

**Ūkaipōtanga:**  
**A Grounded Theory on Optimising Breastfeeding for**  
**Māori Women and their Whānau**

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*Ūkaipōtanga: A grounded theory on optimising breastfeeding for Māori women and their whānau* provides an explanation about how Māori women can achieve optimal breastfeeding. Health data indicates that Māori breastfeeding rates in the past decade have not improved, and continues to be much lower than non-Māori. The question that guided this grounded theory research was, ‘*What is happening for Māori mothers and breastfeeding?*’ This research utilised a Kaupapa Māori methodology that informed Charmaz’s constructivist grounded theory method. Eight women who self-identified as Māori, residing within the Eastern Bay of Plenty, aged between 19 and 36 years, who had breastfed within the past 10 years, were interviewed. A Kaupapa Māori health provider was also interviewed as part of the theoretical sampling. Semi-structured interviews were conducted, and digitally recorded and transcribed. In addition, field notes and reflective memos were documented. The transcripts were the main data source, and were analysed using a process of constant comparative analysis along with theoretical sampling until data saturation was reached to generate the constructivist grounded theory. The basic process, *ūkaipōtanga* (nurturing), optimises *Māori women’s breastfeeding* and contributes to *whānau ora*, knowledge and skills for *supporting other mothers*. Three subcategories were identified: *getting ready* explains what is required for a pregnant wahine, her partner and whānau to prepare for the birth and breastfeeding; *having an engaging midwife* explains the importance of the midwife’s engagement with pregnant wāhine, mothers, her partner and whānau; and *having supportive systems* explains what forms of support are needed to assist a mother to breastfeed from postnatal stage to six months and beyond. The significance of this grounded theory research is that it was able to identify what and how Māori women achieved optimal breastfeeding, and identified that *ūkaipōtanga* (nurturing) is an important part of this process. The midwife and the partner and whānau play important roles in the *ūkaipōtanga* process, and for promoting breastfeeding. Accessible 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 is a crucial element in Māori women successfully breastfeeding. Equally important, is the environments created that promote Māori wāhine breastfeeding that should be considered by health services, employers, policy makers and the wider community.

Ko Makeo toku maunga

Ko Waiaua toku awa

Ko Ngaitamahaua toku hapu

Ko Opape toku marae

Ko Whakatōhea toku iwi

Ko Muriwai toku tipuna

Ko Mātaatua toku waka

Ki te taha o toku whaea

Ko Ngaitai, Ngāti Awa/Ngāti Pukeko, Te Whānau-ā-Apanui, Ngāti Kahunungu, me Ngāpuhi nga Iwi

Ko Tui Edwards ahau

Tēnā koutou, tēnā koutou, tēnā koutou, katoa

Ngā mihi nui ki a koutou katoa.

Everybody who has the welfare of the people at heart knows that the child of today is the man or woman of tomorrow and that the foundation of any strong virile race, fit to fight in the forefront of the battle of life, lies in the care that a mother gives her child before and after the birth (Pomare, 1949, p. 40).

Throughout my years as a health practitioner working in both mainstream and Māori health, I have often felt that efforts to help Māori improve their health and wellbeing were in vain. I, therefore, embarked on this journey to help identify best practices in a bid to try and make a difference. I am now completing my Master's Degree in Public Health. My interest for conducting this breastfeeding research arose through my role as the breastfeeding

coordinator/promoter in the Mātaatua rohe (the Eastern Bay of Plenty (EBOP)). Mothers would share their breastfeeding experiences, and grandmothers and grandfathers would tell me of their daughter's experiences. These experiences were mainly concerning breastfeeding problems. I also worked alongside some very passionate health workers, and saw the dilemmas they faced in helping mothers to breastfeed. I became concerned for the health and wellbeing of these mothers and their babies. These concerns prompted me to investigate why these women encountered breastfeeding problems, to look at strategies to help them avoid these problems, and to identify how to achieve optimal breastfeeding, through fundamentally inquiring, *'what is happening for Māori mothers and breastfeeding?'*

*Ūkaipōtanga: A grounded theory on optimising breastfeeding for Māori women and their whānau*, is about a process for *optimising Māori women's breastfeeding*. It identifies the processes needed and when these need to occur, and it then identifies what is optimal breastfeeding for Māori women and their whānau. This thesis recognises, that to raise a healthy and well child, requires the mother to also be healthy and well. She needs to be supported by her partner, whānau, her midwife, health professionals, her employer, her hapū, her Iwi and the community that she lives in.

It takes a whole village to raise a child (African proverb, author unknown).

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E hara taku toa, I te toa takitahi

Katahi o taku toa, he toa takitini

Mine is not the strength of one alone, it is the strength of many.

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### A

Aroha – love

### H

Hapū – pregnant, conceive, sub tribe, clan

Hinengaro – psychological, mind, thought

### I

Iwi – tribe

### K

Kanohi kitea – known face

Karakia – prayer, incantation

Kaumātua – elder

Kaupapa – strategy or a theme

Kete – basket

Kia tupato – caution be taken

Koha – gift

Koro – old man

Koru – curled shoot

Kōrerō – talk, speak

### M

Mana – prestige

Mana motuhake - autonomy, self- determination

Mana wahine – woman of prestige

Manaakitanga – hospitality, kindness, caring for others

Marae – meeting area of whānau or iwi, central area of buildings and courtyard

Mātauranga – information, knowledge, education

Mauri ora – relates to access to te ao Māori, Māori language, knowledge, culture, whānau,

Māori services and networks

Mirimiri – massage

Mokopuna – grandchild, descendant

## **N**

Ngā manakura – relates to leadership

Noa – free from tapu

## **O**

Ōritetanga – equity, equality

## **P**

Pākehā – non-Māori, European, Caucasian

Papa-tū-ā-nuku – Earth mother

## **R**

Rapou – first pregnancy

Rohe – region, area

## **T**

Tane – male, man

Tāne – men

Tangata whenua – local people, indigenous people of the land

Taonga – treasure, property

Tapu – sacred, forbidden

Tapuhi – birth attendants, nurse

Te ao Māori – the world of Māori

Te mana whakahaere – autonomy, control, recognition of group's aspirations and relevant processes

Te oranga – participation in society

Te reo – Māori language

Tika – correct, true, just, right

Tikanga – custom

Tinana - body, self

Titiro - look

Tohunga – traditional Māori healer, priest, expert

Toi ora – healthy lifestyles

Ture – law, rule, statute, commandment

## **U**

Ūkaipō – place where a person is suckled, source of sustenance, the place of nurturing

Uu - breast

## **W**

Wahakura – woven flax basket

Wahine – woman

Wāhine – women

Waiora – environmental protection

Wairua – spirit, soul

Wānanga – learning, series of discussion

Whakapapa – genealogy

Whakaaetanga - gaining acceptance, agreement, approval, permission, consent

Whakaaro – thoughts, hypothesis

Whakamanawa – encourage, empowerment, personal validation

Whakangungu - advocacy, protection

Whakaritenga - negotiation, reconciliation, arrangements

Whakarongo - listen

Whakarurutanga - ensuring safety, creating safe environments

Whakawhānaungatanga – process of establishing relationships and connections

Whakawhirinaki - building trust, depend on

Whakataukī – proverb

Whānau – family, extended family

Whānau ora – family health and wellbeing

Whaangai uu – wet nursing, breastfeeding

Whare kōhanga – nesting house, building built for child birth, maternity ward

Whare tangata – the house of humanity, womb

Whenua – land, placenta

Whetū - star

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I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma or a university or other institution of higher learning.

# CHAPTER 1

## Introduction

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In early stages of life breast milk is the best form of food for an infant. Breastfeeding is the most natural and normal way to feed infants, and forms the foundations for a healthy life from infancy through to childhood (National Breastfeeding Advisory Committee, 2009). For the mothers, the benefits include protection against breast and ovarian cancer, and postpartum haemorrhaging (National Breastfeeding Advisory Committee). In addition, mothers and babies forming an inseparable biological and social bond through breastfeeding, and importantly, breast milk is important for the baby's physical growth and health (World Health Organisation, 2003). Māori breastfeeding rates are the lowest in New Zealand, and there is need for action to change this status (National Breastfeeding Advisory Committee, 2008; 2009). It will require changing the biomedical influence of colonial breastfeeding and birthing practices that have been engrained in Māori for the past generations, which is proving a challenge for Māori health practitioners (Durie, 1998; Glover, Manaena-Biddle, & Waldon, 2007). Most Māori women want to breastfeed, however, many encounter difficulties or succumb to barriers that result in breastfeeding ceasing prematurely (Glover et al., 2007). A state of whānau ora (family health and wellbeing) is an ideal that all Māori whānau aspire to. Indeed, Sharps, Campbell, Baty, Walker, and Bair-Merritt (2008) suggest that home visitation antenatal programmes improve both pregnancy and infant health, and may assist in relationships with partners and deter partner violence. The connection between the processes of achieving optimal breastfeeding and whānau ora is not entirely comprehended by the majority of the health practitioners or Māori population. Those that do acknowledge this may claim that it is old knowledge (personal communication, kuia and key informant). Which raises the question: Why are breastfeeding rates not improving for Māori? Why are many Māori wāhine not achieving optimal breastfeeding? Without these skills they are unable to support the optimal growth and development of their infants, and other mothers in the future with their breastfeeding. This thesis provides an explanation of what optimal breastfeeding is and how *optimising Māori women's breastfeeding* can be achieved.

In this chapter I provide an introduction and a discussion on the historical and contemporary influences on Māori women breastfeeding. This will be followed by the research overview, the demographic profile of the Eastern Bay of Plenty (EBOP), an overview of the thesis layout, and then the conclusion.

## **Historical Influences on Māori Women Breastfeeding**

The shift from traditional Māori breastfeeding and birthing practices, to westernised infant formula feeding, was accelerated by colonised pedagogical practices and discriminatory legislation from the early 1900s. In 1904 the Midwives Registration Act was introduced ("Midwives' Registration Act," 1904), and required all midwives to be registered by law. Therefore, Māori birth attendants or tapuhi had to be trained in Pākehā ways of birthing. Traditional Māori birth attendants were not recognised. In 1909, there was a common belief that legislation was introduced that forbade the traditional Māori breastfeeding practices of wet nursing, although there is no evidence of its existence (Durie, 1998; Ellison-Loschmann, 1997; Glover et al., 2007; Papakura, 1986).

By the end of World War II legislation was introduced to ensure that Māori birthing was relocated to maternity hospitals, rather than the traditional whare kōhanga (nesting house) under the care of a Māori attendant which were deemed to be unhygienic and unsafe (Durie, 1998; Ellison-Loschmann, 1997; Kenney, 2009; Papakura, 1986; Simmonds, 2011). Despite forcing Māori women to birth in the supposed safety of the hospitals, Māori maternal mortality had risen by the 1960s to be three times that of non-Māori (Donley, 1986; Ellison-Loschmann, 1997; Simmonds, 2011) In search for answers, the "Hunn Report" (Hunn, 1961) blamed Māori women for their poor antenatal care, and unsatisfactory feeding of babies. Māori women were labelled as apathetic and ignorant, rather than apportioning blame to the health system (Simmonds, 2011). These forms of judgements continue to be made by health professionals 30 years later to this day (Donley, 1986; Simmonds, 2011). Simmonds' (2011) study concerning the reclamation of mana wāhine and views on childbirth in Aotearoa, stated that:

Fragmentation of mana wahine knowledge's surrounding birth, and subsequently of whānau, began with the deeply held assumption by colonisers that hospital birth was

safer and cleaner than Māori ways of birthing. The move from home to hospital, however, did not support this belief (p. 20).

Such legislation disestablished the traditional practices of the *whare kōhanga* antenatal and postnatal care, and helped breakdown the traditional nucleus of the *whānau* (family), resulting in isolation and alienation from *whānau*, *hapū* and *iwi*, as did other discriminatory legislation. These included the Tohunga Suppression Act 1907 and the Native Health Act 1909 (Durie, 1998; Ellison-Loschmann, 1997; Papakura, 1986).

Traditional Māori birthing and breastfeeding practices were taught, and included *mirimiri* (massage) of the *uu* (breast) as soon as a *wahine* became *hapū* (pregnant) right up until birth. Māori reportedly never encountered breastfeeding difficulties until colonisation (Papakura, 1986). The expectant mother was taken to the *whare kōhanga* (the nesting house), where she gave birth and stayed for a few weeks being cared for by the *whānau*. This allowed for breastfeeding to be established, time for bonding with her new baby, healing and recovery, and also kept them safe from infections (Best, 1929; Durie, 1998; Hiroa, 1950). The practice of *whaangai uu* (wet nursing) was a valuable traditional practice, which contributed to a mother's sustainability of breastfeeding by providing support when needed (Best, 1929; Durie, 1998; Glover, Manaena-Biddle, Waldon, & Cunningham, 2008a; Papakura, 1986).

There are very few written accounts of *te whare kōhanga* in pre-European times, as Māori were traditionally orators. However, Best (1929) an early coloniser and anthropologist, provides some accounts and insight into Māori birthing preparation and rituals. Best's (1929) accounts of *te whare kōhanga*, were about special huts that were built away from the village as pregnant women were classed as *tapu* or unclean, and a *rapou* woman (first pregnancy) was excessively *tapu*. Whereas, Durie (1998), a Māori academic, explained *te whare kōhanga* and the relevance of *tapu* pertained to health and safety, and containment. He stated that the:

*Whare kōhanga*, equivalent in function to a maternity home but designed for one confinement only, were constructed when an expectant mother was close to delivery. Situated a little away from the rest of the village, the *whare kōhanga* became the delivery suite and the home for the mother, baby, and one or more attendants for a week or so. Then it was destroyed (p. 14).

## Contemporary Influences on Māori Women Breastfeeding

Women, whānau and communities today are aware of and acknowledge the economic benefits, and the biomedical significance of breastfeeding (Earle, 2002; Galtry, 1997; Meyer & De Oliveira, 2003; Wagner, Hulsey, Southgate, & Annibale, 2002; Waring, 2000). Māori have become dependent on colonised systems and concepts of medical doctors, midwives, hospitals, and maternity units. This dependency has contributed to the reason why Māori breastfeeding rates are so low, and there is a need for Māori to regain some of their independence (Durie, Cooper, Grennell, Snively, & Tuaine, 2010; Glover et al., 2007; Glover, Manaena-Biddle, et al., 2008a). Contemporary Māori mothers introduce their babies to other forms of fluid including infant formula, water, fruit juice, soft drinks and solids early. Evidence suggests that this has become a cultural norm for Māori (Glover et al., 2007; Glover, Waldon, Manaena-Biddle, Holdaway, & Cunningham, 2009; Thornley, Waa, & Ball, 2007). Many mothers encounter difficulties initiating breastfeeding causing them to discontinue it. Inadequate and conflicting advice can also be associated with early cessation of breastfeeding, along with disempowering advice and instructions if and when a mother is told they were doing it wrong (Abel, Park, Tipene-Leach, Finau, & Lennan, 2001; Glover et al., 2007). In many instances, health professionals can be obstacles to breastfeeding success if they have rigid or negative attitudes, and offer inappropriate lactation management strategies (Dignam, 1998; Gunn, 1984). Midwives perform multiple roles when providing antenatal, prenatal and postnatal care for a women and her child. Quality care requires the midwife to work in partnership with the women and whānau. However, there is no acknowledgement of a Māori worldview in the midwifery partnership model (Kenney, 2011; Pairman, 1999). Kenney (2011) claimed that:

Non-recognition of Māori epistemologies within the midwifery partnership model and discourses will become increasingly problematic. Culturally inappropriate care and token compliance with health legislation will adversely impact the health and wellbeing of whānau (p. 127).

Other reasons for not breastfeeding or ceasing early include grandparents wanting to care for infants, maternal tiredness, younger mothers still wanting to socialise, embarrassment, attitudes and perceptions, and work commitments (Glover et al., 2007; Glover et al., 2009). There is strong evidence that suggests that countries that have a longer duration of paid parental leave, and supportive social environments tend to have the highest breastfeeding rates at six months and beyond (Galtry, 2002, 2003; Galtry & Callister, 2005). Supportive

workplace policies and practices are needed to ensure workplace environments for breastfeeding mothers are supportive (National Breastfeeding Advisory Committee, 2008; 2009). Another area that needs to be more supportive is the paid parental leave, currently New Zealand only allows for 14 weeks paid parental leave. Galtry and Callister (2005) acknowledged the complexity of parental leave, and highlighted barriers and health-related concerns encountered by working mothers, and claimed that short-term paid parental leave can lead to concerns in the area of public policy. These concerns include: “health protection for working mothers, equal employment opportunities for women, access to adequate antenatal and birthing care, maternal recovery, optimal nutrition for infants, and gender equality within families” (p. 219).

Low socioeconomic groups, such as Māori, are more likely to experience similar breastfeeding barriers and inequalities, these groups are more likely to experience financial pressure, and the need to return to work once parental leave ceases than non-Māori (Galtry, 2002; Galtry & Callister, 2005). For example, the Aboriginal women in Australia have also experienced disruption and disestablishment of their cultural infant-feeding knowledge and practices being passed between generations (Craig et al., 2011; Holmes, Thorpe, & Phillips, 1997). Despite conflicting literature, Craig and Dietsch (2010) claimed that antenatal education is beneficial for first time mothers. They recommend focusing on antenatal breastfeeding strategies that builds confidence in women’s abilities to successfully breastfeed. Sharps et al. (2008) suggested that perinatal home visitation programmes are beneficial and are likely to improve pregnancy, infant health and may reduce intimate partner violence. Other relevant and beneficial information includes informing women of the physiological connection between pregnancy, labour, birth and breastfeeding, and the impact interventions such as synthetic oxytocin, caesarean section and epidural anaesthesia are likely to have on the initiation of breastfeeding (Craig & Dietsch, 2010). In Australia, an appeal by Holmes et al. (1997) was made to the elected Board of Directors of the Victorian Aboriginal Health Service to restore Melbourne Aboriginal community’s traditional breastfeeding rates, and advocated for the increase in breastfeeding rates, under Aboriginal control.

In New Zealand, key strategies were developed to enable the development of whānau-focused policies and programmes with the overall aim of Whānau Ora: in 1995, the development by the Public Health Commission of *He Matariki: A Strategic Plan for Māori Health*, a framework for advancing Māori Public Health, in 2002 the development of *He Korowai Oranga* by the

Ministry of Health, and in 2010 the of Whānau Ora framework by the Ministry of Social Development (Durie et al., 2010; Ministry of Health, 2002b). These strategies acknowledge that whānau ora is a critical link to restore whānau capacity, resilience, aspirations, independence and control over their health and wellbeing (Durie et al., 2010; Ministry of Health, 2002b). In He Korowai Oranga, Pathway One acknowledged “the need to foster conditions that build on strengths and assets of whānau and encourage their health and wellbeing . . . [and] services should be organised around the needs of whānau, and not the needs of providers” (p. 11). The Whānau Ora Framework developed by Durie et al. (2010), showed that whānau ora cannot be fully addressed from the perspective of any single sector. This framework, as detailed in the whānau ora report, on whānau-centred initiatives are distinct, and identify six key characteristics of their whānau ora philosophy that “recognises a collective entity, endorses a group capacity for self-determination, has an intergenerational dynamic, is built on Māori culture foundation, asserts a positive role for whānau within society, and can be applied across a wide range of social and economic sectors” (p. 30). Glover et al. (2008a) identified that “Effective breastfeeding for Māori is expected to impact on the well-being of whānau by improving nutrition of the child. The well-being of the whānau will subsequently be improved from the flow-on effect of less morbidity for the mother and child” (p. 7).

## **Research Overview**

All pregnant women need to prepare for the birth, and decide how they will feed their baby. Will they breastfeed or not? Can they breastfeed? Humans are the only species that choose to feed their baby milk from another species. The World Health Organisation Innocenti Declaration (2005) stated that breastfeeding is a right, and places the responsibility on governments, not women, for access to correct information. In New Zealand, the health system is such that independent midwives have a key role to provide antenatal and postnatal care for the wāhine and baby, up to 6 weeks, but may discharge a wahine at 4 weeks or earlier (Midwifery Council of New Zealand, 2007; 2012). Midwives are required to practise according to the Midwifery Council guidelines, and these guidelines also integrate a statement on cultural competence. Cultural competence ensures midwives integrate culturally safe practises appropriate to an individual’s culture in the context of, and based on, the Treaty of Waitangi to reduce disparities in health services for Māori women and their whānau (Midwifery Council of New Zealand, 2007; 2012). The benefits of breastfeeding are known to benefit tinana (physical health), wairua (spiritual), hinengaro (mental and emotional health), and whānau (health of the family), (National Breastfeeding Advisory Committee, 2008; 2009).

For wāhine to achieve optimal breastfeeding up to and beyond six months is complex. The *ūkaipōtanga (nurturing)* needed by a pregnant wāhine and breastfeeding mothers extends to include their partner, whānau, health professionals, community, employers, and policy-makers to name a few. However, it is the midwife's role to provide the necessary *ūkaipōtanga* in these early stages. Similar to other kaupapa Māori programmes, kaupapa Māori antenatal classes are able to provide holistic teachings and practises within a Māori paradigm (Glover et al. 2008a). However, locally these classes are often not well supported, not well attended and are not provided on a regular basis, as mainstream westernised practises dominate the current health system (personal communications, local Māori health practitioners). This mainstream hegemony impacts the options available to our Māori women and their whānau, and therefore, can inadvertently negatively disrupt any efforts by Māori health practitioners to make change.

This research used kaupapa Māori research methodology with constructivist grounded theory, following the viewpoint of Charmaz (2006), to explain how Māori women manage breastfeeding and how they extend their breastfeeding past the initiating stages to at least six months or beyond. Grounded theory allows for a structure that is rigorous in the analytic process, and Charmaz's (2006) constructivist grounded theory comes from a relational and social viewpoint, which is similar to kaupapa Māori. The purpose was to identify what is needed for Māori women to prepare during the prenatal and postnatal periods, and identify the support required to enable the Māori women to exclusively breastfeed for six months or more. The intention of this research is to provide an explanation of how to achieve optimal breastfeeding for Māori women, and to inform improving Māori women's breastfeeding rates. Therefore, the aims of the research were to:

- Ascertain how Māori women manage breastfeeding;
- Explain the support Māori women need to successfully breastfeed up to and beyond six months; and
- Explain how health care practitioners, policy makers and the community might be able to support Māori women to successfully breastfeed up to and beyond six months.

The question that guided the research was, *what is happening for Māori mothers and breastfeeding?*

## Demographic Profile of the Eastern Bay of Plenty

The Eastern Bay of Plenty (EBOP) comprises of three district councils, Kawerau, Whakatane and Opotiki, and has one of the highest Māori populations per capita. The small township of Kawerau has a total population of 6,930, 58.6% being Māori; Opotiki with 8,970, 54.4% being Māori; and Whakatane with 33,294, 39.6% being Māori (Statistics New Zealand, 2006). All three districts have low socioeconomic groups, high unemployment, and a youthful population with 33% under 20 years, compared to the national average of 19%. There is a high number (25%) of one parent families compared to the national average of 18%. There is limited education and training rates within the EBOP, with 30% of the residents having no qualifications. There are also limited work opportunities and low wages, with 14% earning less than \$18,000 per annum, compared with 9% for the national population. The main source of employment for Māori is low paid labour work, which is mainly seasonal. Eastern Bay of Plenty has a large geographic area with many rural communities being isolated from townships (Statistics New Zealand) (see Table 1 and Figure 1).

There are nine iwi within EBOP boundaries, Te Whānau a Apanui, Ngāitai, Whakatōhea, Ngāti Awa, Ngāi Tūhoe, Ngāti Whare, Ngāti Manawa, Ngāti Tūwharetoa ki Kawerau, Ngāti Rangitihī. The EBOP lies within the Bay of Plenty District Health Board (BOPDHB) boundaries, which includes the Western Bay of Plenty, Tauranga district that has a population of 195,000. The Western Bay of Plenty (WBOP) geographic area is not as large or as isolated as the EBOP, and the population makeup is entirely different to the EBOP – that is, the proportion of Māori is considerably less than the EBOP. However, there are more employment and training opportunities in the WBOP, and it is a growing district, unlike the EBOP (Statistics New Zealand, 2006).

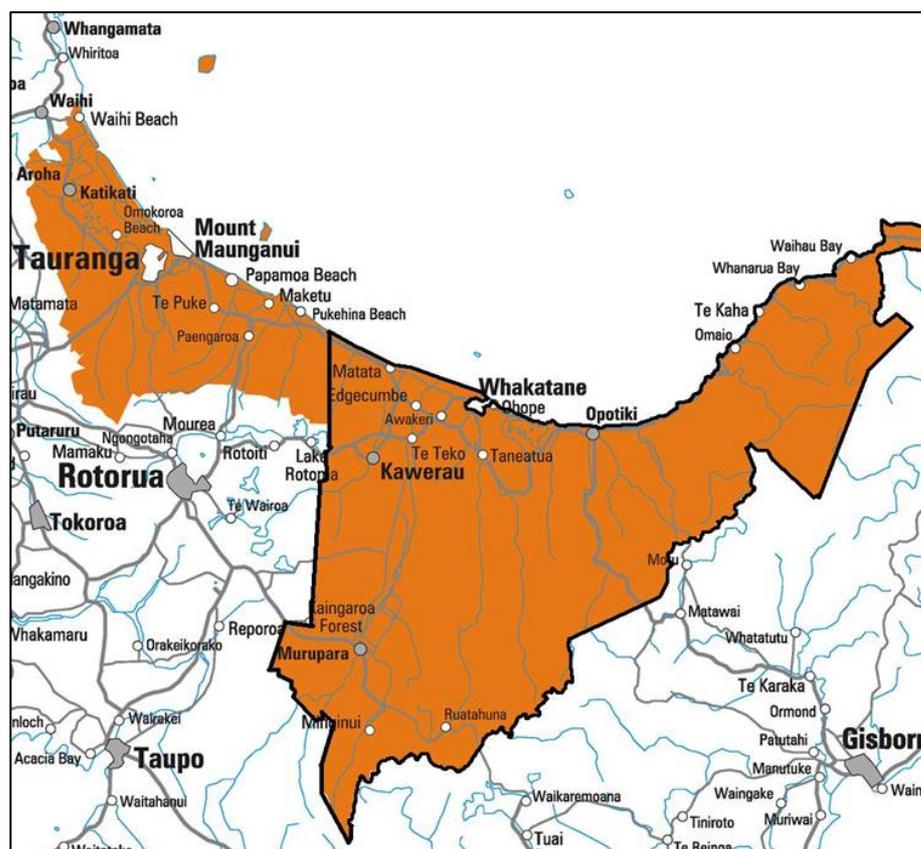
There are two Primary Health Organisations (PHOs) that deliver primary health services within EBOP. The EBOP PHO operates as Eastern Bay of Plenty Primary Health Alliances, and with Lakes PHO they deliver services to Murupara, Kaingaroa, Minginui and Ruatahuna areas. Most of the breastfeeding statistics includes both the EBOP and WBOP districts. Therefore, it is difficult to assess the true breastfeeding health status for the EBOP.

**Table 1**

**EBOP Residential Population**

Eastern Bay of Plenty	Age Groupings					Total
Māori Population	0-14	15-24	25-44	45-64	65+	Total Māori
Whakatane	4662	2016	3429	2391	702	13200 (39.6%)
Kawerau	1521	609	1044	726	156	4056 (58.5%)
Opotiki	1749	654	1170	909	393	4875 (54.3%)
<b>Total</b>	<b>7932</b>	<b>3279</b>	<b>5643</b>	<b>4026</b>	<b>1251</b>	<b>22131 (45%)</b>
Non- Māori Population	0-14	15-24	25-44	45-64	65+	Total Non- Māori
Whakatane	3834	1983	4908	5871	3498	20094
Kawerau	429	216	669	849	708	2871
Opotiki	717	336	846	1341	852	4092
<b>Total</b>	<b>4980</b>	<b>2535</b>	<b>6423</b>	<b>8061</b>	<b>5058</b>	<b>27057</b>
Total Population	0-14	15-24	25-44	45-64	65+	Total
Whakatane	8496	3999	8337	8262	4200	33294
Kawerau	1950	825	1713	1575	864	6927
Opotiki	2466	990	2016	2250	1245	8967
<b>Total</b>	<b>12912</b>	<b>5814</b>	<b>12066</b>	<b>12087</b>	<b>6309</b>	<b>49188</b>

Note: Statistics New Zealand (2006).



**Figure 1:** Demographic map of Eastern and Western Bay of Plenty

Source. EBOP Primary Health Organisation (2010) with permission to reproduce this image

## Thesis Layout

This thesis comprises five chapters. This chapter, Chapter One, *Introduction*, provided a historical account and contemporary account of the influences on Māori women breastfeeding, then an overview of and background to the research. The demographic profile is specifically provided for the EBOP, and the geographic and population base is compared with that of the WBOP, these being the two regions that make up the Bay of Plenty District Health Board (BOPDHB) demographic area. This is then followed by a breakdown of the thesis layout.

Chapter Two, *Review of the Literature*, begins with an introductory discussion on breastfeeding, then information on national and Bay of Plenty regional breastfeeding data, and the Bay of Plenty District Health Board Hospital statistics on births and breastfeeding at discharge. This is followed by a discussion on the health priorities and policies that relate to breastfeeding and maternal health and then the review of breastfeeding literature.

Chapter Three, *Constructing an Appropriate Methodology*, provides a discussion on the kaupapa Māori methodology that informed this research, and how it overarched Charmaz (2006) constructivist grounded theory process. An explanation is also provided on how this process was used to arrive at the constructivist grounded theory of *optimising Māori women's breastfeeding*.

Chapter Four, *Findings: Optimising Māori women's breastfeeding* explains the basic social process of *ūkaipōtanga (nurturing)* that is required for women to breastfeed exclusively for six months or more. The properties within the subcategories *getting ready*, *having an engaging midwife* and *having supportive systems* weaves together to achieve the core category, *optimising Māori women's breastfeeding* are presented. *Optimising Māori women's breastfeeding* contributes to achieving *whānau ora* and developing skills to *support other mothers*.

Chapter Five, *Implications and Discussion*, is the final chapter. This chapter reviews the aims of the research, to identify if the findings that met these aims. The limitations of research are also

discussed, followed by recommended strategies that can assist in supporting Māori women achieve optimal breastfeeding. I then provide recommendations for further research and then finally the conclusion of this research.

## **Conclusion**

Historical accounts indicate that before colonisation Māori had their own prenatal, postnatal and birthing practices, overseen by a Māori birth attendant and supported by the whānau, hapū and iwi. Breastfeeding was the only form of nourishing an infant, and wet nursing was a traditional practice, enabling infants to be breastfed until they were walking (Durie, 1998; Ellison-Loschmann, 1997; Glover et al., 2007; Papakura, 1986). Post-colonisation, traditional Māori practices were replaced with westernised prenatal, postnatal, birthing and breastfeeding practices. Colonised practises that were not conducive to supporting Māori women breastfeed and inequalities in health saw breastfeeding rates drop. Today Māori have the lowest breastfeeding rates. Therefore, it is important that research is undertaken to identify how to optimise Māori women's breastfeeding in a bid to help change this status.

This research undertook to generate theoretical concepts to explain how Māori women manage breastfeeding, provides an understanding of what is *optimising Māori women's breastfeeding*, and on how it is achieved. This was achieved by utilising a grounded theory research method, informed by a kaupapa Māori methodology. The Māori women participating in this research were able to provide their knowledge, and their experiences of breastfeeding and birthing, to identify what contributed to them breastfeeding for six months and beyond, also identifying key time frames, and who assisted in this success. The following chapter, Chapter Two, *Review of the Literature*, will review literature pertaining to Māori women's breastfeeding and other indigenous people, to identify optimal breastfeeding theories.

## CHAPTER 2

### Review of the Literature

---

He aha te mea nui o te ao?

He tangata! He tangata! He tangata!

What is the most important thing in the world?

It is people! It is people! It is people!

There is strong evidence that indicates breastfeeding and appropriate infant feeding contributes to infants', mothers', and families' social and emotional wellbeing (World Health Organisation, 2003). Ellison-Loschmann (1997) concurred, and stated that breastfeeding is linked with women's and families' social and cultural connectedness. Despite this, only 12 per cent of New Zealand babies are exclusively breastfed at six months. Māori, Pacific peoples, and low-income families have lower breastfeeding rates than other ethnic groups (National Breastfeeding Advisory Committee). Pomare (1949) illuminated the importance of quality nurturing of a child, as a foetus inside the mother's womb and after birth, as it builds the foundation of strong healthy person of the future. He stated:

Everybody who has the welfare of the people at heart knows that the child of today is the man or woman of tomorrow and that the foundation of any strong virile race, fit to fight in the forefront of the battle of life, lies in the care that a mother gives her child before and after the birth (p. 40).

Most Māori are aware of the financial benefits of breastfeeding, but have limited knowledge on other associated benefits. Many choose to breastfeed, however, whether they achieve their breastfeeding goals depends on a number of factors and many will cease after the first month postpartum. Whereas historical accounts, before colonisation, suggest that Māori infants were only breastfed (Ellison-Loschmann, 1997). They were breastfed usually until the child was walking (Ellison-Loschmann). In this chapter I will discuss literature pertaining to Māori breastfeeding, the influencing factors that have led to the current health and

breastfeeding inequalities for Māori. I begin with a discussion on New Zealand's breastfeeding data, then the current health and other sectors' strategies and policies, identifying supportive community strategies and policies, that aim to improve and prolong breastfeeding for six months or more. I then provide a review of Māori breastfeeding literature, and then conclude.

## **Breastfeeding Data**

New Zealand breastfeeding rates at birth are consistent with other OECD countries. Rates at six weeks are lower, especially among Māori and Pacific women. Approximately only 12% of infants are exclusively breastfed at six months old nationally, the rates for Māori are lower. Nationally, there has been little or no improvement in the breastfeeding rates for the past ten years (Gray & Cave, 2013; Royal New Zealand Plunket Society, 2013). The World Health Organisation recommends that infants be exclusively fed breast milk from birth to six months, with the introduction of complementary foods and continued breastfeeding thereafter (World Health Organisation, 2003).

The Royal New Zealand Plunket Society collects and reports on infant feeding rates to the Ministry of Health. Nationally, Plunket provides care for 90% new babies, and provide annual breastfeeding statistical data for these children. However, they only see about 65% of Māori babies. Plunket data has limitations regarding how ethnicity groups are prioritised, data is also dependent on core contact with client, and the fact that 10% of population (and more for Māori) is not included in the data (Royal New Zealand Plunket Society, 2013). Plunket records breastfeeding data from the first contact, which can be as early as two weeks of age. The New Zealand Breastfeeding Authority collates breastfeeding data for the Ministry of Health, and aggregates them into interval periods of six weeks, three months and six months. 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 (Ministry of Health, 2002a; Royal New Zealand Plunket Society, 2010).

Only the Northland area was able to achieve the Ministry of Health targets for all ages in 2005, and in 2010 achieved the target for six months. In 2005, the Bay of Plenty area achieved Ministry of Health target for three months, and in 2010 achieved the target for six months (Royal New Zealand Plunket Society, 2010).

Māori and Pacific people are recorded as having lower breastfeeding rates, which inadvertently impacts negatively on their health and wellbeing, becoming a public health issue. Breastfeeding rates have not improved over time (Royal New Zealand Plunket Society, 2010). Over the period 2004 to 2009 Plunket breastfeeding ethnicity data for exclusive breastfeeding rates for other and Māori increased slightly, but did not meet the Ministry of Health targets:

- At two to five weeks rates for others increased from 54% to 59%, for Māori increased from 45% to 48%;
- At six to nine weeks other increased from 45% to 49%, Māori increased from 39% to 41%;
- At 10-15 weeks other increased from 42% to 47%, Māori increased from 30% to 33%; and
- At 16 weeks to seven months other increased from 12% to 19%, however, for Māori rates were the lowest, showing from 6% to 9% during this period (Royal New Zealand Plunket Society).

Plunket data is broken down according to District Health Board (DHB) areas, the Eastern Bay of Plenty (EBOP) and Western Bay of Plenty (WBOP) are aggregated into the Bay of Plenty District Health Board (BOPDHB) area data. There were no data provided for ethnicity by area. The 2009 Bay of Plenty (BOP) data for, exclusive breastfeeding for:

- Two to five weeks was 59%;
- Six to nine weeks was 54%;
- 10-15 weeks was 46%;
- 16 weeks to seven months was 16% and 31% fully breastfed (Royal New Zealand Plunket Society, 2010).

This data does not provide a true reflection of what is happening for breastfeeding in the EBOP, as the population and ethnicity make-up are completely different to WBOP, as explained in Chapter One *Introduction*. EBOP has a high percentage of Māori population and the Māori birth rate that is three times higher. However, EBOP is less populated than the WBOP. More recent information from Plunket indicated that for the period 2008-2012 there was very little change (Royal New Zealand Plunket Society, 2013).

Since 2001 the New Zealand Breastfeeding Authority has been monitoring the exclusive breastfeeding rates at discharge from maternity services for the Ministry of Health. The New Zealand Breastfeeding Authority also receives midwifery data reports for breastfeeding at two weeks, and audits and assesses Baby Friendly maternity services. The average exclusive breastfeeding rate at discharge is currently 84.4% for the 76 accredited maternity services. Moreover, 98.7% of infants born in New Zealand are born in Baby Friendly maternity services, while the remainder are born in the community (i.e. home births) (New Zealand Breastfeeding Authority, 2009).

**Table 2**

*BOP DHB Hospital Exclusive Breastfeeding Statistics 2013*

Bay of Plenty District Health Board Breastfeeding Statistics Year July 2012 to June 2013 Non Special Care Nursery Exclusive Breast Feed KPI (Target for Exclusive Breastfeeding is: 80%)													
HOSPITALS	2012						2013						
	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Av
All Sites	82%	81%	86%	86%	87%	90%	86%	86%	83%	80%	83%	84%	
Tauranga	82%	80%	84%	86%	87%	89%	85%	85%	82%	78%	83%	82%	83%
Whakatane	80%	87%	91%	87%	85%	94%	92%	91%	84%	87%	76%	90%	87%
Opotiki	100	86%	88%	100	100	100	100	100	100	100	100	100	97%
Murupara				X									X

Note: Sourced from the Bay of Plenty District Health Board personal communications in email from Gulliver-Birkett, received 18 October 2013; Av = Average.

BOP Breastfeeding rates, from birth to the time of discharge, from all hospital birthing units for the 2012/2013 year exceeded the Ministry of Health target of 80% for babies to be exclusively breastfed in the non-special care nursery. Tauranga Hospital's (in the WBOP), rate was 83%, Whakatane Hospital's rate was 87%, Opotiki Hospital's rate was 97%, and the Murupara Birthing Unit (all in the EBOP) had only one birth and that baby was artificially fed (see Table 2). For the special care nurseries in Tauranga and Whakatane the figures were much lower, with only 45% of the babies being exclusively breastfed (Bay of Plenty District Health Board personal communications in email from Gulliver-Birkett received 18 October 2013).

Ethnicity data provided for the EBOP was limited to just Whakatane maternity unit, and only available for the year 2012. Māori had the highest birthing rate (64.8%), compared to NZ European (29%), and other ethnicities (6.2%). Exclusive breastfeeding rates were high: Māori 89.4%, NZ European 92.7% and other ethnicities 78.9%. However, the number of Māori artificially feeding was a lot higher than all ethnicities, with 5.2% Māori artificially feeding compared with 0.7% for NZ European, and 0.3% for other ethnicities. Reflective of the population make-up, Tauranga Hospital's birth rates for Māori were three times lower than EBOP at 21.8%, while NZ European were 58.1%, and other ethnicities were 20.1% (Bay of Plenty District Health Board personal communications in email from Gulliver-Birkett received 18 October 2013).

Breastfeeding data from iwi health providers for their Well Child/Tamariki Ora services is not nationally or regionally collated and/or reported. Some providers maybe prepared to provide their individual data; otherwise this information is not readily accessible. Each iwi health provider is required to file quarterly reports to the Ministry of Health; this data was not accessible at the time of writing this thesis. A consistent trend for one EBOP iwi Tamariki Ora provider, is that by the third month most of the mothers in their care cease breastfeeding. There were three contributing factors: returning to work, grandparents caring for the baby and disrupting breastfeeding, and young mothers wanting to socialise (Te Tohu o Te Ora o Ngāti Awa personal communications in email from Kingi-Chase received 16 June 2014). However, the majority of the Māori wāhine is under the care of Plunket. Therefore, Plunket data provides a good indication of breastfeeding trends, until such a time when the Ministry of Health is able to collate all breastfeeding data.

## **Health and Other Sectors Strategies and Policies**

The founding 1990 Innocenti Declaration, which was updated 2005, called for the protection, promotion and the support of breastfeeding to enable women to breastfeed their child up to two years and beyond (World Health Organisation & UNICEF, 2005). Within New Zealand, a National Strategic Plan of Action for Breastfeeding 2008-2012 was developed to implement the Ministry of Health's 2002 breastfeeding guide to action plan, and to provide expert advice to the Director-General of Health. The strategies focus on improving breastfeeding rates in New

Zealand, with the health sector as the leader in the protection, promotion and support of breastfeeding. They also include extending across to other sectors at a local, regional and national level merging with existing work and emerging programmes (Ministry of Health, 2002a; National Breastfeeding Advisory Committee, 2009).

### **Breastfeeding Action Plan Strategies**

The Breastfeeding Action Plan provided strategies that aimed to reinforce a “breastfeeding culture” in New Zealand, and to address a wide range of social, employment and other barriers associated with breastfeeding. It called for support from government and private sectors. The plan identified four settings needed to work to achieve cultural change to ensure breastfeeding rates increased: government, family and community, health services and workplace, childcare and early childhood education. The mother and child relationship is central to the plan, and the settings indicate the support needed from the government, the community, the private sector, strategies and policies (National Breastfeeding Advisory Committee, 2009). The settings and outcomes are:

Setting one: Government:

- 1.1 The Ministry of Health works collaboratively to actively protect, promote and support breastfeeding;
- 1.2 There is an accurate, accessible, comprehensive breastfeeding dataset;
- 1.3 New Zealand specific breastfeeding research provides a robust evidence base and body of knowledge about breastfeeding in this country; and
- 1.4 The regulatory framework supports breastfeeding.

Setting two: Family and community:

- 2.1 Mothers and babies are supported by fathers/partners, their families/whānau, and by breastfeeding knowledge that is embedded in their communities;
- 2.2 Communities have the resources to provide and/or advocate for coordinated, appropriate and accessible breastfeeding support services;
- 2.3 Communities positively support breastfeeding in public places as the established norm.

Setting three: Health services:

- 3.1 There is a strong, capable workforce with the capacity to actively protect, promote and support breastfeeding;

- 3.2 Services that support or influence breastfeeding are high quality and well coordinated; and
- 3.3 The health workforce is responsive to the breastfeeding support needs of Māori, Pacific and other ethnic communities.

Setting four: The workplace, childcare and early childhood education:

- 4.1 Extended paid parental leave (and/or alternative strategies) contribute to improve breastfeeding rates and duration for New Zealand mothers and babies;
- 4.2 Breastfeeding women and their babies are supported by labour market policies, workplace policies, and by tangible support within the workplace;

Each setting has outcomes and set objectives to meet, over a short-term period from 2008 to 2010, medium-term period from 2010 to 2012, and long-term period from 2012 onwards. We are now in the long-term period. Some of the Ministry of Health goals have been met, which includes achieving baby friendly hospitals throughout New Zealand, and to some extent increasing breastfeeding promotion, advocacy and co-ordination (New Zealand Breastfeeding Authority, 2011). However, the majority of the objectives strategies are still a work in progress with very little being accomplished to date to change the low breastfeeding rates for Māori and Pacific.

The Ministry of Health (2002a), has adopted four definitions of breastfeeding - these are exclusive breastfeeding; fully breastfeeding; partial breastfeeding; and artificial feed. Exclusive breastfeeding infants never have any water, infant formula, or other liquid or solid food: they only have breast milk and prescribed medicines from birth; fully breastfeed infants have taken breast milk only and no other liquids or solids, except a minimal amount of water or prescribed medicines within the past 48 hours; partial breastfeeding infants have taken some breast milk and infant formula or other solid food within the past 48 hours; and an artificially feed infant has had no breast milk, but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

### **Other Supportive Strategies and Policies**

There are other supportive health strategies and policies within health and other sectors that have been identified as being able to assist the goals of the Ministry of Health Breastfeeding

Action Plan and the National Strategic Plan of Action for Breastfeeding. In the health sector these includes the:

- Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (Ministry of Health, 2012). However, in 2012 HEHA (Healthy Eating Healthy Action) was no longer a priority and many programmes were disestablished. HEHA was important as many of the HEHA strategies included addressing breastfeeding inequalities;
- Food and Nutrition Guidelines for Healthy Pregnant and Breastfeeding Women: A background paper (Ministry of Health, 2009);
- Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand (Ministry of Health, 2007);
- Well Child Framework (Ministry of Health, 2010);
- He Korowai Oranga: Māori Health Strategy (Ministry of Health, 2002b);
- Whakatakaka Turua: Māori Public Health Action Plan (Ministry of Health, 2006b); and
- Good Oral Health for All: A strategic vision for oral health in New Zealand (Ministry of Health, 2006a).

Health promotion enables strategies to empower the community, through the underpinning concepts of ‘positive health promoting environments’. These environments have the potential to impact the wellbeing of individuals, families, groups and communities (Chile, 2010). For Māori, an indigenous model of health promotion framework such as Te Pae Mahutonga (Durie, 2004), alongside the Ottawa Charter (World Health Organisation, 1986) a generic framework, should to be considered to ensure health promotion strategies are developed and implemented with Māori values.

Te Pae Mahutonga (Durie, 2004) has six components:

- Nga Manakura (Leadership- community, health and alliances formed);
- Mauri ora (access to te ao Māori – access to language, knowledge, culture, whānau, Māori services and networks);
- Waiora (environmental protection);
- Toi ora (healthy lifestyles);
- Te Oranga (participation in society); and
- Te Mana Whakahaere (autonomy/control/ recognition of groups aspirations/ relevant processes).

The Ottawa Charter framework incorporates five components for planning public health strategies. These are; building healthy public policy; creating supportive environments; strengthen community actions; developing personal skills; and reorienting health services (World Health Organisation, 1986).

The employment sector is another area that has supportive strategies and policies. The Parental Leave Employment Protection Act 1987 was brought in to provide statutory rights parental leave. Amendment Acts followed that increased parental leave support and leave entitlement, such as the amendment Act in 2002 for 14 weeks paid parental leave, and subsequent amendment Acts in 2004 and 2006 (Parental Leave and Employment Protection Act, 1987). A policy is in place to increase paid parental leave from 14 weeks to 16 weeks from 1 April 2015, and to increase to 18 weeks paid from 1 April 2016 (Ministry of Business Innovation & Employment, 2014). Other employment related Acts and policies were developed to support mothers to breastfeed in the workforce, such as: A Guide for Employers, Breastfeeding in the Workplace (Department of Labour, 2007); Flexible Working and Guide to Breastfeeding in the Workplace Act 2009 (Department of Labour, 2009); and in 2010 a Code of Employment Practice on Infant Feeding was also developed (Department of Labour, 2010). With the increase of women in the labour workforce, and a steady stream of complaints and enquiries, the Human Rights Commission needed to protect the rights of women to breastfeed. Thus, acknowledging a child's right to the right food and nutrition saw the introduction of The Right to Breastfed Act 2005 (Human Rights Commission, 2005); and Equality Act 2010 Statutory Code of Practice.

## **Review of Breastfeeding Literature**

A search for literature to review initially focussed on studies that examined optimal breastfeeding, and breastfeeding education for Māori women, from 2003 to 2013. However, research conducted regarding Māori breastfeeding was scarce. The majority of the previous breastfeeding studies in New Zealand were undertaken with the general population as cohort studies, or focus groups and surveys. The search for literature was, therefore, extended to include international research that identified supportive strategies for improving breastfeeding, and factors that influenced breastfeeding. In general, studies that investigated interventions to increase breastfeeding rates and duration are also scarce, and those that have

been published have had little influence in improving breastfeeding rates (Meedya, Fahy, & Kable, 2010). Databases searched included Medline, EBSCO Health database and Google Scholar.

Many Māori women encounter barriers to breastfeeding. Many of the barriers encountered by Māori are identified in the Ministry of Health's (2002a) Breastfeeding Guide to Action. These barriers include a lack of, or no, antenatal education; breastfeeding initiating problems, early weaning; dissatisfaction with hospital care; conflicting advice from health professionals; limited or lack of culturally effective maternity services; and lack of postpartum support. Despite acknowledgement, there has been little done to improve these barriers, and inequalities still hinder the ability to change the low Māori breastfeeding rates. A cohort study by Glover et al. (2007) was conducted to identify the factors that influence Māori women's decisions to breastfeed or not. Thirty Māori women who had breastfed within the previous three years (2004-2005) and 11 whānau members were recruited from urban Auckland and small towns in the Bay of Plenty. A mix of closed and open-ended questions was used to collect data. The study identified five influencing factors that diverted Māori women from breastfeeding: interruption to a breastfeeding culture; difficulty establishing breastfeeding within six weeks; poor or insufficient professional support; perceptions of inadequate milk supply; and returning to work. Glover et al. (2007) recommended that public health policies need to support breastfeeding from birth and beyond, and parental leave needs to be extended more than 14 weeks to at least six months for working mothers. The National Breastfeeding Advisory Committee (2009), National Strategic Plan of Action for Breastfeeding 2008-2012 has been developed since. Despite this plan there has been little change in the breastfeeding rates for Māori. The parental leave is still at 14 weeks, with policies in place to increase this to 16 weeks from April 2015, will still not be sufficient to help improve the current breastfeeding rates for Māori (Ministry of Business Innovation & Employment, 2014).

In New Zealand, there has been an emergence of kaupapa Māori antenatal and breastfeeding services in some regions, including the Eastern Bay of Plenty (Glover, Manaena-Biddle, et al., 2008b). Glover, Manaena-Biddle, et al. (2008b), conducted an inductive qualitative research that investigated factors that influenced Māori women to breastfeed, and why they chose kaupapa Māori breastfeeding services over generic services. Participants were selectively sampled, 59 Māori women and 25 partners and family members from Auckland, Palmerston North, Whakatane, Whanganui, and rural areas in the Bay of Plenty and Palmerston North

were recruited. There were two relevant aspects to this study. First, to ascertain what were the direct health consequences of Māori women not being provided with appropriate support, and what their cultural needs were when initiating breastfeeding. The second pertained to the Māori women's, and whānau involvement in, decision-making around breastfeeding. The outcome resulted in the development of a model to understand how Māori women are diverted from breastfeeding, and identified five influences:

- Interruption to an indigenous breastfeeding culture (no longer being taught by their mothers and kuia breastfeeding, now taught within a health system by non-Māori) ;
- Difficulty establishing breastfeeding within the first six weeks;
- Poor or inadequate professional support;
- Perception of insufficient milk supply; and
- Returning to work.

Glover et al. (2007) concluded that these five diverting influences highlighted critical areas and times for intervention strategies. They recommended, "Promotion of breastfeeding to Māori should focus on re-establishing breastfeeding as a tikanga (right cultural practice) rather than a perceived lifestyle choice" (p. 89). These findings are consistent with Glover et al.'s (2007) earlier findings.

Another study conducted by Glover et al. (2009) investigated Māori women's perceptions of breastfeeding. They interviewed 59 Māori women who had given birth in the previous three years (2004-2006), and 27 whānau members, from Auckland, Palmerston North, Whakatane and Whanganui. They identify barriers that prevent exclusive breastfeeding during the first six months, and identified five key areas to increase exclusive breastfeeding for longer among Māori women:

1. Need for intensified effort for smoking cessation for pregnant Māori women;
2. Breastfeeding best practice guidelines should be presented in a manner consistent with Māori belief systems, including having a focus on whānau as well as mothers;
3. Guidelines for Māori mothers should emphasise, and make clear the health benefits for both babies and others;
4. Information on bed-sharing and breastfeeding, tobacco smoking, and breastfeeding, and the relationship between breastfeeding and repeat pregnancy should be made more available, and be accessible to Māori; and

5. Health service providers should recognise the social and cultural circumstances of Māori mothers and their whānau, and attempt to target their advice, in particular, using plain language, and Māori language terms.

Glover et al. (2007; 2008a; 2009), highlighted gaps that exist and recommended that further research should investigate interventions that support exclusive breastfeeding for Māori women, which gave purpose and justification for this research.

There have been numerous research studies conducted nationally and international that concluded there was the need for promotion, education, and interventions to support breastfeeding (Hector & King, 2005; Meedya et al., 2010; Noel - Weiss, Bassett, & Cragg, 2006). The benefits of receiving breastfeeding health promotion material and antenatal education for mothers initiating breastfeeding experience, and assisting the duration of breastfeeding is often deliberated. An Australian study by Craig and Dietsch (2010) identified that antenatal education for first time mothers' breastfeeding was beneficial for informing of the practical breastfeeding skills required. However, this did not foster confidence or the ability for them to initiate breastfeeding. Strength-based antenatal education that builds a women's confidence to successfully breastfeed is recommended, as well as advising them of the physiological connection between pregnancy, labour, birth and breastfeeding, and the impacts of medical interventions on initiating breastfeeding (Craig & Dietsch, 2010).

Pannu, Giglia, Binns, Scott, and Oddy (2011) conducted a longitudinal study in two public maternity hospitals in Perth, Australia with 587 mothers participating. This study identified mothers were 50% less likely to cease breastfeeding before 12 months if they received antenatal education on breastfeeding, and/or received individual consultation by hospital staff. Those mothers that received individual postnatal initiating breastfeeding instructions while in hospital were 30% less likely to cease fully breastfeeding before six months. A randomised control trial by Su et al. (2007) investigated antenatal education and postnatal support strategies of 450 women in the National University Hospital in Singapore. They found that antenatal breastfeeding education and postnatal lactation support as single interventions significantly improved exclusive breastfeeding rates up to six months after delivery. They also found that postnatal support was marginally more effective than antenatal education. This suggests that women who received individualised breastfeeding information, and consultation

during antenatal and postnatal was useful for improving breastfeeding outcomes (Craig & Dietsch, 2010; Pannu et al., 2011; Su et al., 2007).

Scott, Binns, Graham, and Oddy (2006) conducted two longitudinal infant feeding studies in Perth, Australia: the first was conducted in 1992/1993, and the second ten years later in 2002/2003. They concluded that “little may be gained from continuing to target interventions promoting the initiation of breastfeeding at previously identified high-risk groups” (p. 44). Instead, they suggested that future interventions need to aim at influencing modifiable risk factors, including attitudes to infant feeding, in particular maternal and paternal attitudes. Also, they recommended the need for health professionals to include partners in breastfeeding discussions, as partner’s attitude influenced a woman’s attitude and determination to breastfeed. It also highlighted that partners needed to be encouraged to attend antenatal classes, and to undertake support roles they as fathers can play in the process of breastfeeding. This area was explored, and participants were questioned about breastfeeding education and promotion, whether they and their partners attended antenatal classes, and the role their partner played in supporting them to breastfeed.

Understanding influencing factors and barriers to breastfeeding specific to indigenous people, such as Māori or those groups that have low breastfeeding rates, can inform tailored interventions to improve initiation and increase the duration of breastfeeding (Craig et al., 2011; Glover et al., 2007; Glover et al., 2009; Rogers, 2006). In Australia urban Aboriginal women have lower breastfeeding rates than those that live rurally. A longitudinal birth cohort study with urban Aboriginal by Craig et al. (2011) sought to identify interventions to improve initiation and duration of breastfeeding. Interventions found to be effective were based around antenatal and breastfeeding education and support, which need to be face-to-face, intensive, and long-term. They recommended that interventions should begin early, and supportive networks need to be in place (Craig et al.). Initiating breastfeeding success was more significant if the mothers intended to breastfeed, and if she had an education qualification (Craig et al.). These factors also had bearing on breastfeeding duration, as those women that were educated, not working, or non-smokers were more likely to breastfeed and for longer (Craig et al., 2011; Hector, King, & Webb, 2004).

The role of the midwife in prolonging breastfeeding is also posed as a possible useful intervention. Within New Zealand, independent midwives are the lead maternity carers, therefore, during pregnancy and early postpartum the midwife is in the ideal role to intervene. Meedya et al. (2010) conducted an online literature review, aimed to develop a midwifery intervention, to prolong breastfeeding. This research found the modifiable factors that influenced women's decisions to breastfeed were having breastfeeding intention, self-efficacy and social support. However, they also found that midwives did not adequately address women's attempts to modify breastfeeding interventions, and self-efficacy (Meedya et al.).

Early lactation difficulties are common among many breastfeeding mothers, and especially for those mothers with preterm babies (Jones & Spencer, 2007; Laantera, Pietila, Ekstrom & Polkki, 2012). Jones and Spencer (2007) claimed that the majority of the breastfeeding problems encountered are avoidable if mothers were given adequate support by the health care system. They proposed a comprehensive intervention strategy for healthcare professionals responsible for assisting breastfeeding mothers, thereby providing them with up-to-date knowledge of the anatomy and physiology of the breast, the mechanisms of milk secretion and the principles of breastfeeding. This is an important strategy for imparting clinicians with the knowledge required to support breastfeeding mothers to manage breastfeeding, inevitably helping women avoid breastfeeding issues during the critical period following delivery, or for imparting knowledge to help women address breastfeeding issues (Jones & Spencer, 2007). Laantera, Pietila, Ekstrom and Polkki (2012) also advocated similar interventions. Laantera et al.'s study conducted in Finland, sought to gauge the confidence in breastfeeding among pregnant women. One hundred and twenty three women completed a questionnaire. The study indicated that pregnant women needed more information about the physiology of breastfeeding and how to manage if breastfeeding problems occurred. Primiparous women, those that had gaps in breastfeeding, and women who had negative perceptions of breastfeeding needed their confidence enhanced the most.

Continuity of care and supportive behaviours from health professionals are consistently highlighted as a model to improve breastfeeding, and empower new mothers and instil better self-esteem (Ekstrom, Widstrom & Nissen, 2006; The Joanna Briggs Institute, 2012). A research conducted by Ekstrom, Widstrom and Nissen (2006), in Southwest Sweden, investigated responses of 450 primiparous women by comparing the responses of those who were attended by midwives and nurses specially trained in breastfeeding counselling, to gauge

if they perceived they had received better continuity of care, better emotional support and informative breastfeeding support than those mothers who received routine care. Ten municipalities with antenatal and child health centres were randomised into intervention or control municipalities. The intervention involved a programme for health care professional (postnatal nurses and midwives) in breastfeeding counselling and an intervention plan for continuity of care for the first 9 months postpartum. The women in the intervention municipal group started family classes early in their pregnancy. Postnatal nurses were more compliant with the intervention and attended antenatal classes more often than midwives. These nurses were rated as being more sensitive and understanding. The primiparous women completed three questionnaires, at three days, and three and nine months postpartum. The women in the intervention group felt well prepared and better informed to breastfeed and take care of their babies than those mothers in the control group. The intervention group reported that the family classes improved their social networks, thereby improving their support networks (Ekstrom, Widstrom & Nissen, 2006). The Joanna Briggs Institute (2012) conducted a systematic review on 31 qualitative studies that explored women's perception, and experiences of professional or peer breastfeeding support. This systematic review concurred with Ekstrom, Widstrom and Nissen (2006) that programmes and models emphasising relationship-based care, by facilitating the provision of individualised, continuity of care, and advice for women provided positive breastfeeding results and should be adopted. Such models were able to provide practical help for those women who needed it, such as midwifery and nursing education to enhance communication, information and skills; antenatal education; postnatal advice and support; and support schemes that catered for all women.

## **Conclusion**

For Māori, breastfeeding rates are consistently lower than all other ethnicities. Only 6-9% of Māori infants are exclusively breastfed at age of six months. The Ministry of Health developed a cross-sector national breastfeeding strategy in 2002, in-line with the World Health Organisation's Innocenti Declaration (2005) to improve these statistics. Local hospital data at discharge for all ethnicities, including Māori, met Ministry of Health targets. However, targets set after hospital discharge for exclusive breastfeeding have not been met. National exclusive breastfeeding rates at six months have shown little improvement over the past decade. Furthermore, there is no local data available after discharge from hospital. Therefore, it is difficult to know the actual breastfeeding rates for Māori within the Eastern Bay of Plenty.

However, based on the high Māori population in the EBOP it can be presumed to be as low as the national rate, if not lower.

The Ministry of Health strategies to improve breastfeeding are complex. The current low breastfeeding rates suggest either the strategies are not being implemented to the standard required or there is a need for the strategies to be revamped. The process of breastfeeding is beneficial in developing bonding intimacy. Antenatal learning and breastfeeding preparation is associated with developing this bonding intimacy, firstly between a pregnant wahine and partner, then between mother, baby, father and whānau once baby is born (Durie, 1998; Glover, Manaena-Biddle, et al., 2008a; Papakura, 1986). The drop in breastfeeding rates over time inadvertently has had a negative effect on whānau connectedness and whānau ora (family health and wellbeing). The review of literature on Māori breastfeeding is scarce, but what is available is comprehensive, and identified key influences and barriers for Māori women to initiate and prolong breastfeeding. Glover et al. (2007; 2008a; 2009) also provided a list of recommendations to help address these barriers. However, what is apparent, is that there is a lack of breastfeeding research that investigates optimal breastfeeding for Māori women, hence the need for this study.

## CHAPTER 3

# Research Methodology and Design

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I have grappled with selecting an appropriate methodology for this research, as I needed to ensure the methodology was going to be able to provide me with a suitable framework that would suit the worldview of the Māori participants, and also answer the research question. The chosen research design and blueprint for this research utilises grounded theory method informed by a Kaupapa Māori methodology. I have used Charmaz (2006) Constructivist Grounded Theory Method. A Kaupapa Māori methodology ensured that the research was Māori focused from its inception through to its completion.

Within this section, I will provide an explanation of the methodological approach used. Under the heading *Methodology: Kaupapa Māori approach*, I discuss how I took into account the participants' cultural and ethnic backgrounds. I then discuss grounded theory methodological underpinnings under the headings, *grounded theory first generation*, an explanation of the *constructivist grounded theory the second generation* used, and the *relevance of symbolic interactionism* for this study. I then provide an explanation of the *research design* that includes the management of the research process, the ethical considerations, the consent process, the research aim and questions, the participants and sampling strategies, and the process used in constructing the Kaupapa Māori constructivist grounded theory that begins with the data collection process (see Figure 2). I then conclude with an explanation of the evaluative criteria used.

### **Methodology: Kaupapa Māori Approach**

There have been concerns that in the past Māori have been over researched and received little or no return from their participation (Durie, 1996). Others claim that there has not been enough research on Māori, emphasising that research can identify strategies that enable change in health status and help to justify the need for increased resources (Broughton & Lawrence, 1993). It is the historical accounts of inappropriate mainstream researchers' unethical behaviours, with little regard for Māori cultural beliefs and mātauranga (Māori

knowledge), which have been raised as a concern by Māori (Smith, 1999). These shortcomings and the mainstream dominance of Western research methodologies have encouraged the emergence of more appropriate methodologies, such as kaupapa Māori (Durie, 1997). The emergence of kaupapa Māori and Māori centred research methodologies ensures tikanga within the processes, procedures and consultation. This process assists in ensuring that everyone who is connected with the research project is valued, and glad to have been a part of it (Mead, 2003).

Defining and understanding what Kaupapa Māori is can be difficult for some researchers. The simple statement of 'by Māori for Māori' clarifies the delivery source, whether it is for health service delivery or research. According to Smith (1996) and Smith (1999), Kaupapa Māori research must be related to 'being' Māori, and follow Māori philosophies and principles. This viewpoint that Māori should research Māori is supported by Cunningham (2000). However, this is not to suggest that Māori should be solely researched 'by Māori' and 'for Māori' (Durie 1997). Durie (1997) acknowledged the need for mainstream researchers' support as there is a limited number of skilled Māori researchers, but insisting that the Māori community must be included in preparation of any Kaupapa Māori research through to its completion to ensure that research goals are mutually agreed upon and help guide the study. Durie (1995) advocated for inclusive and meaningful research with Māori by all, and stated that:

If indigenisation of Maori research is to mean anything at all, then the research done must arise out of the aspirations and needs of the Maori people (p. 19).

Kaupapa Māori research philosophies and principles highlight the importance of validating te reo Māori (Māori language), whakapapa (genealogy) and mana (control, power) (Smith, 1996). Despite many Māori not being able to speak the Māori language, te reo Māori must be considered in the research design to ensure every step is taken to meet this need if required. Māori in the past were orators, and passed down their knowledge through te reo Māori (Smith, Jackson, Cairns, & Durie, 1996). Smith et al. (1996) asserted that language is the window to Māori ways of knowing and interacting within the world. Whakapapa establishes a connection to ancestral links, to the present and the past, and links to hapū (sub-tribe), iwi (tribe) and whenua (land). There are two quite different meanings to the Māori word hapū; hapū can mean pregnant, "conceived in the womb", or with reference to a sub-tribe (Williams, 1997). These two meanings indicate and express a relationship between people. According to Durie (1997), Māori identity is based on a real sense of belonging, whereby an individual belongs to a whānau, whom also belongs to a hapū that belongs to an iwi, which belongs to

the whenua. Thereby, the birth of a Māori child can always be linked through whakapapa to whānau, hapū, and iwi. Each Māori community has its own whakapapa, tikanga and reo Māori, and Smith et al. (1996) warned against imposing a 'pan-Māori' approach.

Mana Māori in terms of this research relates to mana wāhine, and extends to include mana tāne and mana whānau values (Henare, 1988). Kaupapa Māori extends its theory to include mana wāhine (Pihama, 2001; Smith, 1999). Pihama (2001) advocated that mana wāhine as an exciting development of kaupapa Māori as it allows for explicitly engaging gender relations and she noted that:

The struggles for our people, our lands, our worlds, ourselves are struggles that are part of our daily lives as Māori women, they are never just about being Māori or just being women but are about a combination of what those things mean (p. 232).

A mana wāhine perspective gives challenge to the dominant hegemony that continues to other Māori women. Mana wāhine validates mātauranga, wāhine (Māori women's knowledge), and subsequently mātauranga Māori (Māori knowledge) (Simmonds, 2011). The meaning of wāhine is not the same meaning as the term women in English Pihama (2001) explained:

The term wāhine designates a certain time and space for Māori women but is by no means a universal term like the term woman in English. There are many times and spaces Māori women move through, in our lives, wāhine is one of those. There are others. There are varying terms that relate to times in our lives and relationships. From birth we journey through those spaces (p. 261-262).

The Health Research Council of New Zealand (2010) stipulated specific ethical requirements when conducting Māori research. An explanation is given in the research design section on how these requirements and the kaupapa Māori philosophies were implemented.

## **Grounded Theory**

### **Grounded Theory First Generation**

Grounded theory is a widely cited qualitative research method in the social sciences (Bryant & Charmaz, 2007). However, there is considerable confusion and ongoing debate over the methodological orientation of its approach and procedures (Birks & Mills, 2011; Bryant &

Charmaz, 2007; Charmaz, 2006). There is recognised ambiguity associated with the term 'grounded theory', and thus confusion around what are accepted principles and practices, and how they should be implemented. Grounded theory refers to a research method of comparative data analysis, applied by an inductive research process (Charmaz, 2006). In this section, I discuss the methodological underpinnings under the headings of grounded theory first generation, and constructivist grounded theory the second generation.

Grounded theory method was initially developed by two sociologists working in America, Barney Glaser and Anselm Strauss, through their first publication *The Discovery of Grounded Theory*, and is known as first generation grounded theory, or classical grounded theory (Glaser & Strauss, 1967). Glaser and Strauss (1967) stated that:

We would all agree that in social research generating theory goes hand in hand with verifying it, but many sociologists have been diverted from this truism in their zeal to test either existing theories or a theory that they have barely started to generate (p. 2).

Grounded theory method offers a method of comparative data analysis by using an inductive research process, which allows the development of a theoretical account of the topic being researched, while simultaneously grounding the account in empirical observations or data. It is often described and applied as a method, though the philosophical orientation offered by Glaser and Strauss was intended to be seen as a methodological approach (Glaser & Strauss, 1967). Grounded theorists use gerunds, indicating action and change, where the focus is on a process and trajectory, resulting in identifiable processes, stages and phases (Glaser, 1978, 1992, 1998). After the publication of the *Basics of Qualitative Research* by Strauss and Corbin (1990), about grounded theory procedures and techniques, Glaser and Strauss went their different pathways in the development of grounded theory. A rebuttal by Glaser (1992) also followed. These actions sparked a debate among grounded theory scholars about the merits of the each scholar's work. These debates continue today (Birks & Mills, 2011).

In 2008, Strauss attempted to rectify noticeable gaps by explaining pragmatism and symbolic interactionism as the philosophies that methodologically underpin grounded theory method (Corbin & Strauss, 2008). Birks and Mills (2011) claimed that Glaser had not entered into any conversation, rather he focused on grounded theory method and what constitutes a grounded theory. Glaser dismissed any specific philosophy, and believed that by adopting such perspective would reduce the broader potential of grounded theory (Glaser, 2005). Glaser is

generally cited to be a critical realist within the post-positivist paradigm. This was based on his writing about emergence of core categories from data, during the process of concurrent data collection and analysis (Birks & Mills, 2011).

Classic grounded theory has its roots in symbolic interactionism. With this approach to research there was a need to understand how groups view a phenomena or problem, to understand the meanings within the actions undertaken (Crotty, 1998). Symbolic interactionism is an approach that is said to be 'down-to-earth' approach into human interaction (Blumer, 1986). Charmaz (2006) provided an explanation of symbolic interactionism as:

a theoretical perspective derived from pragmatism, which assumes that people construct selves, society, and reality through interaction. Because this perspective focuses on dynamic relationships between meaning and actions, it addresses the active processes through which people create and mediate meanings. Meanings arise out of actions, and in turn influence actions. This perspective assumes that individuals are active, creative, and reflective and that social life consists of processes (p. 189).

Glaser (1978) suggested the notion of basic social processes, and differentiates between basic social (structural) processes and basic social psychological processes. Charmaz (2000), advocated reinterpretation to "change our concept of it from a real world to be discovered ... to a world made real [sic] in the minds through the words and actions of its members" (p. 523). For the breastfeeding Māori women in my research, understanding their experience was achieved by discovering the interpretation or meaning of actions that optimised and what did not optimise their experiences.

### **Constructivist Grounded Theory - The Second Generation**

Second generation grounded theorists, like Charmaz (2006), have written their own interpretations of Glaser and Strauss grounded theory method using their original work as a launching pad for their own iterations (Birks & Mills, 2011). Charmaz (2006) stated:

In typical grounded theory practice, you follow the leads in your data, as you see them, and constructivist grounded theory takes you one step further. With it you try to make everyone's vantage points and their implications explicit, yours as well as those of your

various participants. Not only does a constructivist approach help you to remain clear about the antecedents of your constructed theory, this approach helps other researchers and policy makers to establish the boundaries of the usefulness of your grounded theory and, possibly to ascertain how and where to modify it (p. 184).

Charmaz (2006) asserted that constructivist grounded theory provides a methodological route to renew and revitalise the pragmatist foundations of classic grounded theory, and can also serve researchers from other traditions. Charmaz (2006) remains consistent in her approach, as illustrated in Charmaz (1991; 2000), placing priority on the area studied, with data and analysis created from shared experiences and relationships with participants. The suitability of constructivist grounded theory for social justice research is useful for those groups that experience disparities and inequalities, as it allows for their experiences, ideas or notions to come forth and be heard. As Charmaz (2005) informed that through:

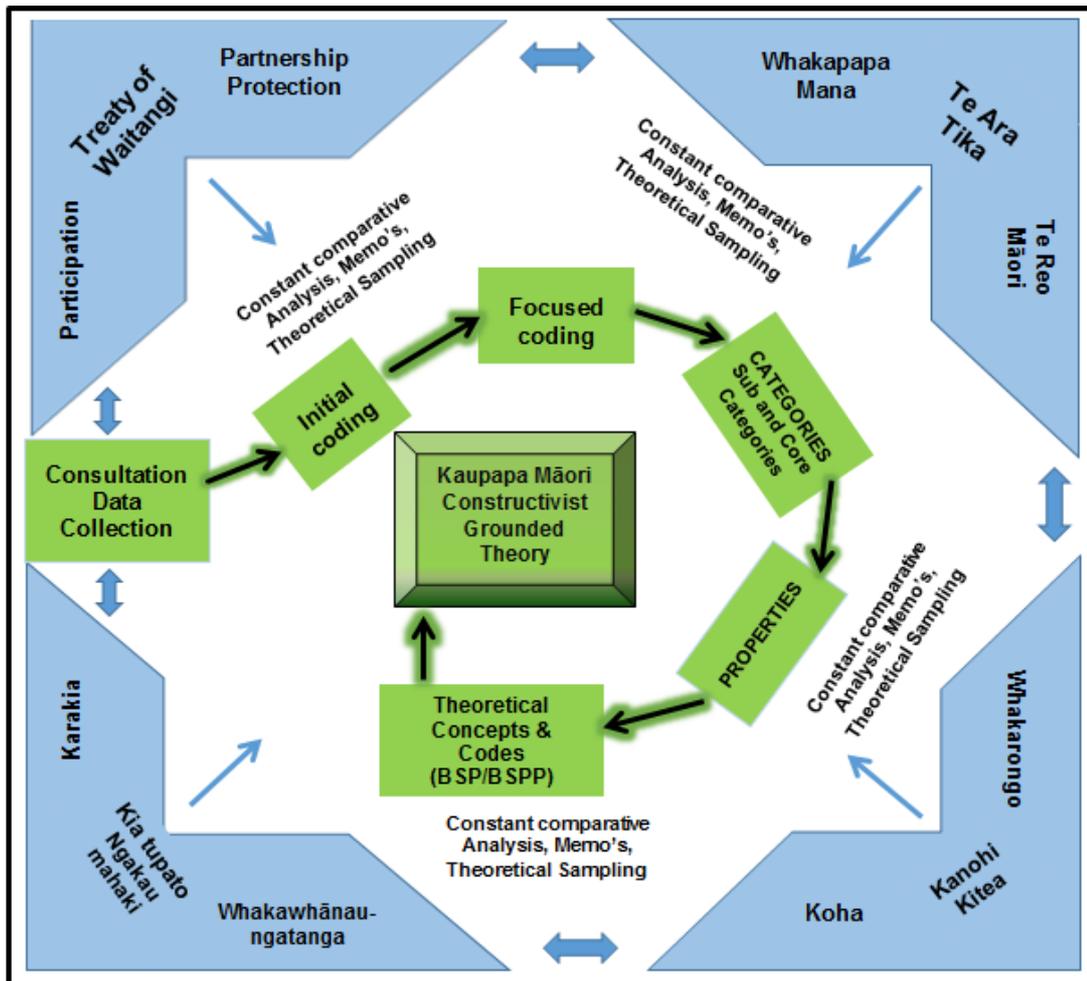
It's, attentiveness to ideas and the ability to identify actions concerning fairness, equity, equality, democratic process, status, hierarchy, and individual and collective rights and obligations, constructivist grounded theory can increase the precision and predictive ability (p. 510).

Concepts such as hegemony and domination are treated as sensitising concepts that show how inequalities are played out, and identify to what extent the participants construct and identify power, privilege, and inequality in their breastfeeding experiences (Charmaz, 2005). Smith (1997), in his development of kaupapa Māori theory and praxis, deliberately linked the term theory to kaupapa Māori to counteract hegemonic practice, and understand the cultural constraints in such question such as "what counts as theory" (Pihama, Cram, & Walker, 2002)? Therefore, using a constructivist grounded theory method, within a kaupapa Māori methodology approach was ideal for this study to generate theory to explain how Māori women manage breastfeeding and how breastfeeding it can be optimised. It also made it possible to explore sensitive hegemonic and pedagogical concepts that may have hindered their ability to achieve optimal breastfeeding, to bring about an awareness and to identify strategies to address these constraints and barriers, as well as identifying how Māori women achieved optimal breastfeeding despite these constraints.

## Research Design

There is limited research that investigates what interactions optimise Māori women's breastfeeding. Therefore, it was imperative that the research design was able to bring to the forefront their experiences, in a way that highlighted how they managed to breastfeed. This section firstly explains the constructivist grounded theory informed by a Kaupapa Māori approach, and how this research also integrated the Health Research Council of New Zealand (2010) and Hudson, Milne, Reynolds, Russell & Smith (2010) ethics requirements, (see Figure 2). I then discuss the management of the research process with regard to maintaining a Kaupapa Māori focus, then the ethical consideration and consent process. This will be followed by the research question, the aim of the research, and the participants sampling strategy. The construction of the Kaupapa Māori constructivist grounded theory process is then explained beginning with the data collection; data analysis strategies of constant comparison and theoretical sampling; initial coding; focused coding; memo's; categories and subcategories; properties; theoretical coding and concepts; then constructing the theory; and then a discussion on the research evaluative criteria.

The process of constructivist grounded theory informed by a Kaupapa Māori methodology I describe as the Whetū Koru framework. It can be graphically depicted using the koru and whetū (see Figure 2). The koru is used in Māori art as a symbol of creation, based on the shape of an unfurling fern frond. For this research, the koru depicts the process of ūkaipōtanga (nurturing) needed for *optimising Māori women's breastfeeding*. Māori ancestors used the whetū to navigate. Feeding into the koru continuously are the kaupapa Māori research philosophies that form a whetū (star) shape around the koru. These kaupapa Māori research philosophies were used to navigate and guide this research from conception to the end. The Kaupapa Māori methodology was also informed by Health Research Council of New Zealand (2010), ethics framework "Te Ara Tika" (Hudson et al., 2010) the Treaty of Waitangi principles, and kaupapa Māori values, explained in the management of research process and ethical consideration section.



**Figure: 2.** Kaupapa Māori Methodology Approach to Constructivist Grounded Theory (Whetū Koru Framework).

The development of the constructivist grounded theory was guided by a kaupapa Māori methodological approach, started with consultation and data collection process, which formed the beginning of the koru. The grounded theory process of constant comparative analysis, theoretical sampling, and memoing was conducted until data saturation occurred, and started once data was collected and continued through until the construction of the grounded theory. This was then followed by initial coding then focused coding, followed by sorting these codes into categories, then reducing these down to selective subcategories and a core category and their properties. Then finally the theoretical concepts and codes were explicated to form the Kaupapa Māori approach informed constructivist grounded theory.

## Research Question and Aims

The research questions explored how Māori women in the EBOP manage breastfeeding, to identify how optimal breastfeeding can be achieved with the ultimate aim to support more Māori women being able to exclusively breastfeed for six months, and beyond. The research question posed was, '*what is happening for Māori mothers and breastfeeding?*' As mentioned in Chapter 1, the research aimed to:

1. Ascertain how Māori women manage breastfeeding;
2. Explain the support Māori women need to successfully breastfeed up to and beyond six months; and
3. Explain how health care practitioners, policy makers and the community might be able to support Māori women to successfully breastfeed up to and beyond six months.

## Management of the Research Process

As a Māori researcher who has been a community worker for over a decade, it was important that I did not take my Iwi connections and my community experience for granted. Seven Kaupapa Māori values recommended by Smith (1996, 1999) and Pipi et al. (2004) were identified as appropriate for this research. These concepts were: kanohi kitea (seen face to face); whakarongo.....korero (look, listen ... speak); kia tūpato (caution is taken); ngākau māhaki (do not flaunt your knowledge); whakawhanaungatanga (building and maintaining relationships); koha (gift) and karakia (prayer) (see Table 3 for details outlining the implementation of these values).

The use of Health Research Council's "Te Ara Tika" framework and the Treaty of Waitangi principles are also incorporated in Table 3 (Health Research Council of New Zealand, 2010; Hudson et al., 2010). The Te Ara Tika framework refers to four tikanga based principles, tika (research design), whakapapa (relationships), manaakitanga (cultural and social responsibility), and mana (justice and equity). The Treaty of Waitangi's three principles, participation, partnership and protection guided the process. Therefore, the Eastern Bay of Plenty Māori community participated in developing an appropriate research design, through partnerships I established with key people and organisations. The process helped ensure the protection of the participants and the data, which is also discussed further in the ethical consideration and consent process section.

**Table 3***Implementation of Kaupapa Māori Values and Te Ara Tika Principles.*

<b>Kaupapa Māori values and Te Ara Tika principles</b>	<b>Translation</b>	<b>Implementation</b>
<b>Tika</b>	Correct, accurate, valid	An appropriate research design was used incorporating kaupapa Māori, Health Research Council and Treaty of Waitangi principles and concepts, which included Māori community involved in the consultation and recruiting process, and a Māori advisory group, to help guide the researcher in what is tika.
<b>Kanohi kitea</b>	Seen face to face	Initial face to face meetings were held with each participant, to gain familiarity, credibility and trust before taking them through the consent process. A face to face second meeting took place for the research interview.
<b>Titiro, Whakarongo ...kōrerō</b>	Look, listen ... speak	Sufficient time was allowed to ensure that the participants were able to share openly, in both the initial meeting and the research interview. I allowed them the time to respectfully speak uninterrupted as I tentatively listened.
<b>Kia tupato</b>	Caution is taken	I was cautious and observant at all times to ensure the safety of participants. This included ensuring that they were comfortable with the surroundings of the interview. The majority chose to be interviewed at a café, and some chose health providers facility.
<b>Ngākau māhaki/mana</b>	Do not flaunt your knowledge/justice and equity	I expressed my sincere gratitude, and was humbled by the participant's willingness to share their experiences.
<b>Whakawhānaugatanga /whakapapa</b>	Building and maintaining relationships	Building and maintaining trust was an important aspect of this research, which was established through making myself known to participants. Several phone contacts were made, before meeting them in person to introduce myself, sharing of whakapapa and building trust before the research interview.
<b>Koha/manaakitanga</b>	Gift/cultural and social responsibility	Koha is a Māori tradition. The provision of refreshments at all interviews, plus a koha in the form of grocery voucher in recognition and appreciation of the participant's time and contribution to this research was given.
<b>Karakia</b>	Prayer	All interviews commenced with an opening and finished with a closing karakia in te reo Māori.

The consultation process with the Eastern Bay of Plenty (EBOP) Māori community commenced before the research study began. Presentations of proposed study at key forums and meetings were conducted throughout the EBOP. Consultation also ensured that the intended method of recruitment and data collection was suitable and acceptable. A Māori advisory group was set up to ensure ongoing participation. Individuals were approached to be part of this advisory group, for specific roles to support the researcher. The group members assisted with the consultation process, and provided valuable guidance on tikanga, and cultural support in the recruitment of participants. Some of these members acted as intermediaries in the consent process. In addition, they ensured appropriate Māori practices, tikanga, customs, and ethics were followed throughout the research. The advisory group members comprised of local Māori health practitioners, including a Māori breastfeeding lactation consultant/midwife, kaumātua, and kuia, and were also members of the Eastern Bay of Plenty Breastfeeding Coalition at the time of set up. Meetings were originally planned for after the coalition's monthly meeting, as a matter of convenience for the group members. However, inconsistent attendance and a change in coalition meetings from monthly to bi-monthly half-way through the study made regular meetings as a group difficult. Therefore, it was necessary to keep regular contact, which was conducted through phone, and organising specific face-to-face meetings. Protection of the Māori participants involved treating them with respect, valuing and appreciating their participation, and protecting the data collected.

## **Ethical Considerations and Consent Process**

Ethical consent for this research was obtained from Auckland University of Technology Research Ethics Committee (reference number 12/59). Ethical approval was also granted for a koha to be given to the participants in recognition for their time and travel costs. There were a number of ethical considerations that I needed to declare to the participants in relation to this study. These included the possibility of participants being coerced, and the potential for study biases or conflicts of interest. Therefore, I declared that I am a mother of four children and have breastfed all four children, and have two grandchildren who were both breastfed. I also acknowledged my Māori whakapapa and affiliation to four of the nine Iwi within the EBOP (Mātaatua Rohe), being Te Whakatōhea, Ngaitai, Ngāti Awa/Ngāti Pukeko and Te Whānau-a-Apanui. At the time, I was also employed as the breastfeeding promoter/educator for a Māori health provider in the EBOP. I approached four Māori health providers to assist with recruiting participants to eliminate coercion concerns. I also commenced the study by writing my own reflective memo to identify, and explore my pre-understandings to alert myself to my own

values, beliefs, and biases. I also advised that Advisory Group and the participants that the purpose of this research was a requirement for me to achieve my Masters in Public Health.

To preserve participants' confidentiality, all identifying information (such as names and place names) was removed from the transcripts, and participants were assigned a pseudonym. Most participants were not concerned with being identified, as they saw the research as an opportunity to help other women. It was not anticipated that there would be any physical or psychological risks to the participants as a result of them participating in this research. However, I remained alert to this possibility and monitored the participants in the study, with the support of my supervisor, to detect and minimise any harm. All data and transcripts were stored in a locked cabinet and password protected computer files, and stored separately from the signed consent forms. Only the research supervisor had access to the raw data.

An information flyer was distributed through the Māori health providers (see Appendix A) accompanied by an information sheet (see Appendix B). The information sheet provided information about the research, including the research purpose, risks, benefits and the expectations of the women participating. They were given the option for interviews to be conducted in te reo. Each participant was taken through an informed consent process. This ensured that participants were fully aware of the research project, their rights, including their right to withdraw at any time, and what would happen to the data. To minimise the risk of the women being coerced into participating, intermediaries from the Māori health organisations were involved in both the recruitment and the informed consent process, and were available as a support person for the participants' interview. A provider's chief executive officer believed the need to have an intermediary involved in process was unnecessary, as she did not think coercion would be a concern, but remained supportive.

Māori women, who expressed interest in participating, were referred by a health worker to me via the Māori provider's intermediary. I made phone contact to clarify their understanding, to ask whether they had any questions, and to ascertain if they were still interested in participating. Several women, who indicated an interest to participate, opted not to take part. There were several women that could not be contacted. Once a potential participant confirmed they were still interested, a suitable time to meet face to face informally was organised to introduce myself, share my hapū and iwi affiliations, and work background. I was

also able to make connection with most of the wāhine and their affiliations. The informal meeting allowed for valuable whakawhanaungatanga. I then discussed the research purpose in more detail providing them with the information sheet (see Appendix B), and then the consent form (see Appendix C) for their approval. Then I organised a suitable date and time for the interview to take place at a venue of their choice.

## **Participant Sampling Strategy**

Purposeful sampling was used to identify the participants being researched, to ensure they met the criteria for inclusion in this study. It is a technique that researchers who have knowledge of the population under study use to purposely select research participants (Creswell, 2009). The sample of Māori women participants was not limited to Māori women affiliated to the Eastern Bay of Plenty Iwi, as explained in the information flyer (see Appendix A) and information sheet (see Appendix B). The participants recruited included those who were either successful or had difficulties in managing breastfeeding, or both. Purposeful sampling ensured that the information obtained reflected diverse and varying breastfeeding experiences. The inclusion criteria required for potential participants were:

- A women who has breastfed in the past 10 years or is still breastfeeding;
- Being able to identify as Māori;
- Currently living in the EBOP; and
- Be aged 16 years of age or older.

## **Data Collection**

Data collection is the first process to generate a grounded theory (see Figure 2). Data were collected through semi-structured interviews that were digitally recorded. The participants had separate open ended questions to the key informant (see Tables 4 and 5). The open ended questions were deliberately broad, to allow for open sharing, whilst at the same time providing some structure that did not impede on the sharing of their reality to generate useful data, a viewpoint espoused by Schreiber and Stern (2001).

Grounded theory allows for diverse sources of data and strategies to generate or collect data. Data collection included field notes and memos, alongside the interview transcripts. Field notes were also taken as a precautionary measure in case of recording failure. These field notes proved valuable when theoretical sampling was engaged; these helped to identify reoccurring concerns and concepts (Glaser, 1998; McCallin, 2003). However, on many occasions I became engrossed in what the wāhine had to share and stopped writing. Therefore, I found writing reflective memos after each interview helpful in addition to the recorded transcripts.

**Table 4**

*Semi Structured Interview Open Ended Questions for Participants.*

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**Initiating semi structured interview open ended questions for participants:**

- Tell me about your breastfeeding experience?
  - Tell me about what helped you?
  - Tell me about what were the difficulties you faced?
  - Tell me about what advice you would give to other women?
  - Tell me about what recommendations you would give to health practitioners?
- 

**Table 5**

*Semi-Structured Interview Open Ended Questions for Key Informant.*

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**Initiating semi structured interview open ended questions for key informant:**

- Tell me about the services you provided?
  - Tell me what makes your service successful for Māori women in making a positive difference in their breastfeeding experience, and their decision to breastfeed?
  - Given your experience in working with Māori mothers who are breastfeeding, what is your whakaaro about what works for them and what does not?
-

## Data Analysis Strategies, Constant Comparison and Theoretical Sampling

Simultaneous data collection and analysis helped to shape and inform the emerging analysis through the process of constant comparison and theoretical sampling (see Figure 4). Charmaz (2006) focuses on the process constant comparison and emphasised creating analyses of action using gerunds, a concept that Glaser and Strauss (1967), and Glaser (1978) supported. As the initial data were analysed, I constantly asked 'what is happening here?' Further data collection explored particular emerging codes, concepts and categories using a process called theoretical sampling (Charmaz, 2006; Glaser, 1978, 1992; Glaser & Strauss, 1967). For example, Figure 3 illustrates how I engaged with the data initially after line by line analysis and coding of the transcripts. To trace participants' excerpts, I utilised line by line codes, each excerpt was coded with their initial and a numerical number. The data were analysed, compared and then theoretically sampled in subsequent interviews. These processes led me to engage more with the data to try and identify:

- Who experienced no difficulties breastfeeding?
- How was this possible?
- What was the teaching?
- Who taught them? When were they taught? and
- Was it from her first, second or third child?

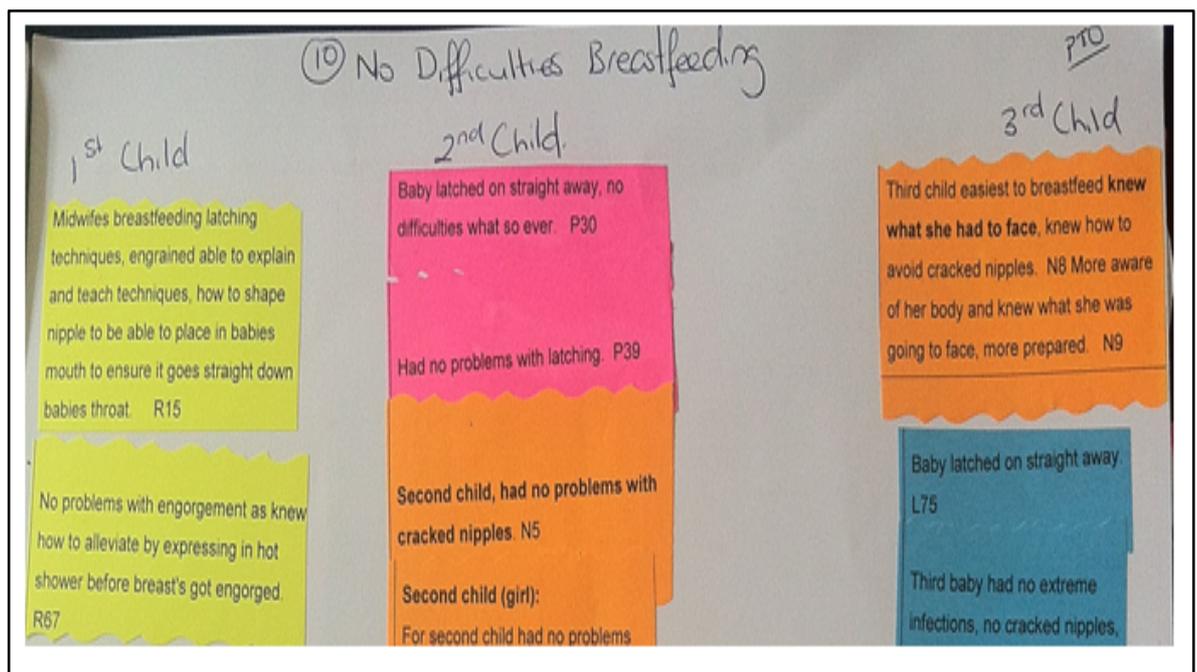


Figure 3. Initial sorting, analysing, comparing and coding of data

Theoretical sampling involved the focused collection of data to explore further emerging codes, concepts and categories, systems of exploration, clarification, verification and eventually saturation (Glaser, 1998). Charmaz (2006) employs theoretical sampling to develop the properties of the categories until no new properties emerge, thus saturating the categories with data to help form the emerging theory. For example, several women gave credit to the same kaupapa Māori provider and her practises for their positive birthing and breastfeeding experiences. I undertook theoretical sampling to help elaborate and refine the categories and emerging theory, by engaging with more data through literature and recruiting the provider as a key informant.

As a Māori woman and Māori health worker working in the field of breastfeeding, I was aware of traditional breastfeeding practices such as wet nursing, historical and current Māori breastfeeding statistics and current health research conducted concerning Māori women breastfeeding. This knowledge was advantageous in theoretical sampling and theoretical sensitivity (Charmaz, 2006; Schreiber & Stern, 2001). However, this posed a potential risk of preconceived ideas being imposed on the data during data analysis. I followed recommendations by Charmaz (2006) and conducted reflexive memos to examine my assumptions and motives, to ensure they did not impact on the data analysed.

### **Initial Coding**

As data were collected I began to separate, sort and synthesise the data through coding. Charmaz (2006) explained that coding distils data, sorts and gives points for comparison with other segments of data, whilst constantly enquiring what is happening. There are two main types of coding in constructivist grounded theory. There is first the initial coding followed by focused coding (Charmaz). Initial coding follows data collection and relates to line-by-line coding that sticks closely to the data. The use of gerunds in initial coding or '*in vivo*' codes is recommended by Glaser (1998), allowing for the participants' words to be used, where possible, to ensure codes accurately reflect what participants are saying. '*In vivo*' codes clearly linked the emerging codes, concepts and categories to the data. The first few interviews were very much about learning how to code. Several initial codes stood out to me, and related to those who had no problems breastfeeding, antenatal education, and midwifery care. The following excerpt (see Table 6), by Rhona (pseudonym), relates to her breastfeeding experience with her first child. Rhona encountered no problems initiating or maintaining breastfeeding. Through this initial coding I was able to analyse each participants data and identify when, how, and why, each one encountered no difficulties breastfeeding (see Figure 3).

Reviewing these initial codes to more focused coding allowed for the data to move to the next stage. Categories made permissible the theoretical concepts, and therefore, theoretical sampling. Theoretical sampling was discussed with my supervisor to clarify and identify emerging codes, concepts, categories and the theory. The theoretical sampling was also discussed with members of the Māori Advisory Group members. This process is discussed further in data analysis section.

**Table: 6**

*Line-By-Line Initial Coding.*

Excerpt from Rhona	Initial coding: Line-by-line
<p><i>Mother of 4. Aged 33.</i></p> <p><i>Children's ages: 13, 9, 4 and 3 years.</i></p> <p>She taught me how [to] shape the titty to the baby's mouth. The bottom of the breast would be heavy on the baby's bottom lip and the bottom piece of the mouth. Your fingers are like that (showing) like a scissors, but you really pinch the nipples, the breast to make it small, to put the whole brown piece in and then just hold the weight from under the baby's mouth. Because it's about how you're putting it into the baby's mouth, so that it shoots in, goes straight down baby's throat and it's not getting stuck around in the mouth so the baby gets thrush. Heaps of different teaching and even when you show someone how to do it, how to breastfeed, you see them lift the breast off this part of the baby's mouth because it's too much pressure.</p> <p>I didn't even have a cracked nipple, they got dry and that was it. No issues with breastfeeding, no nothing, not with breastfeeding. Breastfed for five years and she only stopped breastfeeding because she had to share with the new baby.</p>	<p>Midwives breastfeeding latching techniques, engrained able to explain and teach techniques, how to shape nipple to be able to place in baby's mouth to ensure it goes straight down baby's throat.</p> <p>No difficulties breastfeeding</p>

### **Focused Coding**

Focused coding is the second phase in coding. According to Charmaz (2006), focused coding allows you to separate, sort and synthesize large amounts of data. Rather than selective line-by-line, incident-by-incident initial coding, focused coding utilises the most significant and

frequent initial codes, and requires decisions on what makes the most analytical sense to categorise data (Charmaz). Axial coding is an option that constructivist grounded theory researchers can use. Its purpose is similar to other strategies for coding, that is to sort, synthesise and organise large amounts of data (Birks & Mills, 2011). Charmaz's (2006) preference is to conduct focused coding then move through to constructing sub-categories and categories. Birks and Mills (2011) conceptual terminology map gave me some clarity of the different conceptual terminology used by the various theorists, and confirmed my choice of method. I employed focused coding only (see Table 7). I separated codes to identify which concepts optimised breastfeeding and which did not. I engaged in more memoing (see Table 8). My supervisor identified when I had hit a speed that I needed to engage in more memoing and then clustering to make sense of the codes. Clustering enabled the moving and refining of codes, identifying subcategories and categories and their properties (see Figure 4).

**Table 7**

*Initial Coding and Focused Coding.*

<i>Excerpt 1: From Rhona</i>	Initial coding	Focused coding
<p>She taught me how shape the titty to the baby's mouth. The bottom of the breast would be heavy on the baby's bottom lip and the bottom piece of the mouth. Your fingers are like that (showing) like a scissors, but you really pinch the nipples, the breast to make it small, to put the whole brown piece in and then just hold the weight from under the baby's mouth. Because it's about how you're putting it into the baby's mouth, so that it shoots in, goes straight down baby's throat and it's not getting stuck around in the mouth so the baby gets thrush. Heaps of different teaching and even when you show someone how to do it, how to breastfeed, you see them lift the breast off this part of the baby's mouth because it's too much pressure.</p>	<p>Midwife's breast-feeding latching techniques, engrained able to explain and teach techniques, how to shape nipple to be able to place in baby's mouth to ensure it goes straight down baby's throat.</p>	<p>Midwife's Teachings Midwife's Practices Learning to Breastfeed</p>
<p>I didn't even have a cracked nipple, they got dry and that was it. No issues with breastfeeding, no nothing, not with breastfeeding. Breastfed for five years and she only stopped breastfeeding because she had to share with the new baby.</p>	<p>No difficulties breastfeeding</p>	<p>Supporting other women No difficulties breast-feeding</p>

## **Memos**

The memoing process (see Figure 2) formed as part of the process of data analysing, constant comparison, theoretical sampling and emerging theory. Coding data, the constant comparison of data, and writing about these codes using analytical notes called memos, made it easier to analytically grasp the concepts (Charmaz, 2006). Writing memos helped define emerging ideas that best fit and interpreted the data as tentative analytic categories, concepts and properties, and assisted in the process of theoretical sampling (Glaser, 1998). Glaser (1978) reminded us that the prime rule in grounded theory is to stop and memo, no matter what, to capture thinking around the analysis.

Memoing was not a strong point for me in the early stages, as coding seemed to take hold of my focus and overwhelm me. I quickly figured out that memoing helped unravel and bring clarity to my analysis, helping to move the coded data on to the next level. I used several forms of memos including notes, drawings, and diagrams or clustering (see Table 8, Figures 4 and 4). I found the most useful form to be clustering and free writing. Clustering gives you visual clues and is flexible, helps with organising and understanding your material, speeds up the process, is active, changeable and makes writing less burdensome (Charmaz, 2006).

### **Table 8**

*Example of Free Writing Memo.*

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#### **Free writing memo regarding Rhona:**

Midwife for first child – committed care, engrained teachings for both, birthing, antenatal and postnatal breastfeeding. No breastfeeding difficulties with all four children as she was taught properly, quoted saying “didn’t know anything else”. Compared with the other participants breastfeeding and birthing experiences. She is the only participant, so far, with positive experiences right from her first baby.

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## **Categories and Sub-categories**

The next step along the koru (see Figure 2), was forming the categories and subcategories stage. Developing subcategories to categories enabled me to show the links and learn about the processes the categories represent (Charmaz, 2006). The subcategories specified the properties and dimensions of a category, and reassemble the data that was fractured during

initial coding to give coherence to the emerging analysis (Charmaz). Charmaz (2006) explicated how the categories become more theoretical through the analysis levels, claiming that:

When inevitable questions arise and gaps in our categories appear, we seek data that answer these questions and may fill the gaps. We may return to the research participant's data to learn more and to strengthen our analytic categories. As we proceed, our categories not only coalesce as we interpret the collected data but also the categories become more theoretical because we engage in successive levels of analysis (p. 3).



Figure: 4. First attempt at clustering

I engaged in clustering and free writing to identify the subcategories and categories. I continued to use my first attempt as a guide (see Figure 4). I updated and made changes after constantly analysing and comparing the data and codes again and again. The sub-category titles went through a rehashing to ensure they all fitted and linked. But, most important, was that they reflected the participants' experiences, and what was needed to saturate the core-category *optimising Māori women's breastfeeding*. For example, changing the sub-category title from *supporting networks* to *having supportive systems* was a more inclusive statement to the sub-category. I also moved the getting ready to breastfeed subcategory into the *nurturing circle*. The subcategory title changed several times from preparing to breastfeed, to getting ready to breastfeed to the final title of *getting ready*, to incorporate all prenatal experiences, as the data showed this process was important in achieving *optimising Māori women's breastfeeding*. Lastly, the subcategory, *having an engaging midwife* went through a few changes, from, *interacting with midwife* to *midwife interaction*, then *engaging midwife*, and arriving at *having an engaging midwife*. The three subcategories *getting ready*, *having an engaging midwife* and *having supportive systems* and their properties enabled the achievement of the core category *optimising Māori women's breastfeeding*. What was also revealed, the categories *whānau ora* and *supporting other mothers* were the outcomes of *optimising Māori women's breastfeeding*, as explained in the Chapter Four, Findings: *Optimising Māori Women's Breastfeeding*.

## Properties

Properties are the next step in the koru. Categories and sub-categories have properties that need to be identified. These properties are revealed when comparing data with data of the same experience or event, and re-examining the data coded during initial coding (Charmaz, 2006). According to Strauss and Corbin (1997), properties can be defined as a "characteristic of a category, the delineation of which define the category and gives it meaning" (p. 101). Birks and Mills (2011) maintained that properties should be considered in terms of their dimensions or the range of variance that they demonstrate, and stated "dimensions of properties can also be linked to actions and conditions that they operate under" (p. 98). For example, the sub-category, *getting ready*, has three properties that were identified to fit within the data: these are *learning and knowing breastfeeding*, *preparing nipples* and *involving partner and whānau* which (discussed in Chapter Four, Findings: *Optimising Māori Women's Breastfeeding*).

## Theoretical Coding and Concepts

The next steps in the koru are theoretical coding and concepts (see Figure 2). Charmaz (2006) stated that theoretical coding follows the codes that have been selected during focused coding at a sophisticated level, and specifies possible relationships between categories and focused codes. To raise the categories to concepts requires subjecting the categories to further refining to show their relationships (Charmaz, 2006). Glaser (1978) stated that theoretical codes conceptualise “how the substantive codes may relate to each other as hypotheses to be integrated into a theory” (p. 72). Charmaz (2006) claimed that:

If you use them skilfully, theoretical codes may hone your work and a sharp analytic edge. They can add precision and clarity - as long as they fit your data and substantive analysis (p. 63).

Symbolic interactionism was ideal in informing this study. For example, the substantive analysis of how and who the participants interacted with during prenatal and postnatal period and what helped, revealed the social process of *ūkaipōtanga (nurturing)* needed to achieve optimal breastfeeding. Charmaz (2006) stated that codes arising from symbolic interaction give theoretical or conceptual foundations that integrate narrative. The basic social process relates to processes participants experienced to resolve a social problem or phenomenon of concern, which according to Glaser (1978) are a type of core category. The basic social process of *ūkaipōtanga (nurturing)* explains how and what is needed for Māori women to achieve optimal breastfeeding, and uniquely brings together multiple properties that influences successful breastfeeding. For example, the actions (gerunds) such as *involving partner and whānau* in the subcategory *getting ready* provides an understanding of who should be included in the getting ready to breastfeed process. Some philosophers warned that, participants may or may not see the links between symbolic interactionism, the basic social processes with their experiences or interactions (Charmaz, 2006; Glaser, 1978, 1998; Schreiber & Stern, 2001). However, they may be able to see the links with the process of *ūkaipōtanga (nurturing)*. A constructivist approach encourages you to theorise in the interpretive tradition and I utilised questions (see Table 9) as suggested by Charmaz (2006) to guide the theorising of concepts.

## **Table 9**

### *Questions to Consider When Theorising Concepts.*

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#### **Questions to consider when theorising concepts:**

- Do these concepts help you understand what the data indicate?
  - If so, how do they help?
  - Can you explicate what is happening in this line or segment of data with these concepts?
  - Can you adequately interpret this segment of data without these concepts?
  - What do they add?
- 

Note: Charmaz (2006, p. 68).

When examining *having an engaging midwife* subcategory and its properties, for example, the concepts of *ūkaipōtanga (nurturing)* for *wāhine*, and being the recipient of quality *ūkaipōtanga* from her midwife, contributed towards achieving optimal breastfeeding. But the positive effects were not limited to only optimal breastfeeding. Quality *ūkaipōtanga (nurturing)* also contributed to achieving *whānau ora*, and the skills developed to support other women in the future. The concepts of *ūkaipōtanga (nurturing)* are explained in Chapter Four, Findings: *Optimising Māori Women's Breastfeeding*.

## **Constructing Theory**

Constructing the kaupapa Māori informed constructivist grounded theory is the final process in the koru (see Figure 2). There is a need to understand what the word 'theory' means. There are a number of definitions and these are dependent on the philosophical roots, for example, positivists aim to explain and predict through observing relationships, whereas, interpretivists aim to increase understanding through theory development (Charmaz, 2006). Glaser and Strauss (1967) in classic grounded theory, talk about discovering theory as emerging from data separate from the scientific observation, are seen as positivists (Charmaz, 2006). Charmaz's (2006) constructivist grounded theory is interpretivist, and she has a preference for theorising not theory. Interpretive theorising arises from social constructionist assumptions informed by symbolic interactionism (Charmaz, 2006). Charmaz (2006) concurs with Wuest (2000) when

claiming that theorising required extensive drawing on codes that work, defining what fits, pondering and rethinking anew. (Charmaz, 2006) asserted that:

When you theorize you reach down to fundamentals, up to abstractions, and probe into experience. The content of theorizing cuts to the core of studied life and poses new questions about it (p. 135).

Developing theoretical sensitivity is a necessity. Charmaz (2006) declared theoretical sensitivity is developed with the use of gerunds in coding and memo-writing consistent with (Glaser, 1978). Charmaz (2006) further explained that:

Gerunds foster theoretical sensitivity because these words nudge us out of static topics and into enacted processes ... emphasis on actions and processes, not on individuals, as a strategy in constructing theory and moving beyond categorizing types of individuals (p. 136).

To aid efforts to construct theory, Charmaz (2006) recommended taking a closer look at analysing processes to define and conceptualise relationships between experiences and events. Theories serve different purposes and differ in many aspects, for which Charmaz (2006) acknowledged the subjectivity and ambiguity in constructivist grounded theory, which is not dissimilar to other grounded theory approaches or qualitative approaches. Charmaz (2006) claimed that:

We are part of our constructed theory and this theory reflects the vantage points inherent in our varied experience, whether or not we are aware of them (p. 149).

A constructivist approach encouraged me to explore and interpret statements or participants' actions. Thus, theoretical rendering is an interpretation of the studied world, not an exact picture of it (Charmaz, 2000, 2006; Guba & Lincoln, 1994). The resulting theory is an interpretation, dependent on the researchers' view. It does not and cannot stand outside of it (Bryant, 2003; Charmaz, 2006). The process of the constructing theory for this research is illustrated in Table 10.

**Table 10**

*The Process of Constructing Theory.*

Constructs Used Codes	Sociological Constructs
<p><b>Subcategories:</b></p> <ul style="list-style-type: none"><li>• Getting ready</li><li>• Supporting other mothers</li><li>• Whānau ora</li></ul> <p><b>Concepts:</b></p> <ul style="list-style-type: none"><li>• Connecting through whānau</li><li>• Using mātauranga</li><li>• Using kaupapa Māori practices</li><li>• Acting on fear and past experiences</li><li>• Connecting with appropriate service</li><li>• Building and maintaining relationships</li><li>• Receiving effective teachings practices</li></ul> <p><b>Properties:</b></p> <ul style="list-style-type: none"><li>• Learning and knowing breastfeeding</li><li>• Preparing nipples</li><li>• Involving partner and whānau</li></ul> <p>All the properties identified gerund codes.</p> <p>Sub-category <i>getting ready</i> initial gerund code of <i>preparing</i>, similar to <i>supporting other mothers</i> category initial gerund code was <i>supporting other women</i> were changed to fit.</p>	<p><b>Core Category:</b></p> <ul style="list-style-type: none"><li>• Optimising Māori women’s breastfeeding</li></ul> <p><b>Subcategories:</b></p> <ul style="list-style-type: none"><li>• Having an engaging midwife</li><li>• Having supportive systems</li></ul> <p><b>Concepts:</b></p> <ul style="list-style-type: none"><li>• Ūkaipōtanga (nurturing)</li><li>• Building and maintaining relationships</li><li>• Creating and ensuring safe environments</li><li>• Consent Advocacy and protection</li><li>• Building trust</li><li>• Empowerment</li><li>• Equality and equity</li><li>• Autonomy, self-determination</li></ul> <p><b>Properties:</b></p> <ul style="list-style-type: none"><li>• Working with</li><li>• Engaging culturally</li><li>• Involving partner and whānau</li><li>• Teaching</li><li>• Being available</li><li>• Alternative practices</li><li>• Quality Care</li><li>• Having supportive environments</li><li>• Ūkaipōtanga partner and whānau</li><li>• Supporting other mothers</li></ul>

## Research Evaluative Criteria

Research evaluative criteria proposed by Glaser (1978) are fit, relevance, workability and modifiability. Fit requires that the theory must fit the empirical world it seeks to explain, and be clearly grounded in the data. For a theory to have relevance, it must address the problems and processes of importance to those experiencing a phenomenon. Workability means it will provide a workable understanding and explanation of the world. Modifiability means the theory is open to refinements to make it more precise and enduring. Strauss and Corbin (1990) emphasised criteria of fit along with understanding, generality and control. However, Charmaz (2006) insisted on reaching for quality and claimed that:

The quality and credibility of your study starts with the data. The depth and scope of the data make a difference. A study based upon rich, substantial and relevant data stands out. Thus, in addition to their usefulness for developing core categories, two other criteria for data are their suitability and sufficiency for depicting empirical events (p. 18).

Charmaz (2006) offered four evaluative criteria for constructivist grounded theory method, which I used to evaluate this study. These are credibility, originality, resonance and usefulness. Charmaz (2006) stipulated that, credibility is achieved through familiarity with the topic, sufficient data to merit claims, and the use of systematic comparisons. Originality requires fresh categories that offer new insights, the analysis provides new conceptual rendering of data, and that it is of social and theoretical significance to challenge, extend or refine current ideas concepts and practices. Resonance requires categories to fully portray the studied experience, draw links between larger collectives and individuals as the data indicate, with analytic interpretations. Usefulness requires offering a theory that people can use in their everyday worlds, is examined for implications, provides recommendations of further research, and the research is able to contribute to making a better society. Table 11 illustrates how my research met the evaluative criteria according to Charmaz (2006).

**Table 11**

*Research Evaluative Criteria.*

Criteria	Research Evaluative Criteria Met
<b>Credibility</b>	<ul style="list-style-type: none"><li>• The researcher was employed as the breastfeeding coordinator in the EBOP, a mother of four who were all breastfed and has intimate familiarity with the topic</li><li>• There is sufficient data to claim merit as majority of the participants had between two to five children to share their breastfeeding experiences on</li><li>• Systematic comparison of data was conducted throughout the research data collection and analysis stages.</li></ul>
<b>Originality</b>	<ul style="list-style-type: none"><li>• Through constant comparison, revisiting the data, memoing, clustering and support from my supervisor, enabled me to have new insight, fresh categories, and new concepts. These were achieved through a painstaking process of constantly refining ideas and concepts.</li></ul>
<b>Resonance</b>	<ul style="list-style-type: none"><li>• The categories are provided with fullness of studied experience, and can be linked through the data, and gerunds/in vivo coding, through initial coding, focused coding process, subcategories and properties</li><li>• Excerpts from participants were used to resonate their experiences</li><li>• Discuss with advisory group.</li></ul>
<b>Usefulness</b>	<ul style="list-style-type: none"><li>• Moving the participants excerpts from descriptive to provide analytic interpretations was achieved</li><li>• The study was examined for implications as detailed in Chapter Five</li><li>• Further research recommendations were suggested</li><li>• The findings and recommendations if implemented by policy makers, health practitioners, whānau and the community, can contribute positively towards women achieving optimal breastfeeding. In addition, this would contribute to achieving whānau ora and supporting other mothers to breastfeed.</li></ul>

Within grounded theory, member checking is can be used to validate findings and involves the researcher returning their analysis of qualitative data, to the participants to check and comment upon. However, some question the overreliance of member checking, arguing that it is unnecessary and inherently unreliable, and claim that the process of concurrent data

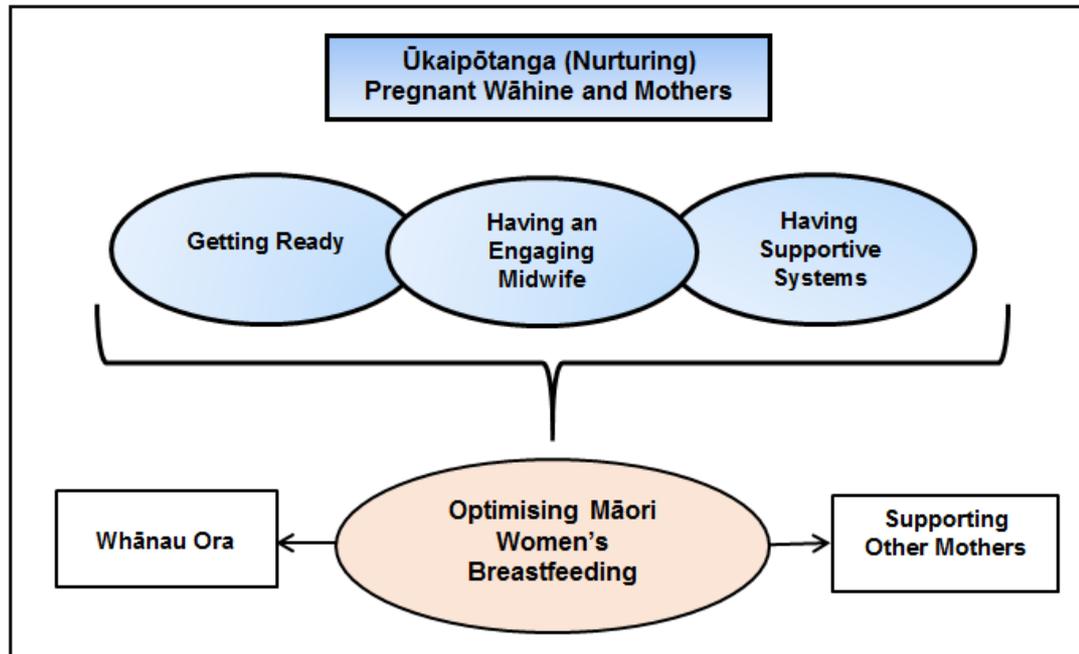
generation, collection and analysis subsumes member checking (Birks & Mills, 2011; Sandelowski, 1993, 2002). Charmaz (2006) concurred that member checking is a redundant source of verification for conceptual analysis, but suggested the term 'member checking' can be included in research proposals as a term for re-entry to the field should your theoretical sampling strategy require the need to achieve category saturation. Therefore, member checking was deemed unnecessary, as the process of concurrent data, collection, and analysis and theoretical sampling was used in this research.

## **Conclusion**

Grounded theory method utilising a kaupapa Māori methodology was developed to guide this research. A kaupapa Māori methodology ensured the research process kept Māori philosophical values central. The Health Research Council guidelines were used to promote the participants safety, and the Eastern Bay of Plenty community supported this process. Charmaz's (2006) constructivist grounded theory method guided the data analysis. I, like many grounded theory researchers, struggled with the volume of data, and the ambiguity of the grounded theory methods. However, once I understood the value of thinking and rethinking, memo's and more memos', the constructivist grounded theory process helped me move forward. The constructivist grounded theory process of concurrent data collection, and analysis methods that utilised gerunds assisted in staying close to the data. Through the words and actions shared by the participants, the basic social process of *ūkaipōtanga (nurturing)* is needed for wāhine to achieve optimal breastfeeding. The constant engaging with the data, concurrent data analysis, comparing, memo writing and clustering helped me take the data through all the necessary stages of coding, categorising, properties and then theorising of *optimising Māori women's breastfeeding, whānau ora and supporting other mothers.*

## Findings: Optimising Māori Women's Breastfeeding

This research investigated how Māori women in the EBOP manage/managed breastfeeding, in an attempt to unravel the influencing factors, and find the mystery formula of how to achieve optimal breastfeeding. In this chapter, I will provide an overview of the core category *optimising Māori women's breastfeeding*, and three subcategories and their properties, *getting ready*, *having an engaging midwife* and *having supportive systems*. The sub-categories and their properties are essential for achieving *optimising Māori women's breastfeeding*, which has the flow-on effect of contributing to *whānau ora*, and the skills for *supporting other mothers*. Each description of a sub-category is supported by a diagram (see Figures 5, 6 and 7) that illustrates how they intertwine or flow together. First, I will describe the participants, then provide an explanation of the basic social process of *ūkaipōtanga* (*nurturing*) the process crucial for achieving optimal breastfeeding (see Figure 5).



**Figure: 5.** Optimising Māori women's breastfeeding

## Participants

Eight Māori women who had breastfed within the past ten years and who resided in the Eastern Bay of Plenty were recruited to participate in this research. These women came from different backgrounds, and had diverse breastfeeding experiences. Their ages ranged between 19 and 35 years of age at the time of the interview. The women self-identified their iwi affiliations which included, Ngāti Awa, Te Arawa, Ngāti Tamatera, Ngai Tūhoe, Te Whānau-ā-Apanui, Ngai Takoto, Whakatōhea, and Te Rarawa, with some affiliating to several iwi. Most wāhine had some cultural connection and involvement, for example in marae, hapū and iwi activities. They were strongly connected with their immediate whānau. The majority of the wāhine had multiple children, three women had given birth to five children, one to four children, two had three children and the other two had two and one child, respectively (see Table 12). Two participants and their partners had children from another relationship. One wāhine had a stillbirth with her fifth child, which prompted her to breastfeed her 17-month old baby because of his frail condition, to provide him the goodness to help strengthen him. The women's children ages ranged from three months to 14 years old of age at the time of the interview. The ages of the women at the time of having their first child ranged from 14 to 27 years old.

At the time of the interview, two wāhine were on maternity leave, while four worked between 32 to 40 hours per week. Two were the main income earners. The other two were stay-at-home mothers; one advised that there was no financial pressure for her to return to work, while the other participant's partner was ill so the family was in receipt of a sickness benefit. Most lived in their own homes, two lived with extended whānau. Their relationship status varied, two were separated or single parents, one was married, and five were in long-term relationships.

The kaupapa Māori provider, recruited as a key informant, was a qualified registered nurse and midwife and had a background in providing a kaupapa Māori midwifery, antenatal and breastfeeding service. The key informant's circumstances changed some years ago, and she is no longer funded to provide these services but is still called upon to assist wāhine.

**Table 12***Participants' Details*

Age	Marital Status	Education	Employment	Children's Details		Months (m) Baby Breastfeed Yes/No (Y/N) if mother worked				
				n	Ages	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
35 yrs	Defacto	Bachelor Degree	Nurse (Main earner)	3	14, 10 & 3	6m Y	24m Y	24m Y		
36 yrs	Defacto	Certificate Business	Sickness Benefit	5	13, 7, 6, 2½ & 8m	6wk Y	3m Y	3wk Y	8m N	8m N
27 yrs	Defacto	Bachelor Degree	Dental Therapist	1	8m	8m N	Still on Maternity Leave (1 year)			
29 yrs	Married	Diploma	Fulltime Mum	5	8, 6, 4, 2 & 7½ m	15m N	20m N	22m N	23m N	7½ & still N
33 yrs	Solo parent	Level 3	Health Worker	5	12,10, 6, 3 & Deceased	9m N	6m N	3m Y	3m Y	3m Y & Dec 17-24
33 yrs	Defacto	Diploma	Health Worker	4	13, 9, 4 & 3	5yr N	1yr N	3m Y	3m Y	
22 yrs	Defacto	Level 1	Receptionist	3	7, 4 & 7m	4m N	1yr N	7m Y	Returned to work when 3m old	
19 yrs	Solo parent	Level 2	Part time Office Admin	2	2 & 3m	1½ yr Y	3m	On Maternity leave returning in a week		

**Ūkaipōtanga (Nurturing)**

Naku te rourou nau te rourou ka ora ai te iwi.

With your basket and my basket the people will live.

*Ūkaipōtanga (nurturing)* is the basic social process that wāhine need to achieve optimal breastfeeding. *Ūkaipōtanga* is derived from the Māori word *ūkaipō*, literally translated as a breast suckled at night, but also meaning a place of sustenance and belonging and referring to nurturing and nourishing people by their home-place. The process of *ūkaipōtanga (nurturing)*

required for achieving optimal breastfeeding for pregnant wāhine and mothers is complex, and ideally involves partners, whānau, and health professionals, such as midwives, and well child nurses. Babies arrive into this world every day, and their mothers bear the ultimate decision and responsibility of if and how she will manage breastfeeding. In most circumstances, if she does manage to breastfeed it is often with great pains and perseverance. Enduring pain from breastfeeding on top of the pains of birth, and managing the subsequent healing process can overwhelm the mother. The above whakataukī (proverb) in relation to this research refers to the co-operation and the resources needed to achieve optimal breastfeeding, through the process of *ūkaipōtanga* or nurturing. Each individual wāhine and her whānau have different *ūkaipōtanga* needs. Those who engage with a wahine need to be responsive in order to weave together her needs, the baby's needs, and those of the whānau.

There is no hierarchy, only the process of working in unity to rear a strong and healthy future generation that is essential for the *ūkaipōtanga* (*nurturing*) required by her partner and building whānau ora (family health and wellbeing).

I was told Te Whaangai Uu [practice] always included the father as being equal with the mother that [is] whānau ora (M034).

Traditional kaupapa Māori birthing and breastfeeding practices are taught, and include mirimiri (massage) of the uu (breast) as soon as a wahine becomes hapū (pregnant). This practice is continued until the birth. The key informant, a kaupapa Māori midwife encouraged this practice.

When I found out that I was pregnant that day, she [my midwife, the key informant] said to me to start preparing your nipples and massaging them out. That was on our very first visit (R001).

The people that need to provide a wāhine *ūkaipōtanga* (*nurturing*) are her partner, whānau, and health professionals who are predominantly midwives. The provision of quality *ūkaipōtanga* (*nurturing*) eventuates in the whole whānau benefiting and being nurtured. A primiparous wāhine who receives quality *ūkaipōtanga* (*nurturing*) will have engrained in her the art or skill of breastfeeding for the remainder of her life. Therefore, there should be less need for her to require concentrated *ūkaipōtanga* (*nurturing*) from her midwife, and other health practitioners with future pregnancies. She will also have the knowledge and skills to pass onto other wāhine, plus her partner and whānau will be responsive and supportive of her

needs. For example, a first time mother and her whānau were provided quality information from her midwife, this was the form of *ūkaipōtanga (nurturing)* she needed to prepare and get ready for the birth and breastfeeding.

I was given such good quality information not just for me but my parents and my tane [partner] ... it was awesome and it was a real whānau ora approach too (R015).

One participant explained how she tried breastfeeding but had encountered difficulties, her aunty responded to her needs by being available to assist her with breastfeeding.

I did try to breastfeed him [son], I ended up [with] having lumps in my titty [breast]. I was in pain and agony. My aunty sat up all night [with me, she] had him on my titty [breast] and fed him. When I woke up they [lumps] were all gone, I felt a bit better (M006).

Another participant's partner responded to her needs by assisting with the domestic household duties.

He was always helpful towards the kids ... he'll do the housework and dinner ... take the washing ... he was really helpful while I was breastfeeding my baby (T039).

There are crucial stages during the prenatal, perinatal, postnatal stages and beyond when wāhine need to receive quality *ūkaipōtanga (nurturing)*. Three sub-categories *getting ready*, *having an engaging midwife* and *having supportive systems* explain the process of *ūkaipōtanga*. Together with the properties of each sub-category, *ūkaipōtanga (nurturing)* leads to *optimising Māori women's breastfeeding*, the core category, that positions the mother with skills to *supporting other wāhine*, and *whānau ora* (see Figure 5). The *getting ready* stage occurs during the antenatal period, and draws on properties from *having an engaging midwife* and *having supportive systems* to deliver quality prenatal *ūkaipōtanga (nurturing)*. Quality prenatal *ūkaipōtanga (nurturing)* has a flow-on effect into the perinatal and postnatal periods, which requires the mother to put into action what she has learnt during the *getting ready* stage. Quality *ūkaipōtanga (nurturing)* in the perinatal and postnatal periods and beyond, can be successfully achieved through receiving the necessary *ūkaipōtanga (nurturing)* within the properties identified in *having an engaging midwife*, and *having supportive systems* sub-categories.

## Getting Ready

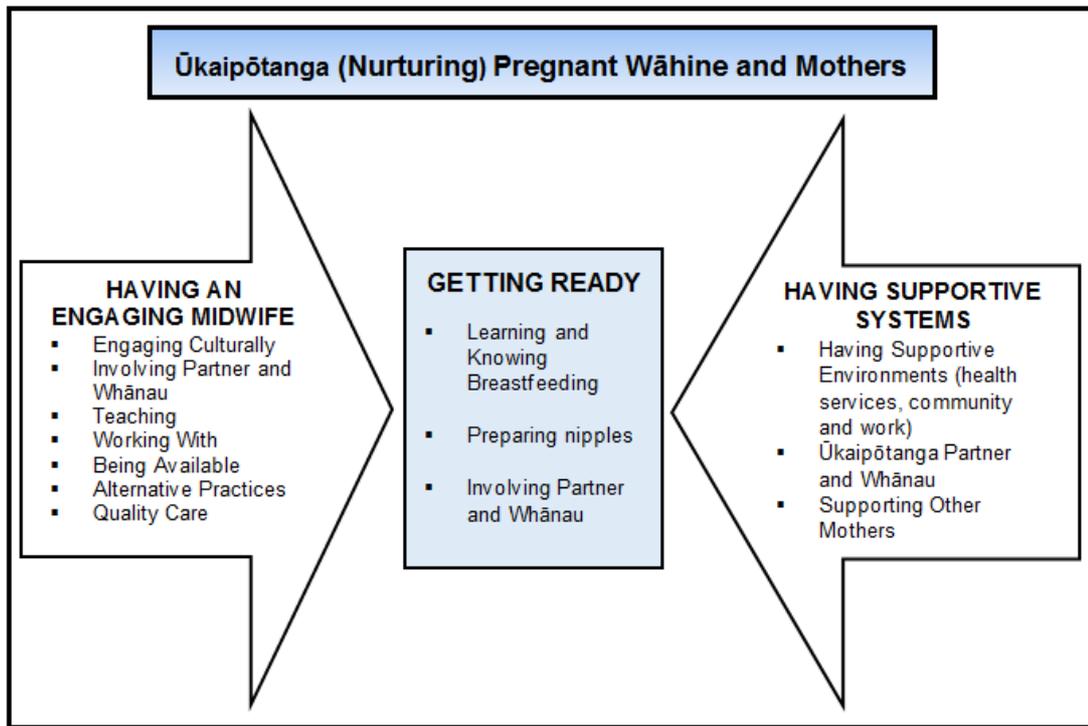
The subcategory, *getting ready*, involves the properties *learning and knowing breastfeeding*, *preparing nipples*, and *involving partner and whānau*. When a wāhine becomes pregnant, her first thoughts are not on *getting ready* to breastfeed. Once the notion of being pregnant is comprehended, it is time for her to take steps to get ready. The prenatal period is when effective quality antenatal *ūkaipōtanga (nurturing)* is required for her to get ready to ensure the health and wellbeing of her and her child. One participant struggled with breastfeeding because she underestimated the need to get ready and learn, prepare and to know how to breastfeed.

I struggled [be]cause I thought that breastfeeding was you just put the baby on the titty [breast] and they sucked the milk, but apparently not and I witnessed that with my seven and six year old, that there was an art in breastfeeding (M029).

It is important for a first time mum to receive quality *ūkaipōtanga (nurturing)* to prepare her and her partner for breastfeeding, the birth and what is to follow as new parents. For those who did not have good *ūkaipōtanga (nurturing)* with their previous child or children, also benefit from receiving similar quality *ūkaipōtanga (nurturing)*. The properties foster the process of *getting ready*, and are assisted by the sub-categories *having an engaging midwife*, and *having supportive systems* (see Figure 6).

## Learning and Knowing Breastfeeding

*Learning and knowing breastfeeding* entails many aspects pertaining to being pregnant and *getting ready*. The key aspects of learning to breastfeed are identified and will be discussed under the following subheadings, the learning needed by the Māori wāhine, learning for partners and whānau, mainstream verses kaupapa Māori, and knowing breastfeeding.



**Figure: 6. Sub-category and properties for *Getting Ready***

### **Learning needed by Māori wāhine**

Most pregnant Māori women feel the need to learn about breastfeeding and giving birth, particularly when the forthcoming birth of their child looms closer. Quality learning can help to ensure a problem free birth and breastfeeding experience. Breastfeeding is an art wāhine need to learn. It does not happen naturally as many first time mums may naively think. However, at the postnatal stage one-on-one teaching of the practical skills of breastfeeding is required. The ideal time to commence learning is during the first or second trimester, rather than the third trimester, to allow for sufficient time to prepare.

We attended antenatal classes. [We] went through the whole latching process, and ... [they] just encouraged us to persevere. [They] let us know that it wasn't going to be easy, it's not as easy as baby just opens his mouth, sucks and gets a good feed. It's quite an art, there's a knack to it. That was good that she told me that, because I had my sister, oldest sister who has five [children] and it [breastfeeding] just comes naturally (J002).

For our Māori, it is educating them about what it really is, not wait [un]til the baby [is] born ... it's too late, that's what a lot are doing, they don't get that teaching right from the start (R032).

## **Learning for partners and whānau**

When first time parents receive quality antenatal learning they gain long term benefits from knowing how to prepare for the birth and breastfeeding. Partner and whānau need to be included in antenatal learning to learn the roles they need to play to ensure the pregnant wahine receives quality *ūkaipōtanga (nurturing)*, before and after the birth of the baby.

All the dads were there [at antenatal class]. All the couples, all the dads were there. It was I think funny for us the ladies having them in there, but they were real mature about it (J006).

[Antenatal class teachings] encouraged your partner to be there too while breastfeeding, so it was the whānau thing, not just the women and the child like it has been in the past for me. Encouraging the partner to be supportive in giving you time out with the other children, taking them away if they need to be taken away, or cleaning the house or cooking tea, you know things like that. That was all part of the education around breastfeeding and supporting each other (P040).

## **Mainstream versus Kaupapa Māori**

Antenatal classes are beneficial in providing education on birthing, breastfeeding and healthy lifestyle choices. If a Māori wahine does attend antenatal classes during her first pregnancy, she will more than likely not attend classes with any consecutive pregnancies. Therefore, it is important that this opportunity is maximised. This highlights the need to ensure that there are antenatal classes that cater specifically for young Māori women and their partners. All the wāhine that attended antenatal classes indicated that their partners provided long-term *ūkaipōtanga (nurturing)* of her and their baby. Whereas, of the other four wāhine that did not attend antenatal classes, only one received *ūkaipōtanga (nurturing)* from her partner.

She did teach breastfeeding [the mainstream antenatal educator provider]. Breastfeeding was a first choice for me. I thought give it a go, never thought about bottle feeding my baby first. There were pamphlets; there were videos how to latch your baby on properly. But it's all new for you as mother and for the baby, to get used to that to [the] different sensation. The baby is trying to learn a new thing, whereas sucking from a bottle it's a different thing again (L019).

I read up quite a bit, but going to the antenatal classes it was just cool to be in group environment with girls around the same [situation], in the same boat as you. You could talk with them. You [are all] going through the same experiences and it's cool hearing their side of the story (J038).

Mainstream antenatal classes have a role to educate and teach breastfeeding, provide information regarding health related messages, and *ūkaipōtanga* (*nurturing*) values by encouraging partners to support their wahine.

[I] only caught the tail end of [mainstream antenatal classes] before I was due to deliver. [That was] fourteen years ago [and] the whole focus was just on the birth (P007).

I ended up doing [mainstream] antenatal classes again with my third child, never too late to learn. It definitely helped me. Being an older mum at that stage you felt a lot more confident and competent ... They talk[ed] about breastfeeding, about your nutrition, about managing your breasts and actually getting them ready to breastfeed (P040).

Some wāhine expressed interest in kaupapa Māori antenatal classes, although most had not attend due to the limited classes being available. Mainstream antenatal classes were generally the only classes regularly available. Kaupapa Māori antenatal classes expand their teachings of *ūkaipōtanga* (*nurturing*), and are flexible to ensure an advantageous learning environment for the Māori women and her whānau. For example, providing home visits for antenatal classes in the wahine's home, to ensure her partner is able to attend. Kaupapa Māori antenatal classes incorporate Māori philosophies and Māori worldviews, such as mātauranga wāhine (Māori women's knowledge) and mātauranga tāne (Māori men's knowledge) and instilling knowledge of his role in providing *ūkaipōtanga* (*nurturing*). Such teachings are essential to bring about awareness and understanding of mana wāhine and mana tāne roles, and to build self-confidence, valuing and appreciation for one another. If a wahine has the opportunity for quality learning about the theoretical and practical art of breastfeeding, she is also able to *support other mothers*. Although, most of their learning will be from their midwife (explained in more detail within the *having an engaging midwife* subcategory). One participant's midwife provided kaupapa Māori antenatal classes in her home to ensure her partner was present:

She'd [kaupapa Māori midwife] comes over [for] a home visit. My partner [was] home and then she's filling him in on everything too. So he knew what to expect when the baby comes. So she made a point of it not being just me and the baby, but him as well. And that was cool, because when the baby did come, it was a partnership, not just the mum. So he

knew that I'll feed the baby and everything, but he grabbed her straight away and wind her, so he would have his role to play with all the babies (R004).

Whānau were another source of knowledge to draw upon that included mothers, aunties, cousins or friends. The internet was also extensively used. Otherwise learning was mainly through their midwife who utilised pamphlets, booklets, DVD's or internet. The wāhine needed practical teaching when the baby was born, which is also discussed further in the *having an engaging midwife* sub-category.

I was one of those mums going through my pregnancy that read a lot you know, that got regular emails and I'll read them, I'd subscribe to the baby centre and they'd send me how big your baby is this week, and what's developing (J037).

You see all those diagrams and pamphlets on [how] you should feed your baby. At the end of the day it's what suits you I reckon, I taught myself. It was great to have those handouts. But my babies they just latch on and I just carried on through [the pain] [be]cause I knew at the end of the day that was the most natural thing for them and the best milk (L079).

### **Knowing breastfeeding**

*Knowing breastfeeding* comes with experience. This knowledge is from childbearing and childrearing experiences. The quality of the teaching a wāhine received from her midwife with her previous child/children is an indication of how well she will manage to breastfeed for consecutive children. For the multiparous wāhine this knowledge is drawn on in the *getting ready* prenatal period. The mother who has received quality teaching and experienced no complications with her previous child or children will know what is required to prepare for the birth and for breastfeeding. She will have developed the art of breastfeeding, in particular knowledge of how to initiate breastfeeding successfully, and her partner and whānau will know what is required to nurture her. A mother that has successfully breastfed knows the benefits of breastfeeding, the financial benefits and the bonding that breastfeeding creates, and she wants nothing else for her and her baby.

When he was 17 months old I gave birth to a daughter... she was stillborn... and because my fourth child he had wobbly legs [and] you could tell they were very weak... I gave him baby's breast milk, so he got the full glucose and all the fresh stuff that you get in the first two weeks. His legs have never been stronger, he's so different to what he was, he could

run, sprint, jump higher than what I've seen people, children his age. He can kick the ball so high, he loves the rugby ball. He's three now, so it's like wow look [at] this kid - you know someone who had weak legs. I know that the goodness he got out of that breast milk... really strengthened him. I believe that, I strongly believe that. I breast fed... [and] he wouldn't let it go [until] 17 months to 24 months. His second birthday he had to get off (N016).

For those mothers who encountered difficulties, their knowing is about the difficulties and the pain they endured. For those that persevered, they are reassured with the knowledge that they were eventually able to breastfeed successfully. This knowledge drove their determination to breastfeed again, whereas others needed to draw on their whānau or their midwife's encouragement to boost their confidence. Further learning was needed for these wāhine as they did not want to go through the same breastfeeding difficulties. The midwife play's an important role in *ūkaipōtanga (nurturing)* to give her confidence to breastfeed again.

After having the first one and going through all those difficulties I knew I could give it another shot at breastfeeding. I definitely got a different midwife, and you know she just really supported me ... she gave me information prior to giving birth, and she knew what my goals and plans were [for] both delivery and after birth. So [I] focused on breastfeeding and latching (P011).

You don't really talk about nipple inversion, odd things like that. A lot Māori women don't really talk about their bodies. So I would say getting yourself ready to a breastfeed, knowing what you have to eat, fluids as well, being really informed (P038).

Another area of knowing is associated with preparing, and pertains to those who work and knowing what other services are provided: knowing their maternity leave entitlements, their rights to breastfeed in the workplace, whether breastfeeding is possible, and if she can manage. This is covered in more detail in *having supportive systems* sub-category.

Actually letting mums know about that policy, that's one of my biggies I've ... come across lately. People don't even know that policy exists. Employers aren't aware of it either, especially within seasonal workers, and there are lots of seasonal workers that are breastfeeding [that] don't even know that that policy exists (P057).

Mothers knowing what [is] ... available, what they can get, [be]cause a lot of the mothers they don't know and they don't ask, they just take what's given (R019).

## **Preparing Nipples**

Some midwives may encourage the practice of nipple preparation. Some wāhine may have learnt this practice from their mothers or grandmothers. Good practice for midwives is to examine the pregnant wahine's breasts and nipples for inversion, and conduct a breastfeeding history assessment to identify any previous breastfeeding problems. This assists in putting in place strategies to help alleviate any problems that may occur or reoccur when initiating breastfeeding. Preparing nipples for breastfeeding daily early in the pregnancy is more beneficial. The wāhine who takes the time to prepare her nipples throughout her pregnancy has taken the first step in preparing to breastfeed.

I had probably, like, the best midwife who prepared me really well, to the point [that] when I found out that I was pregnant that day, she [midwife and key informant] said to me to start preparing your nipples and massaging them out. That was on our very first visit (R001).

She [midwife and key informant told me to] do it every morning. It might feel funny at first but you've got to keep doing it, because a lot of women when they have baby their nipples are inverted and it's because they weren't prepared, ... [when] they found out they were pregnant [but] they didn't get any advice (R002).

[The need to] know about breastfeeding before you give birth to your first child. So it's about that pre-advice about getting your breasts ready to actually feed. Making sure you don't have any problems like nipple inversion, because that's not really talked about until after, and you find out you've got physical problems with your nipples (P037).

## **Involving Partner and Whānau**

Wāhine needs support from her partner and whānau throughout her pregnancy, after the birth, and throughout the baby's life-time. Receiving support when it is needed is also crucial in managing to breastfeed. Without the support of her partner and whānau she will struggle. Whānau is a representation of the family nucleus, mother, father and children. The whānau nucleus can be extended to include extended family, friends, those that are close to a wahine and her partner to provide support in many forms. The importance of partner and whānau

inclusion in antenatal learning to help her get ready is often underestimated. Quality learning will teach partners and whānau what is required of them, and the *ūkaipōtanga (nurturing)* role they should take on to assist the wahine to achieve optimal breastfeeding. The ideal learning required is explained in the *learning and knowing breastfeeding* property, highlighting the benefits of teaching within a Māori paradigm, and teaching the partner his role as the nurturer of the mother of his child, and the baby. Two participants talked about how they benefited from the teachings of a kaupapa Māori antenatal and Te Whaangai Uu (breastfeeding) practice:

I think it's a lot to do with our first midwife because she always made sure he was included. If I had a scan she's like, "You're not to go by yourself. He has to go with you". And it actually worked, then he had the bond with the babies while they are still in the puku so when they come out it's like ooow (R013).

It was all about inclusion making him feel included and now he feels stronger about the role he has to play as a father (R031).

I was told with Te Whaangai Uu [practice] always included the father as being equal with the mother that [is] whānau ora (M034).

## Having an Engaging Midwife

The *having an engaging midwife* sub-category and its properties explains what is required of a midwife to provide quality *ūkaipōtanga (nurturing)*. The midwife is responsible for the care of the pregnant woman and her baby until the baby is six weeks old. The midwife needs to constantly draw upon practical and theoretical knowledge, to prepare the wāhine, partner and whānau for the coming birth and breastfeeding. Seven essential properties were identified for quality *ūkaipōtanga (nurturing)*, with the aim to achieve optimal breastfeeding. These are; *engaging culturally, involving partner and whānau, teaching, working with, being available, alternative practices* and *quality care*. These properties interrelate and need to continuously intertwine and weave together to be effective (see Figure 7).

## Properties of Having an Engaging Midwife

The sub-category, *having an engaging midwife* plays an important and central role in the success of *getting ready*, and enables an empowered and trouble free transition through to *having supportive systems* sub-category and properties, as illustrated in Figure 6. The properties of *having engaging midwife* requires the midwife to have knowledge needed to provide quality *ūkaipōtanga (nurturing)* – these include the concepts of theoretical knowledge (obtained through training to be a qualified midwife), physical/practical knowledge (acquired through experience), and other knowledge (other skills and culture knowledge essential for engaging appropriately with the wāhine in her care).

## Engaging Culturally

*Engaging culturally* embraces all the properties of *having an engaging midwife*. This was achieved through the midwife connecting and embracing a wahine, her culture, her partner and whānau. This also included supporting, acknowledging, and implementing mātauranga Māori (indigenous/cultural knowledge) and cultural practices. For example, being respectful and regarding the mother's dignity, in both birthing and breastfeeding, and respecting the spiritual connection associated with the birthing process. The midwife plays an important role in the life of the whānau, particularly when he or she engages culturally and connects. Subsequently a close bond is formed and the midwife is likely to be welcomed as part of the whānau. The key informant explained her practise:

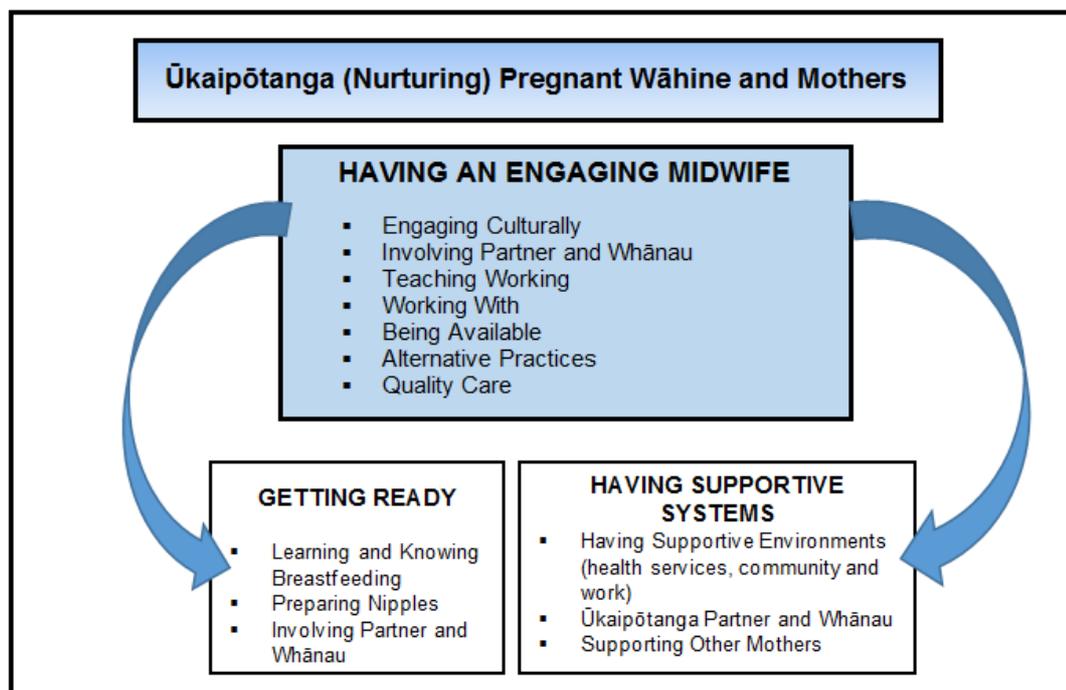
I supervise the birth because I've prepared him [partner] too. He's part of my antenatal preparation. He's there. I tell him what he needs to do. [I] show him, he's the one [who] holds his baby's head. We don't see anything she's got a lava-lava on, everything's covered. The whole whānau in there, there's no embarrassment (H70).

The key informant's niece, whom she taught the practice of Te Whatu Toru (The Third Eye, birthing practice), likens the practises of her new midwife for her fourth child with the key informant. She explained the values of such practises:

I could understand her [new midwife for 4<sup>th</sup> child] from auntie's mahi. She is good. She was awesome support and funny. She added a lot of humour to it, which sort of broke the ice of the serious things (M024).

Another participant, a mother of five valued her midwife and the support she provided, and considered her to be part of the family:

I just continued on with her, liked her service. She pretty much becomes part of the family because all our kids are close in age. So when I'd ring her, I'd say, "Well we're having another baby". And she's like "Oooh are you?" (L046).



**Figure 7. Subcategory and properties of Having an Engaging Midwife.**

### **Involving Partner and Whānau**

Involving partner and whānau relates to all properties of having an engaging midwife, and is linked to involving partner and whānau properties in the *getting ready* sub-category, and ūkaipōtanga partner and whānau properties in *having supportive systems* sub-category. This section explicates the requirements for midwives to include the partner, whānau and extended whānau. It is not common for the partner or whānau to be included in the midwife's antenatal education. However, most mainstream or non-kaupapa Māori midwives conduct antenatal health check-ups within their practice facilities during the day, and it is uncommon for them to provide home visits as part of their antenatal service. Involving partner and whānau can improve emotional bonding with a wahine and their baby, and assist in facilitating ūkaipōtanga (nurturing), and whānau ora values. When working with Māori families, midwives need to look at strategies that remove barriers to attend antenatal appointments. For example, the midwife who provided a kaupapa Māori service conducted home visits to ensure

partner inclusion and to also educate him about his role. Partner and whānau inclusion in the birthing process is also part of kaupapa Māori practice, and provides connection with the baby, fostering a desire to part take in ūkaipōtanga roles to ensure the baby is raised in a positive, healthy environment.

She'd come over (key informant) and do a home visit. My partner's home and then she's filling him in on everything too, so he knew what to expect when the baby comes. So she made a point of it not being just me and the baby, but him as well. And that was cool because when the baby did come, it was a partnership, not just the mum, so he knew that (R004).

She was born at home. There was no hospital not for me. I had her at home and there was 28 people ... and because of the information I was getting from the midwife about how important babies are. They're not just babies but their role in the family and everything and everybody's role to play with my dad, sisters, mum everyone felt really included ... so it was a real family thing (R005).

I think it's more for them to include their partners, [be]cause it's hard to try and do everything on your own, and sometimes if your partner is not included from the very first visit ... they can feel isolated. So when the babies come they may not have that stronger bond ... or feel like they are needed (R20).

## **Teaching**

*Teaching* embraces all the properties within *having an engaging midwife*. *Teaching* relates to the midwife enabling the wahine, her partner and whānau to learn, as explained in the *learning and knowing breastfeeding* property from the *getting ready* sub-category. *Teaching* empowers first time parents to learn, and quality learning instils long-term knowledge. The midwife is the lead maternity carer (LMC), and main health practitioner that will oversee the care of the pregnant wahine. Therefore, the midwife is the ideal person to provide all they need to know pertaining to maternal health, including nutrition, the effects of alcohol and drugs, smoking, and preparing for the birth and breastfeeding. Quality teaching also results in the mother being able to support other mothers.

As explained in the *involving partner and whānau*, the wāhine benefits immensely with her partner and whānau being including in all *teaching* provided. *Teaching* should also include

what is required of them, informing them of their roles in supporting the wahine and her baby. Once baby is born, the midwife needs to be available to teach one-on-one to help the mother initiate breastfeeding, provide advice on breast care, and maintain milk supply to avoid problems. The key informant discusses her *teaching* with one of the participants under her care explains:

When you pick up a woman that's got cracked nipples, I never force baby back on that mother. If anything, we heal. We look at what's happened before, how many children she has had, rather than jump in and do it this way. There are choices for her. Not this [breastfeeding] is the be all, [and] end all for her. Now once you've done a bit of a profile on her, a bit of history, you have to look at her breast to see, does she have inverted nipples. Then you find out that's the problem [why] she couldn't put the baby on, or she's had problems feeding her previous children, so for what reason? Who were the service providers then? What were the teachings back then? So it's a whole new game for these women (H019).

She was quite tough, especially in the first, first couple of days. She made sure. I might slip my finger a bit too much to [the] left or something, and she's like, "No, no, no bring it down and start again". It was like riding a bike or something, [be]cause you had to keep starting again from the beginning not half pie. And even just reminding us when you're feeding baby in the middle of the night, don't lie down and do it (R017).

A wahine's readiness to learn is determined by the midwife's programme content, availability, positive attitude, ability to teach in an encouraging manner, and provision of knowledge that empowers the woman with skills to support other women, something also supported by Jackson (1996). The key informant explains her practice for empowering women:

I teach the mothers. See I empower them [so they] will make a difference (H028).

This kaumātua that was there, sitting in a chair, and he was telling all these women to listen to me, watch me, the birthing. Now that family to this day have the practice (H74).

See those mothers that I have worked with, [those] family[s] know if they have any problems with any situation with the birthing. They know which ones in the family have got it [birthing and breastfeeding knowledge]. Now that's what I've been doing, empowering whānau to help each other (H75).

One participant with her first child, who was under the key informant's care, explained that when she became pregnant with her second child, five years later, she needed very little

support from her new midwife. Her first midwife was no longer practising. She explained how the teachings she received from her first midwife had a positive flow-on affect for her and her new midwife.

[I] chose my new midwife] [be]cause she had a good understanding of our background, and my first midwife. I knew her before I got her. She always says, even if you ask her, she always says, "I like doing theirs [referring that the midwife doesn't need to provide much care as they know what is required], they're the easiest". But it's just due to that education that you get ... early in your pregnancy (R016).

[I] didn't have to go through all the teaching process for each one of them. [I] got taught properly right from the start. It was done properly in the beginning [and] because I was so strong on what I was taught the second midwife she knew that, and [so] she allowed us to do our own thing. She was pretty much there to just sign the paper off. Ideal mother. No worries, none of these ones that have a caesarean. That's due to education, [referring to mothers who encountered problems]. They don't know what's happening to their bodies (R033).

## **Working With**

*Working with* relates to the partnership between the midwife and the pregnant woman, her partner and whānau. *Working with* involves building relationship; establishing continuity of care; achieving mutual trust, and respect; working in collaboration, through negotiation and agreement regarding the provision of care, and includes allowing the women to have a voice; and allowing informed decision making on health care issues. Developing birth and breastfeeding plans, arranging appointments, and providing home visits are examples of *working with*. The midwife's commitment to quality care, includes being available when needed. The key informant advises of her positive *working with* practises.

I'll go back the second time. The baby's spots are all gone. Baby is sleeping longer, dad's present, nanny's present, koro's present, aunties present, they're all there to meet me, because they can't believe it. You know because in their family there has been no one there to right it [to help them] (H035).

It's a good feeling ... when you build up the confidence of a mother. The fathers walking around proud as, holding his baby, showing off to all the other men who talk about, "Well I didn't get any sleep last night. My baby cried all night you know" (H038).

[Midwives], rather than losing clients, they would refer on to me [key informant], to meet her [mother's] needs [be]cause she wanted Whaangai Uu. So that's why the service is successful. It's people believing in it, believing that there is a simple answer to right all, to improve the health, the holistic health of our people (H048).

A participant explains her experience of having a *working with* relationship with her midwife:

That's what's great about my midwife, she just goes with the flow. If she sees [she] needs to intervene that's great. That's her job. But it all depends on the mother too, how you are. She knew that I knew what I was doing (L109).

### **Being Available**

The property of *being available* interrelates with *teaching*, *quality care*, *engaging culturally* and *working with*. *Being available* requires that midwife be committed, available and responsive to the needs of wāhine when required, and providing continuity of, and professional care. *Being available* places responsibility on the midwife to ensure she is not over-committed.

It's having someone there every feed time just to give you that reminder of putting baby on the breast. As a first time mum, you're just getting your head around everything in general, especially first time mamas. It's really important to have someone every feeding time (N024).

[My midwife] always recommended breastfeeding. She was against bottle feeding so she was really supportive of me to breastfeed my child. She would always just say, you know, if I needed any help latching on anytime. Early hours of the night she would come and help me. [She] was really supportive around that (T003).

### **Alternative Practices**

*Alternative practices* embrace all the properties of *having an engaging midwife*. This study indicates quality *ūkaipōtanga (nurturing)* is enhanced when a midwife is able to provide alternative but safe practices, outside of mainstream service framework. *Alternative practices* can include home births, water births, acupuncture, naturopath, and kaupapa Māori practices such as Te Whatu Toru (The Third Eye, birthing practice) and Te Whaangai Uu (breastfeeding

practice). Every woman desires a short labour with no birth complications. While this is possible, it is dependent upon many circumstances.

Several participants were taught the key informant's birthing practice of Te Whatu Toru. These wāhine were the only wāhine who experienced very short labours with no birthing complications for all their babies, they explain the key informant's practices they experienced:

She [aunt and the key informant] informed me of the natural birthing process back to the old ways. I didn't have any drugs in the birthing, and she taught me to use Te Whatu Toru, which is sort of hypnosis to take the pain away. [It is] all to do with the breathing, which worked for me because once he came out and weighed him at 10 pound 6 [4706 grams]. I had my grandmother present and four other aunties with me, which made it real special, made him real special to our family. She had taught me her way of birthing, I never tore, I got up and walked around after I had him (M01).

These wāhine were also taught Te Whaangai Uu (breastfeeding) techniques by the key informant, at various stages in their motherhood and grasped the skills of breastfeeding:

What worked for me was I had Aunty [key informant] there for me, whenever I needed her if I was going wrong, for that support. She just defined a lot, because there's an art in breastfeeding and she was there to define that for me. Everything she was saying of the feelings, [and] reassured me I was doing the right things, the feelings that I was feeling, from if he was on properly ... and just reassured me – okay, right I'm on the right track (M016).

The key informant gives examples of these practices and why they are important:

If we don't have a mother who has a birth vaginally and up-right, we tend to have more problems with that baby like it needs to be cleaned out, suctioned or it's a bit flat or, we don't have those babies see [be]cause when you keep the mother up right (H061).

The reason why I go on about the birthing is because if she has a baby that doesn't need any medical intervention then it's much easier to teach her Te Whaangai Uu (H071).

When he [the father] see's Whaangai Uu in action, he embraces her [be]cause they have a healthy baby. He's so proud of his wife who's given birth to this healthy baby, compared to a father who has a baby that is sick, you see child abuse, domestic violence. We don't see that. It's rare with Whaangai Uu, mothers in a violent relationship let alone abuse their children, the bonding [is strong] (H053).

When you have been the recipient of quality *ūkaipōtanga* (*nurturing*) it is something you desire every wahine to experience. This is reflected by one the participants who recommended antenatal programmes incorporate whānau ora values, believing such programmes would benefit those that may be at risk:

Programmes like Te Ha Ora [a kaupapa Māori antenatal programme] and Te Whaangai Uu, [I] highly recommend those two programmes. They should make it compulsory for mothers to attend to benefit the babies, especially the ones that are on benefits. Work and Income benefit [recipients] should have to attend those [programmes] because they're not actually going to give the babies the best start to life if they don't understand what's actually happening to themselves and their baby and their body (R28).

I reckon even for the fathers if they've got any kind of court history, send them to antenatal classes with their partners. The family violence [cases], [component of] anger management [programme] to [help them] understand how precious the baby is, and [understanding] the mother's body, in order for their baby to grow well. Mum needs to be well, instead of abusing her (R029).

## Quality Care

*Quality care* incorporates all the properties of *having an engaging midwife*. Providing *quality care* is what all midwives should aspire to provide. A midwife needs practical and theoretical midwifery skills combined with knowledge that comes only with experience. *Quality care* includes advocating and supporting the wāhine to make informed choices, combined with the ability to provide alternative practices. Home visits by health professionals like midwives, can prove beneficial for not just *teaching* the pregnant Māori women and her partner, it is also useful in monitoring and organising support needed or deterring domestic violence or partner violence monitoring. However, antenatal home visits were not a common practice of the mainstream midwives. One participant explained that she would have valued more support from health professionals with her first three children. She identified gaps and recommended that visiting health professionals could be of more assistance in assessing and identifying any needs, and then organising appropriate support:

[Health professionals should] just reassure the mother, if they need any support in regards to breastfeeding [and] with their family. Does their family need any help? Just to take that weight off their shoulders, to be able to settle, to be able to breastfeed successfully (M039).

They might have a husband at home that's causing them grief and they can't settle, so the support net should be there for them or guide them, refer them, however [so] they can to support a family, and to make sure their other children are okay and healthy. I was always taught from another aunty [and] this is coming from a support worker, that when you walk into a house the best tools you can use is natural, natural like senses [observing] how the home looks, to how the children are, to reading all of those [signs] to know whether they are in need [of] support, the smell you know all that, rather than going by the books and using policies. It's just common sense at the end of the day whether the person needs help. Support workers should know about that as well, not just going by what a mother says because it could be from the dynamics of abuse, I'm not sure it's definitely the approach to the mother (M040).

The ideology of Māori women receiving quality care from their midwives was possible for some of the research participants. However, only one participant recounted being the recipient of having the ideal midwife with her first child, enabling her to have a problem-free birth and breastfeeding experience. Her midwife practised within a kaupapa Māori framework. Kaupapa Māori practices inherently incorporate partnership. When choosing a midwife, most women wanted a Māori midwife. However, choices were limited to either one or two midwives. One, with her second baby, looked specifically for a reputable older midwife who was experienced, committed, and available. Others chose based on recommendations from whānau or friends.

I was given it [quality teaching for birthing and breastfeeding] from my very first pregnancy. So I haven't really been exposed to anything else other than that, and I think that if you can give that kind of information to mothers on their first pregnancy then they'll [know], as opposed to giving it to someone who's on a third or fourth child or even in their second [child]. [Most women with] the first child, they've got horrible memories with breastfeeding and birthing, then you look at the practices, it's like woou. Then you try and offer them other alternatives, but their mind set,[it] is stuck in that very first time. They get uptight at the mere thought of breastfeeding, some of them (R015).

I reckon if all our mothers had those kinds of teaching we'd have less death. You know how there's been a lot of babies dying due to family violence, there would be way less because then they would know how precious they are I suppose and having that bond (R034).

*Quality care* requires the midwife to provide special focused care for the primiparous wāhine, and for those wāhine who encountered problems with previous child/children. *Quality care* involves *teaching* her, preparing her, building her confidence, *engaging culturally*

appropriately, *working with* her, empowering her and *being available*. *Quality care* is achievable for all midwives, and in doing so, the wāhine in her care will be better positioned to achieve optimal breastfeeding. The key informant explained how she was able to provide *quality care* to her patients:

I only took on three [wahine] at a time. Some midwives were taking on six to ten mothers. Now how can they do justice to the aftercare, postnatal care? I follow my mums for three months (H032).

That holistic approach to the wellbeing of the whānau, it's to do with that baby, once that baby comes. Whaangai Uu had a lot to play with that change in that whānau set up (H055).

Why the services [are] successful ... [is to do with] positive decisions. I've talked about the fathers, mothers but it goes back to the birthing, to the feeding, you got a happy baby, healthy baby, and what goes with it, hardly any bleeding postnatal, you don't get sore nipples, you don't get mastitis, there's no engorgement. So those are the positive decisions, it's on the actions that make the women decide. Because they've heard it from their mate down the road, I want that service (H78).

### **Summary of Having an Engaging Midwife**

Midwives have an important role in the *ūkaipōtanga (nurturing) pregnant wāhine and mother's* process and framework. Including their partners and their whānau in this process is an important aspect of imparting *ūkaipōtanga (nurturing)* knowledge. *Having an engaging midwife* sub-category brings to light the high standard of practice required of a midwife, in particular those midwives that work within a kaupapa Māori framework or alternative care practices. If a midwife does not have the knowledge, skills and ability as illustrated she will not be able to provide quality *ūkaipōtanga (nurturing)* practices to the standard required for the wāhine to achieve optimal breastfeeding.

### **Having Supportive Systems**

The sub-category *having supportive systems*, includes three properties and their concepts that explain what is needed to ensure the wāhine are able to continue breastfeeding beyond the *having an engaging midwife* sub-category stages. There are three properties, *having supportive environments, ūkaipōtanga partner and whānau*, and *supporting other mothers*.

These properties are essential to ensure the continuity of the *ūkaipōtanga (nurturing)* process needed by the wāhine and baby. Figure 8 illustrates how the properties from *having supportive systems* feed into and embrace the sub-categories *getting ready* and *having an engaging midwife*. The wide arrow coming from these two sub-categories, and pointing towards *having supportive systems*, indicates the extension of the *ūkaipōtanga (nurturing)* process needed to assist mothers to achieve exclusive breastfeeding for six months or more to achieve optimal breastfeeding. Some properties have supportive policies linked to them.

### Having Supportive Environments

The *having supportive environments* property relates to supportive environments within the community that the wāhine utilise or frequent before and after the birth of her baby. The *having supportive environments* properties have been identified under the following three headings of, supportive health systems, supportive community, and supportive work environments.

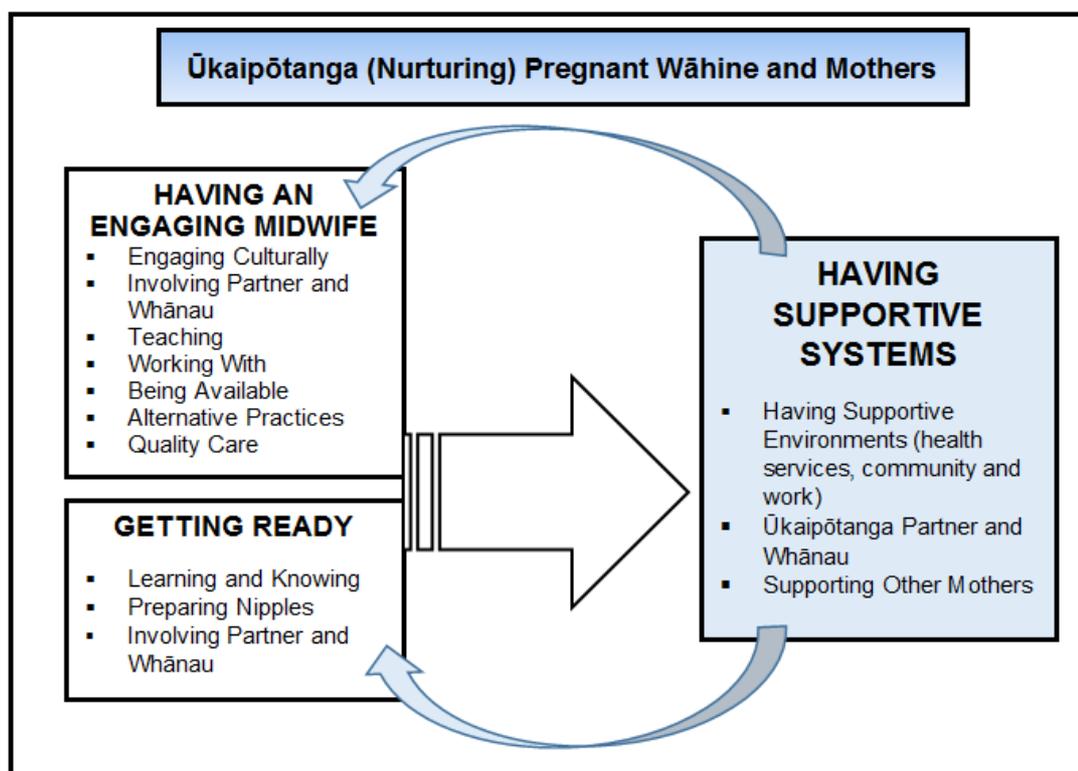


Figure 8. Subcategories and Properties of *Having Supportive Systems*.

## Supportive Health Services

The *supportive health systems* property relates to the hospital maternity units within the public hospitals, and postnatal health services, including well child tamariki ora and family start services. Hospital policies have been developed for the sole purpose of supporting women to breastfeed as explained in Chapter Two Review of Literature. A supportive hospital's maternity unit needs to provide *ūkaipōtanga (nurturing)* to the wāhine, their partners, whānau and their babies. Quality *ūkaipōtanga (nurturing)* necessitates that hospitals are not just breastfeeding friendly, but also environmentally friendly. Environmentally friendly hospitals are inviting, culturally engaging, accommodating, comfortable and safe, encouraging the wāhine to stay until breastfeeding is well established. However, being aware of hospital breastfeeding friendly policies was not an important aspect of the wāhine hospital stay. The *ūkaipōtanga (nurturing)* and hospital environment was of greater concern to them, as the majority of the wāhine had hospital births and would only stay for one or two nights. However, for those that encountered birthing complications or health problems, the hospital was deemed to be the ideal place to stay, and to receive quality health care. Skin to skin birthing practice and the practice of the baby crawl to initiate the first breastfeed was a positive experience for participants. However, this practice did not guarantee initiating breastfeeding would be trouble free.

I stayed at the hospital for two hours after I had her [third baby]. Hour skin to skin [and] just watching the breastfeeding DVD, then I went home (T015).

I always like to stay for that first 24 hours [be]cause everything's going, you need the shower right there, the bedding is there, you don't have to wash dishes, you can just put the towels in there and there so much bleeding going on. That's why I like to stay there for those first few hours (L072).

The mothers that were unfortunate to have babies born with health problems valued the support provided by the hospital and the Special Baby Unit (SCBU).

Five days we were out on the sixth day, most people are quick to get out of the hospital. But I just think it was the best thing I could have done for [me and] my baby, was to stay in the hospital, for one, the nurses were there, dedicated to me and my baby in SCBU (J030).

There were a number of services in the community that were identified as being supportive during the postnatal period and beyond. The Family Start Programme, funded by the Ministry of Social Development, was identified as a service that midwives could utilise. This service supports at-risk families, working with the mothers from pregnancy through to when the child turns five years. When the baby turns six weeks, the midwife hands over the mother and

baby's care to a well-child/tamariki ora services provider, either Plunket or Tamariki Ora provider, through a local Iwi Health Service Provider. When organisations provided quality support services, they gain a good reputation within the community, and therefore, are in high demand. Tamariki Ora was the preferred service, because of their home visits, continuity of care, and whakawhanaungatanga approach. Tamariki ora providers are able to provide wrap-around services like the Family Start programme, which is what differentiates it from Plunket. Tamariki Ora nurses were inspirational although their client base limits the capacity to take on new clients. In this situation, Māori mothers have no option but to go to Plunket.

I felt I had more support [with] Tamariki Ora. [They] had more support to offer a family, in regards to Māori. You know we understand that whānau umbrella and so that's what made it comfortable for me [to be] with Tamariki Ora and why I went there. I never experienced a Māori ... outfit so I thought I was going to try it cause [baby's name] was planned as our last child and I just wanted to get as much experience from here as I could (M025).

What I picked with [the Iwi health providers] because they were a Māori service, they can pretty much communicate to you like your whānau member, well they did for me ... I didn't have to ask, they got to me before I could (M032).

I know with [the Iwi health provider] it is more like they come in have a kōrero, have a talk, put the kettle on, what you been up to. It's ... more relaxed, whereas with Plunket it's kinda like rushing. I know [Iwi] services, I know what they do. They go in and have a kōrero, they get to know you, [and] they get to know your family (J053).

### **Supportive Community**

A *supportive community* is when the community, organisations and private businesses provide a supportive environment for breastfeeding. Some wāhine had negative experiences in other communities outside of the Eastern Bay of Plenty. Television social marketing campaigns were identified as being visually effective in promoting breastfeeding at a local level. Some local restaurants are known to be breastfeeding friendly. Within the Māori community the local marae are inherently breastfeeding friendly. Being able to breastfeed in public was not a concern for the participants, as they would rather breastfeed the baby than have the baby screaming, challenging anyone who might object. For example, one fed her baby in the shopping aisle:

When my baby's hungry I just give it anywhere. Whether I'm shopping, looking through clothes in Farmers, if I'm getting groceries in the supermarket, I just pull it out and give my baby a feed. While I'm going around getting shopping, anywhere, like Christmas in the Park, [I] just feed them, didn't bother me who was around. My baby's hungry, it's gonna have a feed that's how I saw it, and no one was going to deprive my children of not getting any food (N032).

With the first one I was probably conscious of myself. I was quite young and naive, but if baby needed to be fed, anywhere I definitely wanted to make sure they were fed or not crying. I would breastfeed whenever, on demand, whenever they needed to, didn't matter where I was (P021).

### **Supportive Work**

When there is a *supportive work environment*, the employer will know the legislation pertaining to maternity leave entitlements, and will ensure the workplace is breastfeeding friendly. A supportive employer informs the staff member of their entitlements and is flexible and supportive towards their breastfeeding needs, and the needs of the infant. The majority of the participants worked to help provide financial support for the family, except for two. Expressing at work enabled the baby to have breast milk via bottle during the day, and breast at night and weekends. Flexible work environment allowed her to take breaks to breastfeed when needed.

When I had my last child, they brought in the breastfeeding policy for workplaces. I didn't really know what my entitlements were. If I had to go and express solely during my own break, which I would do, but that meant that I wasn't able to nourish myself while I was expressing. It's around sharing that information and making sure that [the] information is shared with other women (P051).

It was kind of hard for her [baby]. [I] took her the bottle but she just wouldn't take it, so I had to sometimes run across the road, feed her then go again. I was working with my mum (MT22).

### **Ūkaipōtanga Partner and Whānau**

The property of *ūkaipōtanga partner and whānau* relates to the women's partner, and her whānau, which includes whakapapa whānau, and friends. A partner's commitment to work can

limit his ability to be supportive. However, if he learns the importance of his role as explained in *getting ready* and the *having an engaging midwife*, he will put in place strategies that will enable him to provide adequate *ūkaipōtanga (nurturing)*. For example, two of the fathers felt they missed out on nurturing their previous children, so with their youngest children, they decided to take parental leave to look after their baby while the mothers returned to work:

He was really helpful while I was breastfeeding my baby. He actually did say, ooh what's going to happen to my baby when you go back to work, I don't want you to leave my baby, I want her to have a titty. I said well you know things happen I got to go to work and I'm really sad for my baby (T041).

[Baby was] thirteen weeks old when I returned to work. [I] discussed it with my partner that he would take leave from his job and stay home and look after her. I think it was good for all, was good for the whānau. He didn't have that experience with the older two, because he just continued to work. He thought he was going to have the easy job (P030).

I think he felt he actually missed out on a lot not being able to feed [baby], because I tried not to give them the bottle until I was actually going back to work. So he feels like he missed out a lot of the time, probably bonding with them. He was there if I needed him to be there, but I don't think he actually understood, how exhausting it can actually be, especially with the first two breastfeeding. There was no little bits of sympathy, but full support [I] suppose. That's why I didn't feel any sympathy on the third child (P034).

He definitely knew what I went through with the two boys, keeping the house clean, looking after the baby, plus having meals cooked. I told him he done such a good job that I didn't want him to go back to work, but he chose to go back after seven months leave (P031).

Many of the wāhine also drew upon support from their mothers, aunties, sisters and friends when they encountered breastfeeding problems. Support included practical advice, doing household chores, babysitting, and one aunt wet nursed to help settle the baby and to give the mother a break.

I actually enjoyed it [breastfeeding] I felt it was comforting and the bond between me and my baby was lovely. I loved the bonding and the support around the breastfeeding from my mother and my family was awesome (T001).

I'd say that encouragement works. I really felt that because people were encouraging me, it just made me want to persevere, you know [being a] first time mum (J054).

### **Supporting Other Mothers**

When a wahine has been the recipient of quality birthing and breastfeeding teaching, quality care and *ūkaipōtanga* (*nurturing*) and had a positive birthing and breastfeeding experience with no complications, she feels empowered. She is empowered and confident about herself and her role as a mother. She will have the ability and confidence to support other wāhine. The key informant explained her teaching and why she believes her practises are successful:

I teach the mothers. See I empower them [so they] will make a difference (H028).

One participant under the key informants care with her first child explained how she was taught to breastfeed, and that the knowledge and skills remained with her to this day. Consequently she is able support other wāhine because of the quality teaching received:

When you show someone how to do it how to breastfeed like that you see them lift the breast off this part of the baby's mouth because it's too much pressure (R008).

Even with that [5 year] break [between my first born] my sister had three babies so I was still involved with her and her birthing and her breastfeeding. So I still got a bit of practice in (R014).

Another participant also a recipient of the key informant's breastfeeding teachings with her fourth child and did need support to initiate breastfeeding with her fifth child. With her first three children, she encountered breastfeeding initiating problems. She now feels confident with the knowledge gained and is happy to support other mothers to breastfeed.

I will support any mum to breastfeed because of those changes for me (M028).

### **Conclusion**

The three sub-categories *getting ready*, *having an engaging midwife* and *having supportive services*, and their properties, provide an explanation of how it is possible for Māori women to

achieve optimal breastfeeding in a bid to identify what *optimising Māori women's breastfeeding* entails. The study identified that quality *ūkaipōtanga (nurturing)* was needed to be provided during prenatal, perinatal, postnatal stages and beyond. The sub-categories and their properties need to intertwine and weave together in delivering quality *ūkaipōtanga (nurturing)*. Alternative practices and kaupapa Māori antenatal, and midwifery practices are well suited in providing the ideal *ūkaipōtanga (nurturing)* for Māori wāhine, her partner, and their whānau. Kaupapa Māori teaching can help to redefine and dignify wāhine who they are as Māori. The inclusion of the partner and whānau is vital in this process. The rewards of quality *ūkaipōtanga (nurturing)* as identified in this study can provide the wāhine, her whānau and the community with positive empowering outcomes that can be passed on to the next generations. The process may seem complex in today's world, but it is what the health policies and literature strive for, and this study indicates that it is achievable. *Optimising Māori women's breastfeeding* not only ensures that the Māori wāhine achieve optimal breastfeeding, *optimising Māori women's breastfeeding* can contribute to achieving *whānau ora*, plus the knowledge, confidence and skills to *support other mothers* to breastfeed.

The following Chapter Five Implications provides an account of impacts these findings can have on, the Māori women, their partners, whānau, the midwives, health practitioner, and the community in general. I also provide recommendations for health practitioners and policy makers, and recommendations for further research.

## CHAPTER 5

# Implications and Discussion

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Becoming pregnant can bring with it a whole mix of emotions, and many uncertainties. But what is certain is that expectant wāhine need to engage and interact with a midwife, health services, and the community at varying points in time during her pregnancy. It is essential that each interaction provides quality *ūkaipōtanga (nurturing)*. Having a positive and problem-free birth and breastfeeding experience, as well as being able to successfully breastfeed for six months, is an aspiration for most wāhine. Within this chapter, I will discuss the implications for the pregnant wāhine, mothers, the babies, the partner and whānau of quality *ūkaipōtanga (nurturing)*, particularly when it is not provided. For different reasons this research has implications for midwives, antenatal and postnatal health care providers, well child tamariki ora providers, and also pregnant wāhine, mothers, their partner, their whānau, extended whānau, the community and policy makers.

Kaupapa Māori methodology informed the generation of the grounded theory, *Optimising Māori women's breastfeeding*, which identifies how Māori women manage breastfeeding. This thesis identifies the quality *ūkaipōtanga (nurturing)* required during a wahine's antenatal and postnatal periods, and beyond to achieve optimal breastfeeding. The act of breastfeeding facilitates bonding between mother and baby. Problem-free births and breastfeeding helps build long-term emotional bonding and attachment, necessary for a babies' healthy development. The development of the partner's bonding and attachment with mother, coupled with being the recipients *ūkaipōtanga (nurturing)* teachings and values has the potential to achieve holistic health and wellbeing (whānau ora). This form of bonding and *ūkaipōtanga (nurturing)* within a whānau nucleus can instil protective and nurturing environment, and contribute to reducing violent inclinations that can result in child abuse and domestic violence. Achieving whānau ora was an aspiration of all Māori wāhine participants, and is also a focus of the Ministry of Health (2006b), and the Ministry of Social Development (2009).

## Review of the Aims of the Research

To recap, the following aims for this research, (presented in Chapter One *Introduction* and Chapter Three *Constructing an Appropriate Methodology*) were to:

1. Ascertain how Māori women manage breastfeeding;
2. Explain the support Māori women need to successfully breastfeed up to and beyond six months; and
3. Explain how health care practitioners, policy makers and the community might be able to support Māori women to successfully breastfeed up to and beyond six months.

As the Māori women shared their experiences, I gained insight into their perspectives on what worked for them and what did not, and what would help them improve theirs and other women's experiences. An inductive process using comparative analysis and Charmaz's (2006) constructivist grounded theory method was informed by a Kaupapa Māori approach developed for this research. The responses of wāhine were analysed to explore emerging concepts. Theoretical sampling identified the need to collect additional data from a kaupapa Māori health provider whose practices instilled positive long-term benefits. Thus, the health provider was recruited as a key informant, providing a kaupapa Māori perspective on why such an approach to services was successful.

The participants' data were analysed and theoretical sampling used to explore and develop the theorising concepts of *optimising Māori women's breastfeeding*, as explained in the Findings Chapter Four Findings: *Optimising Māori Women's Breastfeeding*. I assessed the research aims against the findings, and for the first aim I was able to ascertain that it is possible:

1. To receive good quality care;
2. For first time mothers to experience problem free breastfeeding; and
3. To breastfeed for more than six months.

But for this to happen there are a few things that need to be provided. These provisions also provide an explanation on how the second and third aims are met. I will explain these provisions under the headings, *the importance of antenatal learning using a kaupapa Māori approach, importance of healthy lifestyles for physical and psychological wellbeing, importance of engaging early with a midwife that has quality practises, importance of continuity of care and supportive systems, and importance of partner and whānau ūkaipōtanga*. Some of the

participants' excerpts are utilised as lead-in quotes at the beginning of each section, to support the explanations.

## **The Importance of a Kaupapa Māori Approach to Antenatal Learning**

Many Māori wāhine do not attend antenatal classes. It is important for first time parents to attend antenatal classes. Antenatal classes provide wāhine, their partners and whānau with the knowledge and understanding needed to prepare for problem-free birth and breastfeeding (Craig & Dietsch, 2010; Hildingsson, Dalén, Sarenfelt, & Ransjö-Arvidson, 2013). Kaupapa Māori classes are tailored for all age groups. The learning provides an awareness of alternative Māori practices informed by Māori values that can change the partner attitudes and behaviours. Furthermore, kaupapa Māori antenatal classes potentially provide the opportunity to rectify problematic, historical, colonised birthing, and breastfeeding practices (Marie, Fergusson, & Boden, 2011). Kaupapa Māori antenatal classes are available, but are often not well attended (personal communication with Gulliver-Birkett). Midwives are in the ideal position to promote kaupapa Māori classes.

Antenatal education providers and midwives need to ensure the pregnant wāhine receive the necessary antenatal information. Innovative facilitation skills are required to connect and capture the attention of the young Māori wāhine, providing appropriate Māori concepts and values, information on the benefits of breastfeeding, and how to prepare to avoid complications. Filling gaps in service delivery is also needed to minimise Māori wāhine and their babies suffering from unnecessary health complications, and to also correct historical and problematic practices (Marie et al., 2011). The more mothers who experience positive breastfeeding, the more likely they will share successful breastfeeding experiences and how they were successful, as opposed to focusing on difficulties and bad experiences. This is an important aspect, as Māori women play an important role in promoting health and wellbeing to their children, whānau and future generations (Wilson, 2008).

## **Importance of Healthy Lifestyle for Physical and Psychological Wellbeing**

SUDI (Sudden Unexplained Deaths in Infant), asthma, glue ear, and chest infections are all health issues associated with smoking during pregnancies. Having an awareness of gestational diabetes and foetal alcohol syndrome can be assisting the Māori women to make healthy lifestyle choices. Māori women have the highest prevalence of smoking and many Māori wāhine continue to smoke during pregnancy (Abel & Tipene-Leach, 2013; Glover, Paynter, Bullen, & Kristensen, 2008b). Health professionals can provide an array of information and advice on healthy lifestyles. The Ministry of Health provides resources to assist with the promotion on the benefits of good nutrition, the benefits of being smoke-free, alcohol and drug free. For the pregnant wāhine the midwife is the ideal person to provide and interpret this information and offer advice. Making changes early in the pregnancy can result in better health for either the mother or baby or both (Craig & Dietsch, 2010).

Birthing and maternal health complications can place financial strain and stress on a relationship. The physical and psychological stress of being a pregnant wāhine and a mother is often underestimated. Many pregnancies, birthing and breastfeeding complications can be avoided if wāhine receive quality prenatal *ūkaipōtanga* (*nurturing*) from her partner and whānau, but in particular from her midwife (Nikiéma, Beninguisse, & Haggerty, 2009).

## **Importance of Quality Midwife Engaging**

The midwife plays the most important role in the *ūkaipōtanga* (*nurturing*) process during prenatal and postnatal period, as explained in the *engaging midwife* sub-category in Chapter Four Findings: *Optimising Māori Women's Breastfeeding*. There is a need to understand what the professional requirements of a midwife in New Zealand actually are, and to ensure that they practise to the level required for the women to achieve optimal breastfeeding. Therefore, I will first discuss the midwifery practice guidelines as required by the Midwifery Council of New Zealand (2012), and the how these guidelines can be implemented to meet the needs of Māori wāhine.

## Midwifery Practising Requirements in New Zealand

According to the Midwifery Council of New Zealand (2012), midwives are only required to provide care for up to 6 weeks postpartum. The Midwifery Council provides guidelines on care practices within the philosophy of partnership and culturally safe practices. This requires that midwives recognise Māori as tangata whenua and practice according to the Treaty of Waitangi principles of protection, partnership and participation (Midwifery Council of New Zealand, 2012). All midwives need to demonstrate culturally safe practices that recognise and respect the cultural identity of, and empower the women in their care (Midwifery Council of New Zealand, 2012). It is recognised that culture and upholding cultural care values has positive influence on a person's wellbeing (Durie, 2001).

This is outlined in Competency One that states, "The midwife works in partnership with the woman/wahine throughout the maternity experience". A small footnote follows this and three other competencies, and explains how the term woman/wahine is expanded to include a woman's baby, partner and whānau. According to Kenney (2011), this marginalises the importance of the inclusion. Another concern is that it is the midwife, through a process of self-reflection, who determines if her practices are culturally safe or not. The perceptions of cultural appropriateness from the viewpoint of the women under her care are disregarded, suggesting an imbalance of power in the care provider/care recipient relationship, and detracts from the meaning of equitable partnership (Kenney, 2011). This has big implications for Māori, as midwifery is considered a European women's profession (Kenney, 2011). Only 5% of midwives in New Zealand are Māori, and there is only one Māori midwife currently practising within the EBOP (Kenney, 2011; Midwifery Council New Zealand, 2010).

Kenney (2011) provided a model that she claimed is relevant for midwifery practice in Aotearoa New Zealand. She asserted that this model could assist in the delivery of culturally safe practices. The model is based on 'ngā kete o te wānanga'. Within 'ngā kete o te wānanga' model, there are three kete that pertain to knowledge. Firstly, te kete aronui is knowledge of the physical sense; te kete tuauri, the second kete, represents knowledge that is beyond the physical sense; and te kete tuatea, the third kete, refers to knowledge born from the senses of unity, developed among members of the partnership. There are ten underpinning theoretical concepts of 'ngā kete o te wānanga' these are; whakapapa (genealogy, continuity),

whakawhanaungatanga (building and maintaining relationship), whakarurutanga (ensuring safety, creating safe environments), whakaaetanga (gaining acceptance, agreement, approval, permission, consent), whakaritenga (negotiation, reconciliation), whakangungu (advocacy, protection), whakawhirinaki (building trust), whakamanawa (empowerment, personal validation), ōritetanga (equity), and mana motuhake (autonomy, self- determination). The concepts are appropriate to ensure the midwife partnership with Māori wāhine remains cohesive and congruent (Kenney, 2011) (see Table 13).

**Table 13.**

*Theoretical Concepts of ‘Ngā Kete o Te Wānanga’ and the ‘Midwifery Partnership’*

Concepts		Midwifery Partnership
<b>Whakapapa</b>	Genealogy, continuity	Continuity of care through mutual trust and respect
<b>Whakawhānaugatanga</b>	Building and maintaining relationship	Embraces whakapapa
<b>Whakarurutanga</b>	Ensuring safety, creating safe environments	Facilitating, physical safety, as well as socially safe environment
<b>Whakaaetanga</b>	Gaining acceptance, agreement, approval, permission, consent	Collaborative agreement, informed decisions – linked to Whakarurutanga,
<b>Whakaritenga</b>	Negotiation, reconciliation	Negotiation about elements of care and health services - element of whanaungatanga
<b>Whakangungu</b>	Advocacy, protection	Protecting and advocating on behalf of the wāhine – element of midwifery philosophy, Ottawa Charter for Health Promotion <sup>1</sup> , and Te Pae Mahutonga an Indigenous Health Promotion Model <sup>2</sup> .
<b>Whakawhirinaki</b>	Building trust	Requirements of good faith and mutual trust - relates to whakarurutanga and whakangungu
<b>Whakamanawa</b>	Empowerment, personal validation	Enables women’s voice to be heard
<b>Ōritetanga</b>	Reciprocal respect. Equality and equity	Respecting wāhine and practicing in a manner that can be respected by wāhine
<b>Mana motuhake</b>	Autonomy, self- determination	Acknowledge the autonomy and self-determination of wāhine, whānau and midwives, and allowing wāhine to make informed decision in relation to their health care issues.

Note: <sup>1</sup>WHO (1986); <sup>2</sup>Durie 2004

## Midwife Practice

Midwives are only required to provide care for up to six week postpartum. The key informant was able to provide a kaupapa Māori midwifery service and Te Whaangai Uu (kaupapa Māori

breastfeeding service), which allowed her to care beyond six weeks postpartum. The key informant advised that she would ensure she could do justice to the mother's postnatal care, by limiting the number of pregnant wāhine in her care to just three and follow them for three months. Whereas, other midwives would have six to ten women, and would provide postnatal care for only a few weeks and breastfeeding would not be properly established by then.

For change to happen, midwives need to form a partnership with the pregnant wāhine, her partner and whānau, and provide quality *ūkaipōtanga* (*nurturing*). The partnership should commence as soon as the pregnant woman presents herself, and continue throughout the pregnancy and for up to six weeks during the postpartum period. The midwife has an important role in promoting and educating maternal health and wellbeing (Midwifery Council of New Zealand, 2012). Lack of education or low socioeconomic status has no bearing on a wāhine's readiness to learn (Lacey, 1988). A wāhine's readiness to learn is often determined by the midwives' determination to teach (Jackson, Schmierer, & Schneider, 1996; Kenney, 2011). At times a midwife may need to call upon the expertise of other health practitioners. This indicates that midwives are willing to engage with other health providers for support, and should be viewed as a positive intervention for the mothers, and not an inadequacy of a midwife's practice. Midwives are in the ideal position to promote and encourage the pregnant wāhine to attend kaupapa Māori antenatal classes.

### **Recruiting and Retention of Māori Midwives**

Māori are underrepresented in the field of midwifery, and the majority of the Māori midwives are subjected to the Eurocentric practice. Some Māori midwives incorporate kaupapa Māori practices, and are more likely to provide tailored kaupapa Māori antenatal classes, like Te Ha Ora, a kaupapa Māori antenatal and parenting classes. Despite the high number of Māori births in the EBOP, these classes struggle to get referrals from non-Māori midwives, and have low attendance (personal communication, Gulliver-Birkett). Those midwives that branch out of the dominant midwifery practice, to include kaupapa Māori practices, often struggle with their practice approach not being accepted or supported. A lack of valuing and understanding a kaupapa Māori approach can often lead to being subjected to institutional racism and criticism. Copying aspects of kaupapa Māori practice by non-Māori practitioners, risks undermining mātauranga Māori, the origins of practice, and of course, the correct version of

practice, potentially bringing into disrepute such teaching and learning (Kenney, 2011). Another philosophy that non-Māori, mainstream practitioners struggle with is the notion that only those midwives that identify as Māori can provide kaupapa Māori practices.

There is a need for the recruitment and retention of Māori midwives and Māori nurses, as Indigenous health practitioners are more likely to have the necessary insights and understanding of the cultural and socioeconomic factors that impact the experiences of Māori women and their whānau (Wilson, McKinney & Rapata-Hanning 2011; Ratima, et al. 2007). Regular workforce development for non-Māori midwives may assist in providing them with some understanding and awareness of the needs of Māori (Wilson, 2008). Only then is there a possibility of the midwifery profession assisting in changing in the current breastfeeding statistics for Māori, and the holistic health of the whānau (Durie, 2001; Wilson, 2008)

## **Continuity of Care and Support**

The sub-category *having supportive systems*, as explained in Chapter Four Findings: *Optimising Māori Women's Breastfeeding*, identified environments, systems and policies that support the continuity of care and enables the *ūkaipōtanga (nurturing)* process to continue beyond the six week period of midwifery care. Partner and whānau *ūkaipōtanga* is particularly important and should continue for a lifetime, which will be discussed under the *importance of partner and whānau ūkaipōtanga*. Other environments that are also important to ensure the continuity of care include hospitals, well child/tamariki ora service and work environments for those that work. These environments are discussed under the *importance of supportive community and health services environments*.

## **Importance of Partner and Whānau Ūkaipōtanga**

Kaupapa Māori teachings on *ūkaipōtanga (nurturing)* and whānau ora values can transform individuals (Smith, 1999). The process of transformation starts from being unsupported to being fully supported by a partner and father, and whānau. The supporting roles of partners and whānau are fundamental for long-term *ūkaipōtanga (nurturing)*, to enable mothers to breastfeed for six months or beyond (Pihama, 2001). The benefits of including partner and

whānau into antenatal learning and antenatal home visits have been highlighted in the Chapter Four Findings: *Optimising Māori Women's Breastfeeding*. For those partners that did not attend either kaupapa Māori or mainstream antenatal classes, whānau may have instilled *ūkaipōtanga* (nurturing) values, similar to those taught in kaupapa Māori classes. For those that do not have these values, the mothers of their children are most likely to receive little or no support from their partner and whānau. These mothers will often struggle to cope.

Whānau often want to take the baby into their care to give the mother a break. These are good intentions, but whānau need to ensure the baby is still able to have breast milk, rather than introducing artificial milk. Whānau need to ensure they are supportive and not a barrier to breastfeeding.

### **Importance of Supportive Community Health Services Environments**

World Health Organisation breastfeeding protocol, they encourage the breastfeeding component. That's great, but not to exclude working mums who tend to give alternative methods of feeding. They don't promote any type of bottle. They say exclusive off the breast. I think it's limiting, because you should be able to [be] given options, alternatives, you don't have to exclusively breastfeed to continue (P047).

Hospitals are required to implement the Baby Friendly Hospital Policy (National Breastfeeding Advisory Committee, 2009; New Zealand Breastfeeding Authority, 2011). Hospital environments can be more welcoming and inviting to the mother, her partner and whānau. A hospital system that specifically supports first time mothers to ensure breastfeeding is fully established before they leave the hospital can have a positive long-term impact on breastfeeding rates. This could entail longer stays, and a special *ūkaipō* unit set up to establish breastfeeding.

[Plunket] they come in your home and she's like, she's real quick, she comes in, check, check, check is there any questions, and I'm like, "Oh no", and then she goes. I thought it would be like Ngāti Awa services they come in have a *kōrero*, have a talk put the kettle on, what you been up to, it's more of, more relaxed. Whereas with Plunket it's kind of like, rushing. I know Ngāti Awa services, they go in and have a *kōrero*, they get to know you, [and] they get to know your family. If my partner walked in the door she would never

know who he was, the Plunket nurse, never, never. That's the difference I think is, they get to know [you] (J053).

The main well child/tamariki ora providers in the EBOP are Plunket, with some Iwi Health Providers. They are funded by the Ministry of Health to provide a range of services for children under five. There is a difference in the service provided by these two organisations, the Iwi Provider operates under a kaupapa Māori service framework, and are able to provide other wrap around health and social services. Plunket is the main provider in the EBOP, of which the Māori population makes up approximately 50%. This service provision reflects an imbalance in the distribution of funding, especially as many Māori women are not accessing these services, something this research indicates. Therefore, there appears to be an imbalance in the availability of well child/tamariki ora services delivery in the EBOP, which has resulted in some Māori women denied tamariki ora well child services by Iwi providers. Similar to midwifery service provision, it is important that the option for well child/tamariki ora services is provided by Māori. Kaupapa Māori services inherently deliver services in a manner that is culturally appropriate and specific to the needs of those Māori whānau under their care (Wilson, 2008). For best well child/tamariki ora outcomes, this inequality in service delivery needs to change, and Iwi provider funding to be increased. Another useful intervention in providing continuity of care with one provider is to commence well child/tamariki ora care in the prenatal period.

[Recommend] 12 months paid parental leave, although I'm not having any more kids but I mean for other mothers hey, be fair to the mother and the child, God three months you're still healing you and your baby (R027).

The Department of Labour Employment Relations Act 1987 and Amendment Act 2002 allows 14 weeks paid parental leave. The A Guide for Employers: Breastfeeding in the Workplace 2009 Act, allows for flexible working and breastfeeding in the workplace, and is reinforced by the 2010 Code of Employment Practice on infant feeding and the right to breastfeed (Department of Labour, 2009, 2010). This legislation is not specific enough, and is open to interpretation. More promotion needs to be done to bring about awareness of all entitlements to employers and employees.

Many Māori mothers return to work to subsidise the family income. The more children they have, the more likely the need for them to return to work once the paid maternity leave

ceases. The younger the baby, the harder it was to maintain breastfeeding after returning to work. Managing breastfeeding or expressing at work can be stressful, even if the work place is supportive. Most will not be able to have special breastfeeding breaks, instead having to utilise their tea and lunch breaks which does not allow wāhine enough time to nourish themselves. Consequently, most wāhine will give-up not long after commencing back at work, as work commitments make it difficult and stressful.

The policies and legislation around maternity leave and breastfeeding in the workplace are helpful but do not go far enough to assist in *optimising Māori women's breastfeeding* for the majority of the participants. Maternity leave duration needs to be increased to six months or more, to enable the mothers to care for themselves and their babies, which will enable them to continue breastfeeding longer (Baker & Milligan, 2008; Cooklin, Rowe, & Fisher, 2012).

## **Limitations of Research, Recommended Strategies and Further Research**

This section identifies the limitations of this research. I also recommend strategies that have been identified as being able to assist Māori women to achieve optimal breastfeeding. The majority of these strategies can also benefit the general population. I also provide recommendations for further research.

### **Limitations of Research**

This research was able to achieve theoretical saturation of the codes and categories, and also extend to explore theoretical sampling leads. A kaupapa Māori provider was recruited as a key informant for this purpose, to identify why her service was successful in achieving long-term optimal breastfeeding for several participants. The key informant's services included midwifery and a kaupapa Māori breastfeeding service. It is possible that the key informant's comments introduced bias into the research, as she held her own biases towards her service. However, further theoretical sampling may have been beneficial to this research and strengthened the grounded theory. For example, inclusion of other midwives and participants' partners in the

theoretical sampling, specifically those partners whose support positively impacted participants' breastfeeding experience. Caution must also be taken when using these findings beyond the participant group. The research focused on a small group of Māori women who resided within the small rural provincial towns in the Eastern Bay of Plenty. The experiences of Māori women living in urban areas or larger provincial cities may have different experiences and needs.

### **Recommended Strategies**

Many of the participants made recommendations on what they thought would help women achieve optimal breastfeeding. The following is a list of recommended strategies:

1. Accessible and regular antenatal and breastfeeding antenatal programmes within Kaupapa Māori framework, specifically tailored for first time parents;
2. Kaupapa Māori antenatal education, and regular postnatal follow-up, for the young teenage pregnant wāhine and fathers to be, to encourage continuity of care;
3. Health policies and strategies developed to encourage attendance to antenatal classes for first time parents, which can be assisted through parental leave provision; and
4. Promotion of antenatal care and education for Māori wāhine, and their partners and whānau.

### **Importance of quality midwifery engaging - recommended strategies:**

1. Midwifery specialist teams be established for first time parents who are prepared to work with Māori and others (e.g. Pacific Island);
2. Midwives should work more collaboratively with other services to benefit the women, their babies, partners and whānau, during antenatal and postnatal period;
3. Kaupapa Māori midwifery service provision within Iwi service providers that provide Well Child/Tamariki Ora and/or Family Start Services;
4. Policies be developed to establish a minimum Māori midwifery practising quota for regions with high Māori populations;
5. Midwives should organise introduction visits for their Māori clients to a kaupapa Māori antenatal class facilitator, and kaupapa Māori breastfeeding advisor;
6. Midwives' revisit client quota restrictions in high need regions to enable better quality care;

7. Midwives should consider providing the option of antenatal home visits for wāhine Māori;
8. Increase support for Māori midwives;
9. Provide kaupapa Māori awareness programmes for midwives; and
10. Urgent workforce development in the area of recruitment and retention of Māori into the midwifery practice.

**Importance of supportive systems and health services environments – recommended strategies:**

1. First time mothers are encouraged to remain in hospital until breastfeeding is established, through ensuring hospital stays are a minimum of five days;
2. Flexible hospital policies that allow for wet nursing or expressing options for those women who encounter breastfeeding problems, to enable healing process in the short-term;
3. Specific kaupapa Māori whānau birthing and breastfeeding units for Māori wāhine (and other ethnic groups eg Pacific Island), that caters specifically for first time mothers, and extended stay of periods;
4. Iwi Well Child/Tamariki Ora service provision to be increased to meet needs of Māori community;
5. Policy and funding to enable Well Child/Tamariki Ora services to commence contact during prenatal period to ensure continuity of care; and
6. Maternity leave entitlement is increased to 6 months to enable continued breastfeeding.

**The following recommendations need more immediate action:**

1. Greater promotion of maternity leave and breastfeeding in the workplace entitlements;
2. Workplace leave entitlement be extended to allow attendance at antenatal classes during the day for first time parents; and
3. Breastfeeding in the workplace policies to allow for paid breastfeeding breaks.

## **Recommendations for Further Research**

To my knowledge this is the only research that investigated optimising breastfeeding interventions, to identify what can assist Māori women to achieve optimal breastfeeding for six months and beyond. This research indicates that kaupapa Māori antenatal education, kaupapa Māori midwifery practices, and kaupapa Māori breastfeeding services, can positively influence breastfeeding for Māori women, in particular those services that are able to provide continuity of care from the prenatal through to the postnatal periods for up to 3 months. There is no known research that has investigated how kaupapa Māori antenatal classes and midwifery practices aid breastfeeding, and how they inspire whānau ora (holistic health and wellbeing of the whānau). Further research is needed to investigate these interventions.

## **Conclusion**

This thesis makes a contribution to knowledge related to Māori women and breastfeeding. The research identified how Māori women manage or managed breastfeeding in order to identify what is required for Māori women to achieve optimal breastfeeding. What was revealed has the potential to transform the holistic health and wellbeing for Māori. *Ūkaipōtanga (nurturing)* is the basic social process that is needed to achieve this. A pregnant wāhine needs to receive quality *ūkaipōtanga (nurturing)* at crucial periods during prenatal, postnatal and beyond postnatal period. Chapter Four Findings: *Optimising Māori Women's Breastfeeding* theoretically formulates what is *ūkaipōtanga (nurturing)*, explicating the process of *ūkaipōtanga (nurturing)*, how it should be provided, who should be included, and who the ideal people are to provide *ūkaipōtanga*.

These processes highlighted the benefits of attending antenatal classes for a primiparous Māori woman, and her partner, and whānau, and the value of those classes that teach within a kaupapa Māori paradigm. Also identified was the importance of living a healthy lifestyle to ensure optimal physical and psychological health of the mother, which also impacts positively on the baby, the partner and the whānau. Having a midwife that is able to engage appropriately with Māori woman, in particular a primiparous Māori woman, and her partner and whānau was found to be essential. This study identified that midwives who incorporate cultural values in their delivery and/or practised within a kaupapa Māori paradigm are able to

provide quality *ūkaipōtanga (nurturing)*, appropriate to the needs of Māori women. Such practises that ensure that her partner and whānau are always included assist in ensuring that Māori women are supported to successfully initiate breastfeeding. Furthermore, continuity of care from prenatal to postnatal period and beyond is also identified as being required. This includes midwife's care period, hospital care to well child/tamariki ora care, supportive work environments and policies, and partner and whānau *ūkaipōtanga*. Identified, and of concern, is that hospital environment and policies were inadequate in terms of providing sufficient assistance to Maori women, particularly primiparous mothers, to initiate breastfeeding successfully. On the other hand, well child/tamariki ora and other services provided by Iwi health providers were well positioned to provide a service that positively assisted mothers in the continuity of their breastfeeding. However, it was also found that it would be more beneficial for this care to commence in prenatal period to ensure continuity of care from one provider over a long period. To achieve this would require policy changes and resourcing. With the influence of legislation, work environments have become more supportive towards breastfeeding, but this does not ensure breastfeeding extends past the paid parental leave of 14 weeks. Therefore, there is a need to increase the paid parental leave. Twelve months paid parental leave would ensure six months of breastfeeding would be achievable for most mothers. Then finally, a consistent concept arising throughout this study was the importance of partner and whānau *ūkaipōtanga*, highlighting the positive influence of kaupapa Māori antenatal teaching on the whānau and the partner, in particular, by informing them of the roles they can play in supporting wāhine in breastfeeding. Such teaching can help instil *ūkaipōtanga (nurturing)* values to enable Māori women to receive the support that is needed to nurture her baby.

The above findings indicate the need for changes in processes and policies to enable the health care system to ensure continuity of care from prenatal through to postnatal period and beyond, that will enable Māori women to achieve optimal breastfeeding. The process of *ūkaipōtanga (nurturing)* may seem complex, but it is achievable. The process revealed that it is possible for Māori women to receive quality antenatal and postnatal care, and identifies what is required, but the most important finding is that it is possible for primiparous Māori women to experience problem-free breastfeeding, and it also possible for Māori women to breastfeed for six months and more. Once a primiparous woman learns the art of initiating breastfeeding, she will retain this knowledge and will need little support from health services to breastfeed with future pregnancies. These processes can also contribute towards whānau ora, and the skills and knowledge acquired to support other women. Within this chapter, these processes

and actions were identified, and these processes make it possible for optimal breastfeeding to be achieved.

This chapter also provides recommendations to help implement these processes, as it is evident that within the current system optimal breastfeeding is not attainable or available to the majority of the Māori women in this study. There is also the need for further research to investigate kaupapa Māori antenatal education, and kaupapa Māori midwifery practices, and how they aid breastfeeding success, and influence whānau ora values. This research can also be relevant for all Māori and non-Māori, not just Māori within the Eastern Bay of Plenty, but more research is needed to confirm this.

**Appendix A: Information Flyer**

Appendix B



**Have you breastfeed or are you currently breastfeeding? Are you Māori and would you like to share how you managed breastfeeding?**

**Volunteers wanted!**

I am looking for 8-10 **Māori women** 16 years and over  
,  
who are either currently breastfeeding  
**or**  
have breastfeed within the past 10 years.

As a participant you would be asked to take part  
in a 1 to 1 ½ hour interview  
where we will discuss your breastfeeding experiences.

For more information on this study please contact:

Tui Edwards on 027 8585325  
Email: [red.and.tui@gmail.com](mailto:red.and.tui@gmail.com)

Any concerns regarding the nature of this project should be notified in the first instance to the  
Project Supervisor Associate Professor Denise Wilson 09 921 9999 ext 7392  
Concerns regarding the conduct of the research should be notified to the  
Executive Secretary, AUTEK, 09 921 9999  
Approved by the Auckland University of Technology Ethics Committee on type the date final ethics approval was granted, AUTEK  
Reference number type the reference number.

## Appendix B: Participant Information Sheet

# Participant Information Sheet



### Date Information Sheet Produced:

23 April 2012

### Project Title

Optimizing Māori women's breastfeeding

### An Invitation

Kia ora koutou,

Ko Tui Edwards tōku ingoa

Ko Mataatua me Tanui tōku waka

Ko Whakatohea, Ngati Awa, Te Whanau a Apanui me Ngai Tai, tōku Iwi

Hello

My names is Tui Edwards

My waka are Mataatua and Tainui

My Iwi are Whakatohea, Ngati Awa, Te Whanau a Apanui and Ngai Tai

I am currently studying part-time at AUT University and this research will contribute toward my Masters in Public Health thesis. I am also employed fulltime as the Breastfeeding Promoter/Educator for Te Puna Ora O Mataatua, and have 4 children and 2 grandchildren.

I would like to invite Māori women to participate in this research. Participation is voluntary and you have the right to withdraw yourself or any information you provide for this study at any time, without negative implications.

### What is the purpose of this research?

The purpose of this study is to explore how Māori women manage breastfeeding to understand what support is needed, and how health care professionals might be able to support Māori women to successfully breastfeed and to prolong breastfeeding beyond six months. I am interested in your experiences, but I will not be judging you on your breastfeeding decisions.

This study is being carried out as part of my Masters in Public Health thesis. The research key findings will be presented to the Bay of Plenty District Health Board and key Māori health providers in the Eastern Bay of Plenty. I will also submit research findings for publication in medical journals and presentation at relevant conferences.

### How was I identified and why am I being invited to participate in this research?

You have been identified by your health worker and as being a potential participant, as you are a Māori women over the age of 16 years, who is either still breastfeeding or had breastfeed in the past 10 years, you are able to identify your Iwi affiliation, and are currently residing in the Eastern Bay of Plenty. I appreciate you showing an interest in participating in this study.

Please note that any potential participant who moves residence out of the EBOP at the time of or before the interviews will not be able to participate. The project is limited to ten participants, therefore the first ten Māori women to return a signed consent form will be recruited to participate in the research study. Because of my role as the Breastfeeding Promoter/Educator

This version was last edited on 13 October 2010

and so you feel like you can say not to being part of this research, \_\_\_\_\_ will be talking to you about the research, answering any questions, and getting your consent to take part in the study.

### **What will happen in this research?**

If you decide to participate in this project, I will need to organise with you a time for you to tell me your breastfeeding story. I may need to organise a face to face interview that will last between 1 to 1 ½ hours to ensure I capture your entire breastfeeding experience. I may need to organise a follow-up meeting with you to do this.

### **What are the discomforts and risks?**

I would like to ensure the interview environment is comfortable, where you will feel safe and secure to minimise any anxiety so that you can share how you manage breastfeeding open and freely. If you begin to feel anxious or uncomfortable at any stage during the interview, it is ok for you to ask for a break or to ask for the interview to be rescheduled.

If your preferred language is Māori, you have the choice of the interview being conducted in te reo Māori. If you choose this option, an assistant researcher who can speak te reo Māori will be used to transcribe and translate your interview.

### **How will these discomforts and risks be alleviated?**

The venue for the interview will be of your choice (for example a cafe or a office at the health provider) to ensure you are comfortable with the surroundings. I will also be careful to ensure that you are comfortable during the interviewing process, to minimise the risk of anxiety.

If you choose the interview to be conducted in te reo Māori, I will provide an assistant researcher with te reo Māori who will be able to transcribe and translate the interview.

### **What are the benefits?**

This research aims to explore how Māori women manage breastfeeding to provide an understanding about what support they might need. The research findings have the potential to assist Māori women to be more informed and better prepared to breastfeed their infant, and to also provide information to health care practitioners, District Health Board service planners and policy makers to inform them about the support Māori women need to successfully breastfeed up to and beyond six months.

The research findings are envisaged to benefit:

**The community and Māori health providers:** It is envisaged that this information will be utilised to influence positive changes in the community, antenatal and postnatal health care services to Māori women, to support them to successfully breastfeed up to and beyond 6 months.

**Participants:** Information from the participants on how they manage breastfeeding will be valuable information that will be provide insights into how the community and health care professionals might be able to support Māori women to successfully breastfeed up to and beyond 6 months.

**Researcher:** This research will help me to achieve my personal goal of completing my Masters in Public Health. However the most rewarding aspect of this research is that it gives me the opportunity to help our whānau. It will also increase my capacity as a health worker to positively influence Māori women's health gains.

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### **How will my privacy be protected?**

Any information that you share with me or I collect from you, that is, your signed consent form and data from the interviews, will remain confidential and safely stored in secured cabinets. If you require a Māori interpreter and transcriber they will be required to sign a confidentiality agreement. Only you, my supervisor, and I will have access to your personal information. Your identity will be protected throughout this research as I will remove your name and any other information that might identify you from the interview transcripts. I will replace your name with a pseudonym.

### **What are the costs of participating in this research?**

There will be no monetary cost involved in participating in this project.

In terms of your time and commitment: There will be one interview, lasting 60 to 90 minutes.

### **What opportunity do I have to consider this invitation?**

There is a timeframe for of up to two weeks for you to consider this invitation to participate in my research. Participation is completely voluntary, and you can withdraw from the project at any time prior to the completion of data collection without any consequences. If you desire for the interviews to be conducted in te reo Māori, a Māori translator/transcriber will be engaged. If you decide that you no longer want to be part of the project, you can let me know in person or via email (my details are listed below). If you would like more information on the research, please contact me. A detailed report of the findings will also be made available to you. Please contact me if you are interested in having a copy.

### **How do I agree to participate in this research?**

If you agree to participate in this research please sign the consent form attached to this information sheet and return it to me as soon as possible.

### **Will I receive feedback on the results of this research?**

Yes, you will receive feedback on the findings of this research. You will also be invited to the presentation of my research at the EBOP Breastfeeding Coalition monthly meeting November 2014. In the presentation I will give an overview of the key findings of the research.

### **What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Associate Professor Denise Wilson, [dlwilson@aut.ac.nz](mailto:dlwilson@aut.ac.nz), 09 921 9999 ext 7392

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Dr Rosemary Godbold, [rosemary.godbold@aut.ac.nz](mailto:rosemary.godbold@aut.ac.nz), 921 9999 ext 6902.

### **Whom do I contact for further information about this research?**

#### **Researcher Contact Details:**

Tui Edwards, [red.and.tui@gmail.com](mailto:red.and.tui@gmail.com)

#### **Project Supervisor Contact Details:**

Associate Professor Denise Wilson, Taupua Waiora Centre for Māori Health Research, AUT [dlwilson@aut.ac.nz](mailto:dlwilson@aut.ac.nz), 09 921 9999 ext 7392

Approved by the Auckland University of Technology Ethics Committee on 13<sup>th</sup> April 2012, AUTEK Reference number 12/59.

This version was last edited on 13 October 2010

# Appendix C: Consent Form

## Consent Form



**Project title:** *Optimizing Māori women’s breastfeeding*  
**Project Supervisor:** *Associate Professor Denise Wilson*  
**Researcher:** *Tui Edwards*

- I have read and understood the information provided about this breastfeeding research project in the Information Sheet dated 23 April 2012.
- I have had an opportunity to ask questions and to have them answered.
- I wish my interviews to be in te reo Māori                      **Yes**  **No**
- I understand that if I wish my interviews to be in te reo Māori that a Māori translator will assist the researcher.
- I understand that notes will be taken during the interviews and that they will also be audio-taped, transcribed and translated (translator required only if interview is conducted in te reo Māori).
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this breastfeeding research.
- I wish to receive a copy of the report from the research (please tick one): **Yes**  **No**

Participant’s signature: .....

Participant’s name : .....

Participant’s Contact Details:

.....  
.....  
.....  
.....

Date: \_\_\_\_\_

**Approved by the Auckland University of Technology Ethics Committee on 13<sup>th</sup> April 2012, AUTEK Reference number 12/59.**

*(Note: The Participant should retain a copy of this form).*

## Appendix C: AUT Ethics Approval



# MEMORANDUM

*Auckland University of Technology Ethics Committee (AUTEC)*

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To: Denise Wilson  
From: Rosemary Godbold, Executive Secretary, AUTEC  
Date: 23 October 2012  
Subject: Ethics Application Number **12/59 Optimizing Maori women's breastfeeding.**

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Dear Denise

Thank you for your request for approval of amendments to your ethics application, which was approved by Auckland University of Technology Ethics Committee (AUTEC) on 13 April 2012. I am pleased to advise that I have approved a minor amendment to your ethics application allowing the recruitment of an additional participant. This delegated approval is made in accordance with section 5.3.2 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement by AUTEC at its meeting on 12 November 2012.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 13 April 2015;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 13 April 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact

details may be found in the Ethics Knowledge Base at <http://www.aut.ac.nz/research/research-ethics/ethics>).

On behalf of AUTEK and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold  
Executive Secretary  
**Auckland University of Technology Ethics Committee**

Cc: Isable Tui Rangipohutu Edwards red.and.trui@gmail.com

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