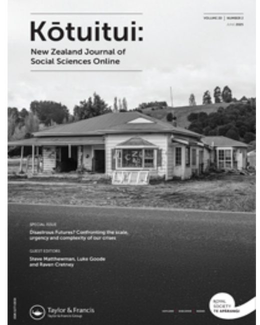

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RESEARCH ARTICLE

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Enhancing maternal sleep health in Aotearoa New Zealand: insights from the Wāhi Kōrero platform

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ABSTRACT

Maternal sleep health is crucial for maternal wellbeing, particularly maternal mental health which has implications for the wellbeing of children, families and whānau. In Aotearoa New Zealand, the Well Child Tamariki Ora (WCTO) service provides a unique opportunity to support mothers, their families, and whānau by providing education on sleep health for both mothers and children. However, there is a need for a deeper understanding of mothers' experiences with WCTO and the sleep information they receive to enhance these services. This primary research used data gathered from the Wāhi Kōrero online story-sharing platform, with 181 stories focusing specifically on sleep. Using thematic analysis, three key themes were identified: maternal instinct as a guide in navigating child sleep practices, promoting strength-based rather than deficit-focused approaches, and the necessity to move beyond rigid, monocultural service models. Findings underscore the importance of tailoring maternal and child health services to better meet the needs and perspectives of mothers, their families, and whānau, particularly in the areas of sleep and maternal mental health. Implications of findings for future policy and practice are discussed, including developing strength-based, culturally responsive approaches within services like WCTO, and adapting policy to support more flexible, whānau-centred models of care.

Glossary of Kupu Māori words: Aotearoa: Māori name of New Zealand; hapū: pregnant; kaupapa Māori: Māori ideology – a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society; kōrero: to tell, say, speak, read, talk, address; Māori: Indigenous people of Aotearoa-NZ; Pākehā: New Zealander of European descent; Kāhui Rangahau: expert advisory group; wāhine: female, women; whānau: family or closely connected kin group

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Introduction

Effective professional support and guidance can play a crucial role in the wellbeing of mothers during the post-natal period, offering substantial benefits to both mother and child. Such support has been shown to enhance breastfeeding practices (Renfrew et al. 2012), strengthen mother–child bonds (Finlayson et al. 2020), boost parental confidence and skills (Lin et al. 2008), and increase overall satisfaction with parenting (Rowe et al. 2013; Finlayson et al. 2020).

However, alongside these benefits, it is also essential to acknowledge and respond to the heightened risks that mothers may face during this time. These include not only biomedical risks such as mental distress (Norhayati et al. 2015), hypertension (Katsi et al. 2020) and venous thromboembolism (Jackson et al. 2011), but also psychosocial and cultural risks. Mothers may experience social isolation, financial insecurity, housing stress, relationship strain, and loss of personal identity – all of which can undermine their ability to care for themselves and their children (Finlayson et al. 2020).

Complex personal circumstances and systemic pressures can exacerbate these risks, often resulting in unhealthy behaviours such as smoking, poor nutrition, and physical inactivity (Walker and Wilging 2000; Fahey and Shenassa 2013). It is crucial to recognise and address broader socio-economic determinants of health, rather than attributing these challenges solely to individual choices or perceived self-neglect. By shifting focus towards structural factors and lived realities, we can better support maternal health and wellbeing during this critical postnatal period.

Recognising these challenges, the World Health Organization (2024) emphasises the importance of maternal care that prioritises mothers' preferences and needs alongside that of their child. Low engagement in maternal care is linked to adverse maternal outcomes (Dawson et al. 2022; Singh et al. 2023), underscoring the importance of effective support. Among the various challenges new mothers encounter, sleep loss and disruption are critical yet often overlooked aspects of postnatal care. Adequate sleep is vital for both maternal and child health, making it essential to address sleep issues within the broader context of maternal and child wellbeing (Signal et al. 2022).

Sleep health

Research highlights the critical importance of sleep health throughout a person's life (Buysse 2014). Adequate sleep has been linked to vital health outcomes, including mortality (Elder et al. 2008), obesity (Buxton and Marcelli 2010), immune function (Del Gallo et al. 2014), and mental distress (Baglioni et al. 2011). In their early years, infants and children spend more time asleep than awake (Iglowstein et al. 2003), with adequate sleep being essential for their development and for maintaining harmony within the family (El-Sheikh and Buckhalt 2015; Muller et al. 2019).

The sleep patterns of mothers and their children are interconnected, with the sleep and feeding schedules of children often leading to sleep disturbances in mothers (Nishihara et al. 2000; Hunter et al. 2009). Beyond these immediate disruptions, mothers' sleep health during this period is also influenced by a variety of factors such as other caring

responsibilities, employment, and life stressors (Signal et al. 2022). This demonstrates the complexity of sleep issues during the postnatal period (Goyal et al. 2007; Hunter et al. 2009).

In addition to the impact of sleep on overall health outcomes, a bidirectional relationship between sleep and maternal mental health has been well-established in the empirical literature (Hunter et al. 2009; Baglioni et al. 2011; Lawson et al. 2015). Mothers experiencing depression often face greater sleep disruptions, while those who face challenges with sleep are at a higher risk of developing depressive symptoms (Goyal et al. 2007; Bhati and Richards 2015). This interconnection persists into the early childhood years, with the sleep quality of children influencing maternal sleep and mental health, and vice versa (Meltzer and Mindell 2007; Meltzer and Montgomery-Downs 2011). Intervention studies have further validated this reciprocal relationship, demonstrating that efforts to improve sleep in the perinatal period can lead to reductions in depressive symptoms (Hollenbach et al. 2013; Avalos et al. 2020; Ladyman et al. 2020; Liu and Yang 2021; Manber et al. 2023). Similarly, interventions aimed at alleviating depressive symptoms have been shown to improve sleep quality. This highlights the potential of maternal sleep as a modifiable risk factor for depression, offering a valuable opportunity for preventative and therapeutic interventions.

Given the intertwined nature of sleep and maternal mental health, it is critical that mothers are provided with comprehensive support and advice not only for infant and child sleep but also for their own sleep. Addressing maternal sleep issues is not just about improving sleep health but is also a proactive step towards enhancing maternal mental health. This underscores the need for a holistic approach in maternal and child health programmes, ensuring that sleep guidance and mental health support are integral components of care for mothers and their whānau and families.

Well Child Tamariki Ora (WCTO)

In Aotearoa New Zealand, the WCTO programme provides crucial support and health services to children from birth to age five. This programme, established under the guidelines of the Well Child Tamariki Ora National Schedule (Ministry of Health 2013a) and the Quality Improvement Framework (Ministry of Health 2013b), is designed to deliver a wide range of care primarily centred around the child's health and development needs. This includes regular visits where a WCTO provider checks the child's growth and development, evaluates the family's health and wellbeing, and provides valuable advice on key areas such as breastfeeding, nutrition, and safe sleeping practices (Ministry of Health 2024).

While the programme aims to support families comprehensively and provide additional help for those most in need, its primary focus remains to monitor and promote the health and development of the child (Ministry of Health 2013a). Consequently, there is less focus on maternal health. Despite the intent of being available for all children in Aotearoa New Zealand, the WCTO programme has struggled to effectively reach and meet the needs of the most underserved communities, thereby exacerbating existing health inequities. Recent evaluations reveal significant gaps, particularly for Māori and Pacific whānau and families (Ministry of Health 2021).

These gaps manifest as lower levels of service engagement, difficulties in accessing care, and a lack of culturally appropriate and responsive services.

Sleep advice within the WCTO programme primarily focuses on ensuring safe infant sleeping practices to mitigate the risk of sudden unexpected death in infancy (SUDI). This advice emphasises guidelines that discourage co-sleeping and advocates for infants to sleep in separate but proximate spaces. The method of advocacy predominantly uses checklist-based inquiries, such as verifying the infant's separate sleeping arrangement, rather than prompting a comprehensive discussion on various safe sleep practices (Ministry of Health 2013a). The intricacies of co-sleeping and the underlying reasons for these recommendations are often overlooked and this approach may not fully address the complexity of SUDI causes. Factors such as poverty, family engagement, maternal smoking during pregnancy, infant health issues, maternal mental wellbeing, and the fragmentation of services can all contribute to the multifaceted nature of SUDI risks (Tipene-Leach and Fidow 2022). This has led to recommendations which move beyond the 'abstinence only' messaging to reduce SUDI (Altfeld et al. 2017). This suggests a need for a more nuanced and thorough exploration of safe sleeping practices within the programme.

Beyond a focus on reducing SUDI risks, the provision of maternal sleep advice within the WCTO programme is limited, overlooking the significant role that sleep plays in the health and wellbeing of mothers and in turn that of the child. The programme guidelines do not require providers to offer guidance or monitor maternal sleep quality or habits, thereby neglecting an essential component of maternal health care (Ministry of Health 2013a). The focus remains heavily on infant sleep, with directives primarily cautioning against co-sleeping, while comprehensive advice or support concerning maternal sleep is conspicuously absent. This gap extends to online resources, where both the New Zealand Ministry of Health (2021) and Te Whatu Ora: Health New Zealand (2023) have dedicated websites that offer extensive safe sleep information for infants but fail to address the significance of sleep for maternal health or provide any practical advice aimed at improving the sleep of mothers. These limitations in the WCTO programme's approach to sleep underscore the need for a more comprehensive and inclusive framework that prioritises the wellbeing of both mothers and babies.

Wāhi Korero

To explore these issues further, stories submitted to Wāhi Kōrero (http://www.wahikorero.co.nz) were analysed. Wāhi Kōrero is a unique online story-sharing platform that allows people to anonymously share their healthcare experiences including difficulties in accessing care, gaps in care, and the appropriateness of the care received (Severinsen et al. 2025). In 2021, the first Wāhi Kōrero project was launched with the prompt: 'Kōrero I wish I could've had with the Well Child nurse', encouraging people to share their experiences of nondisclosure with their Well Child provider.

This article presents findings from the Wāhi Kōrero project specifically related to participants' experiences with sleep and maternal mental well-being. By examining the interactions between mothers and Well Child Tamariki Ora (WCTO) providers, this study aimed to provide insights that could inform future research, shape policy, and enhance the support provided by healthcare professionals to improve the sleep and mental wellbeing of both mothers and their babies.

Method

Approach

This study employed a qualitative approach underpinned by a pragmatic paradigm, focusing on the practical applications of research findings. Pragmatism emphasises solving real-world problems with methods that deliver the most useful results (Morgan 2007; Creswell 2014). Pragmatism is distinct from other epistemological paradigms such as positivism, realism, and constructivism, which each offer different ways of understanding knowledge and its production. The pragmatic paradigm was selected to align with the aim of producing actionable knowledge that enhances maternal and child health services. By prioritising real-world problem-solving, methodological flexibility, and the incorporation of diverse perspectives, the pragmatic approach is useful for navigating the complexities of health service experiences and generating actionable insights (Morgan 2014; Kaushik and Walsh 2019). This paradigm enables research that is responsive to the needs and priorities of the communities we serve, generating knowledge that can inform meaningful improvements in policy and practice (Feilzer 2010).

Positivism, with its emphasis on objective certainty and quantifiable results, often relies on rigid methodologies to ensure reliability and validity (Onwuegbuzie and Leech 2005). In contrast, pragmatism is less concerned with the rigid application of methods and more focused on the usefulness and applicability of findings in real-world contexts (Feilzer 2010; Morgan 2014; Lincoln et al. 2018). While positivism seeks to uncover objective truths, pragmatism prioritises practical outcomes and actionable knowledge, allowing for methodological flexibility in response to research needs (Onwuegbuzie and Leech 2005). Realism, which posits that reality exists independently of human perception but can be understood through both objective and subjective lenses, shares some similarities with pragmatism in its acknowledgment of multiple perspectives. However, realism maintains a more fixed understanding of reality, whereas pragmatism is more fluid, adapting methods and approaches to address practical problems effectively (Cornish and Gillespie 2009). Constructivism, on the other hand, focuses on the subjective nature of knowledge, emphasising how individuals construct their own understanding of reality through their experiences. While constructivism aligns with pragmatism in valuing diverse perspectives, it differs in its focus on the subjective construction of knowledge rather than on practical problem-solving (Cornish and Gillespie 2009; Morgan 2014; Lincoln et al. 2018).

Throughout the research process, we employed abductive reasoning, moving back and forth between inductive and deductive thinking. This allowed us to generate insights from the data while considering existing theories and knowledge related to maternal and child health. For instance, when analysing the data, we inductively identified themes, such as the importance of following maternal instinct in sleep practices, and then deductively examined how these themes aligned with or challenged existing literature on the topic.

Data collection

Data for this study were collected using the Wāhi Kōrero research platform, which invites people to share personal accounts in response to specific prompts developed by the Wāhi Kōrero research team and Kāhui Rangahau (expert advisory group). For this study, the prompt was ‘Kōrero I wish I could’ve had with the Well Child nurse’. This prompt was

designed to encourage participants to discuss their experiences of nondisclosure with their Well Child provider.

Recruitment and participants

Recruitment was conducted through social media platforms (Instagram, Facebook) and community networks, including collaboration with ActionStation, specifically targeting under-served groups such as young mothers and the Māori community. Participants were directed to the Wāhi Kōrero platform via a shared link, where they could respond directly to the prompt. Over a nine-week period, the platform collected 420 stories, demonstrating its effectiveness and participants' willingness to engage. For the purposes of this research, only stories that referenced sleep were included, resulting in 181 sleep-related stories for analysis. Among respondents, 61% disclosed their ethnicity: 81% identified as NZ European Pākehā, 18% as Māori, and 3% as Pasifika. The average age of participants was 34, and most identified as women. The term 'mother' is used throughout this study as it reflects the language participants used in their stories. However, we acknowledge that not all caregivers may identify with the term 'mother' outside of the context of this research.

Ethics

Approval for the Wāhi Kōrero platform was obtained from a University Ethics Committee. All submitted stories were reviewed by the research team: identifying details of people, places, or health services were removed, and inappropriate, destructive, or inflammatory content was edited out. To enhance safety, the platform includes a safe-exit function (similar to those used in family violence websites) allowing users to quickly leave the site if needed. Participants consented to the use of their stories for research purposes prior to submission, with clear terms of use and privacy policies outlined on the platform. All participants were given pseudonyms to protect their privacy. All stories submitted as part of this project are accessible on the Wāhi Kōrero website (https://wahikorero.co.nz/projects/korero-i-wish-i-couldve-had-with-the-wellchild-nurse/).

Data analysis

Thematic analysis followed Braun and Clarke's (2022) six-step iterative process. Initially, the research team familiarised themselves with the data by reading through stories and using the 'read aloud' function to listen to each entry multiple times. This engagement with the data brought the context and content of the stories into sharper focus. Next, Author 1 generated initial semantic codes using NVivo software (Release 1.7.1). These initial codes were then refined and discussed with the broader research team. This collaborative discussion led to the development of a draft thematic map, which was iteratively reviewed by going back and forward through the data, codes and themes and refined through multiple discussions among all authors.

The process included:

1. Familiarisation with the data: Reading and listening to stories multiple times.
2. Generating initial codes: Author 1 coded the data using NVivo, focusing on meaningful segments of text.

3. Searching for themes: Initial codes were grouped into potential themes, forming a draft thematic map.
4. Reviewing themes: The research team collaboratively reviewed and refined the themes to ensure they accurately represented the data.
5. Defining and naming themes: Final themes were defined, named, and reviewed to ensure clarity and coherence.
6. Producing the report: The final themes were used to structure the findings, with illustrative quotes retained to preserve the voices of the participants. Quotes were reproduced with the spelling and grammatical constructions used by the participants.

This rigorous, collaborative process ensured that the themes provided a meaningful and practical representation of the data. While recognising that theme identification was influenced by the researchers' worldviews and positioning within the study – a central tenet of reflexive thematic analysis – we approached the data with openness and critical reflection. As such, the themes are not intended to be definitive or universally replicable, but rather one possible interpretation shaped through our collective lens. By clearly documenting each step of the thematic analysis, we aimed to make the analytical process transparent.

Results

Three themes were identified from the data, namely: maternal instinct as a guide in navigating child sleep practices, shifting from deficit-focused messaging to strength-based approaches, and moving beyond rigid, monocultural service models.

Maternal instinct as a guide in navigating child sleep practices

The term 'instinct' is used here to describe the ways mothers spoke about following their innate instinct and/or intuition. Mothers conveyed a profound sense of their own innate instinct when it came to understanding their child's needs, especially around sleep. While they did not claim to understand the complexities of sleep physiology, their kōrero emphasised the importance of maternal instinct as a valuable guide for making sleep-related decisions. This instinct involved mothers trusting their innate motherly sense to determine what is best for themselves and their children. Maternal instinct was seen to play a pivotal role in sleep practices. Mothers often distinguished between their innate instinct and the advice given by WCTO providers, frequently pointing out discrepancies and/or contradictions between the two.

> I was very keen to do right by my baby and one thing I discovered early on was to listen to my instinct for what he needed. Sometimes this instinct was different to what I knew to be conventional advice. For example, I did not want to put my very young baby down to nap – he needed to be held. – Sarah

Instinct was also central to decisions affecting attachment and bonding during sleep, with many mothers viewing bonding as a continuous process that includes both waking and sleeping periods. At times they described this instinct as contravening accepted sleep advice.

> … our decision to let our child sleep in between me and my partner was always asked, not that I listened to it as I simply followed my motherhood instincts to do what I think is best for us to bond as a family and enjoy this journey. – Jackie

> I wish my nurse could have supported me in my decision to co-sleep. It was such an important way to bond, and it was so much easier for feeding in the night. It also made me feel more connected to the traditions in my culture, and with my own parenting instincts. – Tūī

When external advice conflicted with maternal instincts, it created stress and negatively impacted mental health. Mothers often felt unsupported and judged by providers when their natural inclinations differed from the advice given. They often persisted in attempting to follow the advice, and in doing so, increased their distress:

> I wish we were supp[o]rted to trust our intuition more … with my son I did all they said with regards to sleeping, drowsy but awake, sleep training etc … my son would scream for ages and I'd be crying too not picking him up so he wouldt get spoilt. Going against all intuition etc etc … I ended up with post natal depression and realise now I would have anxiety attacks before bedtimes. – Kaye

These ongoing difficulties led participants to conduct their own research and follow their instinct despite feeling guilty. This tension between following maternal instinct for bonding and navigating professional advice and expectations around sleep practices highlights the power dynamics between mothers and healthcare providers. This power imbalance can lead to feelings of guilt, anxiety and distress as mothers struggle to reconcile their instinct with external expectations.

Shifting from deficit-focused messaging to strength-based approaches

Fear-based health messaging and deficit approaches negatively impacted mothers' feelings about the sleep practices they engaged in to support their children's sleep. This theme encompassed mothers' emotional responses to the messages they received from WCTO providers. Strengths-based and empowerment approaches were seldom present in the kōrero shared by mothers, while the use of fear-based approaches notably harmed the provider-whānau relationship. This often left mothers feeling disempowered and unsupported. These feelings contributed to mental distress and breakdowns in relationships, leading mothers to withhold information about their experiences, creating further division in the provider-whānau relationship.

> I feel like I was made to be scared of co-sleeping. I really wish my [Provider] nurse would have explained how to safely co-sleep and shown me how to breastfeed lying down. Instead I got stern words around making sure I never fell asleep when my baby fell asleep and always sitting up to feed. – Laura

> I wish I could have been able to tell my [Provider] nurse that I was cosleeping and instead of being shamed was educated in the subject. The one time I bought it up my [Provider] nurse acted like it was the end of the world and told me I would kill my baby. It made me carry so much shame for doing something so natural. – Michelle

Conversely, using a strengths-based approach by establishing a trusting, adaptive and supportive relationship between healthcare providers and mothers positively influenced sleep outcomes and mental wellbeing. When healthcare providers acknowledged and respected maternal decisions regarding sleep practices, it cultivated trust between

providers and whānau. This trusting relationship and strengths-based approach improved wellbeing and alleviated mothers' feelings of guilt and judgement.

> She empowered me as a parent every step of the way. She supported my breastfeeding goals and didn't judge me when I said we bed shared, simply checked we were doing it safely. – Josie

> With [First Provider] they told me everything they thought I was doing wrong, [Second Provider] told me everything I was doing well. Big change for maternal mental health. – Tiffany

These contrasting experiences highlight the power dynamics between mothers and healthcare providers. Fear-based messaging and deficit approaches often fail to consider the complex realities of mothers' lives and can exacerbate feelings of powerlessness and shame. The stories highlighted how deficit messages could make mothers feel reprimanded and inadequate. Strengths-based approaches that prioritise trust, respect, and empowerment can foster more positive provider-whānau relationships and improve maternal mental health outcomes. When providers approached mothers respectfully, acknowledged their experiences, and offered support without inducing shame, they built stronger relationships.

Moving beyond rigid, monocultural service models

Many mothers felt that the WCTO providers were adopting a 'tick box' approach to their care, adhering to a predetermined script that resulted in a generic 'one-size-fits-all' strategy. This approach appeared particularly inflexible regarding advice on sleep, lacking customisation or adaptation to meet individual needs. Additionally, this rigid, surveillance-oriented attitude towards sleep practices caused mental distress and feelings of disempowerment among mothers. One mother described their Well Child visits as interview-like, driven by checklists without a foundation of trust, making it difficult for them to reveal their struggles with their child's sleep. They felt worse for not disclosing their attempts at sleep training and felt guilty for bedsharing, even though it was a solution they found effective after their own research.

> I found each well child visit more like an interview, its literally a check list. As there was no pre existing relationship between the nurse and I, I found it very hard to be honest about my struggles with settling my baby and lack of sleep. I was dabbling in sleep training which I didn't tell the nurse. It only made me feel worse. The 'does you baby sleep in a cot or bassinet' question always made me feel guilty since I was bedsharing a lot of the time. I had looked into safe bedsharing myself after the disaster of sleep training. – Alice

Another mother expressed a wish to communicate openly with providers about bedsharing as a response to their child's sleep troubles at four months, emphasising the positive impact it had on both their sleep and their mental health. They highlighted the need for discussions on safe bedsharing to prevent SUDI, suggesting that a lack of guidance on safe practices is a significant oversight.

> I wish I could have told the [Provider] nurses that after my baby hit 4 months, his sleep became so terrible that he was waking every 45 mins and I had no choice but to bedshare with him. He slept SO MUCH better in my bed and I stopped feeling like a broken woman. I felt like they would tell me off for this, despite the fact that I had researched safe bedsharing and was following all the guidelines. Had I not bedshared, my mental

> health would have continued to decline. I wish the [Provider]Nurses could discuss safe bedsharing as SIDS occurs when safe bedsharing isn't followed (which is because no one tells mothers how to do it safely). – Kate

The stories also highlighted the importance of healthcare practices that are culturally sensitive with an ability to acknowledge diverse perspectives on sleep and care. The current approach, heavily influenced by Western norms, fails to accommodate the broad range of needs and worldviews of whānau and families, including Indigenous Māori and Pasifika communities. Mothers stressed that incorporating these cultural perspectives from the onset of care could improve sleep and mental health outcomes for them and their whānau and families.

One mother shared their discomfort within a system that did not align with the holistic needs of being Māori, feeling labelled as a failure for practices such as bedsharing, which conflicted with mainstream healthcare advice. Another emphasised the historical and cultural importance of co-sleeping within their community, likewise encountering difficulties reconciling these practices with the prevailing healthcare advice.

> A lot of the time during being hapū and after having my baby, I felt guilty I could not be up to par in the pākehā worldview. I was told sleeping with my baby was bad and not only in terms of cot death, I felt like a failure … I have never felt comfortable within a system that doesn't share the same holistic overview Māori wahine need to feel safe and nurtured. Although not all nurses and [Provider] people were bad. This just goes to show the difference between what Māori need and how we aren't getting that from current health systems. Things need to change. More cultural awareness should be mandatory for all in any social mahi. – Hinemoa

> My husband and I co-slept with my daughter right from when she was a newborn. It is what my people always did until colonisation, and felt most natural and right to me. Before she was born, I read books about co-sleeping to learn how to do it safely (although really, it was as much to be able to say I had done that, and argue my case, when people questioned it). My well child nurse was a middle-aged white woman. At first I pretended my daughter was sleeping in the baby hammock we had, but eventually told her our sleeping arrangement. Her response was not unkind, but she was clear that the official line was that it wasn't safe. – Tūī

This theme underscores the importance of healthcare professionals recognising and respecting a range of cultural practices in maternal care. The impact of their advice on mothers' feelings of empowerment and the wellbeing of the child were powerful. Instances where mothers felt the need to lie to the WCTO provider or to go against advice to pursue what they believed was best for their children underscores the adverse impacts of unsupportive or uninformed advice. The stories demonstrate how strict adherence to a monocultural approach can foster feelings of guilt, shame and disempowerment among mothers who adhere to different cultural practices and/or have different understandings about sleep and care. Furthermore, inflexible and culturally insensitive sleep advice can significantly affect maternal mental health and child wellbeing.

Discussion

Professional support and guidance during the postnatal period can play a crucial role in promoting maternal wellbeing, offering substantial advantages for both mother and child

(Barlow et al. 2010). Given the close relationship between sleep and mental health, comprehensive support that addresses both the mother's and child's sleep needs is vital. This study used thematic analysis to explore the discussions mothers wished they could have had with their WCTO providers about sleep. The findings demonstrate the importance of aligning maternal and child health services with the needs and perspectives of mothers, families, and whānau, particularly in the areas of sleep and maternal mental health.

Three key themes were identified from our analysis – maternal instinct as a guide in navigating child sleep practices, the need for a shift towards strength-based rather than deficit-focused approaches, and the necessity to move beyond rigid, monocultural service models. These themes indicate a misalignment between the services currently offered by WCTO providers and the needs and perspectives of mothers, families and whānau. Our results emphasise the intersubjective nature of maternal and child health experiences, recognising the common challenges, such as the need for culturally sensitive and supportive care, alongside diverse personal experiences and perspectives. The stories shared by mothers in this study contribute to a deeper understanding of the complexities and opportunities in the WCTO service, highlighting the need for providers to engage in open dialogue with mothers, whānau and families to co-create meaningful solutions.

The role of maternal instinct and/or intuition in promoting positive health outcomes for both mothers and babies is still an evolving area of research. This study highlights the tension mothers experience when professional advice contradicts their instincts, often leading to distress. This echo's recent research from Moon et al. (2024) who identified that mothers often engaged in non-recommended sleep advice to better their own sleep and their baby's sleep. Osorio (2023) also observed that discrepancies between professional sleep recommendations and a mother's preferred methods can elevate stress levels, emphasising the need to support mothers in their intuitive decision-making. Gardner et al. (2020) similarly found that greater confidence in maternal intuition is associated with fewer depressive symptoms, demonstrating the protective effect of trusting one's instincts during the perinatal period. The stories shared by mothers in our study align with these findings, with many mothers expressing a desire for healthcare providers to acknowledge and value their intrinsic understanding of their children's sleep and well-being.

Acknowledging and valuing maternal instinct can lead to more respectful and effective healthcare interactions, empowering mothers and enhancing their confidence and wellbeing (Price et al. 2018; Pease et al. 2021). The experiences shared by mothers emphasise the need for a more nuanced approach when discussing sleep practices, advocating for healthcare providers to be trained in methods that respect and support, rather than dismiss, mothers' caregiving instincts. By integrating maternal instincts with evidence-based safe practice advice, providers can foster a collaborative environment that respects family dynamics and values, improving bonding experiences and maternal mental health outcomes.

However, it is also important to recognise that maternal instinct is not always aligned with safe sleep recommendations. For instance, as Salm Ward (2025) describes some mothers place pillows on adult beds to prevent their babies from rolling off, inadvertently increasing the risk of suffocation. These tensions highlight why a shift is needed – away from rigid, 'tick-box' approaches that tell parents what to do, and towards relational, context-aware conversations that explore *why* certain practices are recommended.

When providers take the time to explain the reasoning behind safe sleep advice and remain open to culturally grounded practices such as co-sleeping, they create space for honest dialogue and shared understanding. In doing so, best-practice advice becomes more meaningful, more trusted, and ultimately more effective.

Transitioning from deficit-focused messaging to strength-based approaches is supported by an expanding body of research underscoring the effectiveness of these methods in enhancing health outcomes (Wepa and Wilson 2019; Tipene-Leach and Fidow 2022; Reweti 2023). In our study, mothers' narratives revealed the detrimental effects of fear-based and deficit-oriented messaging on their sleep practices and mental health, frequently resulting in feelings of disempowerment and a lack of support. This finding resonates with and extends previous studies that have identified how deficit-based approaches can not only perpetuate health disparities but also erode trust in healthcare systems (Silverman et al. 2023).

Our findings advocate for adopting a strength-based approach that fosters resilience, empowerment, and self-determination, which, in turn, leads to more constructive engagements between WCTO providers and mothers. By focusing on the assets of individuals, families, and whānau, health practitioners can foster these positive engagements, as evidenced by recent studies (Wepa and Wilson 2019; Tipene-Leach and Fidow 2022; Reweti 2023). This method emphasises collaboration with mothers, families, and whānau in setting health goals, while highlighting the importance of respectful, supportive relationships. Neglecting the strengths and needs of families can compromise health outcomes, including those related to sleep and mental health (Stevenson et al. 2020). Furthermore, culturally responsive care is crucial for respecting and integrating the diverse traditions and strengths of all families (Bryant et al. 2021), necessitating healthcare practices that are informed by and tailored to the communities they serve (Tipene-Leach and Fidow 2022).

Standardised, monocultural approaches to sleep advice often fail to meet the diverse needs of whānau and families, particularly within Māori and Pasifika communities (Perese et al. 2020). The limitations of a one-size-fits-all approach, are clear from the stories shared by mothers. When mothers feel unsupported or judged for their sleep practices, they may be less inclined to seek assistance or share information with healthcare providers, compromising the quality of care they receive and exacerbating health inequities. These findings are consistent with previous research showing that sleep practices, including the broad acceptance of co-sleeping, the vital role of whānau and family in decision-making, and the comfort and security that these practices provide, differ widely across cultures (Airhihenbuwa et al. 2016). Additionally, qualitative research in Aotearoa New Zealand emphasises the emotional and psychological benefits of co-sleeping with preschool-aged children, corroborating these broader observations (Baddock 2010; Muller et al. 2019; D'Souza et al. 2023). It is crucial to provide sleep guidance that respects family values and circumstances, rather than imposing rigid, one-size-fits-all directives (Crane and Ball 2016; Cunningham et al. 2018).

Furthermore, healthcare communication can be ineffective if it does not relate advice to the specific contexts of the lives of mothers, their whānau and families', which can lead to misunderstandings and non-compliance (Perese et al. 2020). The 'tick-box' approach of the WCTO programme has been criticised for prioritising organisational objectives over the needs of mothers, their whānau and families (Severinsen et al. 2022; Clapham

et al. 2024). This tension becomes especially problematic in complex areas such as bed-sharing. Health providers are required to follow the WCTO schedule, which sets out what must be checked, discussed, and documented during each visit. While this ensures consistency, it can constrain providers from engaging more flexibly or responsively. As a result, advice may be delivered in ways that conflict with mothers' deeply held cultural or familial values, leading some to dismiss the guidance – not due to a lack of understanding, but because of the disconnect between standardised messaging and their lived realities (Crane and Ball 2016; Cunningham et al. 2018). A shift towards a more holistic model that moves away from paternalistic health perspectives could lead to services more attuned to diverse health beliefs, ultimately improving both the inclusivity and effectiveness of care.

The findings of this study have significant implications for both policy and practice in the field of maternal and child health. At a policy level, this study highlights the necessity for a more comprehensive and inclusive approach to maternal and child health services. Such an approach could prioritise the wellbeing of both mothers and children and include the diversity of whānau and family and cultural contexts. This might involve a paradigm shift in how services are funded, designed and delivered, with a greater emphasis on collaboration, partnership, and co-design with mothers, their whānau, families, and communities.

At the practice level, the importance of delivering culturally responsive and whānau/family-centred care is evident. This entails building trusting and empowering relationships between healthcare providers and mothers along with their whānau and families. Achieving this may require additional training and support for healthcare providers to develop the skills needed to provide culturally safe and responsive care. Effective communication strategies within the WCTO programme may be an important component of this practice development. Communication which is culturally responsive and tailored to the specific needs and realities of the communities they serve, is vital. This may be best developed through engagement with community leaders and end users of health services. Developing health messaging which prioritises clear explanations for health advice and ensures that health services are delivered in a way that builds trust and respect may increase engagement with health services (Tipene-Leach and Fidow 2022). Additionally, allied health professionals must be supported and educated well so that they are, in turn, able to support mothers (Meaklim et al. 2020).

Furthermore, these findings indicate the need for a holistic and integrated approach within the WCTO programme to effectively address the complex factors that influence maternal sleep and mental well-being, such as child sleep patterns and cultural views on sleep. Providers would benefit from an approach that recognises the multifaceted nature of these decisions and integrates strategies to promote overall sleep and well-being. It also calls for the development of new, more flexible and adaptable models of care that can better address the diverse needs and circumstances of mothers, their whānau and families.

While our findings are specific to the context of Aotearoa New Zealand and the WCTO programme, the insights generated have potential applicability in other settings where maternal and child health services are provided. Nurturing maternal instincts, adopting strength-based approaches, and embracing cultural inclusivity are lessons which could inform the enhancement of maternal and child health services in various contexts.

Limitations and considerations

The Wāhi Kōrero prompt did not explicitly focus on sleep or mental health but instead invited mothers to share what they wished had been addressed with their Well Child providers. A notable limitation of this approach is that the data were not gather through targeted questions about sleep or mental health, which means the insights may not capture the full scope of issues in these areas. However, many mothers independently raised concerns about sleep and mental health, highlighting these as significant and unmet needs. This underscores their fundamental importance in child health discussions and points to a substantial communication gap between healthcare providers and parents. It suggests a need for more direct and explicit conversations about sleep and mental health during routine healthcare visits to enhance health outcomes. Furthermore, initiating discussions about sleep may serve as an important entry point for addressing other sensitive topics such as mental health.

Our findings also suggest valuable avenues for future research, particularly in how parental choices about sleep positions are influenced. A thorough exploration of this subject could provide insights into how health messaging on sleep practices evolves and how it interacts with established beliefs and practices within whānau, families, and communities. Such understanding could help healthcare providers customise their guidance to better resonate with and support parents.

Conclusion

This study emphasises the critical need to align maternal and child health services with the needs and perspectives of mothers, their whānau and families, particularly in the areas of sleep and maternal mental health. By nurturing maternal instinct, employing strength-based approaches, and moving away from rigid monocultural service models, the WCTO programme has the potential to cultivate a more nurturing, supportive and empowering environment for mothers, their whānau and families. This analysis reaffirms the importance of integrating sleep and mental health into child healthcare discussions. It also stresses the need for health professionals to consider the broader context in which health behaviours and decisions occur. By examining these factors more closely, future research can develop more effective health communication strategies that align with the experiences and needs of mothers, their whānau and families. Moving forward, ongoing research and collaborative efforts will be crucial to ensure that these recommended changes are not only implemented but are effective and sustainable over time. A commitment to continuous improvement and responsiveness within health services is vital for achieving lasting benefits in maternal and child health outcomes.

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