Community Influences on Breastfeeding Described by Native Hawaiian Mothers

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Abstract

Background: Although breastfeeding rates in Hawai`i are among the highest in the United States and meet the United States Healthy People 2010 objectives (a statement of national health objectives), these rates are not consistent in all segments of the population. Among the Native Hawaiian population, breastfeeding rates are 25–30% lower than the general population. This disparity (inequality) has not been well researched. A multiphased ethnographic study was undertaken to better understand the nature and factors influencing this disparity. The aim of this phase of the study was to describe the perceptions of Native Hawaiian women about the influences affecting the breastfeeding disparities found in their community.
Method: Participants were recruited through a community health centre, purposeful sampling continued until saturation was reached. Interviews

were conducted with Native Hawaiian mothers (N=20) who had breastfed at least one child. The analysis was guided by the participants' voices; the data analysis remained grounded in the participants' view. Data were coded, categorized, and conceptually grouped into patterns.

Results: The patterns were identifying resources, difficulty breastfeeding, and unmet expectations. Resources which functioned as supports or assets to the breastfeeding experience included knowledge, prior experience, motivation, support, equipment, and empathy. Breastfeeding was "hard," because of the physical problems with the woman's breast, discomfort, and time demands. Unmet expectations included a discrepancy in values, an assumption of participant knowledge, lifestyle adjustments, and the value of organizational support.

Conclusions: Traditionally, women breastfed in a supportive environment that was not fully available to the study participants. Valuing traditional practices in the context of current influences may improve breastfeeding rates among Native Hawaiian women; therefore, the health of this community.

Keywords: Breastfeeding, community influences, Native Hawaiian, Wai`anae

Introduction

> My parents really want me to breast feed. Actually everybody wanted me to breast feed, even my mother-in-law, my sister-in-laws. (Native Hawaiian participant).

Although "ensuring that breastfeeding mothers have access to comprehensive, up-to-date, and culturally tailored lactation services" is the focus of the national breastfeeding policy (Shealy et al., 2005; U.S. Department of Health and Human Services, 2000, p. 19), progress toward operationalizing this goal has been slow. The importance of evidence-based lactation services has been emphasized for the last twenty years; however, a consensus on what constitutes comprehensive lactation services has not been reached or well researched (Shealy et al. 2005). Populations with the lowest breastfeeding rates are those in low-income ethnic minorities, making culturally tailored lactation services essential to instituting changes in these communities.

The majority of Native Hawaiian new mothers living in Hawai`i are low-income and do not have access to comprehensive culturally appropriate lactation services. Community lactation services available are nutrition counsellors (Women, Infants, and Children's (WIC) Nutrition Program), lay

Healthy Start workers, public health nurses, and health care providers working at federally qualified health centres located in these communities — all with lactation management knowledge ranging from the anecdotal to the up-to-date research base. The cultural relevance of these services is unclear.

Breastfeeding support and promotion is influenced by social and cultural contexts (Stuart-Macadam, 1995). These influences have not been well researched in Native Hawaiian communities. The purpose of this study was to understand the community influences on Native Hawaiian mothers' decisions about breastfeeding from their perspective.

Background

The underlying philosophical approach framing our research was cultural relevancy and decolonizing the positional superiority of Western knowledge (Smith, 1999). Awareness of the importance of creating and maintaining culturally relevant healthcare systems has been steadily growing. Framing health education and promotion within a culturally meaningful context improves the likelihood that providers' messages will be heard. Multiculturalism is currently more the norm than the exception in many locations in the United States (U.S.); however, throughout the last century, it has been a way of life in Hawai`i with many waves of immigration leading to complex cultural nuances. While the warm *aloha* spirit of the Hawaiian Islands has attracted many new residents and millions of visitors, no population has been more marginalized than the colonized indigenous people of Hawai`i.

> The colonization of Hawai`i is not a thing of the past. It can be seen everywhere today: shopping malls, campaigns for standard English; the continued deterioration of health and socio-economic status of Hawaiians; the tourist traps of Waikiki; and the pervasive commercialization of Hawaiian culture (Rohrer, 1977, p. 145).

The effects of colonialization are many for those who have lived with it for generations, as have Native Hawaiians. Described by scholars as historical trauma with a day-to-day lived reality, it has many and varied social, public health, and personal ramifications that often manifest in health disparities (Smith, 1999). Native Hawaiians have the highest maternal and infant health risk indicators and the highest socioeconomic risk scores (Hawaii Family Health Services, 2007). Despite the pervasive commercialization of Hawaiian culture, actual cultural relevancy within the health care systems is called into question when maternal/infant health outcomes are far from

optimal. Understanding the ways in which health care can be tailored to meet the needs of Native Hawaiian mothers through an empowering process is essential before any change can occur.

Smith (1999, p. 59) emphasized the importance of using research methods with indigenous populations, which decolonize rather than perpetuate the positional superiority of Western knowledge. Conceptions of time, space, and the relationship between the individual and society in traditional indigenous cultures, including Native Hawaiian, are not congruent with mainstream Western thinking (Dodgson and Struthers, 2003; Oneha, 2000; Smith, 1999). Of course, most indigenous cultures, particularly those that have been colonized (e.g., Hawaiian), are generations away from living according to cultural traditions and operate within another cultural milieu. Therefore, researching current understandings within indigenous communities is not truly researching traditional culture, but a unique hybrid that emerges (Dodgson and Struthers, 2005). To develop culturally relevant health promotion and support programs that reflect a decolonizing approach, participation by community members is essential.

The Native Hawaiian communities in Hawai`i have many of the social and health issues found in other disenfranchised peoples living within a mainstream culture that is different from their own. Poverty, substance abuse, violence, and complex chronic illnesses pervade these communities creating a complexity that is not easily understood nor addressed by outsiders, however well intentioned. The number of researchers working with Native Hawaiian communities to address health disparities found within their communities is slowly growing.

Native Hawaiian mothers are the best source of information about the influences on infant feeding within their communities. Social and cultural practices influence how all women choose to feed their infants during the early postpartum period (Dodgson, et al., 2003; Tarrant, et al., 2002). The external influences on a Native Hawaiian woman's decisions to breastfeed and wean are multidimensional consisting of family, community, and culture (Carmichael, et al., 2001; Dodgson, et al., 2007; Novotny et al., 2000). A clear understanding of the interplay among these multiple dimensions of influence has yet to be developed.

In a state with one of the highest breastfeeding rates in the country (89.6%), Native Hawaiian women consistently have the lowest rates (64.0%) and Native Hawaiian women who participate in the Women, Infants and Children's Nutritional Program (WIC) have even lower breastfeeding rates

(26.85%) (Dodgson et al., 2007; Grummer-Strawn and Li, 2000). Previous researchers have used quantifiable methods to explore factors influencing Native Hawaiian women's infant feeding practices (Dodgson et al., 2007; Novotny, et al., 1995; Novotny, et al., 1994). Dodgson and colleagues (2007) examined breastfeeding patterns (i.e., exclusive breastfeeding, duration of any breastfeeding) in 200 Native Hawaiian WIC participants. They found longer durations of breastfeeding associated with early exclusive breastfeeding, maternal age over 21 years, and multiparous (more than 4 children) women. Their conclusion was that breastfeeding patterns in the Native Hawaiian population studied mirror the state data (e.g., exclusive breastfeeding for a shorter period than the recommended 6 months), but at much lower rates. Interestingly, a higher percentage of Native Hawaiian women who chose to breastfeed did so for more than 6 months, longer than the general population in Hawaii and in the U.S., indicating some Native Hawaiian breastfeeding women can sustain breastfeeding. This strength needs additional exploration (Dodgson et al., 2007); discovering this community's strengths in facilitation of breastfeeding could provide valuable insights into the ways public health and health care providers provide services to breastfeeding mothers. Building on the strengths of a community is an effective way to make positive change (Israel et al., 2001). The aim of this study was to describe the perceptions of Native Hawaiian breastfeeding mothers concerning the influences affecting the disparities in breastfeeding patterns within one predominately Native Hawaiian community.

Method

This study was part of a multiphased ethnographic study (a research design that facilitates description of a culture and the meaning of events) focused on disparities in breastfeeding rates in the Native Hawaiian community of Wai`anae, on O`ahu, from an ecological perspective. A descriptive cross-sectional qualitative design was used to gather interview data. An emic or cultural insider's perspective was sought. Maintaining the voice of the participants was a priority throughout the process.

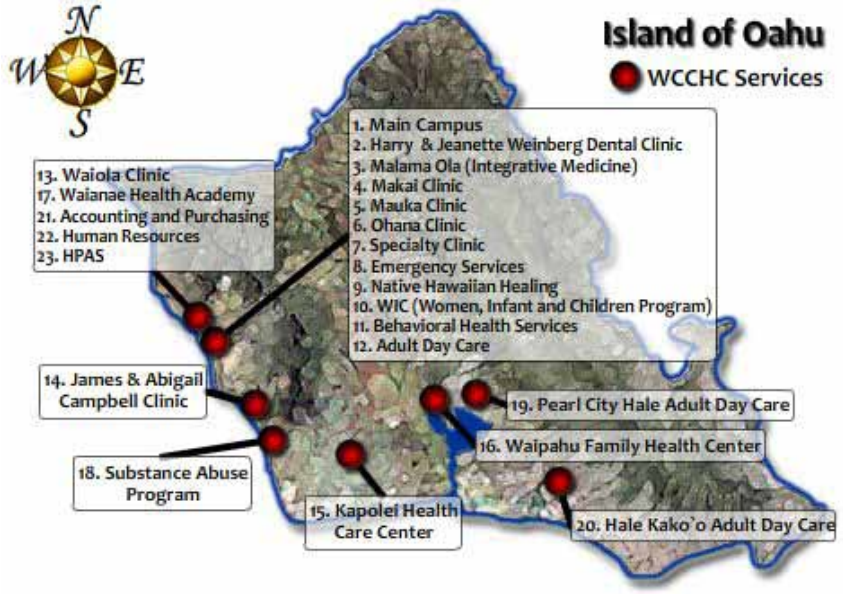
Setting

The Wai`anae Coast is located on the extreme west (leeward) side of O`ahu. It is separated from the rest of the island by the Wai`anae mountain range to the north, and bordered by the ocean to the south. Entrance to the Wai`anae Coast is from the east on the only accessible highway in and out

of the community. According to the U.S. Census 2000, the total population of Wai`anae is 42,342 , with 26,335 (62.2%) Native Hawaiian or Other Pacific Islander. The Hawai`i State Department of Health, *Primary Care Needs Assessment Databook* (2007) ranks Wai`anae second highest in the state, in birth rate of women age 18–44 years and in unemployment (6.1%), poverty (21.9%), households receiving Temporary Aid to Needy Families (10.6%), and households receiving food stamps (41.0%). Other challenges include prevalent psychosocial issues such as substance use, domestic violence, mental health problems, lack of partner/family support, and high risk for multiple medical problems including, obesity, diabetes, hypertension, and asthma.

The creation of the Wai`anae Coast Comprehensive Health Center (WCCHC) is credited to many years of community-driven planning efforts focused on bringing health services to this isolated rural coastline. The 1946 closing of the Wai`anae Sugar Mill dispensary left many residents without medical care, forcing them to drive 1–1½ hours to Honolulu for health care. Designated as a medically underserved area, the WCCHC broke ground with the first phase of the health centre in 1972 with one physician and five staff. The WCCHC is a community owned and operated, nonprofit, health centre serving the Leeward Coast to Central O`ahu through a main clinic and four satellite clinics (Figure 1), offering a range of services including 24-

Figure 1. Location of WCCHC Services



hour emergency care, primary care, specialty services, laboratory and radiology services, dental, transportation, child passenger inspection station, preventive health, case management, adult day care through five sites, mental health and substance abuse treatment, health career training, traditional healing, integrative medicine (pain management, lifestyle enhancement, fitness training), WIC, Healthcare to the Homeless, etc. These services, at the center of the Wai`anae community (Figure 2) have developed in response to community need over the past 37 years.

Figure 2. WCCHC and the Wai`anae Community

Participants

A total of 20 women of childbearing age, who self-identified as Native Hawaiian/part-Hawaiian, who receive health care at WCCHC, weaned from breastfeeding, and live in the Wai`anae community were recruited and interviewed by Native Hawaiian research team members employed at the WCCHC. Purposeful snowball sampling was used until saturation was reached. The demographic description of the women who participated is displayed in Table 1.

Table 1. Demographic Characteristics of Participants

Variables	***n* (%)**	*Variables*	***n* (%)**
Age:			
20 or younger	3 (15%)	Employed	7 (35%)
21-29	13 (65%)		
30 and older	4 (20%)		
Education:			
Less than high school	1 (10%)	WIC participant	18 (90%)
High school	11 (55%)		
Any college	7 (35%)		
Parity — Number of Children:			
Primiparous — first Child	5 (25%)	Use of breast pump	16 (80%)
Multiparious — two or more children	13 (65%)		
Grand multiparous (≥ 5) — more than four children	2 (10%)		
Marital Status:		Duration of any BF:	
Partnered, not married	11 (55%)	< 6 months	17 (85%)
Single	2 (10%)	≥ 6 months	3 (15%)
Married	7 (35%)		

Data Collection

Approval of study protocols was obtained from the Institutional Review Boards at the WCCHC and the University of Hawai`i at Manoa. Informed consent was received from participants and semistructured interviews conducted lasting 30–60 minutes. Although each interview was unique, several general questions to explain or describe the participant's perceptions concerning the influences on breastfeeding within their community were posed. Sample questions that were asked of participants are described in Table 2. All interviews were tape recorded and transcribed.

Data Analysis

The analysis was guided by the participants' voices and remained grounded in the participants' view. Data were coded, categorized, and conceptually grouped into patterns. *Atlas.ti* software facilitated coding and retrieval of data. Coding was data-driven using an inductively derived coding scheme with terminology taken directly from the raw data. The closeness of the codes to the original data enhanced their credibility (Boyatzis, 1998). Codes were analyzed for linkages and grouped into categories. From these categories, patterns in participants' breastfeeding experiences were identified.

Table 2. Interview Guide

Guiding Questions
1. Tell me how the experience of breastfeeding went for you.
2. Were you able to breastfeed as long as you wanted to?
3. What benefits were there for you in breastfeeding? Did you enjoy breastfeeding?
4. What type of support did you have to breastfeed?
5. Who or what influenced you to breastfeed? Did you see other women breastfeeding?
6. What made it hard for you to breastfeed? Did you have any problems breastfeeding? If so, what did you do and did it work?
7. What were the reasons you weaned?
8. What do you feel are the influences in your community on women's decisions about breastfeeding?
9. What do you think would help women be able to breastfeed longer?
10. Are there things that WCCHC could do that would help women continue to breastfeed longer?

Results

Three patterns emerged from the data analysis: identifying resources, difficulty breastfeeding, and unmet expectations. Each pattern is defined and described as it relates to the participants' breastfeeding experiences, followed by an exploration of the relevant traditional cultural norms and values.

Identifying Resources

Participants identified resources that supported or influenced their decision to breastfeed. Resources which functioned as supports or assets to the breastfeeding experience included knowledge, prior experience, motivation, support, equipment, and empathy. Knowledge resources included education or information known by the participant on the benefits of breastfeeding for both infant and mother, as expressed in these quotes by participants:

> That was one of the reasons why I breastfeed. I'm hoping she'll be a lot healthier because I breastfed her. And, I think, she's a happy baby.

> Just his health and just the bond between a mother and, you know, the child. It builds it so tight. It's so different.

> I think it's also good for moms because you end up eating healthier. It helps you to lose weight and all the good stuff.

Prior experience with breastfeeding older children influenced participants' decision to breastfeed their newborns. Although many participants described different breastfeeding experiences with each child, the experience helped to influence whether they would breastfeed subsequent children.

> Everybody told me to breast feed but I already knew that I was going to breastfeed like while I was pregnant because I already knew the benefits of doing that with my first daughter.

> I like to breast feed my kids 'cause like my sister, we all used to breastfeed.

> Because I have two other children, this time it was just a walk in a park. I already knew what to do right. I knew what to expect.

Motivation expressed by participants included a willingness, wish, or urge to breastfeed or to change undesirable behaviour in order to breastfeed. Participants were willing to put in the effort to quit smoking in order to breastfeed their infant. Wanting to breastfeed was expressed by participants as a factor influencing a woman's decision to breastfeed.

> You know I kept on wanting to try and just me and her and without the pump. We had a hard time but I kept on trying and trying and then we finally got it. She did a good job. I was proud of her.

> After I gave birth, I just wanted for breastfeed her. When we was in the hospital, after I had her, the nurse went ask me, "You breastfeeding or bottle?" I said, "I going breastfeed."

> Because I smoking, and they were telling me that I needed to quit because I didn't know what my daughter was going to come up with. Just to keep her healthy, just to breastfeed her so I just did that.

> So I think women will do what a woman's going to do. Whatever it is that they want to do that's just it. And it's really sad that they don't actually see the benefits, the more long term benefits. I don't think you can really do anything. I mean, look at our office, this is the outreach office, we cannot force our clients to do things. They have to want to do it. And I think that's why that was the difference with me was because I wanted to do it so I did it.

Another support resource throughout the breastfeeding experience was support persons. Support persons included: a) family members, most

commonly mothers, mothers-in-law, and sisters; and b) professionals, most commonly, doctors, nurse practitioners, nurses at the hospital, and staff at organizations which support pregnant/postpartum women in the community. Individuals, participants commented, provided support through their presence, encouragement, expertise, and experience.

> My mom was there all the way. She helped me. She kept on supporting me, it end up sore, but she taught me how to comfort. She helped me to massage. So my mom was my number one support breastfeeding. So she kept me going.

> Because my older sister, when she had her first child she was breastfeeding and we used to talk about our kids and about breastfeeding and then my boyfriend and his family, all of them were breastfed. So his mom was a really big help for me.

> My husband supported me a lot on breastfeeding. My mother-in-law supported me a lot. Of course, Cherie supported us because I went to her birthing classes. And her, baby's doctor supported us a lot.

> It was recommended by my doctor to start breastfeeding just to be able to. I really like to share that moment with your child but you know it was also good too because they say that the breast milk was more healthier for the child. So with the doctor's help, that's what made me to decide to breastfeed my children.

Participants identified having a breast pump as an asset to their breastfeeding experience. The benefits of pumping for women included having the opportunity for someone else to feed their baby while they rested, and feeling that pumping made the flow of breast milk easier during feedings. Although a participant described the cost of obtaining a breast pump, the WCCHC WIC program provides free manual and electric breast pumps to participants of their program; therefore, 80% (16) of study participants used a breast pump, 60% (12) pumped daily, and 20% (4) did not use a breast pump.

> I like sleep and they like eat all the time. That was like one of the difficult part like just drained, still so drained out but yet they still hungry. It's like when they like eat all the time that was what was difficult for me. That's why the breast pump came in. So just pump and then you know go sleep and have somebody else feed.

> So you know the more I would pump, the more easier it'll come out. And the more it comes, the more you could do.

> You'll either give them the option to get the milk or to pump 'cause it's not that hard. There's a lot of parents out there that want to do it, but because pumps are so expensive, but to start is so expensive. To be able to pump takes time. I mean if they could get a breast pump, I know a lot of people who would.

A final resource or asset identified by participants was empathy. Empathy or understanding, particularly from health providers who are in a position to support and influence a woman's decision to breastfeed, was critical. Participants recognized that pregnant women in this community presented with multiple high-risk factors including substance use (alcohol, drugs, tobacco), lack of a strong support system, being a teen, lack of knowledge regarding resources/options available in the community to support breastfeeding, and lack of self-esteem. As a result, participants suggested health professionals be empathetic, moving beyond giving information to conveying knowledge and understanding that would be useful within a woman's current life experiences and challenges. Expressing empathy involves acceptance, skillful reflective listening, and recognition that ambivalence is normal. Therefore, identifying and offering the necessary recovery supports to assist with the woman's lifestyle transition was viewed as necessary.

> If they know that the patient goes out, you know, drinks a lot, or smoke or whatever, just explain to them that it's going to be hard in the beginning, but like I said, it's going to be rewarding at the end. To let them know that they're not the only ones in the world that had a child that had to make the decision between alcohol and their baby or drugs and the baby, or going out and partying and work, for that matter, for the baby, the baby is crucial. The baby is going to be a large part in your life. So when they speak about breast feeding, they need to start thinking about the person's life too, and that to let them know that you know where they're coming from.

> First it would be to like getting them to understand why a person can or cannot. I mean if they do choose to breast feed, they should also have a strong support system. No matter from what part it comes from. They have to be willing, willing to make sacrifices and to just respect themselves as they breast feed. Because some women they feel degraded if they breast feed. They feel that if they breast feed in public, people would stare and all of that. But they shouldn't worry about themselves. They should worry about their kids. So they should have that self-esteem and self-respect as a person and a mother to take it upon themselves to do what is right.

Identifying resources for Native Hawaiians dates back to traditional times and the subdivision of land into *ahupua`a*. An *ahupua`a* marked a piece of land which extended from the mountain to the sea and provided all

of the resources necessary for that community in a spirit of shared exchange (Kamehameha Schools Bernice Pauahi Bishop Estate, 1994). All the resources required for survival were contained in the *ahupua`a* including water, plants, and animals. With this as a foundation, the skills and knowledge of the Hawaiian people developed tools and crafts for daily living. The activities of the *ahupua`a* reflected a place of rituals, ceremonies, defined roles and responsibilities of community members, and knowledge transfer to the next generation. The connection exhibited in caring for the land and caring for and sharing with each other is through *aloha* (love), a profound Hawaiian sense that is familial (*`ohana*) and genealogical (Trask, 1993). The *`ohana* (extended family), as well as the *ahupua`a* community, provided the necessary support in an individual's life. The *`ohana* conveyed:

> ... a sense of unity, shared involvement and shared responsibility. It is mutual interdependence and mutual help. It is emotional support, given and received. It is solidarity and cohesiveness. It is love — often; it is loyalty — always. It is all this, encompassed by the joined links of blood relationship (Pukui et al., 1972, p. 171).

Traditionally, the baby's first food was breast milk. Hawaiian women breastfed in a supportive environment. In fact, it was not unusual for breastfeeding to be supplemented by other relatives or wet nurses, and for a mother to be nursing her own child and that of another (Handy and Pukui, 1972; Pukui et al., 1972). Today, participants continue to identify their *`ohana* and the professionals/staff in the community as resources supporting their breastfeeding experiences and conveying knowledge useful in their lives.

> Get your family support because Hawaiian families they support, you get plenty *hu-hu*, plenty problems, and then when things happen you all come together. So when you pregnant that's the most important time because you going need their back up, you need their help, their assistance, whatever you want to call it. And you know the old people, they tell you, give your baby breast milk, better for your baby, right. And of course when the baby is like 3 months, 4 months, put poi in the water, that's how our parents do.

Difficulty Breastfeeding

Participants described conditions or circumstances under which breastfeeding was "hard," including physical problems with their breast, discomfort, and time demands. This is the second pattern related to the participants' breastfeeding experience.

Physical problems encountered by participants included the breast not producing enough milk or coming in late (whether during breastfeeding or pumping), problems with the breast and nipple as mastitis, engorgement, nipples sore, raw, and cracked. Latching-on was also a difficulty experienced by participants. Finding a solution or comfort was eagerly sought; however for some participants, extended difficulty breastfeeding also influenced their duration.

> I started engorging and that was uncomfortable. But was okay after the first two weeks.
>
> I'd pump my breast. It got to the point when I was getting milk, so I was producing milk because she would be sucking. But I thought if you kept pumping, it'll come in. But it didn't happen that way.
>
> The only downfall was that I kept getting mastitis where I would swell and I kind of believe because I didn't have a problem with breast feeding with the other two children who are 14 and 5 years old.
>
> It's real better but I try, and it's just that sometimes come sore. 'Cause I stopped because I was bleeding, my nipple, because I guess when she was sucking then the thing started to rip. I went stop just before it become worst.
>
> You know I know how to breastfeed. I know the positions. I've tried them all, she still can't latch on to it because my nipples inverted. That was the whole problem. But when she got to latching on, it was like she wasn't getting enough.

Discomfort with breastfeeding contributed to difficulties participants experienced. Discomfort was associated with the physical discomfort of breastfeeding as mentioned previously and uneasiness with breastfeeding in public or a crowded living situation. While many participants felt comfortable breastfeeding in public, or breastfeeding subsequent children in public, there were some participants who were not comfortable, particularly with their first child.

> But my oldest daughter, before I would stop because I wasn't comfortable when I go out in public like the popping it out. I would have to wait in the car and feed her first and then I would go out. But my youngest one, I no care. I just pop it out and feed her.
>
> I never felt comfortable. I would see plenty women out there doing that but I felt uncomfortable. So I either did it in private or away from people.
>
> I was active and I like to come out of the room, I wouldn't like to stay in the room long time. And I thought well I'll go breastfeed baby. There's a lot of people in the house.

Time demands were another factor contributing to difficulty breastfeeding. Circumstances related to time demands included changes or consideration of the participant's daily schedule as with school/classes, appointments, routine chores or responsibilities at home, and time with other children. Participants tried to fit breastfeeding in around these schedule demands, changed their schedules because they chose to breastfeed, or shortened the duration of breastfeeding as a result of their time demands.

> Breastfeeding for me was actually easier the first time around. The second time around I had hard time. A lot of difficulties 'cause of changes in my school and the routine had to change.

> I had to go to therapy. So I worked it out where I can breast feed her before I left, give her my breast to suck on it. Put her down for morning nap. So I'd go to my therapy. When I get back, she's already getting up. So that one I had to time her real good.

> There's also the sacrifices if I'm going to feed longer, how am I going to get this done and that done. I know that's what every woman thinks about. That's what I go through every day.

> I had to give her the bottle so I could break away and go do my other household stuff because she constantly wanted to eat.

Difficulties breastfeeding as expressed by Native Hawaiian women today reflect a change in the perception of breastfeeding and the responsibilities or expectations put solely on the mother. Traditionally, breastfeeding was an expectation and therefore breastfeeding in front of other people was a routine part of life and not uncomfortable. Wet nurses gave Native Hawaiian women and their babies other sources of breast milk. If a woman experienced difficulties breastfeeding, as with the flow of milk coming in late, there were other women who could step in to breastfeed. Specific rituals and prayer to the gods was also a part of "making the milk come in," this inspired confidence and served as a source of reassurance for women (Pukui et al., 1972). Today, difficulty breastfeeding without a quick resolution creates frustration and anxiety for women, which without a supportive environment, may shorten the duration of breastfeeding.

Unmet Expectations

The third pattern related to the participant's breastfeeding experience was unmet expectations. Participants held expectations associated with breastfeeding that were not met. Participants planned for or anticipated a par-

ticular set of experiences that did not evolve as they envisioned. Unmet expectations included a discrepancy in values, an assumption of participant knowledge, lifestyle adjustments, and the value of organizational support.

Participants come with a set of values to the breastfeeding experience, yet there are discrepancies when sharing their breastfeeding experience. Four examples of a discrepancy in values are described. First, participants understand when their baby is hungry and needs to eat, but their breast milk may be slow coming in or they feel "there is not enough," and therefore, there is an urgency and need by the participant to "feed" baby something, usually formula.

> My breast couldn't produce enough for her. And so I asked the nurse at Kapiolani if I could have the formula. She said, "Oh, no, we don't give formula." I said, "Wait a minute, what if the child doesn't want to breast feed?" You know, because they were giving me a hard time. So I just said, "No, I decided not to breast feed." Just so they'd give me the formula. And she says, "You know you gotta try and you all this, the lactation specialist to see me. You know I know how to breast feed. I know the positions. I've tried them all, she still can't latch on to it because my nipples inverted in fact. That was the whole problem. But when she got to latching on, it was like she wasn't getting enough.

> Maybe if there would have been more ways to help me keep my milk coming in. Because even though she was drinking I would pump and I would, get lots of fluids, take my prenatal vitamins, it still didn't help with keeping my milk coming and keeping my breast full so she would have enough to eat.

Second, participants identified their influences to breastfeed primarily as their family, yet when asked what would influence women in the community to breastfeed or to breastfeed longer, participants identified the health benefits to mother and baby and shared their personal experience. This is reflected in the example below with the same participant.

> *Interviewer*: Who would you say or what would you say influenced your choice to breast feed?
>
> *Participant*: Well, mostly my mom. She really wanted me. My mom the whole time I was pregnant she kept telling me you going breast feed, just breast feed. So she was the most one that was pushing me.
>
> *Interviewer*: What would help women decide to breastfeed? You know, like say if you have a friend, and she doesn't know whether she should breast feed or not, what would you think would be a decisive thing for her that would make her decide she should breast feed?
>
> *Participant*: Well, I would just tell her from my experience with my son and how with my nephew too. Like our sons was the ones that got

> sick, I don't know if it was because we didn't breast feed, but they had a lot of ear infections and my son was always getting a lot of colds, so I think I would try to tell them that you know it's much better so they come less sick.

The third discrepancy in values reflected by participants pertained to having someone else watch or take care of baby. Some participants felt that having someone else watch their baby meant that they would have to give them formula or have the choice to pump or give formula. Despite the benefits expressed by participants regarding breast milk, if the person taking care of the baby was other than the breastfeeding mother, a choice to pump or give formula seemed to be available.

> I work full time so I didn't like pumping my breast with the manual pump. You know I kind of wish somebody told me about the electric one which would have made it a lot easier then I probably would have gave her breast milk longer but because I'm here most of the time then she's at my parents and they usually give her formula.

The final example of a discrepancy in values involved asking for help. Despite the challenges and difficulties experienced by many participants, some participants were not comfortable in asking for help. Although assistance from family members was sought to watch their child(ren) while they had an appointment, it was unclear whether this referred to help from family, friends, or health care professionals.

> I have one five year old, I have to be attentive to both of them, I have to be there for him I can't ask for help 'cause I don't like to, I just want to be a good mother to my kids.

Another unmet expectation in the participant's breastfeeding experience was an assumption that the participant had breastfeeding knowledge. Participants expressed challenges or difficulties with breastfeeding that seemed to result from a missed opportunity to educate. The difficulties or challenges identified of physical problems with the breast, discomfort, and time demands were not expected by participants.

> I had engorgement so I always had to like go to the shower and relieve the pressure. But sometimes when I'd go see my OB, she would say it's not an engorgement. And I'd say, 'Okay, but I feel different.' And she said, 'You can tell when you have an engorgement because the whole breast gets full.' So the next week I went back and she said, 'Now that's an engorgement.' I was like, 'Well, can you help me?' Because I was really hurting.

> Getting up in the middle of night and staying awake while she was breast feeding. Just the latching was pretty much the hardest thing.

While participants were motivated to breastfeed, they also expressed lifestyle adjustments they experienced or suggested may be reasons why women in the community choose not to breastfeed. The lifestyle adjustments resulted in shortening the duration of breastfeeding or choosing not to breastfeed.

> Whenever somebody gets pregnant, I don't care who it is, somebody always comes up to tell you, you're wasting your life, you know. There went your life. Because now in order for you to do this, do that, you gotta find baby sitter. That's the reason why a lot of people nowadays call on their parents to take care of their kids because they don't want to give up their life.

> I work in a preschool and a lot of the parents over the years, especially the younger, my age ladies and younger, you know it's the drinking, smoking, there's partying. Went to the baby sitter because I ain't coming home and stuff like that.

> I work full time and then in November I got sent to Maui, you know, for a 2-day conference, so I knew that dad was going to have to put up with her, and whatever she wanted. So that started me off and then I was over there on Maui, you know, I wanted my baby because I'm engorged and I was in the bathroom. I started thinking, well, maybe it's just time for take her off because I didn't like pumping. I would feed her all night, I would breastfeed her all night, in the morning drop her off with my parents who watch her all day, give her formula and then I don't breastfeed her until I get home.

> It's really not about the breast milk or the bottle, more the environment, the parents themselves, like how they raise them, would be the turning about outcome of the community.

Finally, participants appreciated the organizational support at the hospital and in the community, for their breastfeeding experience. However, they also noted that medical or community services that could have met their specific needs, were not as useful as they had expected.

> I was alright actually. I have my mother-in-law, all the time with me. I always went to her house. I was never home because I was so sad that what is that program that you have that Healthy Start? But I never was home so they never came.

> They just would like check on me and you know, just weigh my son, weigh my daughters and then check my stitches and my uterus, how it is. And not really asking questions of how I was or how I felt.

Unmet expectations present themselves when there is a discrepancy, an unexpected or challenging adjustment, or a need not fulfilled by an organization providing services in the community. Expectations, values, and adjustments identified by participants may be understood differently by support persons, particularly health care professionals. Participants expect experiences based on what they know and how they understand what they know as a result of their cumulative cultural experience. Identifying discrepancies decolonizes the superiority of Western knowledge. It exposes the problems and challenges experienced with breastfeeding and reveals the core issue of the mother-baby relationship, *malama kou aloha* (preserve, protect, care for, and maintain your love).

Discussion

This study provided insight to the breastfeeding experience of Native Hawaiian women in one community. Reflecting on Native Hawaiian traditions assists in strengthening today's systems or environments, and clearly articulates the needs of Native Hawaiian women who choose to breastfeed. The implication for the community is to create a supportive environment for childbearing women that influences and contributes to prolonging the duration of breastfeeding. A supportive environment would consists of the following:

a. involvement of the *`ohana* (as defined by the woman) to be present, convey knowledge, encourage, empathize, provide respite, acceptance, and comfort;

b. breastfeeding preparation by health care professionals prior to delivery, inviting women to share the breastfeeding preparation experience with support persons or members of their *`ohana*. Breastfeeding preparation would involve in-person contact to convey knowledge on the physiological process of breast milk coming in, latching, frequency of breastfeedings, nipple preparation, and readiness to breastfeed (support available and accessible, time demands, perception and comfort, and cultural conflicts);

c. identifying unmet expectations and discrepancies in the breastfeeding experience by health care professionals. This requires that health care professionals identify and acknowledge discrepancy with experiences shared by breastfeeding women and reflect on their own cultural values regarding breastfeeding and lifestyle adjustments ("being a good mother"). Support and proper breast management during the postpartum

and interconception (between pregnancies) period by a health care professional. Reinforcing knowledge received during breastfeeding preparation and preventing physical problems with the breast and discomfort are vital to increasing the duration of breastfeeding for women and supporting the normal physiological process of breastfeeding.

Limitations

While this study provided valuable lessons in the provision of care to Native Hawaiian women, there are several limitations. First, focusing on one community may not reflect the experiences of all child-bearing Native Hawaiian women. Receiving knowledge from other Native Hawaiian communities would strengthen the findings. Second, age and parity or number of children may have had a different impact on the findings. A broad spectrum of women by age and number of children were recruited and enrolled in the study. Future studies may focus solely on a younger population or a teen population, and likewise first-time mothers. Issues not revealed in this study may be discovered with teens and/or first-time mothers.

Conclusion/Next Steps

Traditionally, women breastfed in a supportive environment that was not fully available to the study participants. Valuing traditional practices in the context of current influences may improve breastfeeding rates among Native Hawaiian women and, therefore, the health of this community. To move these findings forward, three steps have been taken or are under consideration. First, the authors are conducting current research in this community to compare the use of perinatal risk reduction behaviours (prenatal/postpartum preventive health care use, breastfeeding pattern, effective parenting and social networking) in first-time Native Hawaiian mothers who receive a perinatal risk reduction intervention and those who receive the usual perinatal care (control group). Consistent with the findings presented and targeted cultural group, this study encourages pregnant women to identify a support person to assist them through their pregnancy/postpartum period. As part of the intervention, perinatal support services case managers educate support persons on their role in supporting first time mothers through their pregnancy and postpartum period including breastfeeding.

Second, dissemination of findings to women in the community occurred at a Women's Health Day event (Figure 3) held at the participating community health centre in September 2008.

Figure 3. Breastfeeding Results Shared at Women's Health Day

Results discovered from this study of breastfeeding were shared in a lay interactive question and answer format by the authors. Participants, totaling 125, were receptive to the questions and interested in the answers, prompting other questions or a sharing of their own personal breastfeeding experience. This event was a unique opportunity to share findings with the community in which the research was conducted. The information will continue to be a part of breastfeeding information shared at community events through the health centre's perinatal program.

Finally, a review of current breastfeeding information provided through the health centre's prenatal classes and perinatal support services will be conducted. Research findings will be incorporated into the prenatal class curriculum and supportive services provided by perinatal case managers. We anticipate that the opportunity to directly affect practice will influence initiation and duration rates of breastfeeding amongst Native Hawaiian women in this community.

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