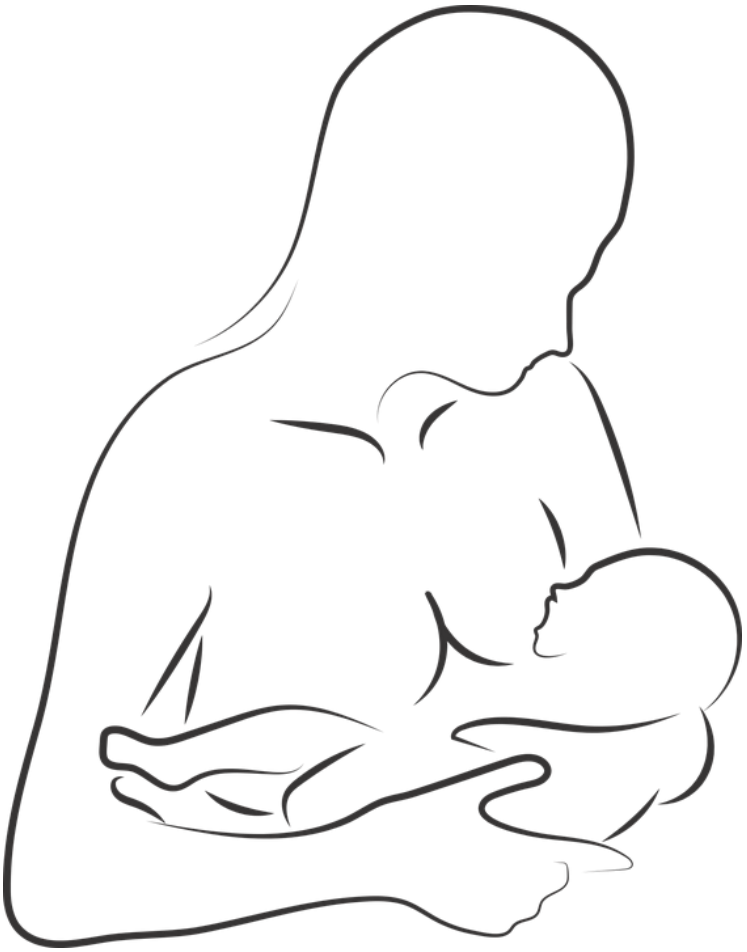
Māori and Pasifika women's experiences of breastfeeding across the South Island

Consumer stories: Quality Improvement Project



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Acknowledgement

The South Island Well Child Tamariki Ora (WCTO) quality improvement steering group is extremely grateful to all the women who participated in the South Island breastfeeding project. We thank you for taking the time, wisdom and courage to share your experience. We acknowledge that the Māori and Pasifika participants in this project belong to a heterogeneous group, with unique cultural values, ideas and beliefs. However, for the purposes of this quality improvement initiative, overall themes will be presented. It is hoped that this report does not sit on a shelf, but listens to the powerful voices behind these stories and provides a practical tool that is used to drive change and influence breastfeeding outcomes for generations to come.

'Breastfeeding is a great achievement for you and your baby, which should be celebrated'
(*Participant, 2018*)

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Executive Summary

Background

The protection, promotion and support of breastfeeding has been identified as fundamental to achieving optimum health in New Zealand. The Ministry of Health recommends infants are exclusively breastfed for their first six months of life and continue to be breastfed, along with the introduction of appropriate complementary foods, up to one year of age or beyond (Ministry of Health, 2012). In New Zealand, Māori and Pasifika populations experience inequitable breastfeeding outcomes in comparison to other population groups (Thornley, Waa and Ball, 2007). Nationally, breastfeeding rates for Māori initially start at a similar rate as the total population but decline more quickly than the total population, at three and six months of age (Ministry of Health, 2012). Therefore, understanding the barriers and motivators to extended breastfeeding among these population groups is essential.

The WCTO Quality Improvement Framework supports each level of the sector to achieve family-centred, high-quality, equitable and effective child health services that deliver the best possible health outcomes for all New Zealand children and their families. The most recent WCTO quality improvement indicator data https://nsfl.health.govt.nz/dhb-planning-package/well-child-tamariki-ora-quality-improvement-framework indicates that despite local and regional improvements in the three breastfeeding indicators below, further improvements can still be made.

- Indicator 4: Infants are exclusively or fully breastfed at two weeks
- Indicator 5: Infants are exclusively or fully breastfed at discharge from LMC
- Indicator 6: Infants are exclusively or fully breastfed at three months

WCTO QIF data, January-June 2018 (published by Ministry of Health, 2018)

Age	Total	Māori	Pasifika	Quintile 5	National Target
2 weeks	80%	79%	79%	77%	85%
6 weeks	72%	68%	69%	64%	75%
3 months	60%	50%	51%	47%	70%

Purpose

Breastfeeding is a priority area, due to the wide-reaching physical, social and emotional benefits. Thus, women and their whānau/family need access to accurate and evidence-based information to enable them to make confident and informed decisions about breastfeeding. This includes their ability to live and work in environments that support their decisions.

Improvements are required to address breastfeeding outcomes, especially in terms of sustaining high rates of exclusive breastfeeding across all population groups. The influences on breastfeeding rates are complex and multi-factorial. Measures to improve breastfeeding rates require an integrated and collaborative approach from families, communities, services and government. Therefore, the purpose of this quality improvement project was to gain a better understanding of Māori and Pasifika experiences of breastfeeding, in order to reduce the inequitable outcomes that currently exist.

Aim: To better understand Māori and Pasifika mother's experiences of breastfeeding and to identify improvements that could be made to ensure their experience is:

- More accessible (equity)
- Meet the needs of whānau (quality)
- Streamlined and user-friendly (best value)

The voices of consumers can be a powerful and effective tool. It can provide parents/caregivers and children the opportunity to share their 'stories' about how they experience health care. The Chair of the South Island WCTO quality improvement steering group, Michael McIlhone, says ensuring the consumer is part of the conversation is vital. "It's so important to listen to what they have to say and take their advice, and this needs to take place in the early stages of planning. We are all working towards a common goal, so the more we look at the system to ensure the best fit, work together and share ideas, the more the community will benefit." Providing women with an opportunity to describe their breastfeeding experience is crucial to ensure relevancy and appropriateness of service provision.

Findings

Seven key themes emerged from the voices of women interviewed for this project, including:

- Breastfeeding experience – a cultural norm/expectation. 'It's easy, natural and just happens?'
- Family first – 'It takes a village'
- Place of birth
- Establishing the foundation 'the first week is crucial/importance of home visits'
- Breastfeeding education and information for wider whānau
- Mothering the mother
- Returning to paid work/breastfeeding-friendly workplace environments

Summary

New Zealand has a relatively high rate of exclusive breastfeeding initiation. According to the New Zealand Breastfeeding Alliance, 81.3 percent of babies in New Zealand are exclusively breastfed on discharge from a Baby-Friendly Hospital Initiative (BFHI) accredited maternity facility (New Zealand Breastfeeding Alliance Report, December 2016/7). However, there remains a significant drop-off in breastfeeding nationally in the first six months, particularly among Māori and Pasifika populations.

The findings are compelling that the experience of breastfeeding cannot be improved in isolation nor solely by the health system/services. Māori and Pasifika women's experiences of breastfeeding are varied and interdependent on many social and cultural factors. Thus, wide reaching and multi-pronged approaches are required to address the disproportionate breastfeeding outcomes. The voices of women in this project illustrates that it 'takes a village to breastfeed,' surrounding oneself with a support network that is able to 'mother the mother'. This is identified in the South Island as the most protective factor for women to be able to successfully breastfeed.

Recommendations/Improvements

1. Implement national breastfeeding strategy to ensure leadership and commitment.
2. Provide Kaupapa Māori Pregnancy and Parenting programme/Hapu Wananga in each South Island DHB district. Ensure accessibility and coverage of programme including rurality and structure (times/venue/duration).
3. Breastfeeding curriculum/component included in Pregnancy and Parenting programmes needs to explicitly address expectations of establishing breastfeeding. Idea proposed by a participant '*talking about the challenges of breastfeeding in more depth and openly.*
4. Recognise the importance of extended family and friends as the primary support and extend all relevant education to them.
5. Promote the utilisation of Primary Birthing Units (place of birth).
6. Increase (DHB funded) lactation consultant availability in maternity facilities and community-based services. Home visits (if preferred) in the first four weeks postnatally.
7. Upskilling LMCs around complex breastfeeding issues (DHB-funded education) and maternity care funded appropriately to provide daily home visits (length of time and frequency dependent on the woman's needs).
8. Breastfeeding-friendly workplace environments (paid unlimited breastfeeding breaks, flexible working hours). Breastfeeding-friendly workplace policy available and enacted.

9. Peer support programme offered in each district (service embedded and closely aligned to the wider community lactation service, adequate referral pathways and awareness. Recruitment and training for Māori and Pasifika LCs and peer supporters to reflect the cultural diversity of the workforce.
10. Donor milk banks available in Primary and Secondary Care across the region.

Quality Improvement Methodology: Model for Improvement

The Model for Improvement was the methodology used to identify themes and improvement ideas. The Model for Improvement is a framework that emphasises rapid cycle improvement using small scale testing. This process generates knowledge about the changes that need to occur in order to make improvements.

1. **What are we trying to accomplish?** To better understand Māori and Pasifika women's experiences of breastfeeding to address inequitable breastfeeding outcomes.
2. **How will we know that a change is an improvement?** Improvement in the breastfeeding rates across all three indicators, as published in the WCTO QIF. In particular, less variation in each indicator.
3. **What change can we make that will result in an improvement?** By implementing the recommendations identified in this report and continue to place these findings at the centre of all decision-making. Continue listening to the voices/stories of Māori and Pasifika women, to improve exclusive breastfeeding rates and extend the duration of breastfeeding among these population groups.

Aim	Outcome Measures	Process Measures	Balancing Measures
To understand the experience of breastfeeding for Māori and Pasifika women to ensure equity and quality.	Exclusivity breastfeeding rates at 2 weeks, 6 weeks and 3 months.	Proportion of women who access breastfeeding support services. Number of participants who have positive breastfeeding experiences'	Disengaged from maternity or WCTO services. Decline services or decide not to breastfeed.

Participant Demographics

Participant selection included women who identified as either Māori and/or Pasifika. Selection criteria included women who breastfed or decided not to breastfeed in the last year. All the participants had breastfed. Twenty eight women were interviewed for this project and included 59 babies/children (breastfeeding experiences). Face-to-face interviews were conducted in locations determined by the participants across the South Island, including Nelson, Canterbury, Ashburton, West Coast, South Canterbury, Dunedin and Invercargill. The average age of women in this project was 30 years. The length of time women breastfed ranged between two days to six years. The average length of time women breastfed across their overall breastfeeding journey was 15 months. The majority of participants identified as Māori (n=18), Tongan (n=6) and Samoan (n=4). Intermediary people (members of the local community, LMCs, WCTO providers, family members) assisted with recruitment from across the South Island DHB districts. Medical conditions that impacted on women's breastfeeding experience's included prematurity, mode of delivery and admission to neonatal intensive care.

Four participants were full-time students, 13 were unemployed and 11 women were either in part or full-time employment. A participant information sheet and advertisement (Appendix one) was provided to equip participants with additional information and outline the aim of the project. A combination of methods were used to illicit information, including focus groups of between three to four women, but predominantly individual interviews were conducted. Consent was obtained using the Canterbury DHB 'general photography and video filming consent form' reference 3228. Participants were aware that all identifying and demographic details were anonymised and privacy of information was strictly upheld.

Participants were made aware that the information they shared would not impact on the health care they received in any way. The project managers contact details (invitation) were given to all participants should they have any queries following the interview. In addition, participants were informed during each interview that they would receive a copy of the report. All interviews were conducted between 30-70 minutes. Interviews were transcribed and analysed using critical thematic analysis and presented in an affinity diagram. This was constructed to sort and group the data; and assist with the discovery of themes by arranging the data into categories. The affinity diagram also provided headings for a Pareto chart.

Interview Findings

A number of qualitative and quantitative studies in New Zealand (Manhire et al, 2018) indicate that several demographic and lifestyle factors impact breastfeeding duration. These include, maternal age, socio-economic status and ethnicity. Shorter duration of breastfeeding is associated with maternal smoking, maternal alcohol consumption and maternal depression. Factors known to prolong breastfeeding include maternal breastfeeding knowledge and beliefs, maternal intention to breastfeed and family support for breastfeeding behaviour. These factors are also reflected in the South Island breastfeeding project.

The findings of this project indicate that seven main themes related to the establishment and maintenance of breastfeeding for Māori and Pasifika women as:

- Breastfeeding experience – a cultural norm/expectation. 'It's easy, natural and just happens'
- Family first – 'It takes a village'
- Place of birth
- Establishing the foundation – 'the first week is crucial/importance of home visits'
- Breastfeeding education and Information for wider whanau
- Mothering the mother
- Returning to paid work/breastfeeding-friendly workplace environments

Theme 1: Breastfeeding experience – a cultural norm/expectation. 'It's easy, natural and just happens'

The majority of women in this project reported that breastfeeding was a positive experience. A significant theme woven throughout this project is that breastfeeding is a normal expectation of infant feeding. There is an innate belief for many Māori and Pasifika women that breastfeeding is a norm or ingrained expectation. However, according to the Well Child Tamariki Ora quality improvement framework indicators for breastfeeding, this cultural belief is not reflected in the breastfeeding rates for Māori and Pasifika women. Many participants were surprised that the rates of breastfeeding among Pasifika and Māori women were lower than the total population. They commented that breastfeeding for Māori and Pasifika women was a 'given', so they found it difficult to grasp this inequity. Many women described an innate belief and expectation that they would breastfeed despite any challenges. It was their determination to persevere although the 'toe curling pain…would make you cringe'.

A Pasifika participant commented that 'God gave me breastmilk, I don't need to get up in the middle of the night or heat it up. You know what's in the milk because it is naturally produced. It was a choice I made before having kids. It was a struggle at the beginning for all four babies, but I told myself no – I am going to breastfeed no matter what'. Similar beliefs in relation to self-determination and expectation to breastfeed prior to pregnancy was echoed by many women in this project. Furthermore, women who had not previously exclusively breastfed were much more determined in their subsequent pregnancies to breastfeed.

One woman's negative experience and inability to breastfeed her first baby led her to purchase nipple shields 'and every nipple cream I could' in order to breastfeed. There is a common belief that breastfeeding is expected to be easy, natural and straight forward. One participant described breastfeeding as 'a natural, intrinsic thing that you do, to nurture your Pepi'. However, the majority of participants in this project voiced the contrary. Subsequently, this belief had a detrimental effect on several women's confidence and ability to breastfeed. One participant commented that 'everyone said it was so easy, so when I was struggling with it I thought, oh no, it's not for me'.

Conversely, one woman experienced the opposite and commented that 'my breastfeeding experience wasn't as bad as I thought it would be, I was told it would be difficult, that my nipples will be cracked and sore but it wasn't my experience at all'. Most women felt that one's attitude determined the success of breastfeeding – 'just go with the flow, if it works it works, if not don't stress about it'. Breastfeeding was described as 'something that just happens' but many women were extremely disappointed and upset when this was not their experience.

Breastfeeding is a skill that many participants thought needed to be learnt through the support of family, friends, Lead Maternity Carer (LMC), core midwives and sometimes specialist services.

Many participants described the immense pain and pressure associated with their experience. "I desperately wanted to breastfeed but it was too painful. There is nothing worse than the pain of breastfeeding, it is nothing that you can imagine, more painful than labour – a pain you cannot describe'. One woman was so overwhelmed with pain that she dreaded each feed time and was so distressed that she had not wanted her baby to wake for the next feed. Ironically, she experienced an abundant milk supply that 'was wasted'. Another mother described breastfeeding as 'I would rather go through labour again, it is nowhere near as painful as breastfeeding' and latching your baby 'is like a blow torch on my boob – it was so painful'. Several women commented on the ways in which latching/breastfeeding pain was dismissed by their LMC/midwives as 'normal' and 'it will get better'.

Several participants echoed the negative experience of breastfeeding such as frustration, pain, inadequacy, hopelessness and depression. Most participants discussed the bonding and connection associated with breastfeeding. There was a mixed response whereby some women who partially or artificially feed their babies felt bonding and attachment was not diminished, nor indifferent. Conversely, mothers who had artificially fed their older children and who were currently breastfeeding felt there was a significant difference in the bonding and connection they had whilst breastfeeding. In summary, the majority of women interviewed in this project had positive breastfeeding experiences, despite the challenges.

Theme 2: Family first – 'It takes a village'

Family members, particularly partners, were recognised as the greatest support and/or enabler to breastfeeding. All participants suggested that they were more likely, in the first instance, to ask for advice/support from close family members than any other service or health professional. Having a supportive partner who will provide reassurance around breastfeeding is key to the duration of breastfeeding. 'I cried to my partner to pick up some formula even though I knew I could do it because I'd done it with the other two children, but he withheld it from me and said 'you know you can do it'. In addition, mothers and sisters provided significant support and encouragement to continue breastfeeding. Thus, partners, whānau, peers and health professionals all have a crucial role to play in providing breastfeeding support and protection. 'It has to be family' – belonging to a supportive network was identified as the most significant factor for continuing breastfeeding.

Pasifika mothers preferred to talk with other mothers in the first instance rather than midwives or other health professionals about breastfeeding. They commented on the ability to share ideas, similar experiences and support one another to breastfeed. One participant noted that breastfeeding around other males was *tapu* in Pasifika – some cultures and women need to go somewhere else or cover up when breastfeeding. However, this belief was not held by all Pasifika participants. Being surrounded by a network of people who will support your decisions and parenting style as 'you know your baby best and what (she) needs' is crucial to improving breastfeeding outcomes. As highlighted in a Midwifery News article (Issue 90, 2018) 'If it takes a village to raise a child in, it also takes a village to breastfeed one – their needs to be a support network to help her'. This analogy is reflected in many of these women's experiences.

Every baby is different and equally, each breastfeeding experience will be unique. A common theme echoed by participants was that breastfeeding support differed depending on parity. It was assumed that if you had breastfed before that you were more likely to be told 'keep going you've done this before, you'll be fine' without understanding or asking what support or advice the woman needed. 'I asked for a lactation consultant review (whilst in hospital) but was specifically told you've done it before. She did eventually see me after I kept asking'. Therefore, it is increasingly obvious and apparent that breastfeeding does not exist in isolation nor is it 'just a woman's issue' as acknowledged by one participant. Strong breastfeeding leadership and advocacy is required to change inter-generational attitudes and to 'normalise' breastfeeding.

Maternity care, WCTO services, general practice, breastfeeding peer support and work-place policies are critical parts of the 'village' needed to ensure that all women who choose to breastfeed are well supported to do so. Additionally, this project highlights the factors that influence women's decisions and ability to breastfeed whilst also being cognisant of the wider cultural and societal issues that impact on their experience.

Theme 3: Place of birth

Most women reported that their place of birth had a huge impact on their breastfeeding experience. Breastfeeding support at either a primary or secondary maternity facility was acknowledged as a defining factor to one's experience. The majority of women who had negative breastfeeding experiences had birthed at a tertiary maternity unit and this often had a detrimental and long-lasting impact on their experience. Receiving inadequate information, using a forceful approach or not listening to women's concerns were described as the most common reasons.

There were mixed responses about support from staff whilst in hospital, in relation to hand expressing and/or latching baby to the breast. A lack of information or discussion and just 'being milked' was associated with deeply-seated hurt and distress. Women felt like it was rushed and 'staff just needed to get it done,' so it was forced. This resulted in some participants not being able to latch their babies independently or confidently, so then it 'made me feel like an idiot'. Another woman highlighted that 'it's hard enough to be told/or know that you have tried everything but can't bear the pain anymore…you feel like a failure anyway for not being able to breastfeed'. Despite the multiple challenges women faced, many suggested they felt very strongly about the need/desire to breastfeed, even if this was unmet.

Primary maternity units were often described as more relaxing and many women found that the core midwives had more time to support with breastfeeding. One woman reported that being able to stay at the primary maternity facility for a week enabled her to feel confident and 'set her up well' to be able to go home and continue breastfeeding successfully. Additionally, culturally appropriate support whilst in hospital was described as 'really helpful and makes you feel comfortable because we are culturally different and there are different cultural needs. The conversation is different – even how you talk to Maori, you don't need to say everything – they just get it.' One participant had artificially fed her first two children but she was currently breastfeeding her third child. She expressed that the pressure and the unhelpful attitude by midwifery staff impacted on her decision to artificially feed.

'I felt like I wasn't doing it properly, there was heaps of pressure and I felt he was hungry and not getting enough so I put him on a bottle, but from what I know now the volume was increasing and my milk was coming in'. She expressed a sense of confidence and increased knowledge about breastfeeding this time, due to her experience in the maternity unit. 'It was different this time, there was lots of information and options. The midwives approached breastfeeding completely different, with lots of reassurance and support. They were so casual in their approach and it was so much better'. The defining factor in this experience was the way in which care was delivered. Providing reassurance, positive encouragement and the approach by health professionals is fundamental to breastfeeding outcomes.

Theme 4: Establishing the foundation –'the first week is crucial/importance of home visits'

A reoccurring theme in this project was the importance of frequent (often daily in the first week) home visits by an LMC, especially for those experiencing complex or challenging breastfeeding issues. Several women described this support in the initial postnatal period as the most important factor in both establishing and sustaining breastfeeding. LMC midwives and core midwives were acknowledged as key enablers who provided 'words of affirmation, positive encouragement' and spent quality time observing a feed. One woman described the face-to-face visits as imperative to breastfeeding. 'Google and YouTube just isn't the same, I'd prefer someone to come to my home'.

Equally, unsupportive LMC midwives impacted negatively on their experience and their ability to breastfeed. A few participants described feeling nervous and fearful to disclose to their LMC or WCTO provider that they had introduced formula. 'I was nervous that she would judge me if I told her but it was perfectly fine, she asked if it was going well and I said it was awesome'. Therefore, investing time at the beginning was identified as key to the success of breastfeeding. LMCs who demonstrated expert breastfeeding skills and knowledge significantly influenced participant's breastfeeding outcomes and experiences. One participant suggested that midwives need to be equipped with extensive knowledge and competence to support women with complex breastfeeding issues. The partnership relationship they have established with their LMC should be utilised as 'bringing someone else in to visit probably wouldn't be the right thing'.

Research in New Zealand exploring the predictors of breastfeeding duration among the Māori population (Manhire et al, 2018) suggest that whilst mothers perceived breastfeeding as natural, easy and normal, support in the initial postpartum period was crucial to the development and maintenance of breastfeeding. A resounding theme was the invaluable support of LMCs and core midwives. One woman said, 'my midwife was fabulous, she told me what to do and always checked up on me, I had her for all four children so I knew her well'. Hence, LMC and core midwives were recognised as key enablers to breastfeeding duration, irrespective of women's experiences. Another sub-theme evident in this project was midwifery workforce demands and capacity. This was identified by one participant as 'the LMC comes and it (her mobile phone) rings six times, which isn't her fault. I think they are pushed for time sometimes and they don't have the time but they are the people you have the relationship with and who have been with you the whole way through'. Furthermore, home visits by a health professional was identified as a protective measure for one participant who had previously been subjected to family violence.

She described the importance of these visits and said they were 'really good and I remember I relied on my home visits. I knew that someone was coming over and he couldn't touch me, like he knew (WCTO provider) would be coming over.' One participant outlined the difficulty of seeking help in these situations but having a trusting relationship with one health professional was vital. 'It's hard to know what to do to make it better, cause it's massive the amount of people that need help the most, don't want the help'. This highlights the need for midwifery care to be flexible, accessible and appropriate.

The majority of participants in this project were not aware and/or did not access community-based breastfeeding support services. Several women described that there is a general lack of knowledge and appropriate access to community breastfeeding services. An automatic referral at birth to a breastfeeding support service (commonly a lactation consultant) was positively received by all women and acknowledged as extremely helpful. This initiative was provided in a South Island district and initiated with a telephone call or email to determine the level of breastfeeding support was required, if any. Once again, home-based breastfeeding support 'was very helpful, if it wasn't a home visit I wouldn't have taken him to see a lactation consultant'.

'Mother for Mother' peer support programmes are available in some South Island DHB districts. These programmes appear to be valuable and are working particularly well in the smaller districts whereby one participant identified that 'you are more likely to see other mums locally that you know' and engage with the service. The literature suggests that peer support programmes are valuable and should be considered as part of a wider breastfeeding strategy within a coordinated programme of interventions (NICE, 2008; Johnson et al, 2017). Many participants identified a lack of knowledge by general practitioners around breastfeeding and treatment of mastitis. 'I kept taking my baby to the GP as he was always vomiting and not gaining weight. My breastmilk was being blamed for him being unwell and told to stop breastfeeding and give formula, but he had a UTI'.

Overall, service provision of primary and secondary breastfeeding support services is varied across the South Island. There is limited literature concerning women's experiences of support services in New Zealand; hence undertaking this South Island breastfeeding project. Most women feel the support they received was a factor in the continuation and discontinuation of breastfeeding. McBride-Henry (2004) reports that unless attention is paid to women's experiences of breastfeeding as part of policy-making and service development design, breastfeeding rates will not change.

Theme 5: Breastfeeding education and Information for wider whānau

It is apparent that breastfeeding knowledge and information needs to start from childhood. Several mothers described the impact of breastfeeding on older siblings, such as breastfeeding as a normalised infant feeding practice. 'My daughter was given a doll with a bottle attached to its hand and she asked me to cut the bottle off because she was boobing her baby'.

The construction of breastfeeding as 'normal' begins in childhood and as reflected in the voices of these participants, breastfeeding is observed and normalised through generations. A very significant finding in this project is that breastfeeding education and information needs to be extended to partners, the wider whānau and friends, not just the mother. Providing women and their whānau/support network with information and knowledge around the expectations and practicalities of breastfeeding was noted as an improvement idea.

For example, one woman reported that information about 'how long it takes for your milk to come in, that it is difficult at times, the time it can take to breastfeed, that they are on the boob a lot and statistics about the health benefits for you' would have been extremely helpful. Also, many women found the practical information about breastfeeding very useful. 'All the extra information was so helpful, like at this age he might be fussy and feed more so don't give up because that's normal, all that sort of thing'. Achieving equitable breastfeeding outcomes for Māori and Pasifika requires culturally responsive Pregnancy and Parenting education (PPE). The majority of women interviewed (n=21) did not engage with any PPE and the rationale behind this decision included:

- Not appropriate – no Kaupapa Māori class available or relevancy of information
- Not comfortable with a group setting
- Did not want to join a mainstream class – felt judged due to being young
- Not accessible – lack of transport
- Limited availability – dates and times limited

However, the most common factor for non-engagement with PPE was a lack of acceptability. Many women felt this information would be irrelevant as they 'learnt from family' and were 'surrounded by children'. This notion suggests that information about the relevance and purpose of PPE needs to be strengthened and promoted to improve equitable participation.

Pasifika women suggested that more information and education is needed to prolong breastfeeding duration. Particularly around the challenges of where to access support and extending education to family members. Manhire et al (2018) suggest that strong maternal and partner support of the mother was the most significant positive predictor of extended breastfeeding duration.

This finding, as alluded to above, was also reflected in this study. Pregnancy and Parenting education (antenatally and postnatally) that includes grandmothers and partners is a suggested improvement idea. Appropriate and user-friendly breastfeeding information should be offered at as many touch points as possible throughout the antenatal and postnatal period. The way in which information is delivered and received is crucial – it should be non-invasive, simple, visually appealing and electronically accessible. 'There are too many pamphlets, just a plain and simple message about where to find help would be useful'. However, all participants preferred face-to-face individualised support than any other form of information. Thus, breastfeeding messages and information need to be delivered in a variety of methods, including face-to-face, electronic and print, but importantly, depict a realistic view of breastfeeding. The BreastFedNZ app was considered a helpful resource that should continue to be promoted.

There is a perception that 'nothing' can prepare a woman to breastfeed. Breastfeeding information incorporated in the Pregnancy and Parenting curriculum was considered non-effective or not as meaningful, it was difficult for many women to understand the true reality and challenges of breastfeeding prior to actually breastfeeding. One woman suggested that 'they tell you everything about breastfeeding, but it goes out the window once you have the baby'. Some mothers found that the volume and content of breastfeeding information was neither timely nor appropriate. 'I just want to be alone when things aren't going well and you're sleep deprived, the last thing you want to do is read information or go online'. If breastfeeding becomes challenging or not an option, it is difficult for women and whānau to know how to artificially feed their babies. Information about all infant feeding methods was identified as an improvement.

A Cochrane review (2017) undertaken by Stevenson on behalf of the Midland Maternity Action Group identified that 'while there are still questions to address how best to provide support, the key messages are clear we have ample evidence to know that women need support characterised by on-going scheduled face-to-face visits that are tailored to the individual'. Support was most effective when offered either by peer or professional personnel, or a combination of both. This review reflects the experiences and improvement ideas of many women in this project. Therefore, education and information provided at the right time, to the right people, by the right people, is vital.

Theme 6: Mothering the mother

The first few weeks were described as the most critical time for breastfeeding. One woman described that first few weeks as 'you need three weeks of intense support, primarily to focus on breastfeeding. Support can be to look after the other children, cooking and cleaning, to be able to overcome the initial challenges and time consuming nature of breastfeeding. It is a crucial time as this is when you are most vulnerable and need the support to persevere and keep breastfeeding, just someone to hold the baby while you sort your boobs out'. Early stage breastfeeding support was identified by Manhire et al (2018) as a key factor to the development and maintenance of breastfeeding, despite young Māori women's perception of breastfeeding as natural, easy and normal. Support with making meals and household tasks was extremely helpful and also supported breastfeeding.

Several women described the protective and nurturing factors of breastfeeding, which allowed them to have some 'me' time. 'It gave me time to rest because if I wasn't breastfeeding I wouldn't be sitting down for a rest as often, there would be too much to do. I would be thinking I haven't got time to sit down so breastfeeding forces me to. I'm thankful for that.' One woman mentioned that she felt a sense of guilt when sitting down to breastfeed. Thus, the notion of 'mothering the mother' is synonymous in the project as one of the most influencing factors that supports breastfeeding.

'Praise and positive words are so important. That support means a lot because it keeps you going even if it's hard.' A Pasifika woman described the supportive breastfeeding environment at her church that impacted positively on both herself and other mothers. She described mothers supporting and encouraging each other in the designated parent's room at church and reaffirmed breastfeeding as the norm. 'You see first-time mums at church and you pat them on the back and say you're doing very well, we all feel the same, we all help each other. Breastfeeding is out in the open, it's just normal there'.

In contrast, a finding apparent in this project was the impact of breastfeeding on maternal health and wellbeing. 'Everyone said he's doing great, he's gaining weight but no one asked how I was feeling, I wasn't listened to. They say everything looks good, keep doing what you're doing, he's getting enough, keep putting the cream on.'

The health benefits of the baby are always focused on but the mental health of the mother is not taken into consideration enough, it is just as, if not more important than the health benefits'. A few women described feeling a sense of isolation and frustration if health professionals deemed breastfeeding to be 'going well' as the baby was putting on weight and sleeping.

However, not asking the woman how she was feeling about breastfeeding was sometimes overlooked and impacted significantly on their experience. Furthermore, some women reported that they often received conflicting advice surrounding breastfeeding without listening or asking them directly. One woman voiced that there are 'lots of different views from health professionals about a good latch or not, or if there is still pain without even asking me.'

Many participants described the immense pressure from health professionals but also wider societal pressure to breastfeed. This notion impacted negatively on women's experiences and created feelings of shame, guilt and inadequacy – 'I felt like such a bad mother'. A few women mentioned feeling 'too scared or nervous' to tell their Lead Maternity Carer or Well Child Tamariki provider that were no longer breastfeeding. Aside from the health, nutritional and emotional benefits alluded to by participants to breastfeed, other motivating factors included the ability to feed their babies themselves. Being the only person able to feed baby was recognised as a common protective factor, particularly voiced by younger mothers. 'Breastfeeding enabled you to be the only one to feed your own baby. I didn't want my baby babysat, it (breastfeeding) was an excuse to always be with my baby'. Other women felt challenged by family members to 'leave baby for the night or weekend with them' but were firm in their decision to breastfeed and mentioned 'they would have time with the baby but not now". Many women noted that it was helpful to receive support from friends and family in terms of meals, cleaning and looking after older children, rather than 'taking baby to feed'.

Theme 7: Returning to paid work/breastfeeding-friendly workplace environments

Workplace environments can significantly influence breastfeeding outcomes. Most of the participants in this project returned to paid work with flexible working conditions. They reported that their employers were supportive of breastfeeding and enabled them to continue to do so. For example, partners or family members were able to bring baby into work for feeds and employers provided appropriate facilities to express and store breastmilk.

The ability to breastfeed on-site was the deciding factor for one woman choosing a particular educational institution. Another woman suggested that childcare facilities which encouraged and supported mothers' breastfeeding during the day was important but rare. Despite having supportive workplace environments and managers, some women felt it was too impractical to bring baby into work for feeds. Thus, they often delayed returning to work until they had discontinued breastfeeding or daytime feeds. However, five women described challenging and negative experiences in relation to returning to work whilst breastfeeding.

Many women felt apprehensive to discuss expressing/feeding times with their employers prior to returning to paid employment. 'I don't know how to ask my employer about returning to work and expressing. I don't want to seem too demanding as it's just me but it would be good to talk to my boss before starting back at work'. Some women felt anxious and stressed about talking about the practicalities of expressing at work, and this was often compounded with feelings of guilt about returning to work.

One woman highlighted that 'breastfeeding and work is a taboo subject. You don't talk about it. It's just a given that once you start working you need to stop breastfeeding'. Another participant mentioned that her working conditions and the employers' non-supportive attitude towards breastfeeding resulted in her discontinuing expressing/breastfeeding due to lack of supply. 'In order to breastfeed I needed to express frequently, two of my three breaks. If I take a break on the machine, everyone has to take break. I went to the toilet to express, it took my entire lunch break so I didn't and when I put my milk in the staff fridge I was told it was disgusting and someone tipped it out. My employer told me 'do what you need to do' and that was all. There was one toilet and we all went to lunch together so I would be frowned upon if I took too long in the toilet. I ended up with mastitis and I never got my supply back so I had to stop'. Therefore, returning to paid work is a critical time and significantly impacts on breastfeeding duration. Employers need to ensure, as practically possible, that every woman is supported to continue breastfeeding including promoting breastfeeding work-place policy, flexible unpaid break time to express and/or breastfeed and appropriate storage and expressing facilities.

By law, as far as reasonable, employers are required to:

- Give women unpaid breaks to breastfeed their baby or express milk at work
- Provide women with facilities to do this

Under the Human Rights Act, it is illegal for someone to stop women breastfeeding in public.

Societal perceptions, comments and views were reported and experienced by some women. However, women's level of breastfeeding experience and confidence determined the impact of any negative breastfeeding comments.

Thus, a mother who had just given birth and breastfed for the first time felt 'uncomfortable' to feed in front of other male family members and friends. Several younger mothers described the stigma and guilt they experienced by being both young and unable to breastfeed. These factors compounded their experience. Supporting other women to breastfeed in public was highlighted and admired. 'I always smile at women (breastfeeding) like 'you're great'.

Overall, women who lived in smaller towns reported that they felt more comfortable to breastfeed in their local community as they had been subjected to negative public comments in larger cities, particularly food court shopping malls. It is important to note that many women felt that generally, societal attitudes towards breastfeeding have improved. The majority of the women in this project felt comfortable to breastfeed wherever and whenever they needed. 'In an ideal world, everyone would have the breastfeeding experience I have had, it is every baby's right. There needs to be a shift in societies' view of breastfeeding and working. This is where it starts – the right of the child to breastfeed for as long as they want.'

Summary/Conclusions

Māori and Pasifika women's experiences of breastfeeding are varied and interdependent on many social and cultural factors. Breastfeeding is often considered a cultural norm and expectation of infant feeding. For many women, the first few weeks are crucial and will set the foundation for successful breastfeeding outcomes. This includes place of birth, supportive in-patient maternity care and regular LMC home visits during the postnatal period. The voices of women in this project illustrates that it 'takes a village to breastfeed', surrounding oneself with a support network that is able to 'mother the mother' is imperative and positively impacts on her experience. Service provision of primary and secondary breastfeeding support services is largely varied across the South Island.

Women commonly reported that the availability and accessibility of lactation consultant services and Kaupapa Māori Pregnancy and Parenting programmes needs to be improved. Family members are regarded as the first point of contact for women experiencing breastfeeding difficulties, therefore women strongly suggested that breastfeeding education and information needs to extend to the wider whānau. Enacting legislation and policy that supports breastfeeding-friendly workplace environments is essential. Returning to paid work was recognised as a defining time for women to continue breastfeeding. Supportive workplace environments, employer's knowledge and understanding of breastfeeding, flexible working conditions and paid expressing/breastfeeding breaks were identified as enablers. More emphasis needs to be placed on organisations and industries to support and promote breastfeeding-friendly workplaces.

Many women interviewed for this project appreciated the opportunity to share their experiences. 'Breastfeeding is special and should be treasured, it is something that you look forward to once baby is born. It is a mothers experience that she will always remember, thank you for allowing me to share mine'.

Appendix One

Canterbury District Health Board Te Poari Hauora o Waitaha

Patient Story | Organisation Development Unit

Patient Story

Information for Patients and their Family/Whānau

What are Patient Stories?
A patient story is you telling us your experience in your own words. We would really like to hear about your overall experience, including the health care you received. We are interested in hearing what it was like for you being a patient, and what it was like for your relative or carers.

Why are Patient Stories Useful?
We have some ideas about how we can provide the best possible health care from our own experience, but your feedback can help us make health care even better by giving us a more complete view. Listening to and recording your story as a patient will help us review the service we provide to see how we might improve it. Patient stories are a powerful way to engage, inform, and teach, because they give us some unique insights about how our delivery of health care really works.

What will be expected of me?
We will agree with you a time and place to meet when you can tell your story. The details of who will be present and the way in which the story will be gathered will be discussed and agreed with you. You can remain anonymous if you wish.

What if I prefer someone to speak on my behalf?
Ideally we would like to talk with you, however we know that sometimes this may be difficult. In these circumstances we would still like to hear your story through a relative or someone you would like to speak on your behalf.

Can I change my mind?
If you do agree to tell your story, you can still change your mind at any time without needing to give a reason. If at any stage after you have told your story you no longer wish us to use it, we will delete it from our records.

Will taking part affect my health care?
No, definitely not. Any future treatment or care you may need will not be affected by telling your story.

What will you do with the information?
The information we collect will be treated in confidence, stored securely and used responsibly for non-commercial purposes only.

If you do ask to remain anonymous, your details will not appear in any report or footage. Your story will be shared with the sole purpose of informing service improvements.

Consent
We will ask you to sign a consent form to make sure that you are fully aware of what is involved and so we can be confident that we both have the same understanding of how your story will be used.

Further Information
If you wish to ask a question about telling your story, or if you want to discuss anything further, please do not hesitate to contact us via email on PatientStories@cdhb.health.nz

Thank you for your generosity in sharing your story with us. Your experience will help us to improve our care and service for other patients, families and whānau.

For more information about:

- your health and medication, go to www.healthinfo.org.nz
- hospital and specialist services, go to www.cdhb.health.nz

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Interview Guide

Interview number:
DHB district:
Ethnicity:
Age:
Parity:
Breastfeeding status:
Pregnancy and Parenting Education attendance:

Any medical/obstetric conditions that impacted on breastfeeding experience:

Employment status/occupation:
Have you returned to work? If so, did returning to work impact on your breastfeeding experience?

Interview questions:

- Did you breastfeed? If not, are there any particular reasons why?
- If yes – how long did you breastfeed? What were your intentions initially/during pregnancy?
- Can you tell me about your experience of breastfeeding?
- Were there any particular people/services or resources that you found helpful in terms of your breastfeeding experience?
- Did you access breastfeeding support services, if so, which ones? Were they free/cost?
- Were there things that made breastfeeding difficult or challenging?
- Are there things that could be changed to help you breastfeed for longer or have a better experience?
- Is there any other information that you would like to share about your experience of breast-feeding?

Well Child
Tamariki Ora

SOUTH ISLAND ALLIANCE
best for people, best for system

You are invited to share your story about breastfeeding as a Māori or Pasifika woman

If you identify as Māori or Pasifika and have breastfed or chosen not to breastfeed within the last year, please join us for a confidential discussion about your experience.

There are significant differences in breastfeeding rates across ethnicities in New Zealand and we want to understand why, so we can shape the way support services are delivered in hospital and in the community.

The discussion will take about one hour and will include:

- Reasons why you did or didn't choose to breastfeed.
- What you found helpful to breastfeed.
- What you found difficult/challenging to breastfeed.
- What improvements could be made for a better experience?

The Well Child Tamariki Ora programme works to improve child health outcomes, particularly breastfeeding support services. To do this we need you.

Your participation would be appreciated and valued. You will be reimbursed for your time with a $25 grocery or petrol voucher.

Well Child
Tamariki Ora

If you are interested, please contact **Anna Foaese** on **027 435 9905** or email **anna.foaese@siapo.health.nz**

Definitions

The following definitions of the extent of breastfeeding, adopted by the Ministry of Health (2002), are used in this report:

- Exclusive breastfeeding: the infant has never had any water, infant formula, or other liquid or solid food: only breast milk and prescribed medicines have been given from birth.
- Full breastfeeding: within the past 48 hours, the infant has taken breast milk only and no other liquids or solids, except a minimal amount of water or prescribed medicines.
- Partial breastfeeding: the infant has taken some breast milk and some infant formula or other solid food in the past 48 hours.
- Artificial feeding: the infant has had no breast milk but has had alternative liquid such as infant formula, with or without solid food, in the past 48 hours.

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