

The meaning of breastfeeding
support
for six New Zealand mothers
in the first six weeks postpartum.

A thesis submitted to Auckland University of
Technology in fulfilment of the requirements for the
degree of Master of Health Science (Midwifery)

Barbara Lorraine Richards

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Abstract

Research has found that any support given to a breastfeeding woman will positively impact on the initiation and duration of her breastfeeding. While much of the research that examines breastfeeding is focused on the need to improve support for breastfeeding women, there has been a lack of clear understanding on what constitutes support. The research statement for this study was “The meaning of breastfeeding support for six New Zealand women in the first six weeks postpartum.” Van Manen’s (1990) steps for data analysis guided the interpretation for this study, and a hermeneutic thematic analysis explored the meaning of breastfeeding support for six New Zealand women.

Three themes were identified from the data analysis: ‘Being With’, which is more than being physically present, it is an active engagement with the woman. ‘Breastfeeding Culture’, which acknowledges that no woman breastfeeds alone. There are family, friends and others whose beliefs, traditions, and their own interpretation of breastfeeding all impact on the woman’s breastfeeding experience. ‘Breastfeeding Space’ is the third theme, and this describes not only the physical space, but also the emotional space a woman breastfeeds in. When the Breastfeeding Space was comfortable and they felt in control of the space, the women in the study felt supported to breastfeed.

A new finding, which was not a theme but rather a thread drawn from the themes, was the notion of a Breastfeeding Triad. The Breastfeeding Triad included a breastfeeding mother, her partner, and their baby. The Breastfeeding Triad was found to be relational, incorporating the authentic presence of ‘Being With’ and adding to it. When family, friends and health professionals support the Breastfeeding Triad, this strengthens the breastfeeding relationship itself.

There are several implications for practice from the findings. For those in a position of decision-making within hospitals, the environment needs to be a priority when planning new rooms. It is difficult for women to feel in control of their Breastfeeding Space when they must share a room or bathroom, or when they want their partners to stay but the hospital does not support this.

Health professionals could benefit from the findings by acknowledging the Breastfeeding Culture that surrounds a breastfeeding woman. By including her whānau/family and other support people, a link can be made between the breastfeeding woman and those who will be providing ongoing support to her once the health professional is no longer part of her care. For those involved in antenatal and breastfeeding education, partners could be included and given information that is specific to them. These findings could also benefit students by giving them a clearer understanding of what it is that supports New Zealand women to breastfeed in the first six weeks postpartum.

Key words: breastfeeding; breastfeeding support; being with; breastfeeding culture; breastfeeding space.

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A handwritten signature in blue ink, consisting of the letters 'BR' followed by a small dot.

08 August 2017

Chapter 1 Orientation to the study

This study explores the meaning of breastfeeding support for six New Zealand mothers in the first six weeks postpartum. The first six weeks are significant in establishing breastfeeding, although women who feel well supported to breastfeed may breastfeed for longer. Breastfeeding for at least six weeks is important, as breastfeeding has significant benefits for both mother and baby. The health benefits for a mother who breastfeeds for at least six weeks, include reducing postpartum bleeding and returning to pre pregnancy weight earlier (American Dietetic Association, 2009; Kramer, 2010; McGovern, 2014; World Health Organization, 2016). For women who breastfeed for longer, the benefits increase significantly, having an impact on maternal metabolic health and reducing the risk of obesity in later life (Schwarz & Nothnagle, 2015). Breastfeeding also reduces the risk of maternal diabetes mellitus and hyperlipidemia. Even breastfeeding for one month, can significantly decrease the risk of diabetes in later life, compared with mothers who do not breastfeed at all. Breastfeeding can also lower the risk of heart disease and hypertension, according to Schwarz & Nothnagle (2015), as breastfeeding affects maternal hormone levels including oxytocin, prolactin, and cortisol.

For a breastfed baby, the benefits include: breastmilk providing optimal nutrition, assisting with a baby's physical and emotional development, a reduction in the incidence of infectious diseases, reducing infant mortality, and according to Kramer's 2010 randomised controlled trial, a statistically significant increase in vocabulary and verbal IQ scores for the 6.5 year follow up of children (Kramer, 2010). While the benefits of breastfeeding appear obvious, the road to successful breastfeeding appears less obvious. The question that led to this study being undertaken was: 'as a nation, as a community, as a midwife, how is support for breastfeeding best given?' This eventually led to the Research Question itself: What is the meaning of breastfeeding support for New Zealand women in the first six weeks postpartum?

The research statement and the aims of the study are overviewed in this chapter. Breastfeeding support is defined, along with the impact of support on breastfeeding. The background and justification for the study, the importance of breastfeeding and the influences that may impact upon breastfeeding rates, are discussed. A brief history of breastfeeding in New Zealand from colonisation to the present provides a background for the following chapters. An overview of the methodology and methods is also given,

along with a discussion of my pre-understandings. A brief overview of each chapter in the thesis follows.

1.1 Research Statement and Aims of the Study

The Research Statement is: “The meaning of breastfeeding support for six New Zealand women in the first six weeks postpartum.”

The aims of the study are:

- to analyse and understand the meanings of breastfeeding support that are experienced by six New Zealand women in their first six weeks postpartum
- To discover what supports breastfeeding for these six New Zealand women

1.2 Definitions used throughout this study

The World Health Organisation (World Health Organization, 2016) defines Exclusive breastfeeding as:

“having only breastmilk (from the breast or expressed) and prescribed medicines since birth.”

Fully breastfeeding is defined as:

“an infant having breastmilk only and no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours.”

These definitions from WHO (2016) are also used by the New Zealand Ministry of Health, and Plunket New Zealand. WHO (2016) also recommend:

“Breastfeeding exclusively for the first six months of a baby’s life for optimal growth, development and health. Breastfeeding should continue with nutritionally safe and adequate complementary foods for up to two years and beyond.”

The Oxford Dictionary of English ("Support," 2016) defines ‘support’ as: giving assistance to; giving approval, comfort and encouragement to; being actively interested in and concerned for the success of. Breastfeeding support has been defined by Kronborg, Harder, and Hall (2014), as facilitating a woman’s transition to her new role of a breastfeeding mother, teaching a new mother to read her baby’s cues, and also building a mother’s confidence in her ability to breastfeed and nurture her new baby.

Support can be from a breastfeeding mother's partner, family, and wider community, including health professionals such as midwives and Well Child/Tamariki Ora providers in New Zealand. In this study, support is defined from the perspective of the breastfeeding women themselves.

1.3 Background and Justification for the Study

Over the past twenty years, breastfeeding and its benefits have been extensively researched (Barclay et al., 2012; Britton, McCormick, Renfrew, Wade, & King, 2007; Hall, McLelland, Gilmour, & Cant, 2014; Hausman, 2003; Kronborg et al., 2014; McBride-Henry & Clendon, 2010; Ministry of Health, 2013; New Zealand Breastfeeding Alliance, 2012; Schwarz & Nothnagle, 2015; Scialli, 1995; Shaw, 2014; World Health Organization, 2016). The documented benefits of breastfeeding are clear, and for the breastfeeding mother these include lowering the risk of obesity, heart disease, diabetes and osteoporosis. For babies who are exclusively breastfed, the benefits include a decreased risk of diarrhoea, pneumonia and neonatal sepsis (Association of Women's Health Obstetric & Neonatal Nursing, 2011; Khresheh, Suhaimat, Jalamdeh, & Barclay, 2011; McLachlan et al., 2014). Despite the World Health Organisation's (2016) recommendations that infants should be exclusively breastfed for the first six months of life, breastfeeding often does not continue past the first six weeks (Dykes & Flacking, 2010; McBride-Henry, 2010). Some of the reasons given for early discontinuation of breastfeeding include early return to work, where there is often limited support; pain and nipple trauma, maternal anxieties and attitudes that impact on breastfeeding success (A. Brown & Davies, 2014).

Breastfeeding statistics from the Ministry of Health (2015) show that exclusive breastfeeding rates at discharge from New Zealand Baby Friendly Hospital Initiative (BFHI) hospitals and birthing units in 2014, averaged 82.2% (Ministry of Health, 2015). While these figures are very good, there is ample literature, both New Zealand and international, that discusses how the duration of breastfeeding needs to improve (Kornides & Kitsantas, 2013; McBride-Henry & Clendon, 2010; McLachlan et al., 2014; Radzyminski & Callister, 2016). While there are many articles discussing breastfeeding support from a health professional's point of view (Aksu, Kucuk, & Duzgun, 2011; Barclay et al., 2012; Britton et al., 2007), there has been an increase in the number of studies that examine what support the breastfeeding woman herself values (Bridges, 2016; Craig & Dietsch, 2010; McBride-Henry, 2010; Sherriff & Hall,

2011; Sherriff, Panton, & Hall, 2014). This research includes a Cochrane Review of over one hundred randomised controlled studies, which examined whether ‘extra support and good care’ contributes to women breastfeeding for longer (McFadden et al., 2017, np). The Cochrane Review will be discussed further within the literature review.

1.4 Benefits of breastfeeding

The benefits of breastfeeding are very well documented within the literature, however the primary health benefits of breastmilk and breastfeeding tend to dominate, compared with the overall health and psychological benefits to a mother and baby. The most commonly stated benefits for infants who are breastfed are a lower risk of diabetes and a reduced risk of childhood leukaemia. Infants may have fewer allergies and dental problems, experience less illness and are more likely to have higher intelligence quotients (IQs) (American Dietetic Association, 2009; Foss, 2010; Kukla, 2006; Ministry of Health, 2016; World Health Organization, 2016). The benefits for breastfeeding mothers are also well documented, with the most common benefits cited being: a reduced risk of breast cancer, especially when breastfeeding for more than one year; a decreased risk of ovarian cancer; a decreased risk of developing Type 2 diabetes; a reduced risk of hip fractures in postmenopausal women; postpartum weight loss, and a decrease in postnatal depressive symptoms (Aksu et al., 2011; American Dietetic Association, 2009; Khresheh et al., 2011; Kramer, 2010; World Health Organization, 1989).

1.5 What influences the initiation and duration of breastfeeding?

The initiation rates of breastfeeding in New Zealand have improved since the advent of the Baby Friendly Hospital Initiative (BFHI) in 2000. In the year 2000, only 50% of babies were exclusively breastfed at discharge from hospital, whereas following the introduction of the BFHI, by 2015 this figure had risen to approximately 82% (Ministry of Health, 2015). At six weeks postpartum, the combined exclusive and fully breastfeeding rate has dropped from the initiation rate of 82%, to 67% (Ministry of Health, 2015). According to the Ministry of Health (2015), these figures drop again to 56% at three months and then again to 27% by six months postpartum. This could be because babies have often been introduced to solids prior to six months of age, which would impact on the exclusive/fully breastfeeding data. In New Zealand, District Health Boards provide the Ministry of Health with breastfeeding data, which is

collected from New Zealand Breastfeeding Alliance (NZBA), and the Well Child / Tamariki Ora providers.

The BFHI's Ten Steps to Successful Breastfeeding was aimed at protecting and promoting breastfeeding throughout maternity systems. It was innovative for hospital births for its time, initiating skin-to-skin contact between a mother and her baby, and ensuring that babies remained in the room with their mothers (Bartle, 2015). Giving mothers time to get to know their new babies and supporting women to breastfeed when their babies were ready following skin-to-skin contact, was common practice for home births, but less common for hospital births at that time. The BFHI initiative also aimed to document historical influences on breastfeeding in New Zealand, provide evidence-based standards for national assessment, and to provide standards relevant to the New Zealand context (New Zealand Breastfeeding Alliance, 2013). The BFHI was initially launched by the World Health Organisation (WHO) and United Nations International Children's Emergency Fund (UNICEF) in 1991, following the Innocenti Declaration of 1990, to which New Zealand was a signatory (Martis & Stufkens, 2013). Despite education and resources given to improve the initiation and sustaining of breastfeeding until the baby is two years of age, the worldwide rates of breastfeeding remain below the standard required by the World Health Organisation (Ministry of Health, 2016; World Health Organization, 2016).

Factors affecting the duration of breastfeeding are complex, however according to the literature, the most common reason for stopping breastfeeding, is perceived insufficient breastmilk (Beasley, 1991; Fenwick, Burns, Sheehan, & Schmied, 2012; Kornides & Kitsantas, 2013; Radzyminski & Callister, 2016). Other reasons cited for stopping breastfeeding are painful nipples, breast infections, unrealistic expectations, going back to work, and being the only person able to feed her baby (American Dietetic Association, 2009; Arora, Gay, & Thirukumar, 2012; Bainbridge, 2005; Barnes, 1999; Beasley, 1991; Bridges, 2016; Davis & Walker, 2010; Glover, Waldon, Manaena-Biddle, Holdaway, & Cunningham, 2009; Hausman, 2003; McBride-Henry, 2010).

A United States study by Kukla (2006), found that women with a history of sexual abuse may be intimidated by breastfeeding, as it meant exposing themselves, which could trigger unpleasant memories and post-traumatic stress disorder. Home may not be a safe place for some women, as they may be dealing with intimate partner violence (Kukla, 2006). In New Zealand intimate partner violence is an important consideration,

with estimates of 35.4% of women having experienced rape, physical violence or stalking by their partner, in their lifetime (Gulliver & Fanslow, 2015).

The culture that surrounds a breastfeeding woman can have a significant impact on whether, and for how long, she will breastfeed (McBride-Henry, 2010). In today's Western society, women may return to work quickly, often within weeks of giving birth (Payne & Nicholls, 2009). While New Zealand does offer paid parental leave, this is limited to 18 weeks (Inland Revenue Te Tari Taake, 2016), and while there is the exhortation to breastfeed, there is little concrete support offered, in terms of household help, free breast pumps or free lactation consultant services, once the woman has left hospital (Palmer, 2011).

1.6 New Zealand and the Lead Maternity Carer model

New Zealand has a unique maternity system, where pregnant women can choose a Lead Maternity Carer (LMC), who may be a midwife, general practitioner or obstetrician, and who will provide continuity of care throughout a woman's pregnancy, labour and birth, and the postpartum period for up to six weeks (Guilliland & Pairman, 1994). Midwives are qualified to care for low risk, healthy women, but are able to refer to the hospital or private obstetrician if required. The continuity or LMC model of care, provides the basis for a partnership between the woman and her whānau¹/family, and her midwife (Guilliland & Pairman, 1994). New Zealand maternity care is fully funded by the New Zealand government for those born in New Zealand, or have citizenship or permanent residency.

1.7 A brief history of breastfeeding in New Zealand

Prior to colonisation in the nineteenth century by Europeans, Māori history was verbal rather than written, therefore little written records of Māori breastfeeding practices exist (McBride-Henry & Clendon, 2010). It is beyond the scope of this thesis to explore the history of Maori women's breastfeeding practices prior to colonisation, however from what is known, breastfeeding was the main source of nutrition for Māori infants prior to colonisation by European settlers.

¹ "Whānau is often translated as 'family', but its meaning is more complex. It includes physical, emotional and spiritual dimensions and is based on whakapapa (genealogy). Whānau is based on a Māori and a tribal world view. It is through whānau that values, histories and traditions from the ancestors are adapted for the contemporary world." (Walker, 2017)

English immigrants to New Zealand tended to follow similar practices to those they had left behind and while Queen Victoria used a wet nurse to breastfeed all her children, this still influenced the women of the time to breastfeed (Yalom, 1997). Prior to 1900, there was no commercial formula available in New Zealand, and breastfeeding was considered to be the responsibility of the mother. During the latter part of the 19th century New Zealand's infant mortality was considered high. The death rate was 79/1000 live births, for babies born of European descent (McBride-Henry & Clendon, 2010). By the end of the nineteenth century, the medical profession had begun to oversee the growth and wellbeing of babies in an effort to improve the infant mortality rate (Davidson, 1984). According to Apple (1994), medicalisation is 'the involvement of medical practitioners in areas of life previously outside medicine' (p31) and in particular, the area of infant feeding (Apple, 1994).

The Royal New Zealand Society for the Health of Women and Children (now known as Plunket: named after an early patron of the society Victoria Plunket who had 8 children and was the wife of William Plunket), was introduced in 1907, bringing a more scientific and medicalised approach to infant feeding. The founder Dr Truby King, had been studying dairy farming and milk production. His belief was that by strict routine, and using a 'humanised' cows' milk formula to either supplement or replace breastfeeding altogether, the mortality rate would improve (Apple, 1994; Davidson, 1984; McBride-Henry & Clendon, 2010). In New Zealand, the use of artificial breastmilk formula (which was modified cow's milk, not the formula that is readily available today), became much more widely accepted as an alternative to breastfeeding. King marketed this new formula as 'humanised milk', which was very effective as a marketing tool (McBride-Henry & Clendon, 2010). The 1920s became a decade of significant change for birthing women, as the medical profession began to have much greater influence and control over both birthing and infant feeding practices, in an effort to reduce the infant mortality rate.

Hospital births increased to 60% by the late 1920s. This meant that women stayed in hospital for fourteen days, where rigid feeding schedules were in place for both breastfed babies and those on infant formula. The nursing and midwifery staff limited feeds to four hourly, no breastfeeding at night, and babies were weighed after each feed to supposedly ensure an adequate intake of fluid. This led to a significant reduction in the number of women breastfeeding (Apple, 1994; McBride-Henry & Clendon, 2010).

In the early 1950s a group of women formed Parents' Centre in order to introduce antenatal education for women, and became politically active, asking for a woman's voice to be heard in relation to birthing and feeding her baby (McBride-Henry & Clendon, 2010). Through the 1960s, feminism had an impact on the way New Zealand women began to see birthing and breastfeeding, developing their own language and taking back ownership of their bodies and their babies from the medical profession. However, despite this change, by 1968 only 47% of New Zealand women were breastfeeding their babies. This was a significant drop from the 1920s when 87% of babies were breastfed (Royal New Zealand Plunket Society, 1995).

The Le Leche League was formed in the United States during the mid-1960s, and on April 25th 1964 it was also established in New Zealand. The Le Leche League formed in the United States may have been the first group of women that believed support for breastfeeding was important. This was a formal support group for breastfeeding mothers and their belief was that mothers who were themselves breastfeeding, were the best people to advise other mothers on breastfeeding. The La Leche League encouraged women to have unlimited access to their babies while in hospital, time on the breast to be unlimited and for as long as the child chose to breastfeed (McBride-Henry & Clendon, 2010).

During the 1970s and 80s, there was an increase in the number and quality of studies undertaken, which examined the benefits of breastfeeding for both mother and baby. These studies all showed the nutritional superiority of breastmilk over artificial formula (Apple, 1994; Gordon, 1998; Kedgley, 1996; McBride-Henry & Clendon, 2010). The Ten Steps to Successful Breastfeeding was introduced by WHO in 1989 and was a global initiative to guide and encourage all maternity units to protect, promote and support breastfeeding (World Health Organization, 1989). The Baby Friendly Hospital Initiative (BFHI) was introduced in New Zealand in the year 2000. This was also a global initiative, launched by WHO (1991) and UNICEF (1991), which recognised that implementing both the Ten Steps to Successful Breastfeeding and the BFHI into health services, is crucial to the success of breastfeeding programmes (New Zealand Breastfeeding Alliance, 2000).

1.8 Does support influence initiation and duration rates of breastfeeding?

How breastfeeding support is offered, has been shown to be critical, not just to the initiation of breastfeeding, but to the duration of the breastfeeding relationship (Burns, Fenwick, Sheehan, & Schmied, 2013; Dykes & Flacking, 2010; Sherriff & Hall, 2011). According to a recent Cochrane Review (McFadden et al., 2017), if women can be supported to breastfeed in the first six weeks postpartum, they are more likely to continue to breastfeed for longer. This review also provided evidence that all forms of extra support showed an increase in the length of time that women continued to breastfeed (McFadden et al., 2017). There have been many factors recognised in the literature that identify how support impacts on breastfeeding, and these include health professional education, appropriate antenatal education, skin-to-skin contact between a mother and her baby, keeping mother and baby together, encouraging baby-led breastfeeding, and arranging peer support for mothers once discharged home from hospital and in the first six weeks postpartum (Dykes, 2006; McBride-Henry, 2010). More recent research is beginning to show the importance of support provided by partners (Mithani, Premani, Kurji, & Rashid, 2015; Sherriff & Hall, 2011; Sherriff et al., 2014).

1.9 Overview of Methodology

The research statement of this study is “The meaning of breastfeeding support for six New Zealand mothers in the first six weeks postpartum.” The study participants were all breastfeeding their babies at the time of the interview; some as first time mothers, some who had breastfed before. The study sought to hear from breastfeeding women themselves, to identify what support means to them.

The aims of the study are:

- To analyse and understand the meanings of breastfeeding support that is experienced by six New Zealand women in their first six weeks postpartum
- To discover what supports breastfeeding for the six New Zealand women

This study sought to understand the meaning of breastfeeding support, therefore an interpretive hermeneutic phenomenology was found to be the right fit for the research, as it is a methodology that seeks to understand what lies beneath the obvious, the day-to-day living. The analysis was also guided by van Manen’s (1990) lifeworld

existentials of lived body, lived time, lived space and lived human relationality.

Van Manen (1990) felt these lifeworld existentials “serve as guides for reflection in the research process” (p101).

Hermeneutics is interpretive, therefore my interpretation of what the women shared when interviewed, will colour how I interpret what is said, and also what is written.

While Husserl (1859-1938) believed these pre-understandings were able to be bracketed, or acknowledged then put aside, Heidegger believed this was not possible (van Manen, 1990). Instead, Heidegger calls for these pre-understandings, beliefs, assumptions, and our already knowing-ness to be brought to the forefront, made explicit and put in plain view. Van Manen (1990) called this “Explicating assumptions and pre-understandings” (p46), in his book *Researching Lived Experience*.

1.9.1 Pre-understandings

Pre-understandings are important to recognise in this methodology, as they create the foundation upon which any future understandings of the topic being researched will rest. Hermeneutics is the “science or art of interpretation” (Grondin, 1991, p1; as cited in Smythe, 2007), but in order to interpret something, there must be some pre-understanding of it first. Heidegger suggested that interpretation always occurs, in every encounter, and this must be interpreted by the social context of the person, their background, history, and philosophy. Once the researcher is able to acknowledge and come to some understanding of their own pre-understandings, they can then begin to interpret the lived experiences of others.

The pre-understandings of breastfeeding support which I bring to this study are based on my background of being a young and new mother initially, then with my experiences of struggling to breastfeed my next two babies. By the time I was pregnant with my fourth baby, I was determined that nothing would stand in the way of successfully breastfeeding this child. Breastfeeding was something I knew nothing about when I had my first baby at 17 years of age. I assumed it was something that just happened and I was totally unprepared for how I felt about it. In 1974, when my daughter was born, there was plenty of formula available, however there was an expectation that a new mother would try and breastfeed. Nurses and midwives would open my top and grasp the breast to ‘attach’ the baby. There was no teaching, no respect for my body or how I felt about being touched; it was the right of the health professional to do whatever was necessary for the good of the mother and her baby.

Thankfully much had changed by the time I had my fourth baby in 1982. However I found that babies were not allowed to room-in with their mothers until the fourth day. Formula was given to every baby during the night so the mother could sleep. I was determined to successfully breastfeed this baby, as I had not been able to do for the other three, so I stood outside the nursery door to ensure he was not given formula at any time.

Ten years later I trained as a midwife, and those early experiences impacted on how I wanted to be with women. I wanted to encourage women to breastfeed without making them feel like ‘bad mothers’ if they chose not to. In some ways, I felt I was fortunate to have experienced both the highs and the lows of breastfeeding. I thought I understood how it felt to be pressured into breastfeeding, regardless of how I felt about it. I also knew what it felt like to fail at breastfeeding, despite my best intentions. When it came to working as a midwife, I approached breastfeeding as someone not wanting to pressure women to breastfeed, but to fully support their own decisions on how to feed their babies.

Over the years of being a midwife, I feel I have developed the skill of supporting women, encouraging them to learn at their own pace, and meeting them where they are at that particular point in their lives. I have learned that women change and grow as they have more children, just like I did. There can be a fine line between encouraging a woman to breastfeed, and putting so much pressure on her that she feels a failure if unable to breastfeed. It is from this perspective that I come to this study, with my own pre understandings, but also with an openness to hear women’s experiences of the support that they had for initiating and sustaining breastfeeding for 6 weeks or more.

1.10 Structure of the Thesis

Chapter One: Orientation to the study

This chapter provides the background and context for the Research Statement, and the study itself.

Chapter Two: Literature Review

This chapter examines the research to gain an understanding of what is already known about support for breastfeeding.

Chapter Three: Methodology and Study Design

This chapter discusses the methodology chosen, and the reasons this was the best fit for the study. Study design, including ethical considerations, methods of sample selection, data collection, data analysis and rigour are discussed.

Chapter Four: Findings – ‘Being With’

In this chapter, the emergence of the themes is analysed and discussed. ‘Being With’ is more than just being present physically, it is an active participation in the negotiated relationship with the woman, her partner, and her family/whānau (O'Boyle, 2013).

Chapter Five: Findings – Breastfeeding Culture

This chapter discusses the second theme identified from the data, which is a Breastfeeding Culture. This can be defined as the breastfeeding customs, beliefs, traditions, and ways of being, that surround breastfeeding women.

Chapter Six: Findings – Breastfeeding Space

This chapter explores the third theme that emerged from the data, Breastfeeding Space. This chapter discusses how the women in the study felt supported when they felt in control of the Breastfeeding Space, both in hospital and at home.

Chapter Seven: Discussion

This chapter discusses the conclusions drawn from the themes, and answers the research question. The implications that the findings may have on education, midwifery practice, and future possibilities for research are discussed, along with the strengths and limitations of the study. The thesis closes with a comprehensive reference list, and Appendices.

1.11 Conclusion

Breastfeeding is important for both the breastfeeding mother and her baby, and while the initiation rates of breastfeeding have continued to improve over the last several years, the duration of breastfeeding has not. The benefits of breastfeeding for both mother and baby have been discussed in this chapter and these benefits are supported by current research. While the benefits of breastfeeding are not in doubt, what appears to be more elusive is the meaning of support for breastfeeding. The study sought to hear from breastfeeding women themselves, to identify what support means to them.

The following chapter will examine and discuss the literature that was reviewed for this study.

Chapter 2 Literature Review

A literature review is an essential tool to understanding what has already been written about a topic. Following van Manen's (1990) recommendation, the literature was examined in depth after analysing the data for themes. Van Manen (1990) stated that "if one examines existing human science texts at the very outset then it may be more difficult to suspend one's interpretive understanding of the phenomena" (p76). Initially a literature search was completed to gain knowledge of what was already known about support for breastfeeding mothers. Once the data analysis was complete, a more in-depth literature was conducted. This chapter begins with a discussion of how breastfeeding support is defined in the literature, and will include some of the influences that contribute to the initiation and duration of breastfeeding. Breastfeeding support will be examined in more depth, discussing what support means and from whose perspective. Any gaps and tensions within the literature will also be examined and discussed.

The literature review includes both international and New Zealand literature, as this enables the reader to situate the knowledge and understanding of breastfeeding support into the New Zealand context. The literature that was reviewed was accessed through AUT's library search engine, and included Ebsco, Medline, CINAHL, Google Scholar databases, and an example of the key words and phrases which were used are: breastfeeding and support; breastfeeding and family; breastfeeding and culture; breastfeeding and New Zealand. Support was searched under different schools of thought, for example teaching and support; emergency workers and support.

Van Manen (1990) asked whether one should read other phenomenological articles in the early or latter part of research. He suggests that while it is necessary to learn what the gaps are in the literature, a thorough search should be done after the data analysis is completed. In view of van Manen's (1990) suggestion, a review of the literature was limited to breastfeeding support before commencing the study, and this highlighted the gaps that became the focus of the study.

2.1 How Breastfeeding Support is defined in the literature

Various aspects of support are noted in the literature, however few studies gave a definition of support, or discussed what breastfeeding support might mean (Abbass,

Stern, Nelson, Watson, & Dennis, 2015; Bunik et al., 2010; Chapman et al., 2013; Cisco, 2017; Clifford & McIntyre, 2008; Ekstrom, Widstrom, & Nissen, 2006).

Several studies have noted the importance of supportive relationships, in particular, the supportive relationship between a breastfeeding woman and her partner/significant other (A. Brown & Davies, 2014; Cisco, 2017; Clifford & McIntyre, 2008; Sherriff & Hall, 2011; Sherriff, Hall, & Pickin, 2009; Sherriff et al., 2014). Brown & Davies (2014) used a qualitative method for a study which was undertaken in the United Kingdom. One hundred and seventeen men (whose partner had given birth within the previous two years and had initiated breastfeeding), were asked to complete an open-ended questionnaire which explored their experiences of breastfeeding, including the information and support they had received. They also asked for their ideas on future breastfeeding education and promotion that could be aimed at fathers. While this study recognised the importance of support, there was no explanation of support, or provided a definition of what it meant in this particular study.

In contrast, support was clearly defined in Cisco's quantitative study (2017) which examined the investment of kin in supporting breastfeeding in the United States. The support criteria outlined were: emotional support and encouragement, childcare, or assistance with breastfeeding difficulties, and/or financial support. This study was undertaken with a cultural anthropological lens, and examined support offered by kin, including partners, grandparents, and other extended family. Cisco (2017) found that maternal support (from mother/grandmother), was less likely to be available in high income countries where the population is very mobile, and parents tended not to live with their adult children. Although this study was not taken from the perspective of a breastfeeding mother, it was none the less informative, offering a different view of who offers breastfeeding support. It showed that, perhaps maternal grandmothers are undervalued in terms of breastfeeding support and education. There is potential for the invitation from antenatal or breastfeeding classes being extended from the prospective mother and her partner, to include their parents and grandparents who may be just as invested in supporting their breastfeeding mothers, as partners or health professionals.

Two small UK qualitative studies (Sherriff & Hall, 2011; Sherriff et al., 2009) focused on the benefits of father support to promote breastfeeding, although neither of these studies gave a definition of support. In a later study by Sherriff, Panton & Hall (2014), the concept of 'father support' was defined, as it was found that 'father support' was not clearly understood by either the parents or health professionals. This UK study was a

concept analysis, which drew on aspects of the evolutionary model of concept development. The study revealed that there were five essential defining aspects of father support: ‘Knowledge about breastfeeding; positive attitude to breastfeeding; involvement in the decision-making process; practical support, and emotional support’ (p21). This could also be extended to others who are committed to supporting a breastfeeding mother, for example grandparents. While they may not be so involved in the decision making process, they may want more information and knowledge about breastfeeding, as well as how they can offer more practical support.

Datta, Graham, and Wellings (2012) study, invited both men and women (18 people altogether), to participate in telephone interviews to discuss the role of fathers in breastfeeding, decision making and support. While support was not specifically defined, all the fathers interviewed spoke of both practical support, which included cleaning, cooking, or childminding of older children, and emotional support, which included encouragement, reassurance and showing affection.

Support appears to be a ‘taken-for-granted’ notion, that does not need defining; however each person will come to their research with their own ‘already knowing’ which may be quite different to mine. Gadamer (1982) spoke of ‘prejudice’, although as E. Smythe and Spence (2012) stated in their article on literature reviews, prejudice can have negative connotations; this is not what Gadamer intended. Gadamer (1982) was talking of acknowledging our assumptions, rather than ignoring them: ‘prejudice means a judgement that is rendered before all the elements that determine a situation have been finally examined’ (p273). Support can mean many things to many people, and research is strengthened when pre-understandings of terms are clearly laid out.

2.2 Breastfeeding support from a breastfeeding mother’s perspective

Kronborg et al. (2014), used a qualitative method to analyse data from 108 Danish first-time mothers, aimed at prolonging the breastfeeding duration, by improving maternal confidence. Kronborg et al. (2014) found that breastfeeding support included facilitating the woman’s transition to her new role of breastfeeding mother, teaching her to read her baby’s cues for breastfeeding and building up her confidence to breastfeed and nurture her new baby. Support came from a midwife, a Lactation Consultant or other health professional (Kronborg et al., 2014). Denmark is known for its 14 week paid maternity leave, followed by a 32 week paid parental leave. According to

Kronborg et al., (2014), the breastfeeding initiation rate is 98%, with 60% of women continuing to breastfeed until the baby is at least four months old. Kronborg et al (2014) found there was a need to understand the personal stories of breastfeeding mothers, which would guide practice, and improve knowledge and understanding.

A. Brown (2016), UK study used a retrospective mixed methods approach to explore mothers' perceptions of breastfeeding education and promotion messages. This study engaged 1130 mothers, to complete a questionnaire exploring their attitudes to breastfeeding support and promotion. The main themes identified by the women were: breastfeeding needed to be normalised rather than seen as 'best'; a focus on the wider benefits of breastfeeding rather than just the health benefits of breastfeeding, and reiterating that every breastfeed is important, rather than focusing on six months exclusive breastfeeding, which is encouraged by WHO (2016). All the women who participated in this study had planned to breastfeed, so this study may have shown different results if it had been open to all women.

A recent New Zealand qualitative study by Alianmoghaddam, Phibbs, and Benn (2017a), recruited thirty heterosexual women (who had also identified that they intended to exclusively breastfeed for six months), and who were interviewed after the birth of their baby, followed up monthly by telephone for six months. The aim of this study was to investigate the influence of male family members' support for breastfeeding. Unfortunately, support itself was not defined in this study. According to Alianmoghaddam et al. (2017a), support from a male partner included having a favourable attitude towards breastfeeding, and was considered to be more important to these women than support from a health professional. Partners were found to offer both emotional and practical support to the breastfeeding women, and supported them when breastfeeding in public. One of the interesting findings that emerged from this New Zealand study, was the unexpected support found from 'other' male family members, for example the father, or father-in-law, or brother of a breastfeeding mother. This study has perhaps opened a new avenue for further research.

2.3 Breastfeeding support and fathers

Sherriff and Hall (2011) study found that fathers were often neglected by service providers, where the only focus appeared to be on the pregnant or breastfeeding woman. They also found in their study that there was a 'no use' discourse surrounding fathers,

where they were perceived to be “unable to cope, childlike, difficult to cope with, unable to take responsibility, and lacking either in practical or emotional commitment to family life” (p469). Fathers may feel frustrated by their inability to help, as men tend to need to resolve or fix perceived issues. The father of the baby may be one of the most influential persons that is close to the mother, and without their support, the initiation and duration of breastfeeding may well be curtailed (Sherriff et al., 2009).

In contrast, the Australian study by Burns et al. (2013) found that fathers were seen by their partners as ‘protectors’ rather than as equal partners in the breastfeeding relationship. There is increasing evidence that partners play an integral role in supporting breastfeeding (A. Brown & Davies, 2014; Clifford & McIntyre, 2008; Mithani et al., 2015; Sherriff & Hall, 2011; Sherriff et al., 2014). Support from a father, beginning with the active participation in the decision to breastfeed, especially when made with knowledge and understanding of breastfeeding, has a strong influence on the woman’s initiation and duration of breastfeeding (Datta et al., 2012; Sherriff et al., 2009). The fathers in these studies, (from Scandinavia, United Kingdom, Pakistan and Australia), tended to see their role as being part of a team, where the breastfeeding mother took care of their baby, while the fathers took care of everything else. They provided emotional support, offering encouragement, reassurance and acts of affection, and these things were regarded as important by the breastfeeding mother.

Mitchell-Box and Braun (2012), conducted a qualitative grounded theory study to explore the male partner’s perceptions of breastfeeding. This research found that the (male) partner is increasingly regarded by breastfeeding women as an important support for breastfeeding, but is often excluded from the mother/infant relationship by health professionals (Mitchell-Box & Braun, 2012). They reported that while the mother/infant relationship is widely known as a ‘breastfeeding dyad’, this refers to the two parts of a pair, and automatically excludes the male partner. While the participants in my study did all have male partners, Mitchell-Box and Braun (2012) research appears to assume that all partners of breastfeeding women will in fact, be male.

2.4 Breastfeeding support and midwives

Burns et al. (2013) used a critical discourse analysis to examine how midwives identified support for breastfeeding women while in hospital in Australia. They found the dominant discourse to be ‘mining for liquid gold’, where the breastmilk was held in

high esteem. The second discourse was labelled ‘not rocket science’, where midwives viewed breastfeeding as natural and easy, depending on how committed the woman was. Then there were a few midwives in the minority, who viewed breastfeeding as a relationship between the mother and her infant.

Fenwick et al. (2012) also used a discourse analysis to explore the language and practices of midwives facilitating antenatal breastfeeding education sessions. They found four dominant discourses, which were: “there is only one feeding option: breastfeeding; selling the ‘breast is best’ message; convincing as many pregnant women as possible to commit to breastfeeding, and, arm the partners with as much information about the value of breastmilk” (p425). While these two Australian studies found similar attitudes within the midwifery field, Battersby (2014) from the UK, found there were both dichotomies and dissonance when examining the midwives’ role in breastfeeding. In order for midwives to create an authentic presence with the women in her care, sufficient time must be allocated by the hospital they worked in. When little time is available to the midwife, she may appear rushed, creating dissonance between what is desirable and what the midwife is actually able to achieve. Battersby (2014) examined the differences between what a midwife believes she needs to do, and the reality of working within an institution under considerable time constraints. Battersby (2014) also found that women could potentially see the promotion of breastfeeding as coercion, particularly when there was a lack of time to sit and talk with women and develop the relational aspects of breastfeeding.

In New Zealand and worldwide, there is a shortage of hospital-based midwifery staff and this significantly impacts on the time a midwife is able to give to each woman in her care (New South Wales Nurses' Association, 2016; Stodart, 2014). This in itself may impact on how midwives relate to the women they work with, as there will be a number of tasks that must be prioritised before their shift is over (Battersby, 2014). Kennedy, Shannon, Chuahorm, and Kravetz (2004) examined the complexities of midwifery practice in their narrative study, and found that ‘mutuality’ was one of the foundations of a relationship between a woman and her midwife (p14). Mutuality is built on trust, respect and alliance, and allows the relationship to be an equal one. Respect between a woman and her midwife, builds a relationship of trust, which in turn supports women to breastfeed. This principle is as important today, as it was in 2004.

McFadden et al. (2017), in their Cochrane review, defined breastfeeding support as being complex including several elements which can be emotional and esteem building, (reassurance and praise), practical help and informational. The review examined whether providing extra organised support for breastfeeding mothers would support them to continue to breastfeed, when compared with the standard maternity care. Various interventions were examined. For example, one study in the United States undertook two weeks of daily breastfeeding support. This was a randomized controlled study (RCT) and a qualitative study of telephone interviews, on a sample of 40 low income, primiparous, mainly Latina women in the study (Bunik et al., 2010). The support of daily telephone calls for two weeks was found to have no statistical effect on the duration of breastfeeding, although the qualitative interviews showed that the intervention was informative and helpful. These women found that breastfeeding was healthier, but harder; formula was found to be a good alternative. In the United States, there is usually no postnatal home visiting offered, therefore having two weeks of daily breastfeeding support was a significant difference when compared with standard maternity care. However, when examined with the overall results, any support given to breastfeeding women was found to increase the duration of breastfeeding.

Memmott and Bonuck (2006) used a qualitative method, where 11 women were interviewed to discover their reactions to a skills-based breastfeeding intervention, it was found that the Lactation Consultant was able to provide technical advice within the context of a relationship, which was built on trust, encouragement, guidance and support. The difference between the Bunik et al's (2010) study and Memmott and Bonuck's (2006) study appears to be the relational aspect which supported breastfeeding women. In the United States, antenatal care is predominantly carried out by doctors or obstetricians, and women would not usually have contact with a Lactation Consultant. Any discussion of infant feeding is at the discretion of the individual physician. In New Zealand, midwives are the predominant point of contact for pregnant, birthing and postnatal women. All birthing women see a midwife postnatally, regardless of her Lead Maternity Carer.

In another study that was included in the Cochrane Review (McFadden et al., 2017), the definition for 'exclusive breastfeeding' was only breastmilk (no water, other liquids or solids), but the definition for 'breastfeeding' was "any breastmilk and any other food or milk" (Bechara Coutinho, Cabral de Lira, de Carvalho Lima, & Ashworth, 2005). This study was situated in Brazil, where there are no home visits for postnatal women and

limited support for breastfeeding. This study compared the rates of breastfeeding using the usual hospital based system (where women birthed but were not offered any breastfeeding support) for the promotion of breastfeeding, and the other was allocated ten postnatal home visits. The findings showed a significant improvement in initiation of breastfeeding (70%) for the intervention group, compared with 21% previously; however this was unable to be sustained, and at ten days of age only 30% of babies were still being breastfed. According to McFadden et al. (2017) this study contributes to the evidence which confirms that any support provided for breastfeeding women, whether informational, or home visits, does have a positive impact, however small.

A Canadian RCT study evaluated the effectiveness of a co-parenting intervention (Abbass et al., 2015). This trial supported earlier studies that found when fathers were encouraged to be involved in breastfeeding education and support, breastfeeding initiation and duration increased. Overall, the Cochrane Review (McFadden et al., 2017) included over 100 randomized controlled studies from 29 countries, but the biggest percentage of women were from high income countries (60%), 34% from middle income countries, and only 4% from low income countries. The review excluded educational only support, and also excluded interventions that did not include a postnatal component. New Zealand has a maternity model based on continuity of care, with midwives involved in almost all New Zealand births; therefore it would be difficult to generalise these studies to that of New Zealand.

2.5 Breastfeeding support and culture

The society that a breastfeeding woman is part of, will have a significant effect on how she views and interprets her breastfeeding experience (McBride-Henry, 2010). Other studies have agreed with these findings. For example, Kronborg et al. (2014) found that breastfeeding is embedded in cultural and social understandings. Where there are low breastfeeding rates (especially after six months), the opportunity for women to see other women breastfeeding is less and less, thereby impacting on the overall breastfeeding culture, which means less and less support for the breastfeeding woman.

False expectations and the impact on breastfeeding is discussed in Thomson and Dykes (2010) study, where for some women, the reality of breastfeeding was trying, difficult or painful. According to an earlier study by Dykes (2006), lack of knowledge and support within a community may adversely affect breastfeeding. These findings were

supported by Kronberg, Harder & Hall's (2014) study, where the mothers they interviewed found everyone had an opinion on how to breastfeed, and this may have created feelings of confusion.

2.6 Conclusion

Breastfeeding support is an intensively covered topic in the research; however there appears to be a lack of consistency in the definition of exactly what support might mean and to whom. This literature review has highlighted what has been found in the literature that does support breastfeeding women, particularly in the first six weeks postpartum. Breastfeeding support has been examined from the perspective of a breastfeeding mother herself, and over the last three years, this has been under the spotlight more. Partners have been found to provide significant support, with emotional support being offered, as well as practical support. Several studies found that the wider family is often undervalued, and when grandparents, in-laws, father, brothers, and sisters of the breastfeeding mother are included in support situations, it increases both the initiation and the duration of breastfeeding. It is vital that women themselves are given their own voice to express their needs in terms of support, and this study sought to address this.

The following chapter discusses the research design and methodology for this study, and the purpose of this study is to understand the meaning of breastfeeding support, from the perspective of the breastfeeding mother herself.

Chapter 3 Research Design and Method

Understanding what philosophical paradigm forms the basis of research is vital, as each researcher approaches their research question from a different perspective. This study sought to understand the meaning of breastfeeding support, therefore an interpretive hermeneutic phenomenology was found to be the right fit for the study. Hermeneutic phenomenology seeks to examine phenomena, while acknowledging there is no one way, or right way of interpreting it. This chapter includes an explanation of the research design and method used for this study. Van Manen's (1990) steps for data analysis guided the interpretation for this study, using hermeneutic thematic analysis to encourage the voices of women's experiences of breastfeeding support to be heard. Van Manen's (1990) lifeworld existentials will be explained as this has also contributed to the analysis of the data. The research methods used, such as the recruitment of participants, data collection methods, ethical considerations, data analysis and trustworthiness will be given.

3.1 Research Design

The research statement is: "The meaning of breastfeeding support for six New Zealand mothers in the first six weeks postpartum."

The aims of the study are:

- To analyse and understand the meanings of breastfeeding support that is experienced by six New Zealand women in their first six weeks postpartum
- To discover what supports breastfeeding for these six New Zealand women

The answer to the research question is revealed through the experiences of breastfeeding women themselves. Hermeneutic thematic analysis encourages the essence of women's experiences of breastfeeding support to be examined, and this enables interpretation. Van Manen's (1990) philosophy of interpreting experiences draws on the work of Heidegger's hermeneutic phenomenology, which supports the women to share their experiences in a meaningful way, encouraging the exploration of lived experiences within their own world (van Manen, 1990).

Hermeneutics makes interpretive sense of the phenomenon being studied, (breastfeeding support) in order to understand its significance, and then uses language and text to

reflect and contribute to a deeper, more thoughtful understanding of the data (van Manen, 1990). Both the research itself and the writing are closely interwoven, and are fundamental to the methodology.

3.2 Background of Hermeneutics

Husserl (1859-1938) has been called the father of phenomenology, writing that “it is time we returned to the things themselves” (Smith, Flowers, & Larkin, 2012, p12). He moved away from his mathematical background, and wanted to examine things from a different perspective (Giddings & Smythe, 2010). Heidegger (1889-1976) was born in Germany, and was taught by Husserl when he arrived in Freiburg in 1916 (Richardson, 2012). Heidegger has been an influential figure in phenomenology, although unusual in that he has been both praised as a philosopher, and also maligned as a charlatan, since he joined the Nazi party in 1933 (Richardson, 2012). Heidegger, like Husserl, drew on the work of Bretano (1838-1917), whose dissertation Heidegger read when he was just 18 years old. What caught his attention was Bretano’s notion of intentionality, stating that we are always conscious of something (Crotty, 1998; Giddings & Smythe, 2010; Richardson, 2012). Heidegger’s most influential work was *Being and Time* (1927/1962). Heidegger was 37 years old when *Being and Time* was published, so he came to its writing with the benefit of many personal challenges and experiences behind him. Heidegger had moved from being a young Catholic boy, intent on becoming a priest, to denouncing his religion altogether, and turning instead to a more scientific mode of thinking. Heidegger challenged the dominant scientific knowing of the day, by focusing his attention on ‘*Dasein*’ or human existence itself, the very Being of being human. Van Manen (1990) describes “*Dasein* as that which refers to the entity or aspect of our humanness which is capable of wondering about its own existence and inquiring into its own Being” (p176).

Heideggerian hermeneutic phenomenology seeks to explore and to ponder on, human experiences. In contrast to quantitative methodologies, hermeneutic phenomenology does not seek to quantify, test theories, or classify information; rather it seeks to understand what this phenomena means. Van Manen (1990) has been instrumental in guiding this study with his work “*Researching Lived Experience*”. This study sought to understand the meaning of support from the perspective of a breastfeeding mother; it was not interested in the number of breastfeeding women who were supported, nor the number or types of support available. This study wanted to uncover what the meaning

of support was, from the people who experienced it themselves – breastfeeding women. Hermeneutic phenomenology was felt to be the perfect methodology to answer the question: What is the meaning of breastfeeding support for New Zealand women in the first six weeks postpartum?

Hermeneutic phenomenology is a way of thinking and understanding a phenomenon, and van Manen (2006) advises that it is “in the act of reading and writing that insights emerge” (p715). This was certainly true for me when actively engaged in the data analysis. I found typing did not allow the insights from the data to flow, and it was not until I began handwriting that the insights van Manen wrote about, began to emerge. Hermeneutics, meaning “the science or art of interpretation”, comes from the 17th century (E. A. Smythe, Ironside, Sims, Swenson, & Spence, 2007, as cited in Grondin, 1991, p1). However van Manen (1990) believes that hermeneutic phenomenological research is “fundamentally a writing activity, where text and interpretation are interlinked and inseparable” (p7).

3.3 The hermeneutic circle

The very act of writing and rewriting, going from the smaller parts of the data to the larger part of the whole, contributes to the hermeneutic circle. As more understanding is gained and new insights are made, the smaller parts are gradually changed bringing new insights to the whole. Thus, hermeneutic phenomenology is circular. Heidegger also called the hermeneutic circle a “circle of understanding” and suggested we must leap into the circle and embrace it fully (Crotty, 1998, p98).

When writing the data analysis, the circle of understanding became clearer in practical terms, as there were times when reading and re-writing what I had written earlier was made clearer. This gave me a depth of understanding that I had not had when I had first written it. I would then go back to the scripts again, and see how the small bit I had focused on actually connected to other interviews, either confirming or challenging my earlier thoughts. It was in the reading and writing, then going back and re-reading and re-writing, that often the clarity and depth of understanding would come. Initially I felt I had missed something important, which is why I needed to keep going back to the data, but as time went on I began to understand that this is what Heidegger meant by the hermeneutic circle. These small changes I had made then gave new insights to the

whole. It was a very important part of the data analysis, and is the basis for the interpretations I made from the data.

While this phenomenological description is my own interpretation of the data, drawn from the transcripts of the breastfeeding women's interviews, it is not the only interpretation, or the 'right' interpretation, as there will always be the possibility of a new or different, perhaps richer, interpretation (van Manen, 1990).

Husserl (1970) was interested in how a person might discover their own meaning of a particular experience, and he argued that we are generally too quick to categorize, trying to make the experience fit to what we already know and understand. He believed that phenomenology must describe the experience without being coloured by one's own experiences or culture (van Manen, 1990). In order to put to one side our own 'taken-for-grantedness', Husserl coined the term 'bracketing' to acknowledge our pre-understandings; to put them in a box and keep them separate from our understanding of the phenomenon. However, Heidegger believed that bracketing of what we already know is not possible, and instead suggested we acknowledge our understandings and beliefs, and allow them to be held in full view.

3.4 Pre-understandings

Van Manen (1990) gives an example of pre-understandings by writing "The problem of phenomenological inquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much." (p46). When we think we already know something, it can be challenging to bracket it, but if there is an understanding of where the knowledge or beliefs come from, acknowledging it then makes the examination of the phenomenon less likely to be compromised by our own beliefs.

Being aware of my own pre-understandings is a significant part of my research process. As a midwife of more than twenty years, I considered myself experienced in working with women and their babies and supporting them to breastfeed, so van Manen's (1990) quote was a pertinent reminder to acknowledge my experience but not let it interfere with the data that was presented to me. My own pre-understanding impacts on how the data is interpreted, how it is read or understood, and requires constant vigilance to allow the data to speak, so its essence can be more fully heard, without hearing what I think I should hear. This was an ongoing challenge throughout the data analysis. At the beginning of the research, my supervisor interviewed me to discover my own pre-

understandings. I ‘already knew’ about supporting breastfeeding women, and this coloured my initial interpretation of the data. I could acknowledge my pre-understandings (and I did), without fully understanding how they insinuated themselves into my very way of being – as a writer, a reader and interpreter of the data.

3.5 Research Method

In this section, ethical considerations and how approval was gained from AUT Ethics Committee, is shown. This will be followed by an explanation of how the participants were recruited, how their confidentiality and anonymity was maintained, as well as an explanation of the interviews that were conducted. Rigour and trustworthiness are then discussed, as well as how the data analysis was completed using van Manen’s lifeworld existentials as a framework.

3.5.1 Ethical considerations

Ethical approval for this study was received from the AUT Ethics committee (AUTEC) on 27th November 2014, numbered 14/349 (see Appendix H). Cultural advice regarding the particular needs of Māori participants was sought from the Komiti for Kawa Whakaruruhau. The guiding principles of the Treaty of Waitangi of Partnership, Protection and Participation are acknowledged and are integral to the research.

Partnership

Participants in the study were encouraged to be equal partners in the research process by ensuring they had all the information regarding the research, how it would be conducted, and what would happen with the results. The participants had a choice of place for the interview, either at their home or at any other suitable place they could choose. All the participants in fact chose their own home for the interviews. It was important that each participant was comfortable throughout the interview process; they were made aware this was not a ‘question and answer’ type of interview, but more a sharing of what they wanted to tell me about their experiences of breastfeeding support. The interview questions were open-ended and designed to encourage women to share openly about their experiences of breastfeeding support. Each woman was reminded that if any emotional issues were uncovered during the interview, support and counselling would be available to them, as per the Participant Information Sheet (Appendix E).

Participation

The principal aim of the research was to understand from the participants' perspectives, their experiences of breastfeeding support. Each woman was encouraged to participate as much or as little as they felt comfortable to do. Participant interviews were a partnership and the information shared by each participant is valued. Often by talking or sharing an account of an incident, fresh insights may be gained by both the participant and the interviewer, leading to further questions and further sharing.

Protection

Each participant received a Participant Information Sheet (Appendix E) and signed a Consent Form (Appendix C) prior to being interviewed. Each participant was allocated a pseudonym with no actual names used at any stage. Interviews were undertaken in the participants' own homes, and generally took an hour. Prior to commencement, the aims of the study, informed consent and permission to record the interview were discussed again, and all participants were happy to continue with the interview. A safe environment was maintained by checking in with each participant during the interview as her story unfolded, ensuring that each woman felt respected and heard. All participants were asked if they would like to be contacted once the thesis was completed. All the participants said yes, and showed an eagerness to participate, to tell their stories and to be heard. Each participant was offered a small token of appreciation for their time by being sent a gift voucher and a Thank You card at the end of the interview. Morning or afternoon tea was taken as a Koha/gift.

Auckland University of Technology (AUT) Counselling and Wellbeing Services were approached to ensure they were able to offer counselling services if required, for any of the women who experienced stress or anxiety surrounding her breastfeeding experiences, either during or after the interview. Although it was unlikely there would be any emotional harm done during the interview, the topic of breastfeeding had the potential to raise unresolved issues around birth or previous breastfeeding experiences, which could contribute to emotional upset. AUT Counselling and Wellbeing were able to offer three counselling sessions to all women participating in the study, free of charge. Kevin Baker (Head of Counselling, AUT) gave this assurance in writing, dated 28th August 2014 (Appendix D).

All the women recruited were given Information Packs that had been prepared before the recruitment process had begun. The Information Packs contained a Research

Invitation (Appendix F), Participant Information Sheet (Appendix E), and a Consent Form (Appendix C). The pack also contained a stamped, self-addressed envelope for the return of the Consent Form.

3.6 Recruitment of the participants

Phenomenology seeks to understand the phenomenon being examined, therefore it was important that the women being interviewed were currently breastfeeding their babies. To make the interviews easier to manage, the breastfeeding women needed to live in the Auckland area, and to have given birth within the previous six months. Recruitment for the study was not expected to be challenging, as only a small number of participants were needed, but in fact recruitment took far longer than anticipated.

The Ethics Committee had approved recruitment from several community groups, including Turuki Health, Family Start, Parents Centre and the Plunket Society. The Information Sheets with posters were printed out and while some did take them, it was found that some of these groups have their own processes that did not easily enable individual student researchers to connect with their clients. Lead Maternity Carer (LMC) midwives were approached, but there were no participants recruited through them. Two Māori midwives were approached, but they were unable to recruit any Māori women to participate.

Eventually I talked to a woman I had worked with nearly twenty years previously, who had recently given birth herself. She was very interested in the research and said she would ask other mothers she knew, who then asked their friends. From there, the process of recruiting became a ‘snowball’ effect, and very quickly six women who were keen to participate, contacted me. While the participants were recruited from a different source, they all received the Information Sheet that was initially printed out, and there was a verbal explanation about the recruitment and what was different on the Information Sheet.

3.7 Study participants

The ages of the women ranged from mid-twenties, to late forties. Of the six women, two had caesarean sections and four had normal vaginal births. One woman had given birth to twins. One participant had a home birth, one participant a water birth and one had a hospital birth. Four of the women had given birth to their first baby, while two

participants had other children. Of the two with other children, one had successfully breastfed her other child, while the second had been unable to breastfeed her other children. Each of the women lived with a supportive partner, were passionate about breastfeeding, and knew at least one other participant in the study, as the recruitment method used was snowballing.

3.8 Interviewing

I interviewed all six women participating in the study and each interview lasted from one to two hours. The first interview took longer than the others, but as I became more confident in my interviewing techniques, I became more focused on listening, keeping to the topic of breastfeeding support. I did not approach the interviews with a list of questions, however I did have my research question written out, with a prompt statement of: “tell me about your experiences of support and breastfeeding”.

In hermeneutic phenomenology, the interview and how it is conducted is important and has two specific purposes. Firstly, the interview can be used as a way to explore and gather the material needed for in-depth understanding of the phenomenon being studied, and secondly, the interview may be used as a means of developing a conversational partnership about the meaning of the experience (van Manen, 1990). It was interesting to note that I had written in my journal (kept as part of the research process) how enthusiastic each of the women were when interviewed. They cared about breastfeeding with a passion, and were delighted to be part of the study. Each of the participants expressed a keen interest in receiving a copy of my thesis once it was completed.

Each transcript was listened to immediately following the interview, in order to capture the feel and emotion of the interview before it was forgotten. Thoughts and ideas were made in the margin of my notebook. The recordings were uploaded one at a time and emailed to the transcriber, who had earlier signed a Confidentiality Agreement (Appendix B). Once the transcripts were returned, I read through them, putting my original notes and ideas from the day of the interview into the margins of the transcripts.

3.9 Reflection and data analysis

The amount of rich data in the transcribed interviews was initially overwhelming. However, van Manen (1990) reminds us that “The purpose of phenomenological

reflection is to try to grasp the essential meaning of something” (p77). With many readings and re-readings, themes began to emerge from the data. It was less a process of pulling themes out, as a process of the themes making themselves known. Van Manen (1990) describes this process as seeking meaning – moving from the notion of something, to gaining a deeper, fuller reflective understanding of the notion.

In order to isolate thematic statements, I used Van Manen’s (1990, p92) approaches:

1. The holistic or sententious approach
2. The selective or highlighting approach
3. The detailed or line-by-line approach

All three approaches were utilized when reading through the data, but the approach used most often was selecting and highlighting. It enabled me to go back to the highlighted data time and again, often bringing out new meanings. Working with the data in this way reminded me again of the Hermeneutic Circle, where the researcher must go from the smaller parts, to the bigger whole, moving back and forth between the two, delving deeper as one comes to grips with the parts, and takes that meaning to the whole. There was much writing and re-writing through this period of crafting, with a cycle of thinking, reading, writing, discussing the ideas and thoughts with my two supervisors, then going back to the thinking, reading and writing again.

3.10 Lifeworld Existentials

Van Manen’s (1990) philosophy has had a significant influence on how this study has been analysed and written. He wrote that real understanding of hermeneutic phenomenology can only be gained “by actively doing it” (p8). This could be because phenomenology aims to gain a deeper understanding of everyday human experiences, which is often only attained by the doing. While the phenomenon under study might, on the surface, be obvious, it is the analysis that lies underneath the obvious that is important. Van Manen (1990) wrote of four fundamental lifeworlds, that is, the particular human experiences that all humans participate in, regardless of culture or background. Van Manen (1990) named these four lifeworlds as existentials. The four lifeworld existentials are: lived space (spatiality), lived body (corporeality), lived time (temporality) and lived human relation (relationality or communality).

Lived space is a felt space rather than a physical, measurable space. It is how the space is perceived by the person occupying the space. For some the space might feel cosy, while for others the space might feel cluttered and claustrophobic. For a breastfeeding woman in the postnatal ward, the lived space might feel comfortable and private; for another breastfeeding woman, another space might be shared, noisy and uncomfortable.

Lived body acknowledges that humans are always physically present; always both showing and concealing some of oneself. What is noticed initially, when meeting a person for the first time, is the physical aspect, and this can impact on first impressions, whether it is conscious or not. It might be the style of dress that is worn or perhaps the way the hair is done, but it will affect each of us in a different way. Assumptions can be made from the physical first impression that may or may not be accurate. For example, when a midwife enters the room of a breastfeeding mother, her physical presence may impact on whether the breastfeeding mother feels comfortable. From my own pre-understandings, if the midwife is smiling, confident, caring and open, a breastfeeding mother may feel more relaxed. If the midwife gives the impression of being very busy, the breastfeeding mother may feel she doesn't want to ask questions or bother the midwife.

Lived time is also dependent on how a person perceives it. There are occasions where time goes slowly, for example when waiting for something exciting, yet when involved in something creative, appears to disappear rapidly. Lived time also refers to the "temporal way of being in the world" (van Manen, 1990, p104). Our past, present and future, according to van Manen (1990), form the landscape of our horizon. Our present situation may alter our reflections of the past. An earlier experience of breastfeeding may colour the present experience of breastfeeding, whether positively, or negatively.

Lived human relation is the lived relation experienced with others who share the same space. It can be seen when a breastfeeding woman in the postnatal ward interacts with another breastfeeding woman, or the midwife who might be caring for her. For some breastfeeding women, the experience of 'other' may be positive and supportive, or it may be disappointing and not live up to expectations. These encounters may well affect future encounters. These four lifeworld existentials inform the data analysis of the transcripts.

Initially, the transcripts were read over and over again, taking notes as I read, pencilling in potential themes, brainstorming and making notes under each heading. Eventually, the themes made themselves known and became clearer. Always it was examining the detail, then moving to look back at the whole; taking the understanding from one to the other and back again. Eventually there came a time where no new analysis revealed itself. It was time to stop. It took a long time to understand Smythe's (2010) comment: "Re-writing does not mean that your first draft wasn't good enough. It means that you know that good can be made better" (Giddings & Smythe, 2010).

3.11 Rigour

Assessing validity and rigour in qualitative research has been the subject of much discussion over the years, as early research was evaluated according to quantitative research standards. This has encouraged development of a number of guidelines for assessing rigour and validity (Hays, Wood, Dahl, & Kirk-Jenkins, 2016; Smith et al., 2012). According to Hays, Wood, Dahl & Kirk-Jenkins (2016), research quality, which is synonymous with rigour, "involves the systematic approach to research design and data analysis, interpretation and presentation" (page 173). These principles can be examined under the following headings of dependability and reflexivity.

3.11.1 Dependability

The relationship between the interviewer, the participant and the data is known as triangulation, and is used to support and describe findings (Hays et al., 2016). It is a complex relationship, and as Gadamer (1990/1960) points out, "It is necessary to keep one's gaze fixed on the things throughout all the constant distractions that originate in the interpreter himself" (as cited in Smith et al., 2012).

There must be clear evidence that the data analysis has remained true to the participants, that there is a clear audit trail (a journal was kept that details this process), and that there have been opportunities given to others, to examine both the evidence (data) and the analysis. My two supervisors have followed this process from the beginning, and my analysis has been discussed as the writing and rewriting progressed. I was also able to present the findings of my thesis to a group of health professionals at a recent Research Symposium. I was pleasantly surprised when several members of the audience approached afterwards, to give me what another researcher has called the 'phenomenological nod' (Giddings & Smythe, 2010). When a reader nods their head

in agreement, as they relate to what they have read, they give the ‘phenomenological nod’. This is what some of the members of the audience came to tell me – that what I had said resonated with their own experiences of breastfeeding and support. For me, this was confirmation that the data analysis had led to findings that resonated with others.

3.11.2 Reflexivity

Examining my own role in the research process shows reflexivity. I have examined my pre-understandings and assumptions, detailing them in my journal. The design and methodology of the research has been made clear, with the data analysis discussed in detail within the Findings chapters. There is an audit trail created by my notes, from the discussions with my supervisors (documented as minutes of meetings), prior to the selection of the participants, through to the notes written in the margins of the interviews as data analysis was begun. Reflecting on the experience of the research process, I am reminded of a wonderful poem I found while reading, that expresses how the experience of ‘doing’ research has been:

Does the road wind up-hill all the way?

Yes, to the very end.

Will the day’s journey take the whole long day?

From morn till night my friend.

Christina Georgina Rossetti (1830-1894)

As cited in Giddings and Smythe (2010).

3.12 Conclusion

The design and methods used for this study are essential parts of the research process. This chapter has described how the study was designed, which methodology was used, and why, as well as what has influenced the analysis of the data. Heidegger’s hermeneutic phenomenology formed the philosophical basis of this study. and Van Manen’s (1990) lifeworld existentials and approaches to thematic analysis were used to inform the research process.

My pre-understandings have been made explicit, acknowledging them for what they are: what I came to the research with; my experience as both mother and midwife. The research methods, which include recruiting of participants, data collection and the

ethical considerations taken into account were explained. The following three chapters detail the findings, explaining the themes that showed themselves from the data that was generously given by the breastfeeding women.

Chapter 4 Findings: ‘Being With’

The purpose of the findings chapters is to discuss the key themes identified from the data of the participants in the study. Each of the women in the study was enthusiastic about telling their story of breastfeeding, and for most of the women, their experiences began with difficulties and ended with success. What the women shared during their interviews showed what supported them through the challenging beginnings, to the feelings of euphoria when they realised they had ‘made it’.

Through phenomenological reflection, three themes emerged from the interview data that the women provided, from the first six weeks' breastfeeding. They were: Being With’, Breastfeeding Culture, and Breastfeeding Space. The three themes were informed by van Manen’s (1990) existential lifeworlds of lived space, lived body, lived time, and lived human relation.

This chapter explores the theme of ‘Being With’.

4.1 ‘Being With’

The women in the study described those who walked alongside them and supported them in their breastfeeding journey as being important, especially in the first six weeks. The concept of ‘Being With’ came from the women when they described how another person (their partner, family, friends, midwives and other health professionals), encouraged them, reminded them of their commitment to breastfeeding when challenges arose, believed in their ability to breastfeed, and shared in both the difficulties and the successes. In the literature, ‘Being With’ has usually been used within the context of labour and birthing (L. Hunter, 2009, 2015). ‘Being With’ is more than just being present physically, it is an active participation in the negotiated relationship with the woman, her partner, and her family/whānau (O’Boyle, 2013).

The participants found these same characteristics of ‘Being With’ just as supportive postnatally, when women establish breastfeeding and adjust to their role as mothers. When the women in the study talked about feeling supported, they described how partners, midwives, friends and family/whānau were ‘Being With’ them.

4.2 Partner support

The women in this study spoke of what was their most important support – and that support was from their partners. While their partners offered practical support, it was also their emotional support that was important, and this was interpreted from the data analysis as ‘Being With’. While midwives and other health professionals may be present for a short time, especially in the first six weeks after giving birth, a partner is there throughout. One of the participants, Fiona, described how her partner supported her when breastfeeding became challenging, once they were at home.

I really wanted to breastfeed and my partner was so supportive. So many times I wanted to give up but my partner said, ‘you can do it, you can do it!’ As much as I wanted to kill him when he said I had to keep going...but in a nice way.

When someone says, ‘*you can do it, you can do it*’, it expresses a depth of feeling, a real belief that the challenge can be achieved, and this is the essence of ‘Being With’ in a way that is more than just spoken words. Fiona said she wanted to give up ‘*so many times*’, but her partner said, ‘*you can do it, you can do it*’. These words built on the foundation of partnership that they had worked on together as parents. The security of their partnership allowed freedom of expression, as Fiona said, ‘*as much as I wanted to kill him when he said I had to keep going!*’ ‘*But*’, she assured me, laughing, ‘*in a nice way*’.

The words reflect powerful emotion, the challenges and frustrations, perhaps the pain, the tiredness and the anxiety of learning to breastfeed a new baby. What supported Fiona in her breastfeeding was her partner’s belief that she COULD do it. Fiona’s partner supported her by ‘Being With’ her, sharing the challenges of breastfeeding, encouraging her when it got difficult, and being able to remind her of their shared commitment to breastfeeding their baby. In contrast, Fiona found it challenging when her partner was not allowed to stay overnight when she was in hospital. Partners are usually able to visit during the day, from 8am to 8pm, but as hospitals are not generally prepared for partners to stay overnight, they are expected to leave at the end of visiting hours. Following a caesarean section, Fiona described how she felt when her partner had to leave.

So yeah, I was just stuck, and when my partner had to leave at night, it was just awful, as I couldn’t get to my baby who just cried 24/7. It was horrible without him and I would just count down the minutes

until 6 o'clock when he was allowed back in the morning. He would do the skin to skin with her, and it would be so good, with him just walking around the room with her.

Being available to Fiona to do the practical things like changing baby's nappy was supportive, but equally important was her partner's availability to her and their baby. Because she was less mobile after a caesarean section, Fiona's partner gave their baby the skin-to-skin contact that Fiona felt was so important after birth. Having her partner leave overnight was so distressing to Fiona that she felt it was 'horrible' without him. Fiona was expressing that for her, support for breastfeeding was when she and her partner were supported and could be together, not only during the day but at night as well.

Van Manen (1990) described lived time (temporality), and this links to 'Being With' in the sense of how it is perceived by those experiencing it. Lived time can appear to either speed up if we are experiencing something exciting, or it can appear to be slowing down, or even pass agonisingly slowly, as it appeared to do for Fiona, where each minute was being counted down until 6 o'clock, when her partner would be allowed back in.

Some of the other participants also spoke of the distress they experienced when their partner was unable to stay with them during the night while in the maternity unit, especially in the early days after giving birth. Annabelle had given birth to twins, and she spoke of how she felt when her partner was unable to stay the night.

It was really hard after I had them. I just cried at the hospital when my partner had to leave me every night. It was horrible.

The depth of emotion Annabelle felt when her partner left, was shown by the words she chose to express it 'it was horrible'. This is the same word that Fiona used to describe her distress when her partner had to leave. Annabelle explains why she felt so distressed.

And in the hospital, every night he had to leave and the midwife said, just call us if you need help, but you don't want to. I didn't call them to help me throughout the night because I didn't want their help. I wanted my partner there. It makes a huge difference, and that's what I find sad, cos they need to be there, helping you and experiencing everything. And I was like, well, I just dreaded it at night, yeah it was horrible.

For Annabelle, there was a clear difference between midwifery support for breastfeeding, and having her partner to support her breastfeeding. Annabelle's partner provided more than just the physical support of bringing the baby to Annabelle. He was 'with' her, experiencing what she was experiencing, sharing the parenting role together. It seemed that when this relationship was encouraged, then breastfeeding flourished. What the women in this study seemed to be describing was a relationship that supported one another, and which then flowed from each other and encompassed their baby. When the breastfeeding mother and her partner were given time to learn breastfeeding together, it nourished their relationship, and therefore nourished the breastfeeding relationship.

Annabelle has described how she felt when her partner had to go home at night – it was horrible. Fiona spoke of how she wanted to kill her partner when he said she had to keep going. Only someone who is totally invested in that breastfeeding relationship would be able to tell her she 'had to keep going'. This shows the essence of 'Being With'. It is trust in the relationship, respect for the opinions and thoughts of the other person, and ultimately the desire to do what is best for their baby.

Annabelle and her partner needed to be together for their twin babies, where they were able to share the parenting role. One of the ways that relationality (van Manen, 1990) shows itself, is by the sense of connection that it brings. All human beings search for this sense of the other, the shared, the communal, as this provides meaningfulness in life (van Manen, 1990). To have that taken away when the hospital policy required Annabelle's partner to leave the hospital at night, caused stress and anxiety for her. Once home, Annabelle and her partner worked together as a team, with her partner able to latch one baby on to breastfeed, while Annabelle was catching up on sleep.

When they were little my partner would bring one over to me and he'd latch one on for me, and then I'd do the other one. So yeah, he's really good and if I've missed having a sleep he'll just come in and put the baby on my boob and then he'll let him feed. Yeah, we've got a really good system.

According to Heidegger (1962), 'being-in-the-world' is also linked to our ability to care for others, which in turn helps us to understand ourselves (as cited in Miles, Chapman, & Francis, 2015). Part of the task parents will undertake is adjusting to their new lifeworld, coming to terms with their new role and how they will work together within it. Annabelle's partner supported her by 'Being With' her, being in her world,

validating their sense of partnership in parenting, which in turn enabled Annabelle to feel supported in her breastfeeding. Relationality is how humans relate to others in the interpersonal space they share. It is an important aspect of 'Being With'. It is important for women that they are acknowledged, that they are not alone, but are part of their wider world, their 'being-in-the-world' (van Manen, 1990).

Another participant, Margaret, spoke of how she felt supported when her partner was 'Being With' her.

*And of course there were times I was just going to chuck in the breastfeeding and I was just in so much pain, and I said to my partner a number of times – usually at 2 in the morning – I would say, 'get in the f*ing car and go get bottles and dummies. Go get formula. I'm done.' He'd go and get dressed, get the car keys, stand at the door and go, 'now do you want me to go?' And I'd say, 'No. No.'*

Margaret's partner showed a sense of acceptance of where Margaret was at with her breastfeeding. He took her at her word, getting the car keys, ready to go and get formula before asking if she still wanted him to go. He knew that Margaret wanted to breastfeed and he understood how important it was to her; yet he was prepared to get up at 2am to get bottles and formula if that was what she wanted. By his actions, he stood by Margaret's decision to breastfeed, while still giving her a choice and a sense of being in control. Margaret's partner showed the meaning of 'Being With' by listening to what Margaret wanted, but also by understanding what she really wanted, the unspoken need – which was to breastfeed their baby.

Margaret's partner knows her intimately; there was a sense of closeness in both the words Margaret used 'go get in the f*ing car and go get bottles and dummies', and in her partner's response to them: 'he got dressed, got the car keys, and said, now do you want me to go?' Margaret was secure in what she asked him, and what she knew he would say. There was a shared understanding between them.

Gadamer (1975) called this merging of experiences, where people work together with a common goal, the fusion of horizons, where each person is able to understand the other in a deeper and more meaningful way. Fusing horizons ensures both participants in the relationship benefit. For example, Margaret is more likely to pass on her knowledge and experience to another who needs breastfeeding support, thereby sharing her learning like a pebble dropped into a pond, where the circles of knowledge and understanding grow and connect with others. While Gadamer (1975) was specifically writing about

researchers when they had that ‘aha’ moment of finding the data that produced a shared understanding of the phenomenon between the interviewer and the interviewee, the fusion of horizons could also be seen as Margaret connected with her partner.

4.3 Midwifery support

The word ‘midwife’ has its origins in the Old English ‘mit’ or ‘mid’ meaning with, and ‘wif’ or ‘wife’, which in the archaic sense means ‘woman’. This expresses the sense of ‘a woman who is with the mother’ (Collins English Dictionary, 2005). The meaning of midwife as ‘Being With’ woman, is not just an etymological one, but also a philosophical one (New Zealand College of Midwives (Inc), 2016). ‘Being With’ is more than just being present physically, it is an active participation in the negotiated relationship with the woman, her partner, and her family/whānau (O’Boyle, 2013).

Each of the following examples is relational, and aligns with van Manen’s (1990) lived human relations (relationality). In the early days of learning to breastfeed a baby, a midwife can support women to breastfeed by ‘Being With’ them. The participants described the support midwives gave them as having the characteristics of ‘Being With’ them.

When Margaret was in the birthing unit, she found it difficult to be assertive and ask her visitors to leave.

The midwife came in the room and said hello to everybody. And she could see the look on my face, and she goes, ‘Right. Now I’m here to do an exam on Margaret, so if everybody would like to leave. You can go and get a cup of tea or coffee.’ When the room was clear she said, ‘Margaret, do you want all these people here?’ And I said, ‘No, I don’t.’ She said, ‘Right, Len, you and I are going to go and tell them that they need to leave, as Margaret has had enough visitors for today, and she needs to rest.’ And she did, and I had no more visitors that day.

When a breastfeeding woman is occupying someone else’s space, it can be difficult to be assertive. When Margaret’s midwife entered the room, she could immediately sense Margaret’s discomfort, and to ensure her intuition was correct, she asked everyone to leave the room so she could check on whether Margaret did indeed want her visitors to leave. The actions of Margaret’s midwife could be seen as an example of phronesis, which is defined by Polkinghorne (2004) as being the kind of knowledge “that varies with situations, is receptive to particulars, and has a quality of improvisation” (p115).

Phronesis is something that occurs on a deeper, more spiritual level, rather than on just a surface level (Crowther & Hall, 2015). When women are learning the new skill of breastfeeding, they need privacy and visitors can hinder this.

Trina experienced both *phronesis* and *techne* (the technical skills) (Polkinghorne, 2004) from the midwife who was working with her in the birthing unit.

Yes, they were quite hands on. They would sit right beside me and actually, sometimes even take the breast – hold the breast or hold the baby's head and position her, perfectly really. They'd take the baby straight off if she wasn't latched correctly, and they would get the cushions and put the support there.

For Trina, these midwifery skills supported her to breastfeed. Polkinghorne (2004) explained that human beings are complex, and while the skills of '*techne*' are important, *phronetic* judgement is also important and together they need to be considered greater than the sum of its parts.

At the birthing unit they were just brilliant. They would say, every time before you latch, ring us. And I'd ring them. They would come in every time before I latched and check to make sure my position was right, and the latch was good, and I think I was very, very lucky to have that. So for two or three days, while I was there, it was really good support. And then to come home, it all just went rapidly downhill from there.

Perhaps Trina felt '*it all went downhill from there*' when she got home, because she lost the sense of 'Being With' from her visiting midwife. Trina's Lead Maternity Care (LMC) midwife was on holiday, therefore the postnatal home visits were undertaken by a midwife that Trina had been unable to build a trust relationship with.

During my postnatal visits I was crying. I was crying most times she would come. The pain of breastfeeding and the stress. I felt that was where I would be looking for my biggest support was in those postnatal visits. That didn't happen there. I really felt like I'd been ripped off.

Trina expressed anger at not having the connection she had hoped for and expected from her visiting midwife. She '*felt ripped off*'. Relationships between a woman and her midwife are built on mutual trust and respect and the loss of this may have affected Trina's lack of feeling supported with her breastfeeding. When Trina's distress went unacknowledged, this may have compounded Trina's feelings of being deprived of an

established relationship with her usual midwife, whom she felt would have supported her breastfeeding.

Trina had an expectation of midwifery care she would receive based on her experiences in the maternity unit. When she went home and the support that she had hoped for was not there, Trina may have lost the sense of 'Being With', that the midwives in the birthing unit had shown when supporting Trina to breastfeed. The impact for Trina was such that she described breastfeeding as going '*rapidly downhill*' once she went home.

In contrast, Annabelle had been able to develop a relationship of trust with her midwife in her first pregnancy, and she chose this same midwife when she discovered she was pregnant a second time – with twins.

My midwife is really supportive of breastfeeding so when I was in the hospital, she actually brought in a lactation consultant to come and see me, just to help cos they weren't latching on properly to start with, and it was quite sore. It was actually a huge help. My midwife suggested this with my first baby, as I had gestational diabetes and they thought the baby would need more colostrum and more top-up feeds, so I had expressed all this milk and had it stored.

Annabelle's midwife had planned ahead in Annabelle's first pregnancy, suggesting that she might hand express breastmilk and store it, because of Annabelle's gestational diabetes. For this pregnancy, her midwife organised a Lactation Consultant (LC) to visit her. This is an example of how *techne* or practical midwifery skills were used to provide breastfeeding support. Technical skills are as important as listening skills, or the ability to 'see or sense' when something needs doing. However, in order to 'Be With' a breastfeeding woman, both *techne* and *phronesis* are needed. Sometimes a hands-on approach is needed to support a woman latching a new baby, but sometimes what is needed is simply to sit and listen.

Priscilla spoke about how her midwife gave her time, and what that meant for her. When describing this, Priscilla emphasised 'over an hour', which sounded like it was amazing, a gift, something that was precious to her.

And the next day my midwife came and she gave me over an hour and showed me everything – how to hold him and how to put him on the breast, and from that point on it worked well.

Time can be subjective; it can depend on how the person experiencing time interprets it themselves (van Manen, 1990). How time is experienced, can affect the memories we hold of this time. The memories we hold become immersed in the new memories being made, where our past, our present and our future make up the horizons of a person's temporal landscape (van Manen, 1990).

The time given to Priscilla was seen as a gift, something precious, something to be valued, and time given to a woman shows respect for her, as well as an acknowledgement of her needs (Dykes & Flacking, 2010). Time can be seen as supportive or non-supportive, depending on the environment or culture the woman is within; it can be seen as a presence, the act of 'Being With' and according to Berg, Ólafsdóttir, and Lundgren (2012), can be viewed as the essence of an encounter between a woman and her midwife.

4.4 Conclusion

The data has shown that women feel supported to breastfeed in the first six weeks postpartum when they experience the concept of 'Being With'. This might be from a woman's partner or her midwife. It was more than being present, more than doing the physical tasks that need doing; it was being present to, having an authentic presence, sharing oneself and one's time. It was 'Being With' that supported the women in the study to breastfeed. Van Manen's (1990) notion of relationality was useful in this chapter to conceptualise how space can be shared with others with an authentic presence.

When reading through the transcripts, I noticed that there was a common thread that ran through all the participants' interviews. This thread seemed to describe 'Being With' their partner, but it was more than 'Being With'. It was 'Being With' yet in a far more in-depth way. This thread I named the Breastfeeding Triad, because it encompassed three parts of the breastfeeding relationship: the breastfeeding mother, her partner (or significant other) and their baby. What the women in this study seemed to be describing was a relationship that supported one another, and which then flowed from each other and encompassed their baby. The Breastfeeding Triad will be discussed in more detail within the Discussion Chapter. Breastfeeding support also came from the Breastfeeding Culture that surrounds a woman and her family/whānau. This is explored in the following chapter.

Chapter 5 Breastfeeding Culture

This chapter discusses the importance of the Breastfeeding Culture that surrounds a breastfeeding woman. A Breastfeeding Culture encompasses past and present experiences, beliefs and traditions, both spoken and unspoken. This chapter examines how a Breastfeeding Culture touched each of the women in the study, sometimes in positive ways, sometimes in more challenging way. But ultimately, the Breastfeeding Culture that the woman brings with her, or finds for herself, impacts on whether, or for how long, she breastfeeds. This chapter briefly touches on Heidegger's (1962) concept of the 'they', as the voice of the 'other', which has informed the interpretation of the way that culture supports women to breastfeed. Social media is examined, and how this was supportive for one of the participants is discussed. The chapter concludes with how the Breastfeeding Culture has positively impacted on the breastfeeding women in this study.

5.1 Breastfeeding Culture and family/whānau

A Breastfeeding Culture can be defined as the breastfeeding customs, beliefs, traditions, and ways of being, that surround breastfeeding women. The Breastfeeding Culture that a woman is immersed in, has been shown to affect the initiation and duration of breastfeeding, as women gain knowledge about breastfeeding from their families, their beliefs, ideas and traditions (Callaghan & Lazard, 2012; McBride-Henry, 2010).

The Breastfeeding Culture that surrounds a breastfeeding woman may be supportive or non-supportive; it includes the influence of a breastfeeding woman's partner or significant other, her parents and in-laws, her friends and extended whānau or family.

Annabelle tells the story of her mother's breastfeeding experience, and how this shaped Annabelle's own story of breastfeeding.

My Mum said that when she had my older sister, that her Mum, my Nan, wasn't supportive of breastfeeding and just said to her "oh, why do you want to breastfeed?" So my Mum listened to her and bottle fed my sister, and then when it came to having me, she decided to breastfeed me. She looks back and regrets that she didn't breastfeed my sister as well, cos she just loved the bonding time that she had when she breastfed me. And so that made me want to breastfeed.

The whānau/family that surrounded Annabelle was a significant support for her. Because Annabelle's Mum had experienced both formula feeding and breastfeeding, she was able to share with her two daughters the significant benefits of breastfeeding.

Annabelle's Mum created an environment within her family where breastfeeding was cherished, despite the influence of her own mother (Annabelle's Nan). The focus for Annabelle's Mum was on the relational aspect of breastfeeding, and not just on the nutritional benefits of breastfeeding. This also extended to Annabelle's friends and wider family/whānau too.

Everyone around me is just used to breastfeeding, cos that's all they've ever done. My family and my friends, they're all breastfeeders, so we've all got each other to talk to about it and stuff. I got mastitis and I've got friends that have breastfed, and they've had mastitis. So being able to say to them, 'what did you do to get rid of it?' That's been a really good support.

For Annabelle, her Breastfeeding Culture was seen as normal. *"It's all they've ever done, they're all breastfeeders"*. This made Annabelle want to breastfeed. Friends and family/whānau were part of the Breastfeeding Culture that enabled Annabelle to see the reality of breastfeeding. She experienced difficulties like mastitis and painful nipples, but was able to see first-hand how to overcome those difficulties. A positive Breastfeeding Culture supported women in this study to breastfeed. Although Annabelle initially experienced pain from cracked nipples, this did not appear to worry her, as in her words:

She just latched on properly and I didn't have any problems with her. I mean, I got cracked nipples and that hurt and it sort of makes you think, oh, do I really want to do this, but I just kept at it and I loved it.

When a Breastfeeding Culture normalises breastfeeding, problems that arise are less likely to be catastrophised; when cracked nipples developed, Annabelle briefly wondered if she could continue; however the Breastfeeding Culture of those around her encouraged her to just keep at it.

Fran was another participant who was surrounded by a supportive Breastfeeding Culture, which included her family/whānau and friends.

I really wanted to breastfeed and my partner was so supportive, and my parents were really good, they were amazing. They even went out and bought me an electric breast pump to help with the breastfeeding.

My partner and I would try and do it ourselves. He would help me, saying, "let's try this, or this" and together it was a bit more helpful. I didn't realise how hard breastfeeding was going to be. I thought it was quite natural.

Fran equated being 'natural' with being relatively easy, and was surprised to find it could be challenging. In Fran's example, her parents both contributed to the Breastfeeding Culture that normalised breastfeeding, supporting Fran and her partner to work through the challenges of the first early weeks. Fran's baby had a tongue-tie that took nearly a week to diagnose, by which time her baby had lost more than 10% of her body weight. Once Fran's baby received formula and was settled, Fran felt she could then begin to relax with her baby, as up until that point, her baby would '*scream and scream and scream and scream.*' While the hospital allowed formula, Fran found using formula also came with a rigid feeding timetable, of expressing breastmilk and topping up her baby via a syringe. When difficulties arise, breastfeeding can often be cast aside if the breastfeeding culture is not one that normalises breastfeeding challenges. When family and friends support breastfeeding, the positive Breastfeeding Culture then becomes the norm; this supports breastfeeding to continue despite the challenges. The Breastfeeding Culture that surrounded Fran, supported her to move from needing to top up with formula, to exclusively breastfeeding within a few weeks.

And then I felt like I could bond with her and I remember feeling in those first few weeks, because nothing had gone how I thought it would. And I didn't feel like I loved her as much as I wanted to. Everything was on schedule. I'd have to wake her every three hours after expressing, and then I'd syringe feed with a tube, cause they didn't want me to use a bottle. Once I got home I just felt I couldn't do it, so I'd give her bottles of formula and top ups and it was like, Oh my God.... but it all worked out.

Fran had not felt prepared for the challenges of breastfeeding, or of a baby who would '*scream and scream and scream*'. Once Fran was home, she felt better able to bond with her baby, as the Breastfeeding Culture of family, friends, and a supportive midwife, helped her to work through the challenges.

I really wanted to breastfeed and it was about six or eight weeks, I think, and then it just became really easy. It was probably the biggest achievement.

It was a big achievement, and by being part of Fran's Breastfeeding Culture, her partner and her family/whānau supported Fran to breastfeed.

5.2 Breastfeeding Culture as ‘they’

Van Manen’s (1990) notion of the lived other (relationality or communality) is concerned with our relation to others in our world. We do not exist alone, but rather we are embedded in the world. Connecting with others who are breastfeeding, whether family/whānau or friends, those in the wider community or even on the Internet, can give some degree of what the reality of breastfeeding might be. Media is a significant part of today’s world, and can form an integral part of a woman’s Breastfeeding Culture.

For those who are surrounded by other breastfeeding women, breastfeeding may appear natural. Problems might be seen as less significant, with issues being discussed openly, and solutions shown in ‘real life’. The duration of breastfeeding is also impacted by the Breastfeeding Culture that the breastfeeding woman is surrounded by. Women who choose to breastfeed for longer than the first few weeks have found they may need to confront those who do not approve.

Priscilla describes two different experiences of breastfeeding in public:

My baby was really tiny and I went to this coffee shop and ordered a decaf coffee, and the waitress came over to where I was sitting and said, “oh, are you breastfeeding?” And I said, “Yes, but I do have a bottle.” Because I felt, oh my goodness, is she going to tell me off because of the coffee? But the waitress said, “If you’re here to breastfeed, do it, and if anybody says something, they will have to leave.” She was so nice and so lovely, but at another coffee shop, they were really freaking out. They didn’t say anything but by the way they behaved because I had to breastfeed, you could sense that they were not happy. I think it’s fabulous that New Zealand makes a lot of effort with breastfeeding, but they don’t support you on the outside of the world. There is a double standard. It’s like alcohol; you don’t drink alcohol in the street, but if you put it in a plastic bag, then that’s fine. And that’s the same with breastfeeding. Breastfeed, but don’t do it here. Do it in private, or go to the toilet and breastfeed. This is not okay. Even Plunket say you have to breastfeed, but only every three hours, but what if he’s hungry?

Priscilla was not born in New Zealand and found that New Zealanders were generally very supportive of breastfeeding, but as she discovered, there are certain cultural unspoken rules that are expected to be followed. There is a voice that is heard, called ‘they’ (McBride-Henry, 2010). McBride-Henry (2010) examined the experience of breastfeeding for women in New Zealand, and one of the themes to emerge from the

data was the silencing of the reality of breastfeeding, and the pervasive influence of ‘the they’. The ‘they’ is a Heideggerian term, and Heidegger explains “It is not this one, not that one, not oneself, not some people, and not the sum of them all [but] the neuter, the [impersonal] “they” (Heidegger, 1962, p164).

For Priscilla, the ‘they’ were not outspoken in their disapproval of breastfeeding in public, but their disapproval was shown by their body language, which can be just as powerful. That may be why Priscilla was almost surprised when the other café owner was supportive of her breastfeeding, and told Priscilla so. Priscilla was well aware of the double standards that societies often display, and this is confirmed within the literature (Beasley, 1991; McBride-Henry, 2004, 2010; McBride-Henry & Clendon, 2010), which suggests that in general, women breastfeeding in Western society are “supported in theory but not in practice” (McBride-Henry, 2010, p34).

5.3 Breastfeeding Culture as Social Media

When Trina found those within her own Breastfeeding Culture were not supportive in the way that Trina needed, she searched for support from other sources. While Trina and her brother were both breastfed, her mother never remembered experiencing any pain, so what might have been supportive for Trina, was in fact, unsupportive.

My mother said she had breastfed my brother and I for three months, and she told me, ‘Well it didn’t hurt me. I don’t know why it’s so hard’.

When others experience breastfeeding in ways that are outside of our own experience, it can be difficult to understand, with perhaps an unspoken pressure to conform to what everyone else does (McBride-Henry, 2010). For example, when Trina’s husband saw how much pain she was in when breastfeeding, he said: *‘Just quit, put her on the bottle.’ And while that seems supportive, it’s not, because you actually want to be able to keep trying to succeed at something that’s important’.*

Seeing someone you care for and love experiencing pain, can be difficult and is something many partners discover during labour and birth. Labour contractions are talked about in antenatal classes and often shown on television. What is less talked about is the pain that some women experience during breastfeeding. When Trina was experiencing pain while breastfeeding but was unable to find the support she needed,

Trina decided to search elsewhere. She found a new Breastfeeding Culture, and she was able to do this via Facebook.

One of the biggest supports, apart from the birthing unit, was actually a friend on Facebook, who was also struggling in the middle of the night and going, 'This is hell'. And actually just having someone else who was in the same boat. That's probably one of the biggest things, having someone to say, 'How are you? I'm dreadful. This is terrible.' And then hers coming right, which was a little bit earlier than mine, and then mine coming right too, like, 'oh my gosh, we made it.' So having someone else go through it with you.

Within this new culture were others on Facebook who were able to share the pain and difficulties and also the triumphs of breastfeeding. The breastfeeding women who were part of the Facebook group, were able to offer breastfeeding support to each other 24 hours a day, giving Trina access to someone to share her breastfeeding experiences with. Heidegger (as cited in Miles et al., 2015), wrote of mutually entering one another's world, and uncovering the meaning given to their experiences. For Trina, discussing the challenges and highlights of her breastfeeding experiences gave meaning to them, validating them and this ultimately supported her to overcome the challenges, saying, *'oh my gosh, we made it'*.

Margaret was another participant who found that initially, her Breastfeeding Culture was unsupportive. Margaret was a first time mother and she spoke about her wish for some preparation of what to expect when beginning to breastfeed, as she was unprepared for how challenging it was initially. Birth appears to be prepared for and discussed much more readily than breastfeeding. The dominant culture around breastfeeding appears to be 'it's natural' and this is often interpreted as 'it's easy'. While for some women breastfeeding might be easy, for others it might be much more challenging (Kronborg et al., 2014).

Margaret had planned to have a home birth and she had practised her breathing and relaxation techniques in preparation for labour. She was expecting labour to be hard, but had mentally prepared herself that she was going to get through it. What she didn't expect was for breastfeeding to be hard, so for her, it came as a shock.

We got told the first thing you need to do is feed your baby, and so I had in my mind it was all going to be a smooth run. Whereas if I'd had someone in front of me, even with a visual photo of the look of pain on their face, because to see pain on someone's face, that hits me. So my seeing this photo, just the baby crying, like the visual

images of seeing the child and the mother. And then have the mother talk to me about it, and then see how wonderful she's doing now, just to see that it IS hard, but you can get through it. You just see movies and it's so true, cos when a baby's just born and you see the bonding but you don't see the hard part and all the stress that goes with it in that first couple of weeks. It's more just focus on the breastfeeding; as long as you breastfeed your baby, everything else comes naturally. But it doesn't.

Because Margaret had never seen anyone breastfeeding, as she would where a breastfeeding culture was normalised, she felt unprepared for some of its challenges. Margaret felt that breastfeeding was idealised, particularly in the media, and yet what she really wanted to see, was a real woman breastfeeding – from the initial difficulties, right through to where the woman felt she had ‘succeeded’. Margaret had decided to breastfeed when she was pregnant, and her partner and family/whānau were fully prepared to support her. Research shows that when a decision to breastfeed is made early (either before or during pregnancy), a woman and her partner are much more likely to continue breastfeeding past the first six weeks (A. Brown & Davies, 2014; Datta et al., 2012; Sherriff et al., 2014).

In contrast, Trina, had already tried to breastfeed her other children, but found it too painful, so stopped breastfeeding early. During her last pregnancy Trina made the decision that she was determined to breastfeed this baby. Trina's Breastfeeding Culture had shifted during the time between her last pregnancy (several years ago), and this one. Trina had a new partner, different friends and was much older than when she had her other four children. Trina had the experience of her previous breastfeeding attempts that had not been successful, as well as having her mother, who had successfully breastfed. This gave her the ability to see both the reality of breastfeeding, but even more importantly for Trina, it gave her a goal of ‘seeing it through’.

This is my fifth child and I've been particularly determined to want to breastfeed and it's been the hardest experience of my life.

Trina also discussed the negative portrayal of breastfeeding by the media, but from a different perspective to Margaret's.

All the posters that show a baby on the boob, and they say you'll lose 500 grams a week or something. Or you're burning an extra 500 calories, and it's just push, push, push. They go, you're going to lose weight, but I was the hungriest I've ever been in my life.

For both Margaret and Trina, there was a significant difference between their expectations of breastfeeding and the embodied reality of breastfeeding. The lack of an initial positive Breastfeeding Culture impacted on both Margaret and Trina by making it more difficult to adequately prepare them for the struggles that they experienced. However, while Margaret felt the Breastfeeding Culture was not so positive within her own family/whānau, she also found a new Breastfeeding Culture, finding a friend who was able to walk the journey with her.

And my friend would come and bring me lunch, cos I wasn't even eating. And she'd say, 'look, it gets easier. My baby's six weeks old and I'm loving it [breastfeeding] now.'

And yeah, everything I was feeling, she said that she had felt like that and it's completely normal, and if I didn't have her saying that it's okay to feel like that, I'd feel like I was going looney.

While this excerpt shows some degree of 'Being With', the themes at times overlap. Margaret's friend was able to offer both physical and emotional support, by bringing her food when she could see Margaret wasn't eating, and by acknowledging Margaret's feelings, normalising those feelings, and reassuring her that what she felt was okay. For Margaret to say '*if I didn't have her saying that it's okay to feel like that, I'd feel like I was going looney*' is a powerful statement which highlights the feeling of aloneness that can occur without a supportive Breastfeeding Culture. The friendship that developed helped to create a positive Breastfeeding Culture that Margaret found very supportive.

There were other friends who had offered advice but to Margaret, they appeared to be critical rather than supportive of her breastfeeding.

'People see you not coping, and they say, 'oh try this, or try that'. I'd have friends who don't even have kids going, 'well, have you tried this, and doing this and doing that?' And I'm thinking, I've tried, don't you think I've tried? But the way my other friend came across, it wasn't as though she was in my face and saying I 'should' be doing this. It's more, well I've tried this when my baby did that, and it helped. Just the way she came across, was like she was thinking of my feelings as a new Mum, instead of just trying to throw the book at me.'

Sometimes people offer well-meaning advice, but what supported Margaret to breastfeed, was her friend who was able to normalise breastfeeding, giving Margaret a new way of managing expectations, challenges and triumphs. Margaret was surrounded by a Breastfeeding Culture that supported her to breastfeeding successfully.

5.4 Conclusion

This chapter has examined the importance of a supportive Breastfeeding Culture that surrounds a breastfeeding woman. Each person will come with their own understandings of what breastfeeding means, and these understandings are passed down from generation to generation. There are many influences on culture, which include family, friends, books, the media, magazines and television. If the Breastfeeding Culture that surrounded a breastfeeding woman was not supportive, some of the women in this study found other ways of creating a new Breastfeeding Culture by using Facebook, or finding other breastfeeding friends with whom to share the journey. For some of the women in this study, they understood breastfeeding through the voice of the 'other' or 'they', where the wider community or culture can be heard in either approval or disapproval (McBride-Henry, 2010). In New Zealand society 'they' say that all mothers should breastfeed, but not in public and not for too long. This study has shown how breastfeeding mothers have sought out support through family/whānau, friends and social media such as Facebook.

Women also need to feel safe in order to breastfeed, and it was found that the environment women breastfeed in is important. This is discussed in the following chapter.

Chapter 6 Breastfeeding Space

This chapter examines the theme that emerged from the data, of a Breastfeeding Space. Women need to feel safe in order to breastfeed, and the environment or space they occupy and how they experience it, contribute to this. L. Hunter (2009) found in her study of ‘being with woman’ during labour and birth, that women needed a home-like environment to support their efforts in birthing. This resonated with the women in this study, as they too, found they wanted a home-like environment, to feel comfortable, and to have control of their Breastfeeding Space.

6.1 Breastfeeding Space: the physical

Annabelle described the difference between the birthing unit, which had single rooms, and the hospital, where she was required to share a bathroom.

At the birthing unit, they've got such a homey feeling. You walk in and you feel just like you're at home. You've got your own little room; your own little bathroom and some of the rooms have a little balcony that you can go out to and stuff. They've got a double bed, and a little bassinette that's attached to the bed. And it's just that that's what you need to make you feel comfortable, because after staying in the hospital with my twins, I didn't feel comfortable. It was all white walls, and white floors and this tiny little bed that I was scared I was going to fall off or drop my babies off. And sharing the bathroom was horrible. I didn't even want to go to the bathroom.

Annabelle experienced the contrast between the starkness of the hospital, which had white walls, white floors and narrow bed, with the comfort and privacy of the birthing unit. The difference was very noticeable to Annabelle, because at the birthing unit it ‘felt like home’. The birthing unit provided Annabelle with a home-like space, where she could breastfeed her twins in a home-like environment where she felt comfortable. Breastfeeding is a deeply personal experience and needs to be learnt in a safe, private and comfortable space.

Fiona also commented on the nature of the Breastfeeding Space at the birthing unit, saying:

It's the room, because it's a proper bed, a double bed. You've got bedside tables, and it's bigger so if your visitors come, they've got space.

Fiona felt supported in her breastfeeding by having a comfortable, home-like environment. She had space for her visitors, and she spoke of a proper bed, with bedside tables. What Fiona found in the birthing unit, was a supportive Breastfeeding Space, where the environment was similar to that of home, so it was private, safe, and comfortable, where she could invite her visitors in. According to Hammond, Foureur, Homer, and Davis (2013) in their study of space, place and the midwife, space sends powerful messages about power, position and productivity. Even when a space is empty, it still conveys a message about ownership. For example, there is usually a marked difference between a community birthing unit, and a multi-storied hospital. The space is set up differently, for different purposes, and usually a hospital is owned by those who work within it, while there is usually a more family/whānau oriented feel to a birthing unit. It has been set up to be more home-like, so the women and their families who use them feel more comfortable (Hammond et al., 2013). Feeling more comfortable within an environment supports women to breastfeed.

6.2 Breastfeeding Space: those that enter it

Sometimes the support we expect to experience from a particular space or those that enter it, is not forthcoming. Margaret had a homebirth, where everything went really well. She chose to go to the local birthing unit where she thought she would receive one-to-one support for her breastfeeding. Perhaps Margaret also thought the staff would be in control of the visitors, which she felt unable to control herself at home. However, things did not go according to plan, as she explains.

The ladies at the birthing unit were so nice. It was just a shame on that particular day, that the person on duty was letting just anybody come in. Not just during the 2 till 8pm visiting hours. So I had visitors from 9 in the morning until late at night and then, well the next day I had more visitors and it was just chaos. Because people weren't just staying for ten or fifteen minutes, they were staying for three hours. It was crazy! ! I reckon that because I had the perfect birth and my baby fed really well after the birth, then when we got to the birthing unit, there were just too many interruptions. And then as soon as we got home again, too many interruptions, and I felt I couldn't breastfeed because I didn't get the one-to-one with the midwife at the unit that I should have.

Margaret was unable to control who came and went in her Breastfeeding Space. There were too many people in her space, both at the birthing unit and at home. Within the hospital or birthing unit it is important for midwives to ascertain what it is the woman

needs, in terms of visitors, while enabling the breastfeeding woman and her partner and family/whānau to control it. Sometimes the breastfeeding woman might want total quiet and peace in which to breastfeed, but conversely, she may want to have all her whānau/family and friends with her for support. It is important that the breastfeeding woman is in control of her space, where she decides what is best for her.

Margaret was unable to control her Breastfeeding Space when she first went home.

For the first two weeks, it was just car pull in, dog go off, people come in. And they just set up camp with a box of beers and just hang out for a bit. And I'm just thinking like, oh, just take (her partner) with you if you just want to hang out with him, just take him away. Leave me and the baby. I was ringing my midwife going, "I can't feed my baby".

While Margaret felt comfortable within her home environment, it was the number of different people coming and 'setting up camp' that impacted on her breastfeeding, to the point where she felt unable to feed her baby. The lack of privacy, as well as lack of control over who came and went within her home, did not give her the space that she needed in order to breastfeed comfortably. When so many visitors wanted to come and celebrate with Margaret's partner, he was unavailable to Margaret and their baby while entertaining his friends. Once Margaret had control of her space, and could ensure that she, her partner and their baby could have private, uninterrupted time to focus on breastfeeding, then she felt supported to breastfeed. In fact, once Margaret had the Breastfeeding Space as she needed it to be, she preferred to stay there until she was confident with her breastfeeding skills.

What helped me was just staying home, and not going anywhere. The first couple of months I wouldn't go out in public, not even to the supermarket. I just didn't want to leave home because I felt like I didn't want to breastfeed in public, because I didn't have it sorted, and so I wasn't comfortable going anywhere until I was okay with breastfeeding.

Margaret's home became her special Breastfeeding Space, a place where she felt secure, private, free from the judgement of others, where she could hone her skills in breastfeeding until she developed enough confidence to venture out.

When Priscilla had her baby by caesarean section, she spoke of how she felt while in the recovery room, which by its very nature is clinical, and not home-like.

I felt pretty overwhelmed because they said I was too cold, so they put this air heated blanket on me, then I had a nurse on my left side, then another on my right side, trying to make my temperature go up. And then someone else tried to just put the baby on my breast to make him breastfeed. And that was too much. It was not respecting of my body, not to ask or whatever. It was really too invasive for me.

Priscilla felt overwhelmed; she was surrounded by staff who did not appear to be talking to her, but doing things to her. She felt disembodied as the staff (who were doing the job that needed to be done), separated her body and the things that needed doing to it, from Priscilla as a woman and new mother. Priscilla felt disrespected as someone attempted to put the baby to Priscilla's breast without asking. For Priscilla, this was 'too much, too invasive' for her.

Sometimes the Breastfeeding Space is not created by the physical comfort of a room, but by the people who are within it. Trina found the midwives at the birthing unit to be supportive, which created a supportive environment for her.

At the birthing centre they were just brilliant. They would say every time before you latch, just ring us, and I'd ring them. They would come in every time before I latched and check to make sure my position was right and the latch was good. They gave me videos to watch while I was there. So for two or three days, while I was there, it was really good support.

What supported Trina to breastfeed was having control over who came into her space, and when, and how people behaved in her space. Staff said to ring the call bell when she was breastfeeding and they would come in to check she had positioned her baby well. For Trina this created her own space that she had control over. She could choose to ring, or not, therefore creating the environment that she wanted and this supported her to breastfeed. However, Trina did choose to call the staff every time she was breastfeeding and she welcomed them into her space. She knew she could trust them to come when she rang, and not to come when she didn't. When staff entered her space it was not intrusive, it was just to confirm to Trina that she had positioned her baby well. Trina describes this as 'brilliant' and 'really good support'. In Hammond et al.'s (2013) research which examined space, place and the midwife, it was found that midwives do play a role in shaping and maintaining the space within the hospital or birthing unit. They also found that the "feelings experienced as a response to the environment play a role in constructing the activities, behaviours and interactions that unfold within it" (p279).

The presence of another person impacts on the space a breastfeeding woman is in. A supportive presence within that space creates a home-like ‘feel’ and encourages a woman to use her own strength to cope with the challenges that learning a new skill can bring. This applies just as well to learning to breastfeed a new baby, as it does to a woman learning to cope with labour and birth.

Annabelle talked of her first night in the birthing unit:

They’re amazing there, they were really nice. That first night, I was so exhausted because I hadn’t slept after the birth, and one of the midwives came in and she just sat next to the bed and latched my baby on to breastfeed, and watched her and then burped her and put her back into bed. So it was a huge help, where you just felt like you’re at home.

Annabelle felt that her midwife was present to her needs, as she acknowledged Annabelle’s need for sleep. Annabelle’s midwife was able to spend time with her, creating a Breastfeeding Space that was peaceful, unhurried, calm, and quiet; this was helpful in a practical way. This supported the Breastfeeding Space, which supported Annabelle to breastfeed.

6.3 Breastfeeding Space: creating it

Once home, a new mother can, ideally, create her own Breastfeeding Space, where she has what she needs at her fingertips; for example food and drink that is easy to access and eat. Trina was disappointed that no-one had shared this information with her.

No-one says you need a little nursing station set up and it would be really good to have some protein and some cheese and some crackers and some drink. Lots of water in and every time you feed, you have a big drink of water or whatever. No-one is actually saying that and preparing you for that. So how on earth are you supposed to know this?

Adequately preparing the space for a breastfeeding mother is important, both at home and within the hospital. Ready access to quick and healthy snacks and water are small things that make a big difference. This is another example of women having control of their own space, having what they need close to hand, not having to ‘ask’ for what they need.

6.4 Breastfeeding Space: owning it

Another participant, Priscilla, found she had to challenge those who supported her when she was at home. Home was Priscilla's comfortable Breastfeeding Space, so despite being so tired, she didn't always want to sleep; she wanted to do the normal things she usually did at home.

So when my baby was asleep, I wanted to do something completely different, not just breastfeeding or sleeping. So, I was baking and doing the cooking. I was doing the normal things I always did in my life, and everybody was saying, 'you have to sleep'. And I really got annoyed and I said, "Stop it. It's my life and my decision. I want to do dinner. I love doing it and it gives me a normal feeling, so give me a break." They were really nice; I know they were just caring about me, because I was overwhelmed.

When Priscilla came home from hospital, she wanted to normalise her environment so that it once more became the space she was used to. Priscilla said she felt overwhelmed and she needed to gain control over her own space once she was home. Breastfeeding women need privacy and comfortable home-like spaces in order to learn new skills and consolidate them. Breastfeeding is perhaps more complex than many new skills, as both the mother and the baby are learning something intimate and very important.

The home is a special place, according to van Manen (1990), which is fundamental to our sense of being. It is where we feel most protected, is linked to our inner sanctity and is where we can be ourselves. When at home, a woman can feel in control, where she can be herself. Home links us to everything else out in the wider world. When we leave there we go home (van Manen, 1990).

When a breastfeeding mother is at home, they often have their partner or their mother to support them, and when Annabelle said she felt like she was at home, it was the support of the midwife who had created the lovely home-like atmosphere, which she was referring to. Feeling like she was home supported Annabelle to be comfortable; this supported her breastfeeding.

Fiona described the effect of a lack of supportive Breastfeeding Space while in hospital, once she was no longer able to be in a single room.

The first night when I was in hospital, I had my own room. The second night I was meant to go to the birthing unit, but they were full. So I had to stay at the hospital and then I went into a joint room with

another person. So when I had to go to the toilet, it was, well you had to go down the corridor and into the bathroom, and I didn't want to leave my baby. Then I'd have to call the nurse, and I'd have to be helped up and someone else would have to look after the baby.

Fiona found she had no privacy, as she was sharing a room with another mother and her baby. The bathroom was not in the room, but down the corridor. Fiona needed support to get there and she was reluctant to leave her baby on her own. In contrast to being 'at home', where there is a sense of safety and security, the hospital room meant sharing with someone Fiona did not know, and leaving her baby with a stranger if she needed to visit the bathroom.

6.5 Breastfeeding Space: as home

Often, the space we inhabit goes unnoticed, as it might if we are comfortable in the space, like when we are at home. When the spaces we occupy are comfortable and safe, they encourage learning (Miles et al., 2015). Some women felt comfortable in their Breastfeeding Space and were supported to make this their 'own' space. For example, Annabelle's description of the birthing unit, where she described it as being "*just like home,*" or Trina's description of the birthing unit where she stayed, and she experienced "*really good support.*" The Breastfeeding Space enabled both women to relax and feel safe, which supported their breastfeeding. To relax, women need to feel they have control over their space; who is invited into it, how the people that are invited in make her feel. The space needs to be large enough to be comfortable, where a breastfeeding woman can have her partner, their families and friends. When the Breastfeeding Space is home-like in this way, women experience support to breastfeed.

6.6 Conclusion

The women in this study spoke of wanting to feel comfortable and home-like when they were breastfeeding. They also wanted to feel in control of the Breastfeeding Space. Space and place are not necessarily just inanimate or functional. A building or a room is of necessity serving a purpose, but the furnishings, the décor and even the floor plan itself, can tell a story of who the space belongs to. When a space is home-like, it gives power to the owner of the space, and for the women in this study, when they were at home they were in control. The women in this study were supported when the people that were within their Breastfeeding Space were able to be invited in.

The following chapter discusses how the research question of ‘what is the meaning of breastfeeding support for New Zealand mothers in the first six weeks postpartum?’ is answered.

Chapter 7 Discussion

The three themes identified from the data analysis answer the research question and its aims: What is the meaning of breastfeeding support for New Zealand women in the first six weeks postpartum? The women who participated in this study identified the meaning of support by the following:

- The positive relationship between the breastfeeding woman, and those that support her with an authentic presence was identified as ‘Being With’.
- The Breastfeeding Culture that a woman and her partner grow up with and are part of is often supportive, but sometimes is not. The women in this study either enjoyed a supportive Breastfeeding Culture, or built a new culture that supported their breastfeeding.
- The Breastfeeding Space, whether in the hospital, home or community, supported women to breastfeed when it was a ‘home-like’ safe environment and the women felt in control of it. A Breastfeeding Space is how the women feels within in it, as much as the physical space that she is enclosed by.

This chapter discusses the themes, situates the findings within the literature, and makes recommendations for practice, education and research. This chapter will also discuss the additional finding of the Breastfeeding Triad. While it is not a theme, as it does not answer the research question, the Breastfeeding Triad does have implications for practice.

7.1 ‘Being With’

The first six weeks after giving birth, is a time of new beginnings. For those who have had their first baby, it can be a significant learning curve, from learning how to hold a baby for breastfeeding, to learning to read their breastfeeding cues (Liu, Chen, Yeh, & Hsieh, 2012). Even for parents who already have children, it can mean adjusting to having a new baby in the family, and for siblings, learning their new role as big brother or sister. Promoting skin to skin contact between mother and baby, and encouraging an early breastfeed within the first hour after birth, both contribute to confidence building from the very first breastfeed. The more confident the breastfeeding mother becomes, the more likely she is to continue to breastfeed (Sriraman & Kellams, 2016).

The women who participated in this study spoke of the importance of how the people who surrounded them interacted with them. When they were authentically present, rather than being simply physically present, they were then an active participant in the relationship with the breastfeeding woman (O'Boyle, 2013). This emerged from the data as the theme of 'Being With'.

Hunter (2009) described 'Being With' as "the provision of emotional, physical, spiritual and psychological presence/support" (L. Hunter, 2009, p20). The literature discusses 'Being With' in many ways: being present for, being receptive to, being available to, or in connection with (Berg, Lundgren, & Wahlberg, 2008; J. Brown, 2008; Davis-Floyd & Davis, 1997; Lundgren & Berg, 2007; O'Boyle, 2013; Pembroke & Pembroke, 2008).

For most of the women in the study, their partners were identified as being very important to their successful breastfeeding. Many of the participants shared their distress when their partner was unable to stay in the hospital with them for the night, following the birth of their baby. The women spoke of their distress as being more than the physical loss of their partner; it was that they missed being able to share the parenting role together or being there to lift the baby to them when unable to move; supporting them to breastfeed. Not having their partners there through the night made some of the women in the study feel '*horrible*' without them. The breastfeeding women in the study spoke of their partner being emotionally available to them, sharing time with them. They spoke of their partners' active involvement in the care of their baby, as well as in the breastfeeding. 'Being With' encompassed their partner walking the journey with them, of being there when breastfeeding was tiring, painful, or challenging. They were there when it was successful, and easy.

Partners of the breastfeeding woman often embody 'Being With' by their belief in their partner's ability to breastfeed their baby, and by listening to both verbal and non-verbal cues. The literature focuses more on the midwifery aspect of 'Being With', although there is a growing body of literature that supports the importance of the relationship between the father/partner as being a vital component of initiation and maintaining breastfeeding (Cisco, 2017; Clifford & McIntyre, 2008; Datta et al., 2012; Kaunonen, Hannula, & Tarkka, 2012; Mithani et al., 2015).

The women in this study also spoke of the importance of the midwifery staff, particularly when they felt the midwife shared time with them and listened to what they needed. The breastfeeding women noticed when their midwife sat quietly with them, perhaps observing a breastfeed, being mostly hands off, but supporting in their attitude and belief in the woman's ability to do it herself; this shows an authentic presence. In the literature, 'Being With' is a term more commonly recognised in labour and birthing research (L. Hunter, 2015). Postnatally, when working with women learning to breastfeed, 'Being With' may mean being authentically present, being respectfully present, giving of time and self (L. Hunter, 2009, 2015; O'Boyle, 2013). 'Having time' for the breastfeeding woman in this study, was mentioned in the data when some of the participants felt the midwife was unable to be present, either physically, or emotionally, to them, and equally, when the midwife was able to sit with them, giving them uninterrupted time, this supported women to breastfeed.

O'Boyle's (2013) ethnographic study of home birthing midwives in Ireland, found that Being With is "more than a passive presence, it is an active engagement with the woman" (p206). The study explored the dichotomy between 'Being With' and 'Being Professional'. 'Being With' is a relational concept, as it is in the finding of this study. 'Being With' also describes a belief in the woman's ability to breastfeed her baby. For a midwife, 'Being With' is ensuring the partnership is maintained, that the breastfeeding woman remains autonomous and supported. It is a shared relationship, and according to O'Boyle (2013), the midwife is the gatekeeper, protecting the space for the mother. And while O'Boyle (2013) was specifically talking of birthing, the concept of 'Being With' relates equally well to the early days of breastfeeding and beyond.

Louise Hunter (2015) uses similar phrases when explaining the concept of 'Being With' women in labour. 'Being With' is defined as giving "emotional, physical, spiritual and psychological presence/support" (L. Hunter, 2015, p20). Hunter (2015) also believes relational support was just as crucial postnatally. 'Being With' women is a relationship built on trust, mutuality and care. The concept of 'Being With' implies an equality in the relationship, where presence is about standing back, hands off, and building up a breastfeeding woman's confidence and her ability to successfully breastfeed her baby.

L. P. Hunter (2002) reviewed the literature concerning the concept of 'Being With' women during childbirth. She described work by Belenky, Clinchy, Gokldberger, and Tarule (1986), where the term 'midwife-teacher' was apparently first used. They wrote

that ideally, midwife teachers assist students to give birth to their own ideas. ‘Thus’, says Hunter (2002), “midwife-teachers are present and available but do not tell the student what to do or how to think” (p651). When midwives and other health professionals are ‘Being With’ a breastfeeding woman, they are also present and available to her, but they too, refrain from telling the breastfeeding mother what to do or how to think. In this study the women described feeling supported to breastfeed when those around them were authentically present with them.

7.2 Breastfeeding Culture

The culture that surrounds a breastfeeding woman has a significant impact on whether and for how long, she breastfeeds (McBride-Henry, 2010). The breastfeeding women in this study all spoke of how the people that surrounded them impacted on their breastfeeding progress. Their attitudes, beliefs, and traditions about breastfeeding, will impact on a breastfeeding woman by affecting how she interprets her breastfeeding experience. For some of the women in the study, the Breastfeeding Culture that they were surrounded by was made up of their whānau, their extended family of siblings, parents and cousins, which normalised breastfeeding, making it a positive experience. For others, the Breastfeeding Culture they were surrounded by was not so positive, so they searched for new ways of building a positive Breastfeeding Culture for themselves. The Breastfeeding Culture extends to the wider influences of media, books and television, and they each send subliminal messages that support and encourage breastfeeding, or conversely, send messages that can negatively impact on the initiation and duration of breastfeeding. In New Zealand society, it is expected that a mother will breastfeed her baby; although there is also the expectation that they will stop breastfeeding well short of the recommended six months exclusive breastfeeding (Alianmoghaddam, Phibbs, & Benn, 2017b; McBride-Henry, 2010; World Health Organization, 2011).

Understanding the socio-cultural context is critical to how midwives support women to breastfeed, as the culture a woman is surrounded by, impacts on how women learn about breastfeeding, or even whether they breastfeed (Dykes, 2011; Dykes & Flacking, 2010). For the women in this study, the Breastfeeding Culture that surrounded them, and how they experienced it, impacted on their breastfeeding in a variety of ways. For some of the participants in the study, the Breastfeeding Culture that surrounded them was positive, giving them the belief that it was assumed breastfeeding would happen.

For others, the Breastfeeding Culture that surrounded them was more challenging, where most women in the family had not breastfed, and breastmilk substitutes were a more viable option.

A Breastfeeding Culture is made up of the breastfeeding beliefs, traditions, family, friends, social media and the community, and these can all contribute in a way that might be supportive or sometimes less than supportive. What supported the women in this study to breastfeed successfully, was the Breastfeeding Culture that surrounded them. For those that found their immediate Breastfeeding Culture was more challenging, they looked further afield, to social media like Facebook to create a positive Breastfeeding Culture for themselves.

7.3 Breastfeeding Space

Some of the women in this study described how the postpartum birthing unit they transferred to after giving birth, often felt more supportive than the hospital they had come from. The women described the postpartum birthing unit as home-like, and they spoke of having privacy and a feeling of comfort. Sometimes it was the people who come into a breastfeeding woman's space that impacted on how the Breastfeeding Space felt. When the breastfeeding space appeared very busy, either with people or with frenetic energy, as it did when the staff were rushed, the feeling of the space changed. Some of the participants commented on how the busy-ness of the breastfeeding space impacted on their breastfeeding activity. Time, or lack of time, can impact on breastfeeding support and how breastfeeding mothers perceive it (L. Hunter, Magill-Cuerden, & McCourt, 2015). The participants also felt supported when they felt they had control over the Breastfeeding Space they were in.

The women in this study, spoke of being rushed when they were learning to breastfeed their newborn baby for the first time, of trying to sit up in an uncomfortable bed, where the sheets may or may not have been changed after giving birth, and trying to latch their baby to the breast. Women stated that they wanted to be in a clean, tidy, comfortable space, to learn about breastfeeding their new baby. They spoke of wanting to share this space with their partner, so they could learn the skill together and develop a bond with their new baby.

Participants described the Breastfeeding Space as sometimes being the physical space they occupied, but it was more often described in terms of how the space made them

feel. In this study, women spoke of the need to feel safe, comfortable and at ease within a space, in order to breastfeed for longer than a few days or weeks. The space they are in, may impact on whether, or for how long, women breastfeed (L. Hunter et al., 2015). The breastfeeding women in this study often spoke of how important it was that their partner was able to stay with them in the first few days after birth, and particularly overnight. Some of the women described being isolated or alone in the space they were given, especially when staff were too busy to attend to them.

When the Breastfeeding Space was supportive, the participants described having a space where they felt in control, where they could decide who visited and when; where midwives came in when they were invited. The Breastfeeding Space sends a message about whose space it is. The layout of the room, whether set up for the hospital or the woman who occupies the room, tells the story of who holds the power. The atmosphere created by those within a space also impact on the space. When the atmosphere is calm and unhurried, it may engender trust, and trust is important when building a relationship, or learning a new skill like breastfeeding (Meedya, Fahy, Parratt, & Yoxall, 2015). The breastfeeding women in this study spoke of feeling supported to breastfeed when the Breastfeeding Space was safe, comfortable and the women felt they had control over their space and who came and went within the space.

When the participants in the study went home, they tried to set up their Breastfeeding Space to support their breastfeeding. The participants spoke of feeling secure, free from the judgement of others, where the skills of breastfeeding could be developed in peace. Some of the participants related how they would stay at home until they felt their breastfeeding was 'under control'. However for other participants, the information and teaching on setting up their Breastfeeding Space, was lacking. Some of the women in the study commented on how disappointed they were, that this was not taught in antenatal classes, as this may have supported them to establish their breastfeeding routine earlier.

Participants in this study also spoke of how the physical room they were in, impacted on their breastfeeding. When the room was single, with an ensuite bathroom, they spoke of it being home-like, which they described as being safe, private, quiet and peaceful. Yet most of the women said they felt comfortable that the midwife was close at hand should they be needed. The midwife came when called and she listened to the breastfeeding mother, rather than assuming they knew what was needed. The women in the study also

spoke of needing a large enough room, of needing a double or queen size bed, where their partner was welcomed and acknowledged as a crucial part of the relationship between the breastfeeding mother and their baby. The Breastfeeding Space also needed to be large enough to invite their friends and family/whānau into, as this supported the women in the study to breastfeed. The Breastfeeding Space needed to be home-like for the women in this study, and particularly in the early days following the birth of their baby, this supported women to breastfeed.

7.4 Breastfeeding Triad: A new finding

What also emerged from the data was the new notion of a Breastfeeding Triad, which includes a breastfeeding mother, her partner or significant other, and their baby. Other literature has referred to a breastfeeding dyad (Brennan & Callaway, 2014; Dieterich, Felice, O'Sullivan, & Rasumssen, 2013; Johnson, Mulder, & Strube, 2007); however the breastfeeding dyad appears to be described as two parts of a breastfeeding pair, whereas what emerged from the data in this study, was the finding that the breastfeeding triad is deeply personal and relational. The partner shared the breastfeeding experience, supporting with latching if required, bringing the baby to the breastfeeding mother, walking alongside them, making decisions about breastfeeding together, thus strengthening the parenting bond (all the women in this study had partners, however this could be a significant other, someone who shared in the role of partner, support person for the breastfeeding mother). When the data was being analysed, it was noticed that the women in the study spoke clearly about how important their partner was, but it was more than the theme of 'Being With'; it seemed to encompass this theme, but take it further.

Annabelle said,

when my partner could stay with us, it made a huge difference, because they're parents too, and they need to be there. When the midwife said, 'just call if you need us', I didn't call them to help me throughout the night, because I didn't want their help – I wanted my partner there.

The midwife was offering support, letting Annabelle know she was available to her, but it Annabelle didn't 'need' the midwife. This implies it was more than the physical presence she wanted; it was her partner, sharing the parenting with her.

Priscilla explained it this way:

When I was grumpy and tired and all overwhelmed, my husband was really patient and lovely. Nobody else but my husband, he was taking it! So we were on the same page together, and we kept close.

Priscilla was able to be herself with her husband, even when tired and overwhelmed. Priscilla and her husband shared the ups and the downs, supporting each other and staying close. When the Breastfeeding Triad of a mother, her partner and their baby are supported, it strengthens their relationship, and supports breastfeeding.

Sherriff et al. (2014) discussed ‘father support’ in their study, and found that fathers were an undervalued resource, with many health professionals failing to engage with fathers in supporting breastfeeding. Partners need to be included in breastfeeding education, with relevant and specific information shared with them. The information needs to be consistent, and the method of delivery must enable partners to feel confident enough to ask the difficult questions. Education also needs to include practical information, which is designed to support parents to manage breastfeeding expectations more realistically by reducing anxiety around common breastfeeding issues, for example nipple pain, or concerns about baby’s weight (Sherriff et al., 2014). The Breastfeeding Triad acknowledges that not all fathers are partners, and not all partners are men; it is the person providing the parenting role to the breastfeeding child, along with the close relationship with that child’s mother that is important. The Breastfeeding Triad contributes to the theme of ‘Being With’, Breastfeeding Culture and Breastfeeding Space. It was not a theme that answered the research question, but rather a thread that appeared in all the themes.

7.5 A Comparison of the literature

This section compares and contrasts the themes that emerged from the findings of this study with what is currently known about support for breastfeeding.

The women who participated in this study confirmed that women feel supported to breastfeed when the people that surround them, are being authentically present to them. This concept is acknowledged in the literature, although most commonly it is discussed in terms of labour and birthing (L. Hunter, 2009; L. P. Hunter, 2002). However there is more recent research which supports the findings in this study, confirming that the postpartum period is just as important as labour and birthing (Jones, Jones, & Feary, 2016).

Partner support as ‘Being With’ was highlighted as being significant to the women in this study. The women spoke of how they felt when their partners were unable to stay overnight in the hospital, and what that loss meant to the women. It was more than not having ‘someone’ there. It was their partner, the other parent of their baby that the women spoke of needing in order to feel supported. A breastfeeding mother and her partner need time to learn breastfeeding together, as this strengthens the bonds of their relationship, which in turn strengthens the relationship with their baby (Datta et al., 2012). The need to work together within this partnership encompasses the notion of the Breastfeeding Triad. There is nothing in the literature that describes or discusses the notion of the Breastfeeding Triad, even though a breastfeeding dyad is referred to in more than one study. The women in this study spoke of trying of new things together, working out what was helpful, and realising together that breastfeeding could sometimes be challenging but worth the effort.

The women in this study also felt supported to breastfeed by other family/whānau members, friends and the wider community. In this study, Breastfeeding Culture was important, as the breastfeeding customs, beliefs, traditions and ways of being that surround a woman inform her own experience of breastfeeding.

The Breastfeeding Space emerged from the data as being important; when it was comfortable, home-like, and encouraged the woman to have control over the space, it supported women to breastfeed. This was, a finding that was also found to be important in the Australian study by Ryan, Todres, and Alexander (2011), which examined the “interembodied experience of breastfeeding” (p731). This qualitative study interviewed 49 women, and found three central dimensions of the phenomenon, “calling, permission, and fulfilment, which occurred within the protected space provided by the mother, a space that was easily disrupted by unsupportive postnatal practices” (p731).

Being comfortable in their environment was seen as important by other studies (Davis & Walker, 2010; Hammond et al., 2013; James, Sweet, & Donnellan-Fernandez, 2016), and while some of these studies spoke specifically of birthing spaces, there is a link between the needs of birthing women, and breastfeeding women, as this study has found. While the findings from this study have been found to be similar to other research (for example, see Alianmoghammad et al., 2017a, 2017b; L. Hunter, 2015; McBride-Henry, 2010; McBride-Henry & Clendon, 2010; Ryan et al., 2011), it is acknowledged that this is a small, qualitative study, and qualitative studies are not

generalisable to other populations. This study describes what six New Zealand women have said is the meaning of breastfeeding support for them.

7.6 Limitations of the study

Hermeneutic phenomenology requires smaller numbers in order to study the essence of a phenomenon. It attempts to interpret and understand the phenomenon with depth and richness (van Manen, 1990). This is sometimes seen as a limitation of the study, as it means that what has been described and interpreted through the data analysis of the women interviewed, will not necessarily be replicated by other breastfeeding women. Other breastfeeding women may have had different experiences within the hospitals or birthing units in other parts of New Zealand. However, the richness of the data from a small number of participants has enabled understanding of the nature of breastfeeding support to be revealed for these women. Another possible limitation of the study, is that all the women interviewed had supportive male partners. For women without supportive partners, the results may well have been different. If the breastfeeding woman was very young, or had few supports available to them, the results could also have been different.

7.7 Implications for practice

Findings from this study have shown that when a relationship of trust and authenticity is built between a health professional and a breastfeeding woman, it encourages and supports breastfeeding. Health professionals have a responsibility to promote the ongoing breastfeeding relationship by supporting the Breastfeeding Culture that a breastfeeding woman is surrounded by. A breastfeeding woman does not stand alone, but is connected to others by her beliefs, her traditions, her family /whānau and her friends. When health professionals are able to encourage these links, a breastfeeding woman is supported. According to the findings, the space that a woman breastfeeds in is also important, as she needs the Breastfeeding Space to feel home-like, comfortable and safe. A breastfeeding woman also needs to feel in control of the space she breastfeeds in. When health professionals acknowledge the importance of this with an awareness that the space ‘belongs’ to the breastfeeding woman, it builds trust and confidence, and this in turn supports women to breastfeed. For those in positions of decision-making within hospitals, the rooms need to be planned with comfort and privacy for breastfeeding women, a priority.

The Breastfeeding Triad also has important implications for practice. When the Breastfeeding Triad is encouraged by including partners in education on breastfeeding, ensuring they feel valued, it contributes to the building of a strong breastfeeding relationship, which has the potential to remain strong even when the health professional is no longer seen on a regular basis. In the early days following the birth of a baby, the Breastfeeding Triad could be acknowledged and supported by the hospital or birthing unit, to encourage the development of this important relationship.

7.8 Implications for education

The findings of this study for student midwives, registered midwives and other health professionals are important. Students could benefit from the findings by understanding and acknowledging the importance of ‘Being With’; being an authentic presence with a breastfeeding mother. The relational aspects of the midwife/student/breastfeeding mother are taught by most Schools of Midwifery in New Zealand, however, it may be helpful for students to have more contact with breastfeeding women, with a focus on ‘Being With’ them.

It may also be helpful for students and midwives to acknowledge the importance of the Breastfeeding Culture that surrounds a breastfeeding woman; that it includes her family/whānau, her beliefs, her traditions and those she comes in contact with. If students and health professionals understand the impact that a positive Breastfeeding Culture has, then the student may be able to pass this knowledge on.

The Breastfeeding Space could be discussed with students to enable understanding that the space a woman breastfeeds in is more than the physical space she occupies. Whether at home or in hospital, the Breastfeeding Space needs to be ‘hers’, where she is in control of the space where she breastfeeds.

Teaching could also include the importance of the Breastfeeding Triad, ensuring the student understands how important it is that the partner is encouraged to feel as valued as the breastfeeding mother, and that the baby is acknowledged as theirs rather than just hers.

7.9 Implications for further research

It would be useful to focus further research on a partner’s perspective of breastfeeding, in order for knowledge about the Breastfeeding Triad to be strengthened. It would also

be useful to examine how effective antenatal breastfeeding education is, and whether this is an area that needs to be strengthened or redefined. It would be of benefit if the larger hospitals were to examine how the space is defined from both a woman's perspective, and also those of her partner, as this may impact on breastfeeding. Breastfeeding is known to be of significant benefit to the baby and the mother. It is also known to impact her family/whānau, her community and ultimately to the country where that woman resides. It is critical that we as a nation examine in more detail, what supports women to breastfeed for longer than six weeks.

7.10 Conclusion

Breastfeeding in the first six weeks postpartum is an important time to establish a healthy breastfeeding relationship, setting the foundation for the potential to continue breastfeeding for at least six months and beyond. The themes to emerge from the data add to the body of breastfeeding knowledge that already exists, and highlight the importance of understanding what supports breastfeeding women to breastfeed. 'Being With' was the first theme to emerge, and when those who surround a breastfeeding mother are 'Being With' her, they show an authentic presence which is more than a passive presence, it is an active engagement with the woman (O'Boyle, 2013). The participants in this study spoke of how this supported them to breastfeed. Meanings of breastfeeding can be passed down through the generations, and when it is positive, it can support breastfeeding. A Breastfeeding Culture is made up of the breastfeeding beliefs, traditions, family, friends, social media and the community, and these can all contribute in a way that might be supportive or sometimes less than supportive. If the breastfeeding experiences within her Breastfeeding Culture have been negative, it can be helpful to acknowledge these. Discussing a woman's background and culture can give insight into how best to encourage her to find other avenues of support, as some of the women in this study were able to do. This study has also revealed an understanding of what a Breastfeeding Space is and its importance in providing support for a breastfeeding mother. When the Breastfeeding Space is home-like and comfortable, and the breastfeeding woman feels she is in control of it, women feel more comfortable to breastfeed.

This study confirms previous research on breastfeeding support, and contributes an additional finding that suggest acknowledging and encouraging the Breastfeeding Triad is also a significant support to breastfeeding women. Understanding the role of the

Breastfeeding Triad has implications for practice. Health professionals can ensure partners are included in breastfeeding discussions and education. This could include positive ways for partners to bond with their baby, for example bathing, story reading, dressing, or taking baby for a walk. Acknowledging the importance of the emotional support partners give their breastfeeding partner (for example, actively engaging with their breastfeeding partner, offering encouragement and affection; being supportive of their partner when breastfeeding in public), will give them practical and specific information which will help support their breastfeeding partner. Health professionals can also reinforce the important role a partner plays in breastfeeding decision making. When the Breastfeeding Triad is supported, the breastfeeding relationship is supported.

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Appendix A: Transcriber Confidentiality Agreement

Confidentiality Agreement



Project title: What is the meaning of breastfeeding support for New Zealand mothers in the first six weeks postpartum?

Project Supervisor: Dr Andrea Gilkison, PhD

Researcher: Barbara Richards, RCompN, RM, PGDip

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

.....

Transcriber's name:

.....

Transcriber's Contact Details (if appropriate):

.....

.....

Date:

Project Supervisor's Contact Details (if appropriate):

Dr Andrea Gilkison, andrea.gilkison@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 27th November 2014, AUTEK Reference number 13/349

Note: The Transcriber should retain a copy of this form.

Appendix B: Typist Confidentiality Agreement

Confidentiality Agreement



Project title: What is the meaning of breastfeeding support for New Zealand mothers in the first six weeks postpartum?

Project Supervisor: Dr Andrea Gilkison, PhD

Researcher: Barbara Richards, RCompN, RM, PGDip

- ☐ I understand that all the material I will be asked to type is confidential.
- ☐ I understand that the contents of the notes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Typist's signature:

.....

Typist's name:

.....

Typist's Contact Details (if appropriate):

.....

.....

Date:

Project Supervisor's Contact Details (if appropriate):

Dr Andrea Gilkison, andrea.gilkison@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 27th November 2014, AUTEK Reference number 13/349

Note: The Typist should retain a copy of this form.

Appendix C: Consent Form

Consent Form



Project title: What is the meaning of breastfeeding support for New Zealand mothers in the first six weeks postpartum?

Project Supervisor: Dr Andrea Gilkison, PhD

Researcher: Barbara Richards, RCompN, RM, PGDip.

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 9th October 2014.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ 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 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 (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 27th November 2014.

Reference Number: 13/349

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

Appendix D: Counselling Agreement

**MEMORANDUM**

TO Barbara Richards

FROM Kevin Baker

SUBJECT Psychological support for research participants

DATE 28th August 2014

Dear Barbara

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

“What is the meaning of breastfeeding support for New Zealand mothers in the first six weeks postpartum?”

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres in person, or by phone **09 921 9992 for City campus (WB219) and South Campus (MB reception) or 09 921 9998 North Shore Campus (AS104)** to make an appointment.
- They will need to let the receptionist know that they are a research participant.
- They will need to provide your contact details to confirm this.
- They can find out more information about our counsellors on our website: **http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing**

Yours sincerely

Kevin Baker
Head of Counselling
Health, Counselling and Wellbeing

Appendix E: Participant Information Sheet

Participant Information Sheet

**Date Information Sheet Produced:**

09 October 2014

Project Title

What is the meaning of breastfeeding support for New Zealand mothers in the first six weeks postpartum?

An Invitation

Hi! My name is Barbara Richards and I am currently completing my Masters in Health Science. For my research component, I am looking for women who are currently breastfeeding their baby, and have given birth within the last six months. Participation in my research is completely voluntary and you may withdraw at any time prior to the collection of data. You will be asked to provide a pseudonym (another name) so you cannot be identified. No details identifying your midwife will be included in the study as the focus of my research is on support, not on individuals.

What is the purpose of this research?

The purpose of my research is to understand how New Zealand breastfeeding women feel supported. My research will also contribute to my gaining a Master in Health Science (Midwifery). The results of my study will be published in the College of Midwives Journal, as well as discussed at Midwifery and Lactation conferences.

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

Posters have been displayed in midwives rooms, Māori Community Midwives rooms, as well as Parent Centre offices. Six to eight women will be the total number of women participating, and as soon as these numbers are filled, the posters will be withdrawn. Women who are currently breastfeeding will be offered this Participant Information Sheet, and it will be up to you if you would like to be involved. My contact details will be displayed at the bottom of this sheet as well as on the Research Invitation sheet. Participants may self identify by responding to the poster advertisement directly.

What will happen in this research?

I will be conducting one to one interviews with you (you are welcome to have Whanau or support people you wish to have with you), asking you about your experiences of support during breastfeeding. There will be one interview only, and it will be recorded so I can accurately remember what is said. I expect the interview to last between one and two hours. Morning or afternoon tea will be provided by the researcher.

What are the discomforts and risks?

Sometimes discussing breastfeeding and support may bring up memories that cause discomfort and I will be sensitive to these potential risks.

How will these discomforts and risks be alleviated?

Counselling will be available for anyone who feels this would be helpful, provided free, by AUT Counselling Services. The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Participants will need to:

- contact our centres in person, or by phone
- 09 921 9992 for City campus (WB219) and South Campus (MB reception) or 09 921 9998 North Shore Campus (AS104) to make an appointment.
- They will need to let the receptionist know that they are a research participant.
- They will need to provide your contact details to confirm this.
- They can find out more information about our counsellors on our website: http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing
- Any discussion on breastfeeding support will be listened to with empathy, sensitivity and compassion.

What are the benefits?

This research will complete my work in a Masters in Health Science (Midwifery). It is hoped that this research will be of benefit to other midwives, lactation consultants, and all those who work with breastfeeding mothers.

How will my privacy be protected?

Confidentiality is important, and you will be asked to provide a pseudonym, which will be used throughout the research. I will be the only person who will know which pseudonym belongs to which person.

What are the costs of participating in this research?

The interview will take between one and two hours of your time.

What opportunity do I have to consider this invitation?

This invitation will be available for a month, or until the maximum number of participants have been reached.

How do I agree to participate in this research?

A Consent Form (Agreement to Participate) will be provided to anyone interested in participating, which will be available from the same place as the Recruitment Posters. The Consent Form may be signed at the interview appointment, before commencing.

Will I receive feedback on the results of this research?

All participants will receive a written summary of the research, ensuring that what I have heard and understood is correct. The results of the complete study will be posted to all participants that would like to receive it. This will be documented at the time of their interview. Transcripts of the interview will be available to participants, to review and edit if they wish to do so.

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, Dr Andrea Gilkison, andrea.gilkison@aut.ac.nz or telephone 09 0219999 ext 7720.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Barbara Richards - Researcher

Researcher Contact Details:

Barbara Richards: Phone 021 711 548

Email: fpilot@xtra.co.nz

Project Supervisor Contact Details:

Dr Andrea Gilkison, andrea.gilkison@aut.ac.nz or telephone: 09 0219999 ext 7720

Ethics Approval gained 27th November 2014

AUTC Reference Number: 14/349

Research Invitation

- ✚ Are you currently breastfeeding?
- ✚ Have you given birth in the last six months?
- ✚ Are you interested in participating in research?

My name is Barbara Richards, and I have been a midwife for over twenty years. I am currently doing my Thesis for a Master in Health Science degree, and I want to explore how New Zealand mothers experience support during breastfeeding. I would like to interview 6-8 women.

The research would involve a one-to-one interview (although Whanau members would be most welcome), in your own home if this is convenient, and the interview may take up to an hour.

Examples of questions I may ask:

- Tell me about your experience of support during breastfeeding...
- What was the most supportive/helpful aspect?
- What might have made you feel more supported?
- How supportive was your midwife around breastfeeding?
- What kind of support do you think might benefit other mum's wanting to breastfeed?

If you would like to know more about my research, or would like to enroll, please contact me by phone or email.

Barbara Richards

Phone: 09 4167908

Cell: 021 711 548

Email: fpilot@xtra.co.nz

Appendix G: Researcher Safety Protocol

Researcher Safety Protocol

For: Barbara Richards (primary researcher)

Title of Research: What is the meaning of breastfeeding support for New Zealand mothers in the first six weeks postpartum?

For the purpose of this research, I will be conducting one to one interviews with a breastfeeding mother, in her own home, (or appropriate other place of her choice). For this reason, a Researcher Safety Protocol would be required.

The researcher will provide her supervisor Dr Andrea Gilkison, a schedule of planned visits for the 6-8 participants taking part in this research. I will also undertake to notify Dr Gilkison before entering the participants' property, and again once I have left.

The schedule will contain the name and address of the participant, and if for any reason I am unable to notify Dr Gilkison when the interview is complete, she will contact me by cell phone.

Barbara Richards (Researcher)

fpilot@xtra.co.nz

Mobile: 021 711 548

Dr Andrea Gilkison (Primary Supervisor)