it, and if you don’t request it you won’t get it…” (WH01)

4.3.3 Theme 3: Whānau Support

In the context of the *Kia Mau, Kia Ū* study, whānau are those people who are close to the mother and support her in her breastfeeding journey. Whānau are inclusive of people who are connected to the bloodlines of the infant, for example, the father, the grandparents, aunties and uncles. Friends are also considered whānau and in some contexts health professionals are too.

In general, whānau provide a significant amount of practical (e.g. assisting with household chores) and emotional support to the breastfeeding woman. Some whānau members were intensely involved in supporting the wāhine participants to breastfeed:

> “…We had the supply drop go so she [mother] did the whole two hours, wake up [wāhine], come on, it’s time to feed, and of course you’d just finished doing the whole change, feed, change feed, and the two hours had passed again. So she was up basically with me for the whole 24-48 hours getting the supply of breast up, drinking the brewer’s yeast, breastfeeding cookies.” (WM06)

While emotional and practical support were important, in some instances whānau imparted important breastfeeding knowledge and were seen as a more relevant and accessible source of information than health professionals:

> "Yeah cause my mum she, well my little sister's five months older than my baby. So living with my mum at the time you saw everything." (WM02)

> "I had my older sister - she's just not long had her first baby, and she breastfed and so probably through my sister breastfeeding [child], would have been where I got most of my education. She fed [child], didn't eat anything else right for the first year, my sister just breastfed her anywhere and everywhere, and so she was probably the best ambassador in our family for breastfeeding." (WM05).

Given the role whānau play in supporting breastfeeding women, the participants deemed it important for whānau to have access to high quality and reliable breastfeeding information also:

> "…if they [whānau] had the information about women what they have to go through for breastfeeding, so they have more of an understanding and accept it, some people don't accept breastfeeding and I find that sad." (WM08)

Many women felt a lot of the information was targeted to women, whereas breastfeeding information for fathers was unsatisfactory:

> "If it was more suitable for a male; he doesn't need to know some of the stuff that I needed to know, but there's some information…this is how your involvement is. You see it on the ads sort of, but it's only an ad and it's not for very long. So what does that mean; they say 'breast is best' but how does the father help the mother when she's at home?" (WM07)

Some women felt whānau needed assistance with understanding the significance of breastfeeding and that their roles as support people needed to be given some status.

Highlighting the important role of whānau in the breastfeeding relationship and how partners and whānau can support breastfeeding mothers was recommended:

> "I think too that if the family could be educated that what you're doing, it's not about you, it's for your baby… You need someone else to come in and say to them, this is what it's actually like for them [the mother]." (WM05)

> "I think whānau support and people around you are very important. You need encouragement because at times it really did hurt; a bit more information on why it's good yeah." (WM09)

Maintaining breastfeeding came with challenges, and many of the wāhine participants felt that if it wasn't for their whānau and their support they would have given up breastfeeding:

> *"Overall, what are the major factors that you think have meant you've continued to breastfeed?"*
> "Mummy and my sister-in-law, she was amazing, and just my family. And my husband; he was incredible cos like I said he had no knowledge of breastfeeding. He's [son] completely bottle fed…he [husband] was amazing cos he was just like, 'No, this is what you want to do and this is what you think is best'. Yeah it was the people around were just amazing." (WM06)

Pleasing respected whānau members was also an important motivator for many of the wāhine participants. In some instances, however, this added pressure to women who were already struggling with breastfeeding:

> "One of the things I do like is…the sign of approval that I get from my nan; she's actually quite proud of it." (WM05)

> "I could never look at my mother in the eye and say I gave him formula [be]cause the look of…that look of disappointment." (WM06)

Although many wāhine participants highlighted the support they received from whānau as being fundamental to their breastfeeding journey, some wāhine felt pressure from whānau to feed their infants artificial infant formula.

> "…it was me that wanted to stick [to breastfeeding], everyone was saying you should just put him on formula…." (WM08)

Negatives attitudes to extended breastfeeding[18] from some whānau members were also experienced by some of the wāhine participants however:

> "But even so, like I remember some of [partner's] family like we'd rock up and [baby] was like six months and they were like are you *STILL* breastfeeding?" (WM10)

Overall there was a strong call for whānau members to be included in breastfeeding education. Providing whānau with breastfeeding information in both the antenatal and post-partum periods was recommended so that they were adequately prepared and resourced to support the mother and infant dyad:

> "…it will be good if there was support out there for a whole whānau or friends and sisters, or whoever's gonna be round you at the time and you could all go together and learn…" (WM01)

> "Whānau is our key, whānau is what keeps us all together, to hear that Māori women aren't doing it [breastfeeding]…so to hear that it's dropping in our Māori population, it's quite sad. Whānau is the key to quite a bit of our problems; if we have a strong unit in our families, then it will be successful." (WM03)

It was acknowledged by the wāhine participants that to successfully breastfeed, practical assistance and emotional support from those within their wider social circles, was

[18] Extended breastfeeding refers to feeding infants into toddlerhood, i.e. over two years old. Wahine participants highlighted that some whānau held strong beliefs, despite well founded health recommendations, on the length of time an infant should be breastfeed for.

imperative. Therefore, access to support people in the community was highlighted as important, particularly for those who do not have a partner or whānau available:

> "I don't think you can breastfeed without the support of someone else." (WM06)

4.3.4 Theme 4: Hapori - Supportive Communities

The importance of the community setting within the breastfeeding context was highlighted by the wāhine participants. The need for communities to support breastfeeding through greater understanding and acceptance s strongly emphasised. However, to be a supportive community requires political commitment. Communities need to be supported by legislation, policies and access to resources. By prioritising breastfeeding, the Government can influence policies and legislation and ultimately will support the development of a healthy breastfeeding culture within our society.

Paid parental leave, supportive workplaces and breastfeeding in public spaces were the three key points raised in relation to breastfeeding in the community setting. Paid parental leave is a government-funded entitlement that is paid to eligible working mothers and adoptive parents when they take parental leave from their job(s) to care for their newborn infant or adopted child under the age of six. Paid parental leave was identified by four of the wāhine participants as an important system that supported a successful breastfeeding relationship.

> "*Did you have paid maternity leave?"*
> "I did."
> *"Did that help?"*
> "Yep, that was really good cos you didn't have to worry about that - and I had also accumulated annual leave. So I had the whole five months paid off basically". (WM07)

Paid parental leave lifted some of the financial burden faced by young families. Additionally, having the ability to return to the workforce by having their roles protected through legislation alleviated some of the stress and pressure felt by these wāhine:

> "…mothers can apply for up to 24 months maternity leave, and still have a job afterwards, so having that two year scope is really for us it was really important, that's the first two years of our sons life that I could be with him, so that's what we took, we've taken it to the start of 2015 which was going to be about 18 months because we were early, so turns out to be two years….They have a maternity grant which is six week's salary, so that financial assistance really helped, and when we talked about resources that's one of the resources that we are fortunate to have, so that we can afford to live off one income…." (WM11)

Paid maternity leave and financial incentives were important for women to be able to commit to caring for their infant long term. These strategies provided space and time for the women to focus on breastfeeding and care-giving instead of worrying about money and the need to return to paid employment. The longer women can take off work the greater their chance of breastfeeding up to and beyond the recommendation:

> "…there should be an incentive for the women to stay at home such as the grants they get for day care for the women who do stay at home. So a kind of grant like that, cos they give the money to the day care. Some people don't believe in day care and want the money to be transferred, which might take the load off a little, that they don't have to go back [to work] as much as what they might need to." (WM06)

At the time of the interviews, three participants had returned to paid employment. They were successful in their desire to maintain breastfeeding because of a range of supportive practices offered by their workplaces, including provision of a suitable and private space for expressing milk, having the ability to store the expressed milk at work, being able to have their infant brought into their workplace to be breastfed, or being able to leave the workplace to breastfeed.

> "My manager is amazing, and really supportive… I just used to come home all the time (to feed) and then I'd come home and be like, oh, I'm not going back to the

office cos I just want to be home, and they were completely sweet, and they still are." (WM06)

"It was the support of my work environment….to be quite honest if (manager) wasn't my manager, I really don't think I would have got the support or encouragement like she has been with me." (WM07)

"It was quite interesting cause I was the first mum to…go through a pregnancy, have maternity leave and come back to work. My job is one of the definitely the easiest to just say what you need to have and they're just like, yip" (WM01)

Having a supportive work environment was seen as key to supporting extended breastfeeding:

"I guess the work environment is big, because most people go back to work now, I think even the tertiary and school environment. I'm a policy person so I actually think people, health professionals who work in it that they really should be trying to get those types of policies down with those. It's all good to hold an event but is that long lasting, how much of a difference is that going to make? But if they work to put those things in those places, you're making it easy for the mother." (WM07)

The issue of breastfeeding in public spaces was highlighted as a concern for a number of the 'under-30' participants. In particular, identifying public spaces where breastfeeding is welcomed and increasing knowledge about a woman's legal right to breastfeed in public spaces was recommended:

"…we have obviously stickers that identify places that are pro-breastfeeding. I think that's really cool cos obviously you don't want to go to a place that doesn't support it and have customers look at you and go, err, what's she doing?" (WM01)

"Basically the law on breastfeeding because when you go out in public so many people are kind of telling you can't do that there." (WM04)

4.3.5 Theme 5: Role-modelling Breastfeeding

All of the wāhine participants said that their intention, before birth, was to breastfeed:

> "When we first got hapū, but even before that, I had for some reason just instinctively knew that I wanted to breastfeed" (WM11)

For many of the participants, this intention to breastfeed was influenced by breastfeeding role models within their whānau. The importance of the tuakana and teina roles in the breastfeeding context was presented as a key consideration when wāhine made decisions around breastfeeding in the antenatal period. The tuakana/teina relationship is a fundamental part of traditional Māori society, providing a model for peer education and support. Generally, this system involves an older or more expert tuakana, an olderbrother, sister or cousin, helping and guiding a younger or less expert teina,a younger sibling or cousin of the same gender, in a particular task:

> "…cause my own mother is pro breastfeeding and obviously influence my own sister and obviously, I mean, I got pregnant, everyone was getting excited and you always talk about it (breastfeeding)." (WM01)

> "I was trying to think back, how come back then because I was only 17 when I had her, why I actually did breastfeed, and I think it came down to, just before she was born I had a couple of cousins who had had babies, and they were feeding." (WM07)

Having an older female whānau member, a breastfeeding tuakana, who had successfully breastfed appeared to have a significant influence on a woman's decision to breastfeed:

> "All of my whānau, because most of them have breastfed, it was only my mum that really didn't, that she didn't really breastfeed but everyone else did." (MW09)

Despite all participants stating their intentions to breastfeed while they were pregnant, there was a marked difference in responses from those women who were 'over-30' compared to those who were 'under-30'. The over-30's were clear that breastfeeding was the only infant feeding option and it seemed that their resolve was strengthened through their access to a breastfeeding tuakana:

> "…I grew up with it so I just knew I wanted to do it. There wasn't any other option for me." (WM06)

> "…my nan calls him a gift, so I am going to do everything and anything possible to make sure he has the best start in life, and I had that in my mindset and breastfeeding is (the best start in life)." (WM07)

In comparison, the under-30's tended to say they would breastfeed if they could, but felt formula feeding was a suitable option if breastfeeding didn't go well. For the women in this age-group, it was commonly reported that the older females in their whānau had difficulties breastfeeding and/or used artificial infant formula:

> "…when I found out I was pregnant I wanted to breastfeed if I could, [but] I wasn't sure cause my mother had problems breastfeeding. So I wanted to, but if not there was bottle" (WM04)

This age difference suggests that peer-support is particularly important for supporting the breastfeeding practices of younger women.

Breastfeeding tuakana, and role-modelling breastfeeding behaviours and practices, were seen as imperative to "normalising" it within society:

> "Seeing people doing it."
> *"Yeah, role modelling?"*
> "Yeah. I've had friends' little kids come over and they'll be like, oh, or we go out to….my nana runs a kohanga in Inglewood and a little girl goes, "What are

you doing?" and just explaining to them. And that it's just nature - horses feed theirs, cows feed theirs." (WM06)

"If you see other women breastfeeding, if you see that, well if I see it I'm going to keep doing it. If I don't see it, I think I'd stop I suppose; it's like a trend - if you start a trend people will just follow it." (WM08)

The majority of the wāhine Māori participants felt they were now in a positive position to offer breastfeeding support and advice to other women in their whānau and broader community, and could be considered breastfeeding tuakana:

"I think with my girl, I actually think that if I wasn't there to encourage her as much as I did, and her living at home with me, she would have stopped." (WM07)

"Yeah cos my friends were asking me for, you know."

"Information?"

"Yeah asking me about things too."

"So you in some respects have become a bit of a breastfeeding role model for your circle of friends?"

"Yeah, yeah. And most of them breastfed too…." (WM10)

Additionally, the women who experienced shorter breastfeeding relationships with their infants indicated that they would attempt breastfeeding again with any children they may have in the future. They felt their experiences had equipped them with important knowledge and some confidence to identify breastfeeding issues at an earlier stage. In a sense their experiences have now made them breastfeeding tuakana:

"…next time I want to have it naturally and try. I would really want to breastfeed; it sort of put me off at the start knowing that stuff can happen." (WM09)

4.4 The Whānau Māori Participants

Two individuals were interviewed for this part of the study. The male partner was the partner of one of the wāhine Māori participants I had interviewed. This was his third child; he has two older children from a previous relationship. His child discussed for this interview was born pre-term and spent some time in the Newborn Intensive Care Unit at Waikato Hospital as well as the Neonatal Unit at Taranaki Base Hospital. His child was six months old at the time of the interview. The male partner was employed, and was working as a shift worker, as this situation enabled him to spend time with his whānau. His whakapapa links were to the northern Taranaki iwi.

The female whānau member I interviewed was the older sister of one wāhine Māori participant and the step-mother to another. She was a mother and grandmother and at the time of the interview was employed as a Health Worker. Although she does not directly whakapapa to Taranaki iwi, she has lived most of her life in the region and is very involved in the Māori community.

Both the whānau members were in the over 30 years age range.

Table 6: *Characteristics of the whānau Māori participants in the* Kia Mau, Kia Ū *study*

Participant	**Age**	**Marital Status**	**Employment**	**Connection to breastfeeding mother**
WH01	>30	Married	Programme coordinator	Sister, step-mother
WH02	>30	Married	Casual shift-worker	Husband

4.5 Ngā hua o ngā kōrero – whānau Māori

4.5.1 Theme 1: The Breastfeeding Support Role

Although the nature of breastfeeding support can vary, within the context of whānau there were some very clear tasks associated with their breastfeeding support role. Whānau provide practical support, emotional support and when needed, they can act as advocates for the breastfeeding mother. The importance of whānau support for successful breastfeeding was clearly articulated in these interviews. Whānau support enabled women

to get on with what they needed to do to ensure breastfeeding was established and maintained with their infants:

> "My mother-in-law was probably the main one [source of support] for [baby], because she stepped up with the other kids, and so gave me that time. I wanted to stay in hospital because I wanted the time, I knew people had said to me be careful, you've got lots of other kids at home, that you don't go home and get carried away, and this little bubba will be pushed out." (WM05)

> "…if it wasn't for Kui coming over you know vacuuming or something or hanging out a bit of washing, then there'd be that much more stress on us." (WM02)

Practical support around the home was a key aspect of their role:

> "…if you're going to expect them to be the vessel every three hours for the first couple of weeks, they need a rest. Clean the house, drop some food off, do the washing… I was out there I'd say sleep and I'll watch the baby…" (WH01)

> "I try to put in as much as possible so if I'm awake first, I'll wake (baby) up and I'll pass him to her when she's ready to receive him, and I'll burp him so we start with one breast, when he's finished there we do the burping then the nappy…." (WH02)

Nonetheless, offering emotional support and in particular encouragement was a significant way in which they could support the wāhine and their breastfeeding journey:

> "I just said to her 'go with what your instinct tells you to do, because you actually fight your instinct, your instinct tells you to do something then things you read, books you read and things you get frustrated because you can't do what the book says'. I said to her 'bubby it will come; he'll be fine just try not to get so stressed about it'…." (WH01)

The whānau participants understood that effective breastfeeding support people needed to be non-judgemental rather than pushy. They saw giving reassurance as an important part of their role:

> "…the support I gave her was not to pressure her. I think you have so much pressure, you don't know whether to listen to your mum, your sister, your husband, your midwife, your aunty and your uncle. I think more than anything you just need to support them, not too much advice - just reassure them they're doing OK." (WH01)

While the wāhine Māori participants highlighted whānau support as integral to their breastfeeding journey, the whānau participants appeared to under-estimate and under-value their contribution as key supporters of a breastfeeding mother. The whānau participants considered health professionals to be more valuable to the breastfeeding mother:

> "…there wasn't too much to breastfeeding for me, in that simply the sooner we get on and feeding stronger, the sooner we can go home. I couldn't really participate too heavily in that. There was a process that the nurses had to train (partner) in; it was really up to her and (baby) to get that process down pat, so from my perspective I got everything I needed." (WH02)

4.5.2 Theme 2: Access to Information

Having access to breastfeeding information, delivered in appropriate and manageable ways throughout the perinatal period is imperative for whānau to adequately fulfil their breastfeeding support role. As for the wāhine Māori participants, the whānau Māori participants did not receive adequate breastfeeding information in the antenatal period:

> *"So when [partner] was hapū, did you get any information about breastfeeding? Did you, as a whānau member?"*
> "No, not from anybody but mind you [midwife] knows us; she talked to [partner] about all that sort of stuff..." (WH01)

"So when you guys were pregnant did you receive much information about breastfeeding?"

"No, most of it was post-birth from my perspective." (WH02)

Both of the whānau participants had attended one antenatal education session with their pregnant whānau members. While the male partner felt that the single session he attended was informative, the female whānau member was critical about the style of delivery and as a result she did not attend any further sessions:

"One, I attended one with her, she did it with [provider] when she first got home, they are so boring."

"The antenatal classes?"

"Yeah, so boring." (WH01)

Both whānau participants had some knowledge and understanding of the benefits of breastfeeding and they supported their family members' pre-birth intention to breastfeed:

"The marketing publicity on 'breast is best' is really good. We took that on board, we made a decision early in the piece about that." (WH02)

The whānau participants had picked-up on messages around the importance of breastfeeding from the national breastfeeding social marketing campaigns that ran from around 2008. Their ability to retain that information until such time as they had a hapū family member/partner suggests that breastfeeding promotion and public campaigns have long-lasting effects. Moreover, these strategies may be particularly important for those who are not catered for by standard antenatal education programmes.

The whānau members expressed a strong desire to have access to breastfeeding information and to have the ability to be more involved in planning for breastfeeding during the antenatal period:

> "I think it would be nice to have like a whānau hui to say if we want the best for this baby, we all need to help her out by x, y, z like spelling it out…Practical support, none of this read this and be an expert"
>
> *"I like the idea of a hui with the whānau as well."*
>
> "Yeah just even the practical, like, people don't know what questions to ask if they don't know what they're asking. If you've never been to a birth or if you've never done something, if nobody has shown you anything about something how would you know." (WH01)

For the antenatal period, the whānau members felt it was important that the wāhine had access to good information and that they were supported by engaging health professionals:

> "I just got all that information and took it to her. I said you've probably got these in your baby packs anyway, they were in the bounty packs, there's lots of information in the bounty packs. She Googled lots of stuff too… information was not a problem." (WH01)

> "I was present with a couple of lactation visits…the midwife I think gave more comforting advice on breastfeeding and expressing, and how [partner] was. I was never concerned about [baby]. I was more concerned about [partner], and whether she was in pain or was coping really, supply and demand and so forth, so the midwife was very good with that…" (WH02)

The whānau members identified a range of issues and concerns with the breastfeeding information they received. For example, the resources did not explain the breastfeeding process in sufficient breadth or depth:

> "It didn't seem like there was enough"
> *So he was cluster feeding, wanting to be on the boob all the time?*
> "And she wasn't sure of it all. I don't think any woman is." (WH01)

Similarly, the information did not adequately address challenges that might occur after breastfeeding is initiated. For example, understanding what might happen during a growth spurt:

> "…more information about the growth spurt. I didn't correlate growth spurt - I was expecting the baby to grow, [but] not necessarily matched that to increased feed. I never put the connection together so some information on that, when a growth spurt comes what will happen is he will want to feed a lot more, so don't be surprised." (WH02)

Or how to work through times of low milk supply:

> "…the domperidone[19] really solved that problem with the volume. Once that kicked in [she] were swimming in the stuff." (WH02)

There was a lack of information about latching and feeding positions:

> *"So how was that for you watching that process?"*
> "Watching him latch?"
> *"Watching the beginning, watching him start breastfeeding?"*
> "It was all very natural for me, natural progression and things. It was more…comforting for me to know he was more comfortable with the tube out of his nose, he was breathing properly and things." (WH02)

Having knowledge of the support services available in the community was also deemed useful in supporting the breastfeeding mother:

> "I remember being at work and she goes 'I can't do it'; she said 'come and help me' and I'm at work thinking this kid needs me, mum's not home, my baby sister needs me, I'm thinking how am I going to get out of work… I rang up one of the Kaiawhina, rang up and say 'are you out the coast?' she goes 'yeah'. I says; this

[19] Domperidone is a prescription drug that can enhance lactation.

might be a strange request', she goes 'what is it?'; I said 'my sister's just had a baby, there isn't any breastfeeding services to help her out there'. I said 'no one wants to travel out here, we had rung around', and I just asked her to go out." (WH01)

Overall this theme highlighted the importance of access to comprehensive information for whānau. The whānau participants need information that covers multiple breastfeeding topics including the physiological process of breastfeeding and issues that may arise, so that the women and their whānau can be prepared. Also emphasised was the importance of ensuring that both the education session and delivery mode is interesting and relevant for the whānau because this can set the scene for how well whānau engage with breastfeeding support.

4.5.3 Theme 3: Supporting the Supporters

This theme identified the range of factors that enabled the whānau participants to fulfil their support role. For example, flexible working arrangements (e.g. flexible hours, ability to work from home) were imperative as they enabled whānau members to be more involved in the care and support of the mother and newborn infants. Although parental leave for partners to take time off work after the baby is born is sometimes provided for within employment contracts, the whānau participants' workplace policies that allow for partners/whānau to accompany wāhine to their antenatal appointments was also critical to their advocacy role:

"I've been fortunate in that I've been working casually so I haven't had any fixed work commitments, which may be difficult for other fathers. That way I've been able to participate a lot more, and adjust my sleeping hours accordingly…." (WH02)

Having access to knowledgeable and caring health professionals was also important for the whānau participants. The clinical knowledge of health professionals was valued and

seen as providing support in an area where the whānau members felt they had knowledge gaps:

> "…she needed a professional to reassure her, but she would have breastfed anyway. But as far as technique goes it might have meant the difference between her carrying on, had she not had support she might not have wanted to… I saw her go to health professionals when mum wasn't around…." (WH01)

It was also suggested that health professionals could support whānau by knowing when to provide space for them by to be involved in the day to day care of both the mother and infant. This insight would also support whānau to be confident in their capabilities as key breastfeeding supporters and to see themselves and their role as important:

> "They were great on participation, and he was only three or four days old when he had his bath. I was able to participate in that as well…they were really good with paternal contact." (WH02)

The whānau participants also acknowledged the need for wider community support and acceptance of breastfeeding. The building of a breastfeeding culture in the community was acknowledged as challenging but integral to the enhancement of the breastfeeding support role. Whānau participants felt this could be achieved through local government policies, for example prioritising the establishment of suitable places to feed:

> "Seems more places for smokers to go to smoke than there are for mums to breastfeed, what's with that?" (WH02)

Supporting the supporters is about valuing the breastfeeding support role, and enabling whānau to care for Māori women who are responsible for nurturing the infant. Fostering a supportive environment in the whānau unit requires the acknowledgement and development of whānau capacities.

4.6 Conclusion

The findings of the *Kia Mau, Kia Ū* study highlight the desires of Māori women to breastfeed. Within the five themes (*Filling the Kete, Health Service Support, Whānau Support, Hapori – Supportive Communities* and *Role-modelling Breastfeeding*) we hear an urgent call for better access to high quality breastfeeding information, a compassionate and culturally-safe maternity healthcare workforce, active whānau involvement, greater acceptance of breastfeeding by the wider community and access to breastfeeding role models. While partners and whānau provide important emotional and practical support to breastfeeding women as highlighted by the theme *The Breastfeeding Support Role*, the significance of this role needs to be acknowledged and encouraged. The theme S*upporting the Supporters* highlights the need to build whānau capacity and capabilities whereas the theme A*ccess to Information* stresses the importance of breastfeeding support for whānau beginning in the antenatal period.

Chapter Five: Discussion

5.1 Introduction

Having a baby can be a life-changing event for the mother and her whānau. Establishing and maintaining breastfeeding can be challenging even for those women who have clear intentions to breastfeed and have dedicated breastfeeding support. For those who enter parenthood with limited or no access to breastfeeding resources and support, the journey towards a successful breastfeeding relationship can be filled with feelings of tremendous disappointment, shame and regret. Moreover, the international evidence suggests that the breakdown of the breastfeeding relationship can come at a significant cost to the physical and emotional health of the mother and her infant and a financial burden for the whānau and wider society.

The primary goal of this study was to develop a breastfeeding support framework for wāhine Māori living in Taranaki as a way of increasing breastfeeding initiation and maintenance for wāhine Māori and enhancing the breastfeeding relationship between Taranaki women and their pēpī. To achieve this, it was necessary to identify the barriers to and facilitators of successful breastfeeding as experienced by wāhine Māori and their main supporters - partners and whānau. The use of Kaupapa Māori and Mana Wāhine research methodologies ensured that the breastfeeding support framework prioritised Māori knowledge and understandings whilst at the same time privileging the rights of wāhine to determine their breastfeeding journey.

The first part of this chapter presents a discussion of the main study findings with reference to the original research questions and the existing literature. Part two of this chapter considers the implications of the study findings for whānau, health care providers and the wider community. This final section of this chapter uses the knowledge gained to develop a Kaupapa Māori breastfeeding support framework.

5.2 General Summary

What are the barriers to breastfeeding for wāhine Māori in Taranaki?

The interviews with wāhine Māori provided much needed insight into the breastfeeding realities for Māori women in Taranaki. The thematic analysis clearly demonstrated, that the Māori women interviewed aspired to breastfeed their infants, just as their tūpuna did. The participants described a range of barriers to accessing high quality breastfeeding education and resources, which in turn created gaps in their knowledge and understanding of the common issues that can occur throughout their breastfeeding journey. The wāhine Māori also identified inconsistencies in the breastfeeding information they received, for example being exposed to multiple techniques for latching the baby to the breast. The postnatal experience had a significant impact on overall breastfeeding success, with reports of rude or rough treatment by health professionals, and practices that were incongruent with their desire to breastfeed (e.g. offering artificial infant formula) were commonly reported. Finally, the wāhine Māori spoke of the challenges associated with breaking through social barriers, including peer/whānau pressure to cease breastfeeding and negative attitudes towards breastfeeding in public spaces, including workplaces. These findings echo prior evidence which suggests that Māori women desire to breastfeed, that whānau view it as important and that Māori women and their whānau face significant physical, cultural and social barriers to breastfeeding (Glover, 2007; Glover & Cunningham, 2011; Glover et al., 2008; Glover et al., 2007; Glover et al., 2009; Hayes-Edwards, 2014; Manaena-Biddle et al., 2007).

Many of the barriers to breastfeeding identified in the male partner/whānau member interviews were consistent with those described by the wāhine Māori. However, the thematic analysis uncovered some important barriers that are unique to those who provide support to breastfeeding women. For example, the partner/whānau members spoke of issues navigating the ‘maternity’ health system and a lack of clarity around the range and availability of breastfeeding support services. For support people, major barriers to successful breastfeeding occurred when they were unable to attend antenatal appointments or if the breastfeeding education programmes were delivered in a manner or style that made engaging with the information challenging.

What do Māori women in Taranaki need to support their breastfeeding journey?

Māori women in Taranaki need exposure to breastfeeding within both the whānau and community settings. Breastfeeding role-models are important for infant feeding decision-making, even before a woman is hapū. Māori women need access to breastfeeding information and support throughout the perinatal period. Access to compassionate and professional maternity healthcare staff postnatally is essential to support the establishment of breastfeeding. Like the Māori women who participated in the studies by Glover et al. (2008) and Hayes-Edwards (2014), thewāhine Māori in the present study highlighted the significant role of whānau in the support of their breastfeeding journey. Finally, changes to legislation and policy were considered integral to establishing supportive breastfeeding practices, particularly in the community setting.

What do whānau Māori in Taranaki need to provide support to Māori women to increase breastfeeding duration?

Whānau Māori need access to high quality breastfeeding information that is tailored towards them. Whānau Māori also require legislation and policy to recognise the importance of whānau so that they can fully engage in the care and support of hapū and breastfeeding Māori women. The maternity healthcare sector must acknowledge whānau capacity and capability and encourage and actively involve whānau in the care and support of Māori women. Whānau need to be supported to acquire knowledge and understanding of the maternity healthcare system and the resources that are available to them.

Table 7: *Barriers and facilitators to breastfeeding for Wāhine Māori and Whānau Māori in Taranaki*

	Barriers to Breastfeeding	**Facilitators of Breastfeeding**
Wāhine Māori	• Gaps in breastfeeding knowledge • Inconsistent breastfeeding information • Rude/rough behaviour from health professionals • Experience of poor practice (i.e. being separated from baby by hospital/being advised to "top-up" with formula) • Social pressure to bottle feed • Misunderstanding laws related to breastfeeding in public	• Breastfeeding role models within the whānau • Breastfeeding promotion within the community • Access to breastfeeding information in the antenatal period • Professional and/or culturally competent maternity healthcare staff • Experiencing breastfeeding best practice early postpartum • Supportive whānau • Paid parent leave • Supportive workplaces
Whānau Māori	• Gaps in breastfeeding knowledge • Gaps in knowledge of health care system and support services available • Inflexible work conditions • Limited access to breastfeeding information • Limited access to antenatal appointments and education	• Access to breastfeeding information • Flexible working arrangements • Respectful relationships with midwives and other hospital staff • Knowledge of the health care system and support services • Ability to advocate

5.3 Implications

The present study found that wāhine Māori aspire to breastfeed their infants. This finding is important because it extends existing research conducted in other areas of Aotearoa (Glover, 2007; Glover & Cunningham, 2011; Glover et al., 2008; Glover et al., 2007; Glover et al., 2009; Hayes-Edwards, 2014; Manaena-Biddle et al., 2007). However, current breastfeeding data indicates that Māori women are not achieving these aspirations.

Moreover, there is evidence of persistent ethnic inequities in breastfeeding rates between Māori and non-Māori. Although some might argue that differences in health status and health behaviours between ethnic groups reflect 'cultural' differences or preferences, the Kaupapa Māori and Mana Wāhine theoretical frameworks utilised in this study rejects any interpretation of breastfeeding inequities as the fault of the mother, or a uniquely "Māori problem". Instead, these frameworks demand that we view and consider the issues raised by the participants in this study within the context of colonisation and the marginalisation of Māori women within society.

The following section will present the key interventions that are necessary to support a successful breastfeeding relationship. As part of my commitment to the Kaupapa Māori position of my study, I have used whakataukī or Māori proverbs to align these interventions points with mātauranga Māori and to enhance their relevance to whānau, hapū and iwi. Metge and Jones (1995) note that the word 'whakataukī' is derived from *whakatau* which means 'to search or examine', 'to adorn' and 'to address in formal speech'. Whakataukī is often oversimplified as a 'saying' or 'proverb', which does not capture the broader significance of the term. I believe that whakataukī offer important lessons and directions that have come from our tūpuna and yet are still relevant today. Whakataukī are profound and insightful, and through the words contained within them we are exposed to a Māori way of thinking and being.

My use of whakataukī to explore intervention points for breastfeeding support is more than just a nice thing to do. In the context of this thesis, the whakataukī provide cultural validation to the solutions and strategies identified by wāhine Māori and their whānau. The majority of the whakataukī used here are not from Taranaki, but are commonly used throughout Māori society. The benefit of using widely recognised and understood whakataukī is that it will enhance the relevance of the *Kia Mau, Kia Ū* study findings to Māori huri noa te motu,throughout the land. Finally, I acknowledge that all whakataukī have a whakapapa and I am eternally grateful to our tūpuna for their ongoing and continued guidance.

5.3.1 Mā ngā Wāhine – Implications for Māori Women

5.3.1a Tuakana/teina – Peer Support/Mentoring in the Māori Context

Mā te tuakana ka tōtiki te teina, mā te teina ka tōtika te tuakana.

The older sibling guides the younger sibling, the younger sibling teaches tolerance and patience.

This whakataukī draws on the tuakana/teina relationship that was inherent within the participants' talk. The whakataukī focuses on the inbuilt whānau support system. It reminds us of the obligations and responsibility that goes with being the tuakana, or older sibling, to support and guide our teina, or younger siblings. The reciprocal nature of this relationship is also emphasised. While tuakana/teina is often considered to reflect a sibling relationship, the importance of extended whānau means that it also applies to other important relationships for example, between cousins, colleagues, and friends.

The importance of the tuakana/teina relationship to breastfeeding support was evident in this study. Decisions related to breastfeeding were heavily influenced by whether or not breastfeeding was practiced by women within the whānau. More experienced mothers within the whānau were an important source of information for the mother-to-be or new mother. Wāhine Māori found great comfort and encouragement, during pregnancy and early post-partum, when tuakana were able to offer breastfeeding support and advice.

Women-to-women breastfeeding support programmes, also known as breastfeeding peer-support programmes, involve partnering an experienced woman with a new mother. This partnership generally begins in the antenatal period, however women can also engage with the programme during the postpartum period as they establish breastfeeding within the hospital, home and/or community environments. These programmes affirm the importance of interpersonal relationships as part of the breastfeeding journey and the value of mentoring and support for new mothers who aspire to achieve successful breastfeeding practice.

Evidence suggests that women-to-women breastfeeding support programmes are as effective as professional breastfeeding support, if not more so (Cattaneo & Quintero, 2006). Importantly, these programmes are an effective strategy for increasing

breastfeeding rates, particularly for marginalised women and in areas where breastfeeding is not the cultural norm (Anderson, Damio, Young, Chapman, & Perez-Escamilla, 2005; Bolton, Chow, Benton, & Olson, 2008; Dykes, 2005; Ingram, Rosser, & Jackson, 2004; Lumbiganon et al., 2011; MacArther et al., 2009; Meier, Olson, Benton, Eghtedary, & Song, 2007; Pugh et al., 2002; Renfrew et al., 2005; Renfrew et al., 2012; Rossman, 2007). Viewing these programmes through the message of this whakataukī offers a culturally-specific solution to breastfeeding promotion and protection. Reconceptualising breastfeeding peer support programmes as a tuakana/teina programme would enable Māori women and their whānau to practice a long-held tikanga and empower whānau to utilise their own breastfeeding knowledge. The reciprocal nature of the tuakana/teina relationship means that there is scope to share breastfeeding knowledge between the teina and tuakana. Not only would this facilitate the transmission of "new" and "old" breastfeeding knowledge, but it ensures that both the tuakana and teina are considered experts within their own breastfeeding journey.

Although a breastfeeding peer support programme has operated from a Māori health service within the Taranaki DHB region since 2012, the programme co-ordinator has indicated that referrals from Lead Maternity Carers are infrequent and rates of self-referrals amongst Māori women remain low (J. Foley, personal communication, 30 January 2015) . Hayes-Edwards (2014) has previously suggested that low rates of Lead Maternity Carer (LMC) referrals into Kaupapa Māori antenatal services present significant barriers to Māori women accessing appropriate and available breastfeeding services. She has also urged LMCs to view additional Kauapapa Māori services as complementing their practice rather than perceiving them as a threat.

Whilst a tuakana/teina breastfeeding support programme could have many advantages, there is a risk that it could be interpreted as an intervention that relies heavily on whānau relationships and support. Whilst I acknowledge the vital role of whānau in a breastfeeding support system, it is imperative that any new initiatives are accessible to all wāhine Māori regardless of their personal situation and whānau links. Therefore, it is vital that those wāhine Māori who do not have access to breastfeeding tuakana within their own social networks are identified early in pregnancy. Whilst LMCs are most often in the best position to do this, inadequate access to midwifery care means that pregnant Māori

women are often engaged with a number of services as part of their antenatal care (e.g. their general practitioner, or whānau ora services) (Makowharemahihi et al., 2014; Ratima & Crengle, 2013). Therefore, a successful tuakana/teina breastfeeding support programme will rely on a coordinated approach to maternity health care as well as clear and transparent referral pathways across a range of mainstream and kaupapa Māori services.

This whakataukī also captures the aspiration of wāhine Māori to engage with an antenatal education programme that welcomes and values the participation and knowledge of whānau, as their primary breastfeeding supporters. A whānau ora model of breastfeeding antenatal education and support, which is inclusive of whānau members, that is flexible in delivery and is based on the tuakana/teina model is needed within the Taranaki DHB region. A whānau ora antenatal education programme would facilitate the sharing of breastfeeding knowledge and information between LMCs/educators and whānau and once again value the role of each party as integral to a successful breastfeeding relationship for the wāhine hapū.

5.3.1b Mātauranga me te māramatanga – Knowledge and Understanding

Whaowhia te kete mātauranga

Fill the basket of knowledge

This whakataukī refers to the atua Tāne and his pursuit of the kete of knowledge. This was a journey of striving for understanding and education and enlightenment, to enable his descendants to become better people. Within the whakataukī presented here, and the kōrero of Tāne, we learn that knowledge is power.

Preparing to breastfeed in the antenatal period requires access to mātauranga and māramatanga of that information. Previous research by Glover (2008) and Hayes-Edwards (2014) suggests that Māori women have minimal access to breastfeeding information. Gaining access to breastfeeding information that is relevant and easy to understand is challenging for Māori women. In the present study, access to breastfeeding

information and the relevance and suitability of breastfeeding information was also of concern.

Health literacy has become a common discourse within the health sector. Health literacy refers to the degree to which people are able to access and understand essential health information in order to make informed and appropriate health decisions (Ministry of Health, 2013). Health literacy could be viewed as an issue for individuals, with an onus put on them to improve their literacy skills in order to better navigate health services. However, the Ministry of Health acknowledges that the quality of practitioner communication and the user-friendliness of health services also influences health literacy (Ministry of Health, 2014b). Shifting the focus away from individual skill requires an active and purposeful process that focuses at the level of the health system and is driven by health care organisations (Ministry of Health, 2014d).

In the context of this whakataukī, health literacy is viewed as a policy intervention that seeks to change the way that health services approach breastfeeding education so that wāhine and whānau can fill their kete of knowledge. A health literacy intervention for breastfeeding support would seek out and engage friends and extended whānau of wāhine hapū and incorporate their breastfeeding knowledge within their antenatal education programme. The whakataukī reminds us that acquiring knowledge is a journey that involves several stages and challenges. Improving health literacy and therefore breastfeeding relationships will require time for the health provider to build rapport and develop a trusting relationship with the whānau unit. Thus, engaging with whānau and friends early in the antenatal period would increase the likelihood of success. Other strategies could include organising regular whānau hui to establish support systems and coordinate tasks. Respecting the knowledge held within whānau is also key to addressing health literacy. Health workers, particularly Lead Maternity Carers and antenatal education providers, will need professional development in the area.

The internet and online social networking media sites have dramatically influenced how humans stay connected, and how we access information. Internet enabled devices, particularly ‘smartphones’ have also changed the way in which we communicate, interact and how information is received (Statistics New Zealand, 2013b). Further, online social

networking media sites offer a platform for health literacy interventions as they provide health professionals the ability to deliver a variety of public health messages, from evidence-based guidance to critical information during an emergency, directly and quickly (Currie, 2012). Because of its low cost and ease of use, many health sector organisations and individuals are becoming involved in social networking media, with some campaigns earning both recognition and avid followers (Currie, 2012). There are a number of breastfeeding campaigns (e.g. Breastfeeding New Zealand), and organisations (e.g. La Leche League New Zealand) that have an online presence and operate within social networking sites (e.g Facebook and Youtube) where people can readily gain access to breastfeeding information.

Whilst earlier research has indicated that Māori have limited access to the internet (Parker, 2003) the digital landscape has changed dramatically over the last decade (Statistics New Zealand, 2013b). There are more types of devices available to connect people with the internet, for example mobile phones and tablets, and these are something New Zealanders on the whole are embracing (Statistics New Zealand, 2013b). Māori have readily adopted these information and communication technologies (O'Carroll, 2013; Statistics New Zealand, 2013b) with a large proportion of Māori internet users engaged in social networking (Statistics New Zealand, 2013b). The use of social networking media is therefore enabling Māori all over the world to connect and participate in relationships with friends, whānau and community as well as acquiring knowledge and practicing aspects of their culture (O'Carroll, 2013).

Kaupapa Māori breastfeeding information and support delivered through online mediums (particularly social networking sites) could be one way to address health literacy and engage with Māori women. While research on the role of online social networking media in breastfeeding support is limited, early evidence indicates that it is a useful tool for breastfeeding support, providing a platform for both peer and professional advice (Guy, Paterson, Currie, Lee, & Cumming, 2010). Investigating its utility for Māori breastfeeding support is still required.

"Whaowhia te kete mātauranga" reminds us that as there are many forms of knowledge, and that there are many ways to convey the knowledge that we need in order to fill our

kete. Māori women need access to resourcing to navigate and determine the learning mediums that best suit their needs. Accessibility of breastfeeding information, the type of information available, and how it is imparted to women and their whānau are all important considerations in addressing health literacy.

5.3.1c Whānau Ora

Tū tama wāhine i te wā o te kore

Rise up in the time of need

The whakataukī "Tu tama wāhine i te wā o te kore" were the words of Taranaki leader Te Whiti o Rongomai (Te Whiti). Te Whiti led the anti-colonial movement at Parihaka Pā during the late 1800s with his Uncle Tohu Kakahi. The whakataukī was said at a time when many of our men, my tupuna, from the Parihaka movement were taken and imprisoned in jails as far away as Otago. The whakataukī is empowering as it is a message to the women of the time to rise up, to take on the roles that were required to fulfil the needs of the community. In the modern context this message is applicable to our Māori community as a whole.

It is apparent from the wāhine participants of the *Kia Mau, Kia Ū* project that whānau can fill the gaps in existing breastfeeding education and support and meet the needs of wāhine in order to support the breastfeeding journey. Whānau provide emotional and practical support to a mother in the early post-partum period, but additionally the ability of whānau to offer technical breastfeeding advice from their own breastfeeding experiences is critical. Whānau have the ability to advocate and navigate the healthcare system in order to provide wāhine with the support they need to establish and maintain a breastfeeding relationship.

Whilst access to breastfeeding information is important for whānau, their success as key breastfeeding supporters lies in their ability to be actively involved in the care of pregnant and breastfeeding women. Although the wāhine participants clearly acknowledged whānau to be a support system for a successful breastfeeding relationship, I found that the whānau participants minimised their significance within the breastfeeding journey.

Whānau need to be reminded about how important they are, and perhaps for those who are less engaged, this could be because their role is not validated by health professionals and society in general. Maternity health care providers must engage fathers, partners and whānau early in the antenatal period in order to build whānau capability to prevent crises and manage problems. Whānau strengths need to be endorsed, whānau ownership of solutions and actions should be encouraged, and partnerships between whānau and providers needs to be normalised, and needs to exist (Taskforce on Whanau Centred Initiatives, 2010). Whānau need to be viewed by the Maternity Health Care sector as a resource. Positive engagement of whānau, by the sector, that seeks out whānau attributes and uses those to address and lift whānau capabilities can be beneficial for all parties involved.

Engaging with whānau in this way will require significant additional time and resources for the maternity health care sector. Workforce capacity and capability, must be enhanced so that the sector can be responsive and flexible enough to align with and support whānau breastfeeding aspirations (Taskforce on Whanau Centred Initiatives, 2010). Contributing to whānau empowerment and breastfeeding support, as well as strengthening whānau integrity to achieve the best possible breastfeeding experience for whānau requires specialised knowledge of the maternity healthcare sector and high cultural safety and competency skills. Political commitment is required so that Māori women and their whānau have access to skilled practitioners within the maternity health care sector. Funding to increase the cultural capacity of the current workforce, as well increasing the Māori workforce (particularly midwives and lactation consultants) is needed. Kaupapa Māori antenatal education and breastfeeding support programmes must be adequately resourced to ensure that they are sustainable.

The message in the whakataukī “Tu tama wāhine i te wa o te kore” reminds us of our collective responsibility to whānau ora.

5.3.1d Kaimahi Hauora – The Maternity Healthcare Workforce

Mā mahi ka ora

With work there is wellness

This whakataukī reminds us that good outcomes do not always come easily. It tells us that reducing inequities in breastfeeding rates between Māori and non-Māori will require a consistent, concerted and supportive effort. Improving breastfeeding rates and enhancing the breastfeeding journey will require commitment and hard work. It is recognised that the maternity healthcare workforce is central to the protection, promotion and support of breastfeeding in Aotearoa (National Breastfeeding Advisory Committee of New Zealand, 2009b).

In the present study, rough treatment, for example forcefully putting a baby to the breast, and the physical handling of women's breasts was raised as a significant barrier to successful breastfeeding relationships. Participants noted their dislike of this kind of treatment from health professionals. Participants were not asked for permission to physically touch them, and having their personal space invaded in such manner made participants uncomfortable, but the power-relationship meant that women often felt too vulnerable to say something. Additionally, a sense of disempowerment was created when women were not supported to breastfeed but were instead forced into having someone else do it for them.

There is little support for the hands-on approach to breastfeeding support, however one study conducted in Sweden highlights the negative impact this type of approach can have (Weimers et al., 2006). In that study, hands-on help to breastfeed was considered unpleasant, unhelpful and resulted in the study participants feeling objectified. The study authors noted that while most mothers accepted the hands-on help from maternity staff, the unexpected and unexplained manner in which the behaviour was conducted was inconsiderate and violated the participants' integrity. They recommended the avoidance of the hands-on approach to breastfeeding help and suggest using alternative methods to support breastfeeding women experiencing breastfeeding difficulties, for example demonstrating feeding using an artificial breast and/or using a doll.

Although a hands-off approach could be considered to be a slow and/or time-consuming way of supporting women to breastfeed, in the right framework it could be viewed as a way of increasing a woman's confidence in her own abilities. The whakataukī "Ma mahi

ka ora" provides such a framework. Taking the time to give verbal guidance, encouragement and support enhances the confidence and wellbeing of wāhine Māori. Forcefully putting a baby to the breast without explanation disempowers us.

When engaging with health professionals, particularly in the early post-partum period, Māori women want access to a professional and clinically skilled workforce. Handling the breast was not perceived as best practice by the study participants. The demands and pressures of working within the maternity health care sector should not affect staff empathy or the quality of care extended to Māori women.

Workforce capacity within the maternity healthcare sector is an ongoing concern and the need to build Māori workforce capacity within the sector has been highlighted (Gabel, 2013; Glover et al., 2008; Hayes-Edwards, 2014; Kenney, 2011; Simmonds, 2009). According to the Ministry of Health (2011) for the period 2006 to 2010, the proportion of active Māori midwives was between 6 and 8 percent of the total active midwife workforce. As Māori women generally have a higher fertility rate than other population groups (Statistics New Zealand, 2013a), there is a need to see more Māori midwives move through training and development.

Enhancing cultural competency and strengthening the cultural safety of the current maternity workforce is also needed. There are two basic principles that relate to cultural competency. Firstly, it is important to explore and understand the socio-cultural factors that influence a healthcare consumer's values, beliefs, and behaviours associated with health and healthcare. Secondly, it is important to develop multi-level strategies in the design and delivery of healthcare in order to address disparities that result from socio-cultural barriers (Betancourt & Green, 2007). In contrast, cultural safety emphasises the importance of self-reflection by the healthcare workforce and recognition of the views and beliefs of those that differ to them.

Cultural safety also focuses on changing the unequal power-relationships that exist between health practitioners and their clients. As a breastfeeding support intervention, increasing the cultural competency of the maternity health care workforce would enhance their ability to understand the complex realities of wāhine Māori and how they intersect to influence their ability to develop a successful breastfeeding relationship. On the other

hand, improving the cultural safety of the maternity workforce would facilitate greater recognition of the structural causes of inequalities in breastfeeding and greater focus on the provision of more equitable and acceptable service delivery (DeSouza, 2008).

"Mā mahi ka ora" teaches us that taking on the challenges of health system responsiveness to health inequities in breastfeeding will ultimately lead to wellness for women and their infants.

5.3.1e Mahi-a-iwi – Support in the Community Setting

Nā tau rourou, nā taku rourou, ka ora te iwi

With your food basket, and with mine, the people will prosper.

This whakataukī highlights the value of co-operation, the action of reciprocity and the spirit of working for the greater good of the community. It recognises that people do not exist in isolation; that the interconnectedness of an individual to broader social units like whānau, hapū and iwi are important and that how we operate as individuals within this context is integral to the well-being of the community.

For women to successfully integrate their aspirations to breastfeed with their multiple identities and roles – mother, family member, dedicated employee – it is vital that the wider community acknowledges and supports breastfeeding as an important part of our social landscape. *The National Strategic Plan of Action for Breastfeeding 2008-2012* (National Breastfeeding Advisory Committee of New Zealand, 2009b) recognises the relationship between settings (i.e. government, workplaces, health services) and breastfeeding. The experiences of the wāhine Māori in the *Kia Mau Kia U* suggests that there are three key settings that can influence their breastfeeding journey.

1. ***Health Providers***

Encouragement and support from health care providers is important for the establishment of a successful breastfeeding relationship. However, in order to achieve the WHO

recommendations for breastfeeding duration, it is also important this supportive behaviour is extended to women beyond the antenatal and early postnatal period. This study, and others, suggests that unclear and indifferent breastfeeding advice from Health Providers can be a major reason why Māori women cease breastfeeding before six months.

Co-operation of the maternity health care sector and the wider health professional network is required to support Māori women to breastfeed. Although professional guidelines and policies to promote and protect breastfeeding exist, the principles of these appear to be lost in practice. The Baby Friendly Community Initiative (BFCI) extends the action of protecting, promoting and supporting breastfeeding entrenched in the Baby Friendly Hospital Initiative into the community setting. The objectives of the BFCI are to:

- Increase the percentage of babies who are breastfed;
- Increase the duration of exclusive breastfeeding;
- Sustain breastfeeding after six months alongside the introduction of complementary foods (New Zealand Breastfeeding Authority, 2007a).

This is done through an accreditation programme than involves a set of standards of care for health and community services. The overall outcome for organisations participating in the programme is:

> staff in Baby Friendly accredited services adopt best practice standards for infant and young child feeding that aim to protect, promote and support breastfeeding. Services provide factual information and support for pregnant women and mothers. (New Zealand Breastfeeding Authority, 2007a)

This programme operates within the Taranaki District, however only three organisations are accredited. Further promotion and funding is required to enable more health services and organisations to become BFCI-accredited. Participation in this programme will help ensure breastfeeding policy is in place, but will also provide training to staff so that consistent support and breastfeeding advice is imparted to clients and their whānau. This will in turn support community health providers to contribute to the national breastfeeding goals.

2. Workplaces

Under Section 69Z of the Employment Relations Act 2000, it is a legal requirement in New Zealand for workplaces to provide appropriate breaks and facilities for employees who wish to breastfeed their infants or express milk during work hours. The power of this Act to enable the maintenance of a successful breastfeeding relationship for working mothers was clear in the present study. However, the underlying culture of their respective workplaces also needs to be recognised.

The *Kia Mau, Kia Ū* participants acknowledged the importance of supportive management, flexible work arrangements and proper facilities for feeding and/or expressing. Developing a workplace culture that supports breastfeeding could be achieved through active promotion and increased funding for the Breastfeeding Friendly Certified Workplace programme. This programme is administered by Women's Health Action, and enables organisations to register and become audited online for Breastfeeding Friendly Workplace Certification (Women's Health Action, 2011). Organisations that employ Māori women could be approached and actively encouraged to become certified under this programme. Arguments for increased productivity and increasing the likelihood of staff returning to their position after a period of maternity leave could be used to persuade those organisations that are reluctant to engage with such a programme. For those that do agree, then resourcing would be required to ensure that they could be supported to become certified.

3. Public Spaces

Confusion around breastfeeding in public spaces was prevalent in the *Kia Mau, Kia Ū* research project. Māori women need to be made aware that they are well within their rights to breastfeed in public and that they are protected by law to do so. Whānau also need to be aware of the rights of women to breastfeed in public spaces so that they can be advocates if the need arises.

A social marketing campaign covering the law around breastfeeding in public could provide a useful method for breaking down the misconceptions and misunderstandings surrounding breastfeeding and raising awareness amongst Māori women and their whānau. A social marketing campaign could also reinforce our responsibilities as a wider community to protect and promote breastfeeding.

The whakataukī offered here suggests that we all have an ability to make a positive contribution towards increasing Māori breastfeeding rates.

5.3.2 Mā ngā Whānau – Implications for Fathers, Partners and Whānau

5.3.2a Pou tautoko, tiaki ūkaipō – The importance of the support role

Te amorangi ki mua, te hāpai o ki muri.

The leader at the front and the workers behind the scenes

This whakataukī is a reference to the operation of the marae. The kaikaranga and kaikōrero, the public face of the community, are positioned at the front of the meeting house whilst the ringawera are at the back. What is important to note, and is highlighted by the whakataukī, is that the roles are equally important regardless of their position. Moreover, each role relies on the other to support them in their work. If one role does not operate smoothly, then everything would fail.

This acknowledgement of the equal importance of different people and roles within whānau and our wider community should be applied to breastfeeding support. The importance of breastfeeding and the mother-infant dyad has been highlighted throughout this research. While breastfeeding is the unequivocally preferred method to nourish and support healthy infant development, the mother needs support in order to breastfeed successfully.

Fathers, partners and whānau all have an important role to play in the support of breastfeeding and increasing Māori breastfeeding rates. While the support role is often acknowledged in breastfeeding policy, it is not always possible for whānau to be actively engaged in this role. As this study has shown, employment responsibilities and work schedules, the nature of midwifery practice and a sole focus on individuals within breastfeeding education programmes, can create significant barriers to full whānau participation in breastfeeding support. Unfortunately, the burden associated with the exclusion of whānau from breastfeeding support is carried by wāhine Māori and ultimately their babies.

Full acknowledgement of the pivotal role of fathers, partners, and whānau needs to occur at the level of policy. For example, whānau friendly employment laws might include provisions for fathers/partners/whānau to attend antenatal appointments with wāhine hapū, and/or parental leave entitlements so that they can take leave to support the wāhine during the early postnatal period. Employers and managers could provide whānau friendly work environments via flexible schedules and/or provisions to leave the workplace during lunch breaks so that whānau could use this time to provide some breastfeeding support. This should be for at least the first six weeks postpartum so that the wāhine can be supported to establish breastfeeding. Strategies such as these would allow whānau to actively support Māori women without the fear of their income being at risk.

Inclusion of fathers, partners and whānau during antenatal and postnatal appointments and breastfeeding programmes could be facilitated by maternity health care providers with some careful consideration and additional resourcing; for example, ensuring that antenatal/postnatal appointments occur at suitable venues with space to accommodate

support people and/or other children. The maternity healthcare workforce could also participate in cultural competency and cultural safety training to ensure that they have skills required to effectively and appropriately engage and communicate with whānau.

"Te amorangi ki mua, te hapai o ki muri" reminds us that there are many roles involved in breastfeeding support if women are to be successful in their breastfeeding relationship. They need all of those who care for them to be viewed and treated with respect and valued for their contribution. Commitment from policy makers, employers and health care providers would enable active participation of whānau in breastfeeding support.

5.3.2b Kaiarahi – Whānau as Navigators and Advocates

Kohia te kai rangatira, ruia te taitea[20]

Gather the best food, cast away the rubbish

This whakataukī is closely linked to another commonly used proverb "ko te kai a te rangatira he kōrero - the food of chiefs is language". Both whakataukī speak of the importance of language, information and knowledge to Māori society. The whakataukī presented here goes further by reminding us of the importance of identifying and gathering the richest information and separating it from the "rubbish" that might be presented alongside it.

Our tūpuna saw the value and power in acquiring knowledge. In supporting the breastfeeding journey, fathers, partners and whānau must equip themselves with knowledge. They must gather knowledge about the breastfeeding process, the health care system, and the support services available in the community, in order to effectively support Māori women to breastfeed. In the context of this study, fathers, partners and whānau must be able to seek out useful information and discard any unhelpful information they might encounter along the way. Consequently, when fathers, partners and whānau

[20] *Taitea* is sapwood. In the context of the above whakataukī it is a reference to stripping the sapwood away (the less desirable) to reveal the hardwood (the desirable).

are armed with appropriate knowledge, they are in a powerful position to navigate and advocate for the breastfeeding mother when and as necessary.

In some instances, fathers, partners and whānau will need additional support to access information and knowledge. Lead Maternity Carers will need to be able to recognise when whānau need additional support and refer them to appropriate services, including Kaupapa Māori health providers. "Kohia te kai rangatira, ruia te taitea", however reminds us the capacity and capabilities within whānau must be acknowledged as a resource.

5.4 Kua Takoto te Mānuka - The Call to Action

The phrase *Kia Mau, Kia Ū* literally means "to hold firmly, to be resolute". The phrase speaks to the myriad ways in which breastfeeding is valued within Māori society. *Kia Mau, Kia Ū* highlights the aspirations of Māori women to hold onto tikanga ūkaipō. It also reminds us that we can use our tikanga to protect and sustain the breastfeeding relationship and therefore protect whānau ora.

As I embarked on this study I was cognisant that the 'problem' of low breastfeeding rates was often viewed as a 'problem' of the individual. This view was completely opposed to my own understanding which was based on an awareness of ūkaipō as an important component of tikanga Māori and my observation that successful and sustained breastfeeding could have profound benefits for whānau ora. Armed with this knowledge I embarked on this study with two questions clear in my mind: 1) How are we as a society honouring wāhine Māori aspirations to breastfeed? And 2) How are we as a society honouring mothering? The wāhine Māori involved in this study spoke openly about the factors that facilitated their breastfeeding journey and the barriers they met along the way. Whānau also discussed the challenges and positive aspects of supporting their loved one to breastfeed. Their kōrero offers explanations for the disparities and inequity reflected in our local and national breastfeeding data. When viewed through a Kaupapa Māori and Mana Wāhine theoretical lens, their experiences and insight can be used to develop solutions that will benefit whānau, hapū and iwi.

5.4.1 I ngā wā o mua – Looking back to go forward

In literal terms the phrase *i ngā wā o mua* translates to 'from the times ahead'. The intent, however, is a description of the past. From a Māori world view, we look to the past for our guidance, as that is where we came from, and we use that ancient knowledge to plan a clear pathway for our present and future lives. *Kia Mau, Kia Ū* is the intent of this research; to find pathways so that we, as Māori, can hold onto breastfeeding as our tikanga, but also reinstating tikanga that were created to protect and sustain the breastfeeding relationship on a pathway towards whānau ora.

Figure 2 below presents an image of the Pā Harakeke. The Pā Harakeke is well-recognised by Māori as a symbol of whānau and of protection (Pihama, Jenkins, & Middleton, 2003).

Hutia te rito o te harakeke, kei whea te kōmako e kō?
Kī mai ki ahau, He aha te mea nui o te Ao?
Māku e kī atu, he tāngata, he tāngata, he tāngata

If the heart of harakeke was removed, where will the bellbird sing?
If I was asked, what was the most important thing in the world;
I would be compelled to reply, it is people, it is people, it is people!

The Pā Harakeke is present in many whakataukī that discuss whānau (Metge & Jones, 1995; Pihama et al., 2003). Māori view the harakeke plant as a symbol of whānau and strength (Pihama et al., 2003). The whakataukī above references the rito, or central shoot of the flax plant, which symbolises the child. The shoots either side of the rito are the parents, and beyond them are extended whānau members – all of whom protect the developing child from the harmful effects of nature.

Te Pā Harakeke has been a point of reference and a working model in a range of Kaupapa Māori research projects that have focussed on topics such as parenting (Rokx, 1997), youth development (Ware, 2009), and traditional Māori child raising practices (Pihama, 2014). At the service delivery level, Te Pā Harakeke has been used by Māori health and social service providers as a framework of achieving whānau ora (Te Arawa Whanau Ora Collective, 2014).

In terms of supporting and protecting breastfeeding, Te Pā Harakeke offers a plan of action and a way of being for breastfeeding wāhine Māori, their whānau and the wider networks and factors that facilitate the breastfeeding journey.

The culmination of this study is presented in Figures 2 and 3. *Tiakina Te Ūkaipō* is a framework of action for breastfeeding support in Taranaki. At the heart of this Pā Harakeke is the mother-infant dyad. Although Te Pā Harakeke models usually assign children and young people to the rito, in the context of breastfeeding the mother and child is an inseparable partnership, each depending on the other to ensure that the process of breastfeeding is successful. Listening to the kōrero of the participants in this study, the shoots immediately surrounding and protecting the mother-infant dyad are the male partners and female whānau members – their core supporters and advocates of breastfeeding. Supporting the partners and female whānau members are the wider whānau, who are, in turn, supported by the maternity health care system, who themselves essentially become part of the whānau support system. These interweaving layers of support, although increasingly distant from the rito of the flax plant, are vital for ensuring that the mother and pēpī are protected throughout the breastfeeding journey. At the root of the Pā Harakeke is tikanga ūkaipō, or the cultural protocols of breastfeeding. When tikanga ūkaipō are strong within the whānau, breastfeeding can be established and maintained and the mother/infant relationship can flourish.

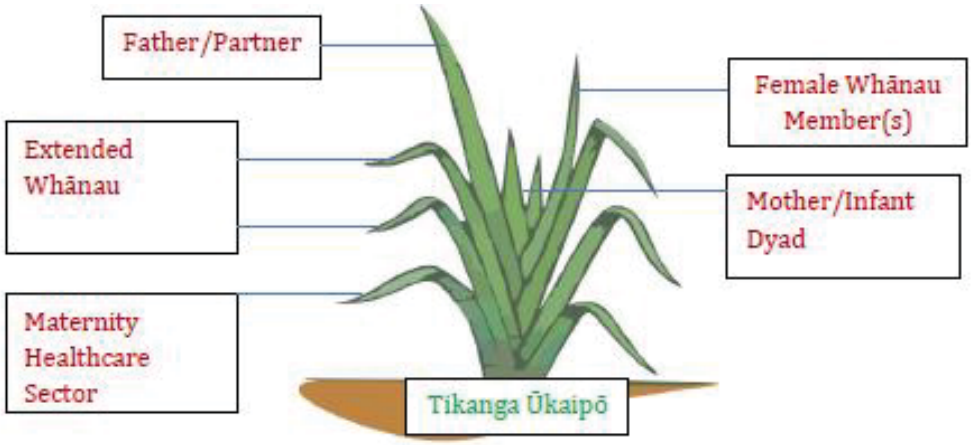

Figure 2: *Tiakina Te Ūkaipō: A Kaupapa Māori Framework for supporting breastfeeding in Taranaki*

Hāpai Te Tikanga Ūkaipō (Figure 3) highlights the factors that can influence and impact on tikanga ūkaipō. The factors outlined in this diagram can have both positive and negative influences on the breastfeeding journey. An impact assessment that focuses on whether and how policy and interventions impact tikanga ūkaipō is critical.

In this diagram, the layers of the Pā Harakeke capture the importance of the appropriate timing of breastfeeding interventions. The kōrero from this study suggests that the antenatal period represents the best window of opportunity for increasing knowledge and awareness of the benefits of breastfeeding and for identifying those wāhine who might need to be supported to join a tuakana/teina breastfeeding support programme. The critical nature of these steps for successful breastfeeding initiation dictates that the antenatal period is positioned within the centre of the Pā Harakeke. Each layer thereafter represents the support that is required during the immediate postpartum (e.g. compassion and culturally-safe engagement by health professionals), the first six weeks (e.g. support to navigate breastfeeding challenges and workplace policies that support whānau to care for their Wāhine) and beyond (e.g. establishment of breastfeeding spaces within the community). This study has shown that each of these time points represent critical milestones within a successful breastfeeding journey.

Te Pā Harakeke also provides a metaphor about the importance of relationships. Harakeke plants generally grow in groups and it is not usual to see a plant in isolation. Like the harakeke, whānau do not exist in isolation. A successful breastfeeding support framework for whānau will require a concerted and coordinated effort from Government, the health care sector and the wider community. Interestingly, the spacing of harakeke plants in gardens is integral to encourage growth. Within this framework, the space between each plant represents the importance of mana motuhake which recognises the need to maintain their own authority whilst remaining connected to the broader social, political, economic environments surrounding them. Furthermore, the spacing between the harakeke plants allows easy access to the plants by our kairaranga, ourweavers. This imagery captures the need for appropriate interventions at the right time.

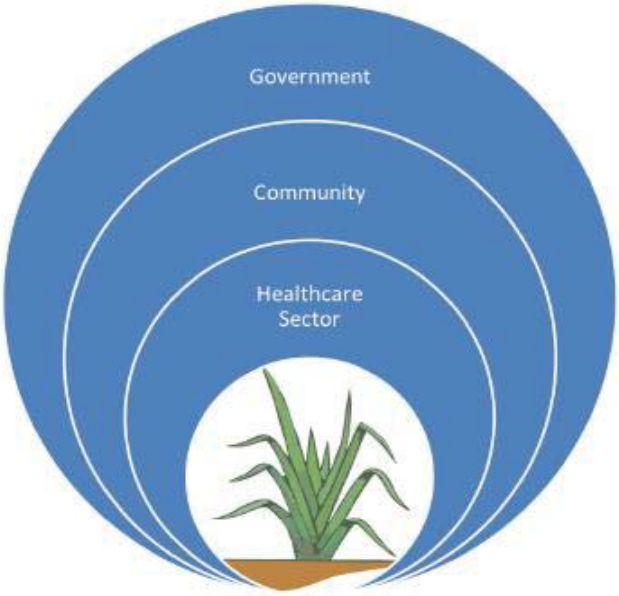

Figure 3: *Hāpai Te Tikanga Ūkaipō: A Kaupapa Māori Framework for protecting Tikanga Ūkaipō*

5.5 Conclusion

The findings of the *Kia Mau, Kia Ū* study have highlighted the need for Māori women to have access to culturally relevant breastfeeding support programmes that recognise the role of health literacy and additionally take a whānau ora approach. Attention also needs to be directed towards capability-building within the current maternity healthcare workforce as well as building the capacity of the Māori workforce to ensure that whānau have access to well-informed Māori providers. Greater support for breastfeeding within the community context is also needed. The inclusion of whānau in the care of pregnant women will ensure their breastfeeding support role is validated. Extending support to whānau will increase their capacity and capabilities to navigate the health system and advocate when needed.

The *Kia Mau, Kia U* study presents a Kaupapa Māori breastfeeding support framework that highlights two areas of action. *Tiakina Te Ūkaipō* describes the relationship between whānau and maternity providers and they ways in which they can protect the mother/infant dyad. It also offers a pathway for supporting Māori women in their breastfeeding aspirations. *Hāpai Te Tikanga Ūkaipō* describes the responsibilities of Government, the health care sector and the wider community to protect tikanga ūkaipō.

Chapter Six – Conclusion

Tiaki Wāhine, tiaki whānau me te ora – Protect Wāhine, protect whānau and protect collective well-being

6.1 Introduction

The concluding chapter of the *Kia Mau, Kia Ū* study begins with a description of the strengths and limitations of the present research. The ethical considerations for undertaking breastfeeding research with Māori women are examined, as is the place of whānau ora within the context of maternity healthcare provision. Finally, a number of recommendations are provided in order to generate further research and action.

6.2 Study strengths and limitations

6.2.1 Generalisability

Qualitative samples are often small (Ryan, Coughlan, & Cronin, 2007), and this is certainly the case for the *Kia Mau, Kia Ū* study. The main limitation of a small sample size is that it prevents generalisability of the study findings to the whole population. It should be noted, however, that this study did not set out to describe the breastfeeding experiences of all Māori in Aotearoa, or in fact all Māori of Taranaki. Instead, I hoped that this study would provide a deeper understanding of the range of factors that can impact on Māori breastfeeding and to give voice to these issues. With this in mind, the use of qualitative methods in this study took advantage of a number of important strengths (Myers, 2000; Ryan et al., 2007). The goal of a qualitative research is to focus on a contemporary issue of importance and use in-depth descriptions to gain a more personal understanding of the issues and to contribute valuable knowledge to the community and society (Myers, 2000). Therefore, qualitative research and researchers aim to recruit people who share common values or characteristics that are important to the issues and through engaging with them we hope to understand the issues in-depth rather than in-breadth.

As stated above, generalisability was not the goal of this study, therefore the small sample size will have implications for the extensiveness of the research and it is possible that some important barriers and facilitators to breastfeeding may have been missed. Nonetheless, a small sample size has provided the opportunity to undertake a thorough examination of breastfeeding from various perspectives within the limited timeframe available. Moreover, the purposeful recruitment of women with varying experiences of breastfeeding has ensured that a wide range of issues were covered. Replication of this study in the future with more participants, particularly within the whānau/partners group, would allow the data and themes to be explored for robustness.

6.2.2 Validity and reliability

Issues of validity and reliability are particularly relevant to qualitative research. Qualitative researchers are concerned with ensuring that their methods and processes safe-guard the analysis and interpretation of the data (Brink, 1993). Much of the literature on qualitative research highlights reflexivity as important (Darawsheh, 2014). The notion of reflexivity offers an opportunity to engage in a continuous process of self-reflection which generates awareness about our actions, feelings and perceptions (Darawsheh, 2014). While Kaupapa Māori takes for granted the location of Māori researchers within our community and the phenomenon being explored, there are a number of activities I employed throughout the *Kia Mau, Kia Ū* study that enabled me to bring my thoughts and actions to a conscious level and enhanced my awareness of how my position might influence the research process (Darawsheh, 2014):

- I developed selection criteria to guide participant recruitment and to make sure I stayed within the scope of my original research questions;
- The interviews were limited to a geographic region to provide some homogeneity in terms of the types of breastfeeding education and support available;
- I used an interview schedule, and was involved in all aspects of the study to ensure consistency across interviews;

- I digitally recorded participant interviews and was able to check back to these and my transcripts for accuracy;
- I sent transcripts back to the research participants for checking, commenting and editing;
- I worked with my supervisor during the data analysis phase to ensure that my personal views were not dominating the analysis and interpretation. I also discussed my preliminary findings with Māori health and public health colleagues. I obtained valuable feedback from the maternity healthcare sector during a number of presentations of my study. These actions provided some level of triangulation within my process; and
- Finally, my application of a Kaupapa Māori and Mana Wāhine framework enhanced the validity of the study findings in terms of mātauranga Māori (Māori knowledge). It also increased the reliability and relevance of the study by prioritising women and the intersecting nature of being Māori and female within the breastfeeding context.

Prior to and during the research process I was privileged to engage with the local Taranaki breastfeeding network (Taranaki Whangai Ū Coalition) whose members include Māori health providers, WellChild/Tamariki Ora providers and other key stakeholders in the Taranaki DHB region. It was this network that provided quality guidance and invaluable feedback prior to commencing and during this research project. This interaction with the Taranaki Whangai Ū Coalition was extremely beneficial from an ethical standpoint (Cram, 2001b). This network ensured that the present study and the research process undertaken was guided and mediated by authoritative Māori people. Additionally, the local knowledge of the maternal healthcare sector and clinical expertise within the coalition was also invaluable throughout the duration of the research project.

6.2.3 Ethical considerations for conducting breastfeeding research with Māori

> *It is widely acknowledged in Kaupapa Māori literature that Māori researchers have obligations which supersede that of non-Māori and that, as Māori researchers, we need to meet these obligations as well as fulfil the requirements of a University thesis.* (Simmonds, 2009)

Breastfeeding research is a highly contested field of enquiry. Moreover, conducting research with Māori comes with a legacy of unethical and inappropriate research practices. The following section describes the processes and procedures that were employed within the *Kia Mau, Kia Ū* study to help navigate the challenges of conducting this study.

My project, "Application 11/26", was reviewed and approved by the Massey University Human Ethics Committee: Southern A. While I satisfied the University's requirements for ethical conduct, it is important to note that research ethics for Māori communities extend far beyond issues of individual consent and confidentiality (L. T. Smith, 1999). As a Māori researcher/woman/mother, I accepted that I had responsibilities not only in the way I conducted myself for the duration of the research project, but also for the way in which the research was to be presented and disseminated. Understanding the range of responsibilities linked to my identity as a Māori researcher and the challenges associated with undertaking breastfeeding research are important to consider when interpreting the study findings.

To meet the overall goal of this study, I purposely recruited and interviewed women who had varying experiences with breastfeeding. For those women who did not have a positive experience, I acknowledged that their participation in this project could trigger feelings of grief and guilt. Therefore, I felt it was important to have information readily available on the local support services, including Māori counsellors, for all participants. I also ensured that I familiarised myself with contact details for ante-natal educators and/or

lactation consultants in the Taranaki region and identified referral pathways for those women who may have wanted to access specific support for breastfeeding.

Breastfeeding can be an intimate and personal journey for women. Talking about barriers to breastfeeding was likely to raise issues surrounding the women's bodies or dissatisfaction with the level of support they had received. Given the small community and whānau links in Taranaki, all the participants were known to me, therefore I anticipated that some participants might have been concerned about how their participation and information could be protected. With this in mind, I considered communication and transparency of processes to be important mechanisms for approaching issues of confidentiality and anonymity. For example, I reminded my participants of my role as a researcher in this project and that because of this position I was bound by the Code of Ethical Conduct to uphold their right to confidentiality. I also ensured that the principle of confidentiality was highlighted in the information sheet. With regards to anonymity, I clarified verbally and in writing that their involvement in my project would not be disclosed to anyone outside the research team.

I also explained that their personal details and/or specific features of their kōrero (e.g. details about their whānau, area where they lived, name of LMC) would not be included in any presentation and that their quotes would be marked using pseudonyms to reduce the likelihood that a participant or their whānau would be identified. If these strategies did not alleviate the participants concerns then I was also in a position to be able to offer an alternative interviewer, at their request. Protecting confidentiality for the participants also requires a sharing of the power relationship that is involved in research. To achieve this, I provided an opportunity for the participants to review and amend their transcripts prior to analysis and reminded the participants that they could withdraw from the study at any time, without question or comment.

Remaining conscious of my personal beliefs and considering how they might influence my research conduct was an important lesson for me during this project. For example, I was aware that issues such as sexualisation of the breast might impact on the way people view breastfeeding, and I recognised that this might have led some people to question the

value of the research study. Whilst I do not share this view, I understood the importance of remaining somewhat objective when undertaking a research project and therefore I made every effort not to question the beliefs and values of my participants. Instead, I used my Kaupapa Māori and Mana Wāhine frameworks to consider how historical and contemporary experiences of being Māori and being a woman might have influenced the views of my participants. These frameworks reject victim-blaming analyses, and so they provide an important tool to challenge the systems and ideologies that can impact on a Māori woman's right to breastfeed her child.

Reflecting on my identity within this project I became acutely aware of the multiple ways in which participants may have viewed me and also the multiple ways in which I viewed the topic of my enquiry. For example, I was aware that some participants may have felt "judged" by me in my capacity as "the researcher", particularly if they held feelings of guilt associated with their breastfeeding experience. Whilst I acknowledge that I am pro-breastfeeding, I believe that I am understanding of and empathetic towards women who have had difficulty breastfeeding. I made a conscious effort to convey this during my data collection process by approaching each interview with an acknowledgment that breastfeeding experiences for women are all different. I shared my own story with them, highlighting the difficulties I had faced in my own breastfeeding experiences and reminded them of the fact that women make decisions around infant feeding with the best intentions and based on the best information they have at the time. I also worked closely with my supervisor during the analysis and interpretation of the data as a way of ensuring that my personal views and/or opinions were not reflected too strongly in the presentation of the findings.

Kaupapa Māori methodology certainly set the pathway for the *Kia Mau, Kia Ū* research project and enabled a clear consideration of how the design, analysis and ethical practices might translate into a transformative and empowering research experience for all involved. Kaupapa Māori research also enabled me to incorporate tikanga Māori as an integral part of the research process, and to draw on relationships as part of a whanaungatanga process. Ultimately, however, the incorporation of tikanga Māori enabled me to preserve the integrity and safeguard the mana of those who participated in

this research project. Whakapapa and whakawhanaungatanga are two specifically Kaupapa Māori concepts that are useful for maintaining ethical research practices and negotiating the complexities that are inherent in breastfeeding research (Simmonds, 2009).

As a member of the Taranaki community, there was a possibility that my 'insider/outsider' status would put me in a position whereby the distinction between my professional role as the researcher and my personal role as a whānau member might seem unclear. This could lead to disputes or disagreements about the research encroaching on my personal/whānau life. Although consideration of the impact of our 'insider/outsider' status on the research is important, I also believe that professional and personal relationships can combine to create positive outcomes for the project (e.g. gaining a broad perspective on breastfeeding experiences of Māori women) and the participants (e.g. gaining new knowledge on support services that are available in the region).

6.2.4 Communication Technology

Communication technology played an important role in my research study. Kanohi ki te kanohi is an important aspect of Kaupapa Māori research. However, the emergence of social media and other communication technologies has changed how we are able to engage with our research communities. The widespread availability of email and text messaging services was evident in this study as they provided the primary communication method between me, my participants and my supervisor.

Surprisingly however, was the effectiveness of the social networking site Facebook for promoting and recruiting participants into this study. Although social media may not be suited to all research projects, it enabled me to recruit participants who were previously difficult to enlist into the study. There are certainly risks and ethical considerations in using Facebook in the research context. For example, using Facebook may have introduced bias if it was found to result in disproportionate numbers of younger mums or people who have technology readily available taking part in the study. This certainly wasn't that case for my participant characteristics as that I engaged with people from varied backgrounds. Kaupapa Māori research is about connecting and communicating

particularly with those in our communities who can be hard to find and contact. In that sense, Facebook had a positive impact for this study. Future studies investigating the role of social media for achieving kanohi ki te kanohi within contemporary Māori research will be important to increase our understanding and for ensuring the continual evolution of Kaupapa Māori research approaches.

6.2.5 Whānau Ora

Mā whero mā pango ka oti ai te mahi

With red and black the work will be complete

This whakataukī talks of the colours of black and red that are commonly used in the kōwhaiwhai patterns that adorn many whare or meeting houses around the country. Although they are separate colours with their own unique properties, when they come together in the kōwhaiwhai design they create a story, a memorandum, and a whole picture; our tūpuna relied on mahi-tahi, or working as one, for the whole and the collective wellbeing of the community. This whakataukī reminds us that cooperation and working together is vital for successful breastfeeding support.

The message of working together was strong in pre-European history. However, the messages of standing firm and striving for the greater good was important during post-colonial times, as evidenced in the waiata of Parihaka. The message of working together for a common goal is still relevant today. Many of our traditional societal structures and health protecting practices have been eroded by European colonisation. Whānau are resilient and despite ongoing government actions and neo-liberal policies that have impacted on generations of Māori, the understanding that whānau form the basis of Māori society remains strong (Durie, 1998, 2006b; Taskforce on Whanau Centred Initiatives, 2010).

Whānau Ora has been a dominant Māori development policy over the last decade (Ministry of Health, 2002b). Since 2010 Whānau Ora has been a key cross-government work programme jointly implemented by the Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development. It is an approach that situates whānau at the centre of

service delivery provisions, and necessitates the integration of health, education and social services (Ministry of Health, 2014e). Many health and social service initiatives focusing on strengthening and building whānau capabilities and capacity have been developed since the roll-out of this policy. However, a Whānau Ora approach appears to be missing from the Maternity Healthcare sector.

Government level commitment is needed to enable whānau participation in maternity health care, particularly in the antenatal and early post-partum period. Midwifery policy and practice also needs to broaden its focus from individual women and acknowledge the importance and value of the collective (Kenney, 2011). Whānau ora approaches to antenatal and maternity care (e.g. where whānau plan and together with support services establish the provisions necessary to support the arrival of a new child and the breastfeeding mother) will strengthen whānau and benefit the mother-infant dyad and breastfeeding relationship. Additionally, strengthening whānau capabilities could benefit the health care sector by shifting the distribution of resources into other areas.

6.3 Recommendations

"Ma whero ma pango ka oti ai te mahi" challenges everyone involved in maternity health care to work together in order to further the goals of *The National Strategic Plan of Action for Breastfeeding 2008-2012* (National Breastfeeding Advisory Committee of New Zealand, 2009b). The Strategic plan identified four key settings where action is required to protect, promote and support breastfeeding:

- Government;
- Family and community;
- Health services; and
- Workplace, childcare and early childhood education.

'Ma whero ma pango ka oti ai te mahi' highlights the need for continued commitment within these areas to improve breastfeeding rate for Māori women in Taranaki. The

following section provides some recommended actions categorised according to these key settings.

6.3.2 For Public Health Policy

- Revisiting *The National Strategic Plan of Action for Breastfeeding 2008-2012* (National Breastfeeding Advisory Committee of New Zealand, 2009b) is urgently required. A stocktake and review of the current evidence should occur, followed up with a needs assessment. The setting of new goals and the re-development of a new strategy that builds on the small gains made is essential, as is political commitment to the strategy;
- New funding streams and adequate resourcing will be necessary to support the new recommendations;
- Extension of the paid parental leave scheme for mothers to a minimum of six months postpartum so that mothers can breastfeed to the WHO recommendations;
- Make provisions within employment law to enable fathers/partners and/or whānau members to carry out their support duties. These provisions must recognise the changing needs of whānau across the maternity continuum of care (antenatal to minimum of six weeks postpartum).

6.3.3 For the Community

- Breastfeeding promotion in the community and a national social marketing campaign is required. The use of mixed media is vital to ensure that all corners of society are reached (i.e. television, print, social networking sites and radio). Issues to highlight include the valuable role of whānau and the broader community in supporting a healthy developing infant, clarifying the rights of women to breastfeeding in public and the responsibilities of the general public to uphold and respect the rights of the breastfeeding women;
- Raising awareness and increase promotion of the *Breastfeeding Friendly Workplace* initiative. Provide incentives for those businesses that work towards and achieve accreditation;

- Implementation of the *Baby Friendly Community Initiative* across all healthcare services that provide antenatal and postnatal care to women in the Taranaki DHB region. Uptake of this programme would ensure that all women receive consistent breastfeeding messages.

6.3.4 For the Maternity Healthcare Sector

- Reorientation of maternity health services to enable a Whānau Ora delivery approach in the antenatal and postnatal care of Māori women and their whānau;
- A review of breastfeeding support practice in the Taranaki DHB's postnatal wards, particularly concerning the handling of women's breasts;
- Increase cultural competency of current workforce so Māori women are treated with care and respect;
- Increase the Māori workforce in all areas across the maternity healthcare sector. Ensure areas with a high Māori population have access to Māori LMC's;
- A review of the current antenatal education programmes available in Taranaki is needed. Additionally, a review of current literature pertaining to antenatal education for indigenous and/or ethnic minority populations and a needs assessment within the Taranaki Māori community is needed;
- Development of a Kaupapa Māori antenatal programme that supports women and their whānau from the time of antenatal enrolment until at least six weeks postpartum;
- Further resourcing and development of the current breastfeeding peer support programme currently being delivered. The ongoing training of the current peer-supporters and the need to recruit and train more Māori peer-supporters is essential to provide the reach necessary to influence breastfeeding rates. Further provisions are required to enable streamlined referral processes from LMC's and other maternity care providers to the programme;
- Development of a Kaupapa Māori maternity health literacy programme is required;

- Development of national online Kaupapa Māori breastfeeding information and support campaign and/or network to complement local breastfeeding promotion and support strategies.

6.3.5 For wāhine Māori and their whānau

- More breastfeeding information and support needed during the antenatal period for Māori women and their whānau;
- The active promotion of and referral to breastfeeding peer support programme by LMC's;
- Access to specialised breastfeeding care in the first six weeks postpartum;
- Raise awareness of maternity leave and workplace responsibilities so Māori women and their whānau understand their entitlements;
- Develop and initiate tuakana/teina breastfeeding support programmes that are tailored to high need sectors of the Māori community for example, first time parents, young parents and women who have had unsuccessful experiences of breastfeeding in the past.

6.3.6 For Research

Kia Mau, Kia Ū was the first Taranaki-based research study that has sought to explore the experiences of breastfeeding Māori women and their whānau. Based on my study findings, there a number of areas that need to be addressed:

- More qualitative research with fathers/partners and whānau members is required to gain broader perspectives of their needs in supporting breastfeeding women. Extending the research into other regions would be beneficial;
- Research on the views and perspectives of the maternity healthcare workforce is needed to gain a full picture of the issues within the sector. This research would also support the views of the participants in the present study that LMCs are an important part of their support system;

- Impact assessment of existing peer-support programmes for Māori women is necessary. This would provide an opportunity to refine the programme according to the evidence acquired here.
- As there are a number of culturally based indigenous antenatal education programmes and postnatal breastfeeding support programmes in operation within Aotearoa/New Zealand and internationally, more research is required to explore the influence of these programmes on breastfeeding outcomes;
- The role of online social networking sites (i.e. Youtube, Facebook and Twitter) in supporting Māori women, their whānau and the breastfeeding journey is an emerging area of enquiry.

6.3.7 Ensuring Action

The *Kia Mau, Kia Ū* study provides important insights on a range of factors that influence the breastfeeding journey of Māori women and their whānau in Taranaki. Whilst this new knowledge is important, the Kauapa Māori research approach used in the present study necessitates that the research is transformative – that it will be used to create the types of changes that are necessary to enhance the wellbeing of whānau, hapu and iwi. The recommendations provided in this thesis provide specific guidance on areas where change could be created. The following section articulates my vision for how the health and disability sector can begin to make these changes occur. It is essential that breastfeeding data in the Taranaki DHB region is continuously updated and monitored. In particular, it is critical that the data be monitored for inequities, thus data must be available by ethnicity, age and socioeconomic deprivation so that the DHB is able to identify areas that require additional support and for action to be developed accordingly. Increasing the quality and availability of breastfeeding data will require greater input and investment from across the sector to ensure that actions to increase breastfeeding rates in Taranaki include a range of stakeholder views. The next step towards ensuring action could include the development of a policy brief which includes the full range of evidence from Taranaki but also national policy and guidance as part of the development of some recommendations for the DHB. Additionally, a regional breastfeeding plan of action relating to those recommendations could be developed not only to support and address national health goals, but to identify specific areas that need attention for the improvement

of Māori breastfeeding rates in Taranaki. Broad sector representation and commitment to the implementation of the action plan could be strengthened through the formation of a committee comprised of key stakeholders in the Taranaki DHB whose mandate is to action and monitor a regional breastfeeding action plan. Finally, addressing inequities in breastfeeding rates in Taranaki require actions that will link national strategies, with local issues that are being addressed through locally-identified solutions.

6.4 Conclusion

That almost 90% of our Māori babies aged six months in Taranaki do not receive the full health protecting and promoting properties of breastmilk from their mothers disturbs me. It troubles me because I believe that this statistic is symptomatic of the continued effects of colonisation. It concerns me as a Māori woman because it means that my people are experiencing inequities in access to high quality healthcare. It shocks me because it means that the discourse of blame continues to be directed at Māori women and not the health care system itself. It saddens me to know that discriminatory attitudes and practices towards Māori women, as evident in the 1961 Hunn Report, persist.

The sanctity of pregnancy, birth and breastfeeding has become somewhat of a commodity in today's society. The tapu of Māori women during this time is forsaken; for schedules, for a lack of resourcing and capacity, for not fully understanding the ongoing and enduring impact colonisation has on our people. As a result, breastfeeding has become a "lifestyle-choice" for those of us in the community who are resourced. Breastfeeding has become a privilege.

Wāhine Māori are the pillar of whānau and whānau ora. When the mother of a whānau is well, whānau are well. Wāhine Māori require care and attention in order to nurture a new life and to make their contribution to the continuation of a well and healthy whānau. If the whānau is not being supported to function at full capacity during this time, the impact of this is felt by Māori women with dire consequences for our breastfeeding experiences. It took my own breastfeeding experiences to understand this. Despite our best intentions, the breastfeeding journey for Māori women can be cut short due to a multitude of factors, many of which are beyond our control.

The aim of *Kia Mau, Kia Ū* was to create change and to initiate the transformation of the breastfeeding relationship for Māori women in Taranaki. By listening to and acknowledging the experiences of the participants in this study, *Kia Mau, Kia Ū* has validated motherhood and the role of whānau in the re-establishment of supportive breastfeeding practices. It is my firm belief that by reinstating and protecting tikanga ūkaipō we will see better health outcomes for our people.

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Appendices

Appendix A: Approval letter from ethics committee

MASSEY UNIVERSITY

7 June 2011

Marnie Reinfelds
17 York Crescent
Westown
NEW PLYMOUTH 4310

Dear Marnie

Re: HEC: Southern A Application – 11/26
Kia mau, kia uu – Supporting the breast-feeding journey of Māori women and their whānau in Taranaki

Thank you for your letter dated 7 June 2011.

On behalf of the Massey University Human Ethics Committee: Southern A I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

JM Boddy

Prof Julie Doddy, Chair
Massey University Human Ethics Committee: Southern A

cc Dr Sarah-Jane Paine
The Sleep/Wake Research Centre
WELLINGTON

Prof Philippa Gander, Director
The Sleep/Wake Research Centre
WELLINGTON

Appendix B: Wāhine Māori Interview Schedule

Kia Mau, Kia Uu – Supporting the breastfeeding journey for Māori women and their whānau in Taranaki

Key Informant – Interview Schedule

Introduction
Researcher to introduce self and to give overview of the research project.
Thank participant for agreeing to take part in the project.
Emphasise their rights as highlighted in the information sheet:

- decline to answer any particular question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study at any time without having to give a reason;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Pregnancy
Can you tell me a bit about your pregnancy?
Overall how was your pregnancy?
Was this pregnancy planned?
Was this your first pregnancy?

- If not, how many other children do you have?

Can you describe your breastfeeding experiences for your other children?
Did your past breastfeeding experiences affect the way in which you made decisions around infant feeding for your most recently born child?

- If yes – how?

Did you receive much information about breastfeeding when you were pregnant?

- Where did this breastfeeding information come from?
    - Friends/Family
    - Midwife
    - other health professionals
    - other sources ie. TV, Social Media sites (ie. Facebook), books

Birth
How many weeks pregnant were you when you gave birth?
How was your baby born?
If you experienced labour how long was it for?
Where was your baby born? If in hospital:

- How long did you stay in hospital?

Breastfeeding
How long after birth was your baby's first feed?
How was baby feed?
Can you describe feeding your baby to start with (in the first 24-48 hours)?
Can you describe feeding your baby in the first few (1-2) weeks?

How was breastfeeding for you?

- Was is difficult?
- Did you have problems? Were they ongoing?
- Was it fine once you established feeding?

Are you still breastfeeding your baby?

- If yes,
  - How long have you been breastfeeding? i.e. how old is baby?
  - How was your baby fed in the last 48 hours
    - Baby has received only breast milk
    - Baby has received some breast milk and some formula
    - Baby has received only infant formula
    - Other _____i.e. baby has 2 solid feeds a day and 5-6 breastfeeds

- If no, how long did you breastfeed for?

Support received

Who gave you breastfeeding information and support in the first 24-48 hours after baby was born?

- Medical professionals
  - Midwife
  - Nurse
  - Lactation consultant
  - Other_____
- Family
  - Mother/sister/partner/other_____
- Friends
- Other – social network sites, books etc

What kind of things did they do to support you?

- Helped with the physical task of breastfeeding
- Helped with other aspects of life i.e.
  - Taking care of other children
  - Cooking meals
  - Providing rongoa

Who gave you breastfeeding information and support in the first few weeks of breastfeeding (1-6 weeks) after baby was born?

- Medical professionals
  - Midwife
  - Nurse
  - Lactation consultant
  - Well child provider
  - Other_____
- Family
  - Mother/sister/partner/other_____
- Friends
- Other

What kind of things did they do to support you breastfeeding?

- Helped with the physical task of breastfeeding
- Helped with other aspects of life (emotional/practical support) i.e.
  - Taking care of other children
  - Cooking meals
  - Providing rongoa
  - Being a listening ear

What role, if any, did health professionals play in your decisions around infant feeding?

- Before birth?
- After birth?
- 3+months after birth?

What role, if any, did your whanau play in your decision around infant feeding?

- Before birth?
- After birth?
- 3+months after birth?

What could have been useful?

Thinking back to when you were pregnant, do you feel you received enough breastfeeding support/information?

What kinds of support/information would you like in the future or would recommend for other women who are pregnant?

- For first time mothers?
- For mothers who have had bad experiences of breastfeeding?

What about in the early days after the birth, do you feel you received enough breastfeeding support/information?

What kinds of support/information would you like in the future or would recommend for other women whom have not long given birth?

Do you believe you received enough breastfeeding support and information six weeks after birth of your baby?

What kinds of support/information would you like in the future or would recommend for other women whose babies are six weeks or older?

Overall support for extended duration of breastfeeding

The World Health Organisation recommends that babies are exclusively breastfeed until 6 months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.

In your opinion what are some of the things that could help you or other women like you to breastfeed for longer?

Prompt for:

- knowledge of the benefits of breastfeeding
- BF-friendly workplaces
- support from family or friends
- paid maternity leave
- other services/supports if you have problems
- Lack of awareness of changes in breastfeeding over time

In your opinion, what things do you feel could be useful for whanau to help them support you or other women like you to breastfeed for longer?

Demographic Questions

What is your iwi?

What is your age?

- Under 30
- Over 30

What is your marital status?

- Single
- Defacto relationship
- Married
- Widowed
- Divorced
- Separated

What is the highest level of education you completed?

- Primary school only
- Some high school, but did not finish.
    - NCEA Level 1-2
    - School Certificate/Six From Certificate
- Completed high school
    - NCEA Level 3
    - Bursary
- Some tertiary education, but did not finish
- Completed tertiary qualification i.e. certificate/diploma
- Completed undergraduate degree i.e. B.A. / B.Ed
- Some graduate work
- Completed Postgraduate qualification/Masters
- Advanced Postgraduate work or Ph.D.

How would you describe your current employment status?

- Employed full time
- Employed part time
- Self-employed
- Unemployed / Looking for work
- Student
- Homemaker
- Other_____

What do you expect your 2011 family income from all sources before taxes to be?

• Under $25,000 • $25,000 - $39,999 • $40,000 - $49,999 • $50,000 - $74,999	• $75,000 - $99,999 • $100,000 - $124,999 • $125,000 - $149,999 • Over $150,000

Appendix C: Whānau/Partner Interview Schedule

Kia Mau, Kia Uu – Supporting the breastfeeding journey for Māori women and their whānau in Taranaki

Whānau/Partner– Interview Schedule

Introduction
Researcher to introduce self and to give an overview of the research project.
Thank participant for agreeing to take part in the interview discussion.
Emphasize that their rights as highlighted in the information sheet:

- decline to answer any particular question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study at any time without having to give a reason;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Can you tell me a bit about your partner's/whanau member's pregnancy?

Was this your whanau member's first pregnancy?

- If not, how many other children do they have?

Can you describe the breastfeeding experiences for their other children?
Do you think past breastfeeding experiences affect the way in which decisions were made around infant feeding the most recently born child?

- If yes – how?

Did you receive much information about breastfeeding when your whanau member was pregnant?

- Where did this breastfeeding information come from?
    - Friends/Family
    - Midwife
    - other health professionals
    - other sources ie. TV, Social Media sites (ie. Facebook), books

Did you attend any antenatal appointments with your partner/whanau member?
If yes - how were they for you?
If no – why was that?
Did you attend antenatal education classes with your partner/whanau member?
If yes - how were they for you?
If no – why was that?

Birth
Were you present at the birth?
How was it for you?

Breastfeeding
Do you know how long after birth before baby was fed?
How was baby fed?
Can you describe feeding the baby to start with (in the first 24-48 hours)?
Can you describe feeding the baby in the first few 1-2 weeks?
How was breastfeeding for your whanau member?

- Was is difficult?
- Did they have problems? Were they ongoing?
- Was it fine once they established feeding?

Is your whanau member still breastfeeding baby?

- If yes,
  - How long have they been breastfeeding? i.e. how old is baby?
  - Do you know how baby was fed in the last 48 hours?
    - Baby has received only breast milk
    - Baby has received some breast milk and some formula
    - Baby has received only infant formula
    - Other _____i.e. baby has 2 solid feeds a day and 5-6 breastfeeds
- If no, how long did they breastfeed for?

Support Given to Partner/Whanau Member

What kind of breastfeeding support did you give your whanau member?

- Taking care of other children
- House work
- Cooking meals
- Running errands for the whanau
- Seeking breastfeeding information
- Purchasing breastfeeding support equipment (pumps, maternity bras, breast pads etc)
- Making up rongoa
- Other_____

Support received

Did you receive any breastfeeding information and support in the first 24-48 hours after baby was born?

If yes, who from

- Medical professionals
  - Midwife
  - Nurse
  - Lactation consultant
  - Other_____
- Family
  - Mother/sister/partner/other_____
- Friends
- Other – social network sites, books etc

If no, would receiving breastfeeding information/support as a support person been useful for you?

- How?
- What kinds of information and/or support would be useful?

Did you receive any breastfeeding information and support in the first few weeks (1-6 weeks) after baby was born?

If yes, who from

- Medical professionals
  - Midwife
  - Nurse
  - Lactation consultant
  - Other_____

- Family
  - Mother/sister/partner/other_____
- Friends
- Other – social network sites, books etc

If no, would receiving breastfeeding information/support as a support person been useful for you?

- How?
- What kinds of information and/or support would be useful?

What role, if any, did health professionals play in your whanau members' decisions around infant feeding?

- Before birth?
- After birth?
- 3+months after birth?

What role, if any, did you as whanau play in your whanau members' decisions around infant feeding?

- Before birth?
- After birth?
- 3+months after birth?

What could have been useful?

Thinking back to when your partner/whanau member was pregnant, do you feel you received enough breastfeeding support/information?

What kinds of support/information would you like in the future or would recommend for other support people of women who are pregnant?

- For first time mothers?
- For mothers who have previously bad experiences of breastfeeding?

What about in the early days after the birth, do you feel you received enough breastfeeding support/information?

What kinds of support/information would you like in the future or would recommend for other whanau of women whom have not long given birth?

Do you believe you received enough breastfeeding support and information after six weeks after birth of baby?

What kinds of support/information would you like in the future or would recommend for other whanau whom have babies are six weeks or older?

Overall support for extended duration of breastfeeding

The World Health Organisation recommends that babies are exclusively breastfeed until 6 months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.

In your opinion what are some of the things that could help you to support women in your whanau to breastfeed for longer?

Prompt for:

- knowledge of the benefits of breastfeeding
- knowledge of the physiological changes during breastfeeding
- support from other family or friends

- paid leave
- other services/supports if whanau have problems
    - ie. Support with housing, budgeting, transport

Demographic Questions

What is your relationship to the breastfeeding whanau member?

What is/are your iwi?

What is your age?

- Under 30
- Over 30

What is the highest level of education you completed?

- Primary school only
- Some high school, but did not finish.
    - NCEA Level 1-2
    - School Certificate/Six From Certificate
- Completed high school
    - NCEA Level 3
    - Bursary
- Some tertiary education, but did not finish
- Completed tertiary qualification i.e. certificate/diploma
- Completed undergraduate degree i.e. B.A. / B.Ed
- Some graduate work
- Completed Postgraduate qualification/Masters
- Advanced Postgraduate work or Ph.D.

How would you describe your current employment status?

- Employed full time
- Employed part time
- Self-employed
- Unemployed / Looking for work
- Student
- Homemaker
- Other_____

What do you expect your 2013 family income from all sources before taxes to be?

• Under $25,000 • $25,000 - $39,999 • $40,000 - $49,999 • $50,000 - $74,999	• $75,000 - $99,999 • $100,000 - $124,999 • $125,000 - $149,999 • Over $150,000

Appendix D: Wāhine Māori Information Sheet

MASSEY UNIVERSITY

SLEEP–WAKE research centre
MOETIKA–MOE PAI

Kia Mau, Kia Uu
Supporting the breastfeeding journey for Māori women and their whānau in Taranaki

INFORMATION SHEET
Key Informant Interview

Tena koe. He mokopuna ahau o te maunga titohia. Ko Ngati Mutunga toku nei iwi. Ko Marnie Reinfelds ahau.

My Name is Marnie Reinfelds and I am a student at Massey University studying towards a Masters in Public Health at Massey University. My primary supervisor is Dr. Sarah-Jane Paine (Ngai Tuhoe) from the Sleep/Wake Research Centre at Massey University, Wellington.

The research I am undertaking for my thesis is looking at breastfeeding for Māori women and their whānau in Taranaki. Breastfeeding has wide ranging health benefits for both mother and pepi, however there are significant inequalities in the breastfeeding rates between Māori and non-Māori women.

I am interested in speaking with Māori women and their whānau about their experiences of breastfeeding, irrespective of how long they breastfed. I am particularly interested in hearing about your experiences, the support you believe is helpful, or what could be done differently to ensure that Māori women are supported throughout their breastfeeding journey.

We would like to invite you to take part in this important research project.

What is it about?

This aim of this study is to identify the ways in which whānau Māori, and in turn wahine Māori, from Taranaki can be better supported to initiate and continue to breastfeed. The project is particularly interested in support and promotion of breastfeeding in the community setting.

We are looking for 10-15 Māori women to take part in this study. To be involved in this study you must:

- Self-identify as Māori
- Living in the Taranaki area
- Be 16 years or older
- Have breastfed within the last 12 months. Please note it does not matter how long you breastfed for, of if you used other methods of feeding as well.
- Be willing to take part in a one-on-one interview with the researcher

We would like to hear from women who have had good experiences of breastfeeding and also women who found breastfeeding challenging. Gathering a range of thoughts, opinions and experiences will provide valuable insight for health workers in the development of relevant health and social service programmes.

What does it involve?

If you agree to be a part of this research project you will be interviewed by the researcher at a suitable time and place.

During this interview you will be asked questions about

- your pregnancy and birth experience
- the kind of support you received with your newborn
- your experiences of breastfeeding
- the role of whānau when it comes to making decisions around infant feeding.
- your ideas on supporting breastfeeding women and their whānau

This interview will be audio-recorded with your permission and will take approximately 1 to 1.5 hours. You will have an opportunity to read the transcripts from your interview and make changes or editions as you see fit. Your name will not appear in the transcription or in any reports or publications that come from this study.

You will receive a brochure summarising the main findings from this project. The findings of this study will also be presented in the Masters thesis of Marnie Reinfelds and shared with breastfeeding support service providers. The results may also be written up as article to be published in a peer-reviewed academic journal.

Important Points

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study at any time without having to give a reason;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

If you have any queries regarding this research project please contact the researcher and/or supervisor on the details below.

Marnie Reinfelds (Researcher) Phone/Text: 021 0299 4912 Email: ngatau@gmail.com	**Dr. Sarah-Jane Paine (Supervisor)** Sleep/Wake Research Centre Moe Tika, Moe Pai Massey University, Wellington Campus Private Bag 756 Wellington Phone: 04 801 5799 extn 6039 Email: S.J.Paine@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application __/__ *(insert application number)*. If you have any concerns about the conduct of this research, please contact Professor Julie Boddy, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 2541, email humanethicsoutha@massey.ac.nz.

Appendix E: Wāhine Māori Consent Form

MASSEY UNIVERSITY

Kia Mau, Kia Uu – Supporting the breastfeeding journey for Māori women and their whānau in Taranaki

PARTICIPANT CONSENT FORM – Key Informant Interview

- I have read the Information Sheet and have had the details of the study explained to me.
- My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I know whom to contact if I have any further questions about the study.
- I have had sufficient time to consider whether to take part.
- I understand that participation in this study is confidential and that no material, which could identify me, will be used in any reports on this study.
- I give my consent for my comments to be included in the research
- I agree/do not agree to the interview being sound recorded.
- I wish/do not wish to have my recordings returned to me.
- I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name - printed _____

☐ Tick here if you are interested in receiving a pamphlet with a summary of the research findings
Please provide a contact phone number:_____

Researcher: Marnie Reinfelds (Ngati Mutunga/Te Atiawa/Taranaki/Ngati Toa)
Contact Phone Number: 021 0299 4912
Email: ngatau@gmail.com

Supervisor: Dr. Sarah-Jane Paine
Contact Phone Number: 04 801-5799 x6039
Email: S.J.Paine@massey.ac.nz

Appendix F: Partner Information Sheet

MASSEY UNIVERSITY

Kia Mau, Kia Uu
Supporting the breast-feeding journey for Māori women and their whānau in Taranaki

INFORMATION SHEET
PARTNER INTERVIEW

Tena koe. He mokopuna ahau o te maunga titohia. Ko Ngati Mutunga toku nei iwi. Ko Marnie Reinfelds ahau.

My Name is Marnie Reinfelds and I am a student at Massey University studying towards a Masters in Public Health at Massey University. My primary supervisor is Dr. Sarah-Jane Paine (Ngai Tuhoe) from the Sleep/Wake Research Centre at Massey University, Wellington.

The research I am undertaking for my thesis is looking at breast-feeding for Māori women and their whānau in Taranaki. Breast-feeding has wide ranging health benefits for both mother and pepi, however Māori breast-feeding rates are below the recommended level and lower than the breast-feeding rates for non-Māori.

I am interested in speaking with Māori women and their whānau about their experiences of breast-feeding, irrespective of how long they breastfed. I am particularly interested in hearing about your experiences as whānau, the support you believe is helpful, or what could be done differently to ensure that whānau Māori are empowered to support wahine Māori throughout their breast-feeding journey.

We would like to invite you to take part in this important research project.

What is it about?

This aim of this study is to identify the ways in which whānau Māori, and in turn wahine Māori, from Taranaki can be better supported to initiate and continue to breastfeed. The project is particularly interested in support and promotion of breast-feeding in the community setting.

I am wanting to kōrero with **the male partners** of Māori women who have breastfed (regardless of duration) in the previous 12 months. To be involved in this study you must:

- Self-identify as Māori
- Live in the Taranaki area
- Be 16 years or older
- Have had a partner breast-feed within the last 12 months. Please note it does not matter how long they breastfed for, or if they used other methods to feed their baby
- Be willing to take part in an interview

Your thoughts, opinions, experiences will provide valuable insight for health workers in the development of relevant health and social service programmes. You will receive a $20 koha for your participation.

What does it involve?

This interview will be audio-recorded with your permission and will take approximately 1 to 1.5 hours. You will have an opportunity to read the transcripts from your interview and make changes or editions as you see fit. Your name will not appear in the transcription or in any reports or publications that come from this study.

You will receive a brochure summarising the main findings from this project. The findings of this study will also be presented in the Masters thesis of Marnie Reinfelds and shared with breast-feeding support service providers. The results may also be written up as article to be published in a peer-reviewed academic journal.

Important Points

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study at any time without having to give a reason;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

If you have any queries regarding this research project please contact the researcher and/or supervisor on the details below.

Marnie Reinfelds (Researcher) Phone/Text: 021 0299 4912 Email: ngatau@gmail.com	**Dr. Sarah-Jane Paine (Supervisor)** Sleep/Wake Research Centre Moe Tika, Moe Pai Massey University, Wellington Campus Private Bag 756 Wellington Phone: 04 801 5799 extn 6039 Email: S.J.Paine@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 11/26. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz

Appendix G: Partner Consent Form

MASSEY UNIVERSITY

SLEEP–WAKE research centre
MOETIKA–MOE PAI

Kia Mau, Kia Uu – Supporting the breastfeeding journey for Māori women and their whānau in Taranaki

PARTNER/WHANAU MEMBER INTERVIEW
PARTICIPANT CONSENT FORM

- I have read the Information Sheet and have had the details of the study explained to me.
- My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I know whom to contact if I have any further questions about the study.
- I have had sufficient time to consider whether to take part.
- I understand that participation in this study is confidential and that no material, which could identify me, will be used in any reports on this study.
- I give my consent for my comments to be included in the research
- I agree/do not agree to the interview being sound recorded.
- I wish/do not wish to have my recordings returned to me.
- I agree to not disclose anything discussed in the interview.
- I agree to participate in this study under the conditions set out in the Information Sheet.

Date:

Signature: _____ _____

Full Name - printed _____

☐ Tick here if you are interested in receiving a pamphlet with a summary of the research findings
Please provide a contact phone number:_____

Researcher: Marnie Reinfelds (Ngati Mutunga/Te Atiawa/Taranaki/Ngati Toa)
Contact Phone Number: 021 0299 4912
Email: ngatau@gmail.com

Supervisor: Dr. Sarah-Jane Paine
Contact Phone Number: 04 801-5799 x6039
Email: S.J.Paine@massey.ac.nz

Appendix H: Whānau Information Sheet

MASSEY UNIVERSITY

SLEEP–WAKE research centre
HOETIKA–MOE PAI

Kia Mau, Kia Uu
Supporting the breast-feeding journey for Māori women and their whānau in Taranaki

INFORMATION SHEET
WHANAU MEMBER INTERVIEW

Tena koe. He mokopuna ahau o te maunga titohia. Ko Ngati Mutunga toku nei iwi. Ko Marnie Reinfelds ahau.

My Name is Marnie Reinfelds and I am a student at Massey University studying towards a Masters in Public Health at Massey University. My primary supervisor is Dr. Sarah-Jane Paine (Ngai Tuhoe) from the Sleep/Wake Research Centre at Massey University, Wellington.

The research I am undertaking for my thesis is looking at breast-feeding for Māori women and their whānau in Taranaki. Breast-feeding has wide ranging health benefits for both mother and pepi, however Māori breast-feeding rates are below the recommended level and lower than the breast-feeding rates for non-Māori.

I am interested in speaking with Māori women and their whānau about their experiences of breast-feeding, irrespective of how long they breastfed. I am particularly interested in hearing about your experiences as whānau, the support you believe is helpful, or what could be done differently to ensure that whānau Māori are empowered to support wahine Māori throughout their breast-feeding journey.

We would like to invite you to take part in this important research project.

What is it about?

This aim of this study is to identify the ways in which whānau Māori, and in turn wahine Māori, from Taranaki can be better supported to initiate and continue to breastfeed. The project is particularly interested in support and promotion of breast-feeding in the community setting.

I am wanting to korero with female **whānau** members of Māori women who have breastfed (regardless of duration) in the previous 12 months. To be involved in this study you must:

- Self-identify as Māori
- Live in the Taranaki area
- Be 16 years or older
- Have had a whānau member breastfeed their baby within the last 12 months. Please note it does not matter how long they breastfed for, or if they used other methods to feed their baby
- Be willing to take part in an interview

Your thoughts, opinions, experiences will provide valuable insight for health workers in the development of relevant health and social service programmes. You will receive a $20 koha for your participation.

What does it involve?

This interview will be audio-recorded with your permission and will take approximately 1 to 1.5 hours. You will have an opportunity to read the transcripts from your interview and make changes or editions as you see fit. Your name will not appear in the transcription or in any reports or publications that come from this study.

You will receive a brochure summarising the main findings from this project. The findings of this study will also be presented in the Masters thesis of Marnie Reinfelds and shared with breast-feeding support service providers. The results may also be written up as article to be published in a peer-reviewed academic journal.

Important Points

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study at any time without having to give a reason;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

If you have any queries regarding this research project please contact the researcher and/or supervisor on the details below.

Marnie Reinfelds (Researcher) Phone/Text: 021 0299 4912 Email: ngatau@gmail.com	**Dr. Sarah-Jane Paine (Supervisor)** Sleep/Wake Research Centre Moe Tika, Moe Pai Massey University, Wellington Campus Private Bag 756 Wellington Phone: 04 801 5799 extn 6039 Email: S.J.Paine@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 11/26. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.

Appendix I: Whānau Consent Form

MASSEY UNIVERSITY

SLEEP–WAKE research centre
MOETIKA–MOE PAI

Kia Mau, Kia Uu – Supporting the breastfeeding journey for Māori women and their whānau in Taranaki

PARTNER/WHANAU MEMBER INTERVIEW
PARTICIPANT CONSENT FORM

- I have read the Information Sheet and have had the details of the study explained to me.
- My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I know whom to contact if I have any further questions about the study.
- I have had sufficient time to consider whether to take part.
- I understand that participation in this study is confidential and that no material, which could identify me, will be used in any reports on this study.
- I give my consent for my comments to be included in the research
- I agree/do not agree to the interview being sound recorded.
- I wish/do not wish to have my recordings returned to me.
- I agree to not disclose anything discussed in the interview.
- I agree to participate in this study under the conditions set out in the Information Sheet.

Date:

Signature: _____ _____

Full Name - printed _____

☐ Tick here if you are interested in receiving a pamphlet with a summary of the research findings
Please provide a contact phone number:_____

Researcher: Marnie Reinfelds (Ngati Mutunga/Te Atiawa/Taranaki/Ngati Toa)
Contact Phone Number: 021 0299 4912
Email: ngatau@gmail.com

Supervisor: Dr. Sarah-Jane Paine
Contact Phone Number: 04 801-5799 x6039
Email: S.J.Paine@massey.ac.nz