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Māori Solo Mothers' Healthcare Access

Experiences, Barriers and Complexities of Access

Rochelle Lee

Abstract

Aims: The aim of the present research was to better understand any issues, barriers and facilitators experienced by Māori solo mothers with access to and through healthcare within New Zealand, in taking care of their personal health.

Design: Essentially exploratory, the qualitative study employed a general inductive design within an overarching Kaupapa Māori approach.

Methods: Kaupapa Māori methodology informed the study design, participant recruitment, and data collection processes through cultural protocols, consultation and supervision. The recruitment strategy employed flyer distribution and snowballing techniques to purposively recruit seven Māori solo mothers. Data collection was digitally-recorded semi-structured interviews with each participant. Transcribed interview data underwent general inductive thematic analysis to identify commonalities and patterns in participants' experiences. Emergent themes were categorised and developed from analyses across accounts.

Findings: Major themes emerged that capture and describe participants' experiences and encounters in accessing healthcare. Common experiences elucidated barriers, facilitating factors, cultural complexities and issues, and access inequities. The major barrier to access is cost, which limits poverty-driven options. Other barriers are: waiting times; low quality healthcare; prioritising children's healthcare; difficulties with childcare and/or transport; lack of low-cost health services; and unhelpful attitudes of health professionals. Factors facilitating access include: access to regular GPs; 'caring' healthcare; convenient access to local, low-cost and organised services; and connectedness of social and health services. Complexities and issues emerged that complicate and hinder access: contemporary cultural issues; cultural and personal barriers; lack of healthcare options; stigmatisation and marginalisation, and need for Māori health professionals and culturally-safe healthcare.

Conclusions: The research generated meaningful knowledge of barriers, complexities, and issues impacting participants' healthcare experiences and access. Factors and strategies facilitating access to healthcare illuminate ways to improve access to services. Findings promote understanding of Māori solo mothers' experiences of healthcare, elucidate the sociopolitical, cultural and personal complexities influencing access, and illuminate socioeconomic inequities underpinning access options and uptake of health services. It is recommended that the access issues be addressed and barriers to access be removed at policy, funding and practice levels to improve health outcomes and provide equitable healthcare access for Māori solo mothers.

Acknowledgements

Table of Contents

List of Figures

Glossary

A&E   Accident and Emergency – community-based healthcare clinic dealing
                            offering a variety of services, depending on the individual clinic,
                            including triage, general practice, radiology, and after-hours services.

CADs   Community Alcohol and Drug Services – community-based drug
                            rehabilitation Services.

DPB   Domestic Purposes Benefit - a welfare benefit paid to eligible solo
                            parents through Work and Income New Zealand.

ED   Emergency Department – hospital-based department dealing with
                            triage, assessment, and pre-admission patients.

GP   General Practitioner – a doctor who specialises in general practice.
                            GPs are the cornerstone of primary healthcare and gateway to
                            secondary healthcare in New Zealand's health system.

Housing NZ   Housing New Zealand – government department that oversees the
                            purchase, allocation and monitoring of state-own housing.

IUD   Intrauterine device – type of long-term contraceptive implanted in the
                            uterus.

SoPH   School of Population Health at the University of Auckland.

Te Aitanga-A-Mahaki   Māori iwi (tribe), situated near Gisborne, on the east coast of the
                            North Island, New Zealand.

Te Kupenga Hauora Māori   Faculty of Māori Health, at the School of Population Health,
                            University of Auckland.

WINZ   Work and Income New Zealand – a part of New Zealand's Ministry of
                            Social Development, charged with the distribution and monitoring of
                            welfare benefits.

Chapter 1. Introduction

1.1. Introduction

Chapter 1 introduces the research project conducted for a Master of Health Science thesis. This introduction will lay the foundation for the remaining chapters in the thesis. Firstly, a summarised background informing the research is presented and the research question is given. Then the gap in research underpinning the research is explained and the significance of the research topic will be justified. Thereafter, the structure of the thesis is presented. Now a presentation of the background to the current research will commence the thesis.

1.2. Background to the Research

Health is a fundamental human right. This is the message campaigned globally by the World Health Organisation (WHO) to move nations toward (Butterworth, 2003; Landero, Estrada, & Gonzalez, 2009; Seccombe et al., 2007; Young, Cunningham, & Buist, 2005) *Health for All* people, which is achieved with systemic changes and recognition that "access to and utilisation of health care is vital to good and equitable health (Commission on Social Determinants of Health (CSDH), 2008, p. 8)."

Led by the WHO, the last three decades have seen increasing recognition of and research into disparities in health among nations (Jatrana & Crampton, 2009; Malcom, 2004; Ministry of Health & University of Otago, 2006). Internationally, studies have consistently reported the existence of social gradients of health, with income shown to have the strongest association with health status, and the poor overwhelmingly bearing the burden of morbidity and mortality (Curtis & Pennock, 2006; Tobias & Howden-Chapman, 2000; Worth & McMillan, 2004). As research into disparities of health continues, determinants of health are increasingly investigated; growing evidence suggests socioeconomic status not only impacts health, but is inextricably linked with access, to primary care services and, through healthcare systems (Ellison-Loschmann & Pearce, 2006; Malcom, 2004). Although under-researched, solo motherhood is shown internationally to be associated with low socioeconomic status, ethnic minorities, poor health status (Sarfati & Scott, 2001), and underutilisation of health services (McGrath, Yeung, & Bedi, 2002).

International research investigating the health of solo mothers has found evidence that health status and access to healthcare of solo mothers reflects a social and ethnic gradient (Kaestner & Kaushal, 2003; Kaushal & Kaestner, 2005; Seccombe et al., 2007; Shouls, Whitehead, Burström, &

Diderichsen, 1999; Taylor, Larsen-Rife, Conger, Widaman, & Cutrona, 2010; Young et al., 2005). Solo mothers are regarded as existing at the interface of disadvantage from single parenting, poverty, and often ethnic minority (Fritzell, Ringback Weitoft, Fritzell, & Burstrom, 2007; Higgins, Young, Cunningham, & Naylor, 2006; Taylor et al., 2010). This convergence of disadvantaged circumstances is reflected dynamically by solo mothers' persistently poorer health and suboptimal healthcare access (Curtis & Pennock, 2006; McGrath et al., 2002; Seccombe et al., 2007). Barriers and facilitators of healthcare access for solo mothers are underpinned by personal circumstances as well as social, economic, cultural and political climates (Landero et al., 2009; Young et al., 2005). Lack of research-based understanding, limitations on dissemination, and political inaction are acknowledged as reinforcing stigma, misunderstandings and disadvantage for solo mothers, their health and healthcare access (Curtis & Pennock, 2006; Kaestner & Kaushal, 2003; Kaushal & Kaestner, 2005; Reeves, Kendrick, Denman, & Roberts, 1994; Seccombe et al., 2007; Taylor et al., 2010)

New Zealand research investigating the health of solo mothers revealed that solo mothers' self-reported health status is poorer than that of married women or single childless women. One key study, based on the 1996/97 New Zealand Health Survey data also reported that solo mothers in New Zealand were more than twice as likely to be of Māori ethnicity than other ethnicities (Sarfati & Scott, 2001). Overwhelmingly, the limited extant international and New Zealand research recognises solo mothers as a disadvantaged group deserving special consideration in health research and policy (Sarfati & Scott, 2001; Tobias, Gerritsen, Kokaua, & Templeton, 2009). With Māori women constituting over half the solo mother population they can be considered a significant sub-population of solo mothers (Sarfati & Scott, 2001). Māori solo mothers are a marginalised and disadvantaged group, according to extant research, and deserving of investigation to better understand the factors underpinning their poorer health (Sarfati & Scott, 2001; Tobias et al., 2009). Drawing upon international research it is recognised that inextricable links between health status and access to healthcare exist, with poor health associated with difficulties in accessing healthcare services (Ellison-Loschmann & Pearce, 2006).

Therefore, it is suggested that for Māori solo mothers access to healthcare is limited and health services underutilised. To better understand Māori solo mothers' poorer self-reported health, and to improve health outcomes through targeted healthcare provision, research is needed to explore the access to healthcare of this disadvantage group of women.

1.2.1. Research Question

The research presented in this thesis asks the question:

What are the experiences of Māori solo mothers in accessing healthcare for personal health needs?

1.3. Justification for the Research

The international research has evidenced that solo mothers are an increasing group in global societies and they are consistently found to be disadvantaged and marginalised (Reeves et al., 1994; Reid, Frisby, & Ponic, 2002; Shouls et al., 1999). The self-reported health of solo mothers is persistently poor and limited research shows underutilisation of healthcare for this group of women (Fritzell et al., 2007; McGrath et al., 2002). New Zealand's research on the health or healthcare access of solo mothers is limited (Sarfati & Scott, 2001), but research into the health and healthcare access of Māori solo mothers is scarce (Jatrana & Crampton, 2009): indicating a significant research gap. Thus, an investigation of the experiences of Māori solo mothers' in accessing healthcare in New Zealand is a significant research topic, of an under-researched population, in an under-investigated area of health research.

Solo mothers as an under-researched population

An investigation into extant literature related to solo mothers' health and healthcare access, as presented in chapter 2, revealed a limited but growing body of knowledge. Internationally, solo mothers are recognised as one of the fastest growing sub-populations in most Westernised nations as contemporary societies witness increasing numbers of marriage break-ups, never-married mothers, and aging populations (Landero et al., 2009; Shouls et al., 1999; Statistics New Zealand, 2004). In recent decades, as solo parent ing became more prevalent health research surveys and national census data revealed that demographic categorisation of family type consistently showed poorer self-reported health status of solo mothers compared to their married and childless counterparts, and the general population (Beaudet & Perez, 1999; Fritzell et al., 2007; Reeves et al., 1994; Shouls et al., 1999). As health research continued it was found that solo mothers tended to be on very low incomes and had poorer health outcomes compared to other population groups (Curtis & Pennock, 2006; Higgins et al., 2006). Although research continues into solo mothers' self-reported and actual health status, limited research has investigated the access to healthcare of this significant group of women (Jatrana & Crampton, 2009; McGrath et al., 2002) .

Likewise, New Zealand research investigating the health of solo mothers and their access to health services is limited. In New Zealand, four key studies have investigated the general physical and mental health status of solo mothers, two in relation to welfare work-activation programmes, with findings reflecting international evidence. Solo mothers in New Zealand were found to have: higher prevalence of treated hypertension and poorer mental health compared to partnered mothers, possibly due to higher stress levels (Sarfati & Scott, 2001); high prevalence of chronic, acute, current, reoccurring and multiple incidences of health conditions, including physical functioning problems, respiratory conditions, gynaecological issues, substance abuse, mental health conditions, emotional problems, which some linked to poverty (Baker & Tippin, 2004); fatigue and misery, and poor health

status with poor social, physical and emotional functioning compared to national data for women (Worth & McMillan, 2004); and twice the likelihood of experiencing mental health issues and a notably increased risk of mood disorders, suicidal ideation and substance abuse than coupled mothers (Tobias et al., 2009).

New Zealand's Significant Solo Mother Population

The four aforementioned key New Zealand studies related to solo mothers health paint a dismal picture of poor health for this group of women compared to the general population. But it is the size of this solo mother population that should make their poor health a dire reality for New Zealand's policy-makers. Solo parent s may be solo mothers, solo fathers, or others such as a single grandparent raising dependent grandchildren. However, as shown in Figure 1-1., the 2001 census data reported that solo mothers constituted 15%, compared to 3% of solo fathers, of the solo parent population which constituted 18% of the New Zealand population of parents aged 25 to 49 years of age (Statistics New Zealand, 2004). With 18% of the parent population composed of solo parent families this sub-population can be considered statistically significant. Although solo fathers are an important group in New Zealand society they are a less significant sub-population and therefore more difficult to research. In contrast, this census data shows solo mothers constitute over 80% of the solo parent population making them a significant group of women in the population (Statistics New Zealand, 2002a).
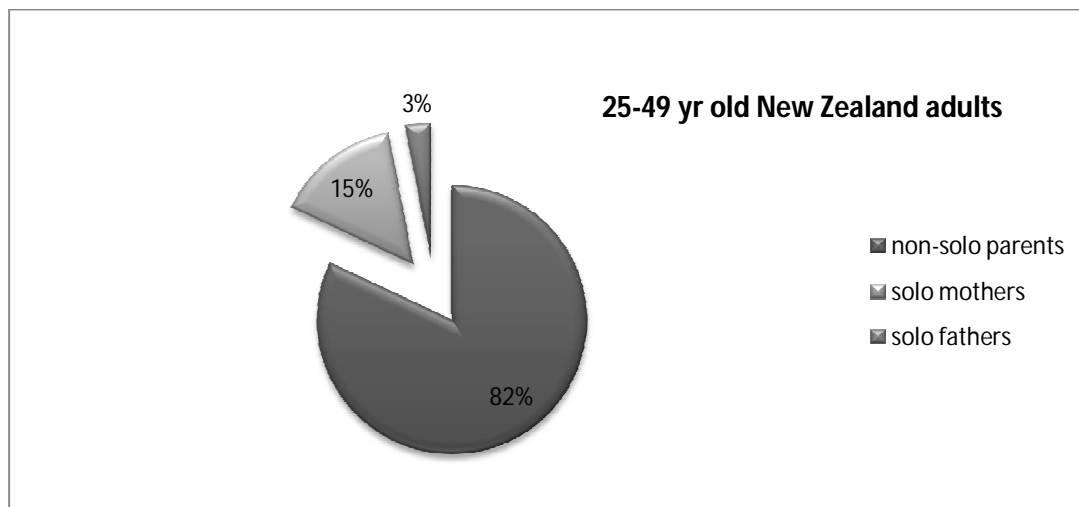
Figure 1-1. Solo-Parent Population of New Zealand Adults Aged 25 – 49 years From Census 2001 Data (Statistics New Zealand, 2004).

6

Aligning with global trends in family composition, New Zealand's solo parent population is increasing exponentially compared to other family types. New Zealand census data from 1981 to 2006 provides a clear overview to the rise in solo parent families. Figure 1-2. shows the progressive and significant increase in solo parent families in the New Zealand population (Cotterell, von Randow, & Wheldon, 2008); solo mothers represent the vast majority of these solo parent households, as shown in Figure 1-1. (Statistics New Zealand, 2004). The baseline 1981 census data reports 58,473 households were headed by a solo parent with dependent children aged 18 years or less, out of a total of 354,276 couple with dependent children households. Interestingly, as the number of solo parent households increased the prevalence of two parent households decreased overall until rising again to 370, 809 in 2006; by comparison, the number of solo parent households had risen to 145,032 which is an increase of 86, 559 over a 25 year period (Cotterell et al., 2008).
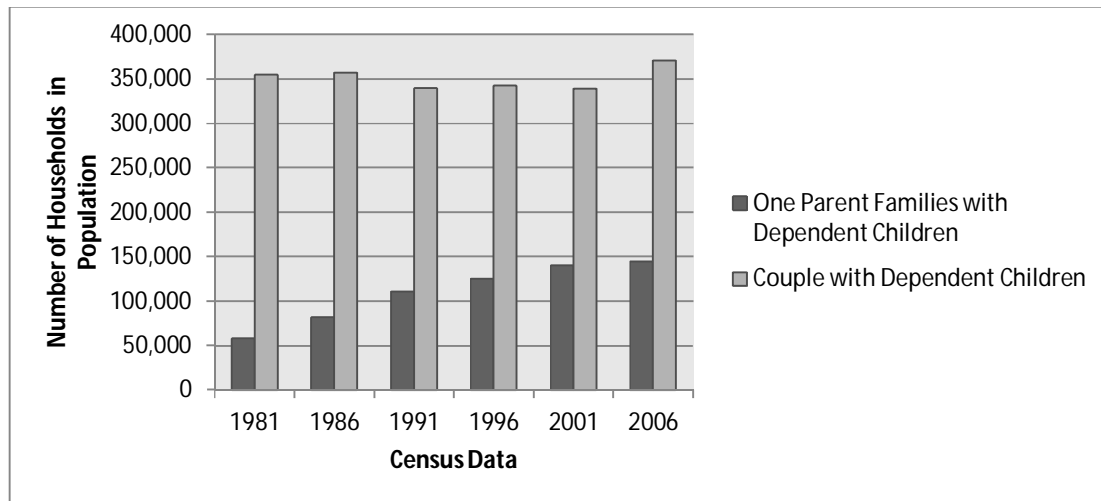
Figure 1-2. Population Increase in One-parent Households in New Zealand (Cotterell et al., 2008, p. 11).

Furthermore, Statistics NZ (2004) population trend projections based on census data reveal predicted changes in family-type trends by 2021. Using 2001 census data as the baseline for family-type populations, Statistics NZ estimates a significant increase in solo parent families with at least one dependent child and congruent decrease in two-parent families with at least one dependent child. These trends are attributed to projected changes in the population: fertility decline; more childless couples; more unpartnered or between partner parents; and partnered parents living independently. According to 2001 baseline data two-parent with dependent children families represented 78% of families with children in New Zealand. This population of 446,000 families (2001) is projected to decrease to 418,000 by 2021, which will represent 72% of families with children.

7

In contrast, solo parent families with at least one dependent child are expected to increase 28% over the same time period. As such, this solo parent population is projected to increase from 153,000 in 2001 to approximately 196,000 (2021). An alternative projection series, using the baseline data, places this increase in solo parent families as high as 36% to number 276,000 families by 2021. Figure 1-3. presents the population trend projections for both two-parent and solo parent family types with dependent children (Statistics New Zealand, 2004).
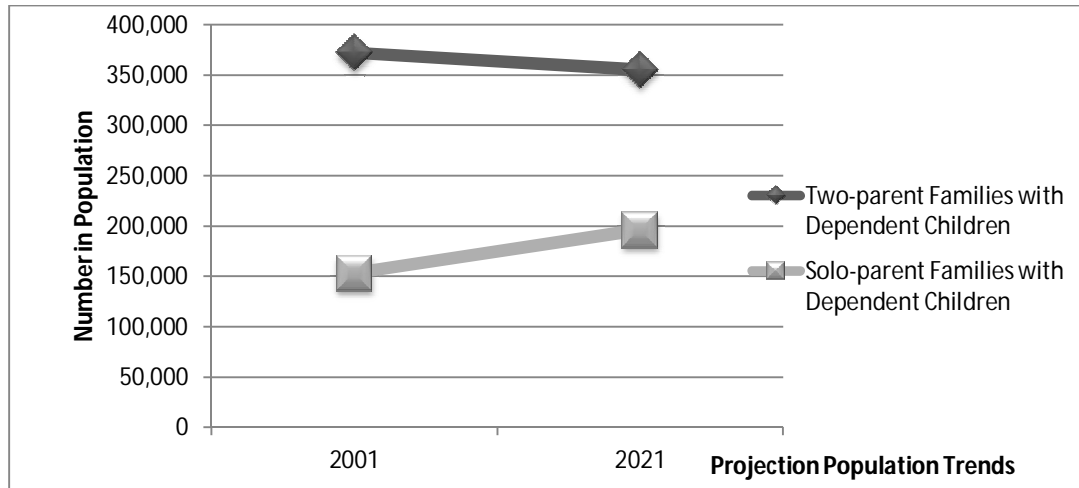
Figure 1-3. Population Trends for Two-parent and Solo Parent Families with Dependent Children Projected from 2001 (baseline) Census Data (Statistics New Zealand, 2004, pp. 41,43).

If these Statistics NZ (2004) projections are fairly accurate, by 2021 nearly half of all families with dependent children will be solo parent families. As mentioned previously, and shown in Figure 1-1., the vast majority of solo parents are solo mothers (Statistics New Zealand, 2002a), which means the projected increase in solo parent families can be assumed to also mean a substantial increase in the number of solo mothers with dependent children. Such population trends suggest solo mothers with dependent children are an important sub-population and deserving of health and social policies that reflect their significance in the New Zealand population (Sarfati & Scott, 2001). To inform equitable policies, accurate research-generated knowledge of solo mothers' social, economic, and health status' and needs, is required.

Although, New Zealand studies consistently reported the poorer health of solo mothers, researchers did not investigate solo mothers' healthcare access or uncover connections between health and healthcare access (Baker & Tippin, 2004; Sarfati & Scott, 2001; Tobias et al., 2009; Worth & McMillan, 2004). With inextricable links between health status, access to healthcare and health outcomes (Jatrana & Crampton, 2009), it is suggested that solo mothers' healthcare access needs investigation.

Māori Women Over-represented in Solo Mother Population

Similarly, no ethnic disparities in health were explored or found in the extant research, although Sarfati and Scott (2001) did report solo mothers in the nationally-representative sample (n=721) had significantly worse self-reported mental health, higher prevalence of hypertension medication use, and were more than twice as likely to be Māori ethnicity, as shown in Figure 1-4.
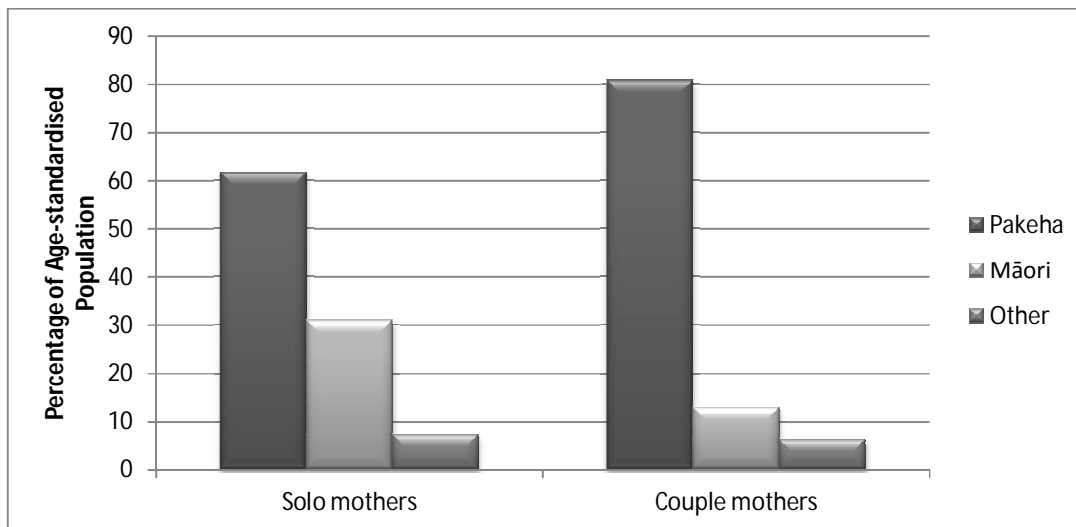
Figure 1-4. Age-standardised Ethnicity of Solo and Couple Mothers using 1996/97 New Zealand

Health Survey Data (Sarfati & Scott, 2001).

However, international research has also shown that solo mothers not only report poorer health, but tend to be of minority ethnicities too (Taylor et al., 2010; Young et al., 2005). As such, Māori solo mothers potentially represent a significant and double-disadvantaged group in New Zealand's population. With solo mothers considered a disadvantaged and marginalised group in society, it is critical to better understand the healthcare access needs and experiences, and ethnic complexities in the healthcare of these women (Sarfati & Scott, 2001).

Confirming Sarfati and Scott's (2001) findings that Māori women are overrepresented in the solo parent population, 2001 census data presented in Figure 1-5. shows the proportion of Māori who are solo parents compared to two-parent families across ethnicities. According to the 2001 Census of Population Dwellings (Statistics New Zealand, 2002a, 2002b), of the total 36,627 Māori families with at least one dependent child, a vast 16,761 of those were headed by one parent. Among the other population ethnic groups, solo parent families constituted: 28,368 European families; 5,373 Pacific Island families; 1,767 Asian families; and 327 other. That nearly half of all Māori families were recorded as solo parent families is disproportionate among the Māori population compared to the

other ethnic groups. Further investigation, across census data reveals how many of these Māori solo parent families in fact Māori solo mother families constituted.
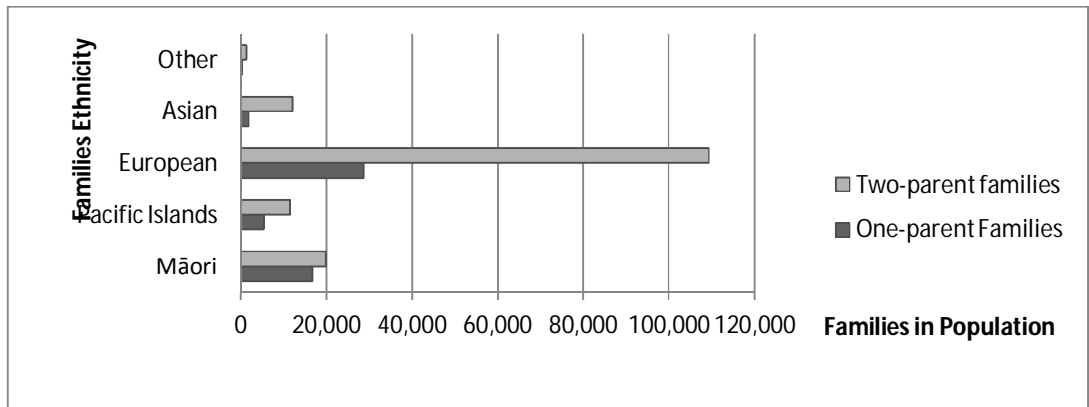
Figure 1-5. Ethnicity of One-parent & Two-parent Families from 2001 Census Data (Statistics New Zealand, 2002b)

Figure 1-6. shows the number of Māori solo mother families in New Zealand as recorded in the Census of Population Dwellings 1996, 2001, and 2006 (Statistics New Zealand, 2011). There were 34,854 Māori solo mother families in 1996 out of a total 131,769 solo mother families. By 2001, Māori solo mothers with dependent children constituted 37,080 of all 147, 858 solo mother families. The 2006 census reports there were 39,822 families headed by a Māori solo mother with a total solo mother population of 155,739. Considering the last census data for Māori solo mother families was six years ago, there is a strong likelihood this sub-group of solo mothers will have increased in number.
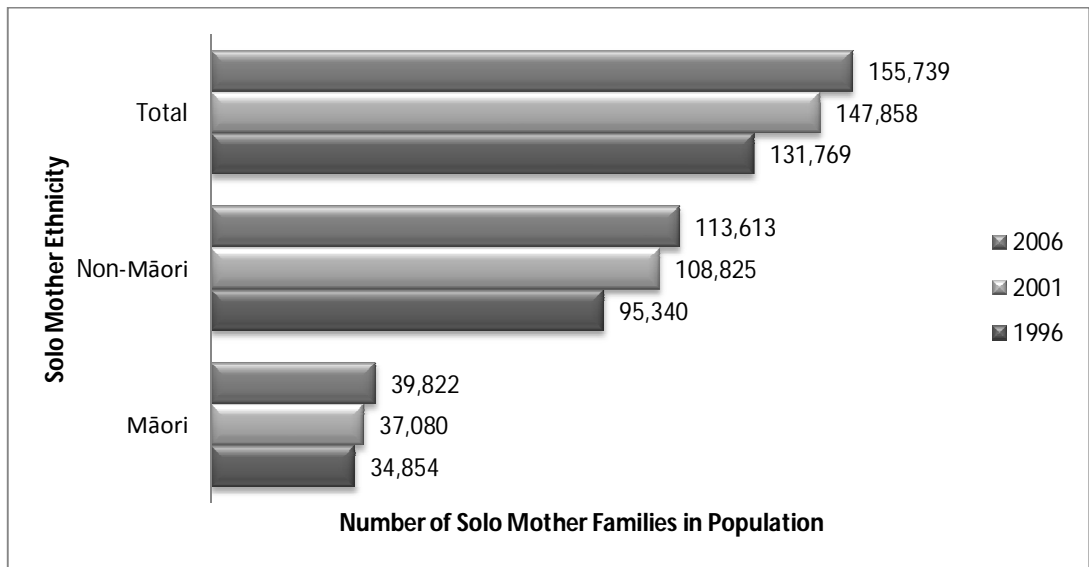
Figure 1- 6. Number of Solo-mother Families by Ethnicity using New Zealand Census Data (Statistics New Zealand, 2011)

Across the statistics presented in this section and Figure 1-6., it is clear that Māori solo mother families represent a substantial proportion of all Māori families. Therefore, Māori solo mothers' evidenced poor health is a significant Māori Health issue. Moreover, using the same census data from 1996, 2001 and 2006 (Statistics New Zealand, 2011), Figure 1-7. shows the composition of Māori solo mother families by dependent children's age groups, as compared to non-Māori solo mothers. Reflecting the young Māori population in general, the children of Māori solo mothers tend to be younger. With younger children to care for, Māori solo mothers would have higher childcare workload which may impact their general emotional well-being and ability to access health services especially if they lack social support and access to adequate childcare (Fritzell et al., 2007; Jatrana & Crampton, 2009; Reeves et al., 1994).
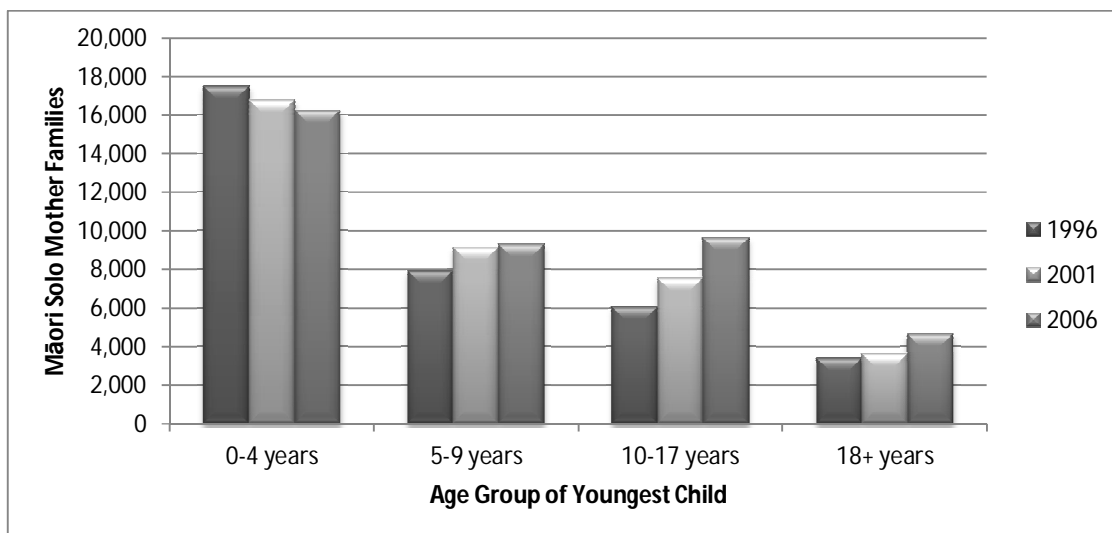
Figure 1-7. Families Headed by Māori Solo Mothers by Age Group of Youngest Child (Statistics New Zealand, 2011)

In sum, persistent ethnic inequalities, that undermine Māori health and access to and through healthcare within New Zealand, are well-evidenced (E Curtis, C Wright, & M Wall, 2005; Ellison-Loschmann & Pearce, 2006; P Jansen, Bacal, & Crengle, 2008; Kerr, Penney, Moewaka Barnes, & McCreanor, 2010; Mauri Ora Associates, 2006); specifically, extensive research reports Māori women face evidenced health inequalities (E Curtis et al., 2005; P Jansen & Jansen, 2010; Worth & McMillan, 2004). As such, Māori solo mothers represent a significant and double-disadvantaged group in New Zealand's population. With solo mothers considered a disadvantaged and vulnerable group in society, it is critical to better understand the healthcare access needs and experiences of these women (Sarfati & Scott, 2001).

Solo Mothers of Low Socioeconomic Status

Drawing upon the WHO's strategy to ensure health for all people, the Ministry of Health placed high priority on reducing health inequalities by removing socioeconomic barriers to healthcare access (Malcom, 2004; Minister of Health, 2001); unfortunately recent research indicates the *Primary Health Care Strategy* has not transformed policy into equity (Jatrana & Crampton, 2009; Minister of Health, 2009). Considering the importance of effective health strategies and equitable health status, research-based evidence is needed to inform policy so as to improve health for all. New Zealand's current health strategies promise equitable healthcare access for even the poorest citizens and purport to reduce health disparities between Māori and non-Māori (Minister of Health, 2009); however, if equity is to be achieved meaningful research is needed into the areas of greatest concern, such as the health and healthcare access of Māori solo mothers.
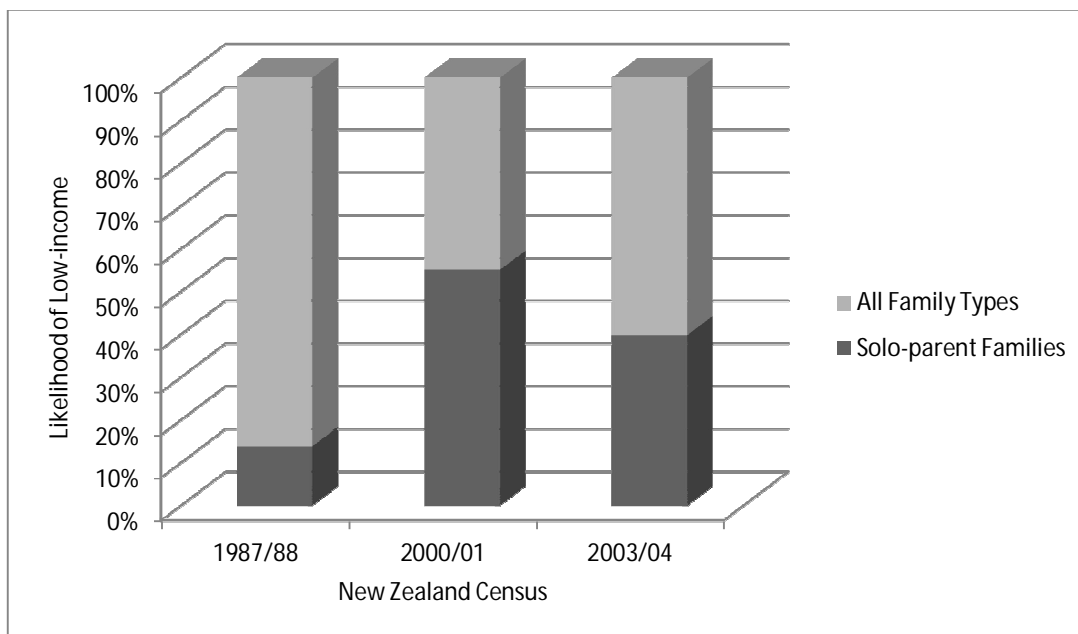
Figure 1-8. Likelihood of Low-Income Among Solo-Parent Families (Cotterell et al., 2008)

A report analysing whanau (family) changes and well-being used census data to measure Māori families and wellness in a variety of ways. Of particular interest were the findings that across all family types, those with at least one Māori parent were more likely than the other families, to have incomes 60% less than median gross family income. Similarly, as shown in Figure 1-8., of all family types recorded in census data, the solo parent families have the greatest increase in likelihood to have a low income. The likelihood of a solo parent family receiving a low income was 13.9% in 1996/97, then increased by 2000/01 to 55.1% likelihood of low income, before decreasing to 39.8% in 2003/04

(Cotterell et al., 2008). These two findings confirm that: solo parents are consistently more likely to be of low income than all other families over time and families with at least one Māori parent are more likely to receive substantially less income than all other families across types of households. This suggests Māori solo mother families are likely to be on a low income that is well below that of their married or childless counterparts.
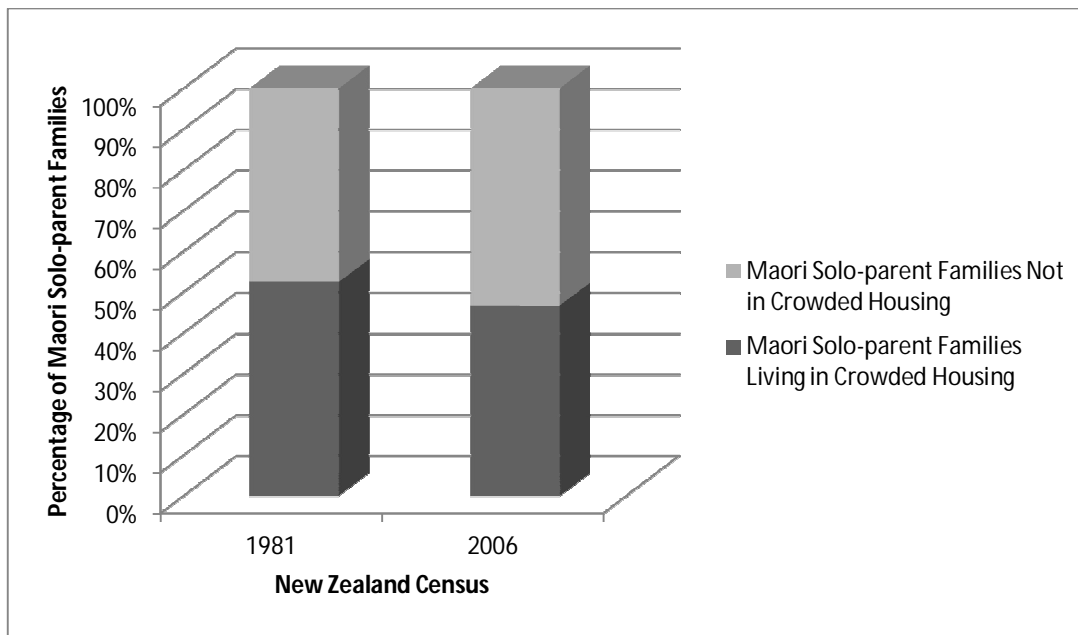
Figure 1-9. Likelihood of Māori Solo-Parent Families To Be in Crowded Living Conditions (Cotterell et al., 2008)

Moreover, although a low income level is an accurate measure of poverty and an indicator of poor health status, housing conditions are another indicator of poverty and poor health (Fritzell et al., 2007). Census data was used to the likelihood of Māori families to be living in crowded conditions (see Figure 1-9.). It was found that the family type most likely to be living in crowded conditions between 1981 an 2006 were solo parent families with at least one Māori parent and dependent children; the 1981 census reported 52.5% of these families were in crowded housing, but this number declined to 46.7% by 2006. Data across all types of families showed that families with at least one Māori parent were more likely than all counterparts across family types to be living in crowded hosing conditions (Cotterell et al., 2008). These findings suggest that Māori solo mother are not just at risk of ethnic disparities in health and healthcare, but are also highly likely to be on low income, and experiencing poverty-based conditions such as crowded housing. Socioeconomic disadvantage such as low income and poor housing is linked to poorer health and difficulties accessing healthcare (Fritzell et al., 2007; Reeves et al., 1994).

Māori solo mothers' health under the Treaty of Waitangi

Under Treaty of Waitangi obligations, the New Zealand government is obliged to 'protect' Māori health in order that Māori people benefit from wellbeing that is equitable with non-Māori. The Treaty also requires the government to uphold Māori rights to full participation in the same societal structures and processes in which non-Māori participate. It could be argued that equitable access and utilisation of the entire health system would be a fundamental right for Māori. However, the well-evidenced disparities in Māori health compared to non-Māori health point to failure of the government to remove cultural, social, economic and political barriers to equitable access to healthcare and improved health outcomes (Ellison-Loschmann & Pearce, 2006). Māori solo mothers qualify for targeted intervention to ensure they enjoy the same health outcomes as the greater population.

Thus, needed research-generated knowledge about the experiences of Māori solo mothers access to healthcare in caring for their health will improve knowledge and contribute to theory about the health of women, disadvantaged groups, and mothers in need. Therefore, an investigation into the healthcare access of Māori solo mothers was an unexplored area of research that would potentially reveal healthcare access inequalities. Any healthcare inequities for Māori solo mothers are a violation of the government's Treaty of Waitangi obligations of 'protection' and unacceptable (Bramley et al., 2004). Meaningful, accurate findings may inform policy and strategies to improve access for this underprivileged group, leading to better healthcare and health outcomes (Sarfati & Scott, 2001).

The question addressed in this research is: *What are the experiences of Māori solo mothers in accessing healthcare for personal health needs?* Essentially I argue that Māori solo mothers' healthcare access experiences are a similar phenomenon underpinned by socioeconomic disparities as well as political and cultural complexities. Improvements in policy and practice, targeting this disadvantaged group of mothers, will be beneficial for their healthcare access and health outcomes.

1.4. Structure of Thesis

Chapter One - **Introduction**

This introductory chapter presented the background to the research featured in this thesis. Then the research topic and objectives were then given, followed by justification of the research topic and significance for health research, theory and policy. Next the qualitative and Kaupapa Māori

methodologies were briefly described and justified. Following this, the researcher's position, the thesis structure, and study definitions were given, before scope limitations were described and justified.

Chapter Two - Literature Review

Chapter 2 presents the background to the research. A literature review yielded extant international and New Zealand research from the growing body of knowledge regarding solo mothers' health, and the rarer researcher on solo mothers' healthcare access. The current research-generated knowledge on solo mothers healthcare access will be presented to provide foundational knowledge which will be discussed against findings from the current research in chapter 5. Literature on Māori health, health and healthcare access disparities, and New Zealand health policy will also be described to better contextualise the significance of the current research topic.

Chapter Three - Methodology

In chapter 3 the research question and objectives are reviewed before the Methodologies section. Firstly, Theoretical Underpinnings describes and justifies a qualitative approach to the research, using a social constructivist paradigm, within a Kaupapa Māori framework; then application of these methodologies in the current study is given. Inherent political, cultural and ethical issues are then considered and how these considerations were addressed is explained. Next the Methods section describes the participant recruitment strategy and data collection procedures, followed by description of general inductive thematic analysis and data analyses processes. In finishing, rigour and trustworthiness of data and findings is discussed.

Chapter Four – Findings

The findings of the research are presented in chapter 4. To begin, a participant profile is given to contextualise the following description of participants' self-reported health and current health concerns. Next a detailed description of participant's actual healthcare access and reasons underpinning the access is featured. Following this, Barriers to Accessing Healthcare are presented thematically, described and illustrated with participants' responses. . Thereafter, the participants' experiences and strategies for Moving the Barriers are given as themes found to be common which are again described and illustrated. The next section feature participants' suggestions for Improving Access as illustrated themes. The final section of findings illuminates patterns found across participants' accounts which relate to personal and cultural complexities facing the participants as Māori , solo mothers, and beneficiaries, which can operate as barriers to access; additionally, issues related to stigmatisation, marginalisation and Māori healthcare delivery are thematically presented and illustrated as they impacted the participants access and experiences of healthcare.

Chapter Five – Discussion

Chapter 5 will examine the research findings in relation to the research objectives stated in chapters 3. The thematic findings will then be discussed in relation to the extant research on solo mothers' health and healthcare access reviewed in chapter 2. Findings will be compared and contrasted with findings from previous research and relevant literature to reveal where the findings are supported, differ, or go beyond extant knowledge. The implications of the findings will be explored in terms of contribution to theory, improving practice and informing policy. Recommendations, regarding Māori solo mothers' healthcare access, at practice and policy levels will be given. Limitations of the study will be discussed and the chapter will conclude with suggestions for future research.

1.5. Summary

This introductory chapter has laid the foundations for this thesis. The research question and issues were introduced as was the research objectives. Then the research topic was justified, key definitions were presented, the methodologies were briefly described and justified. Additionally, the thesis was outlined, and the scope limitations were given. Building on these foundations, the thesis will continue with a detailed description of the Masters research project.

Chapter 2. Solo Mothers' Health and Healthcare Access:

A Literature Review

2.1. Introduction

Chapter 1 laid the foundations for this thesis by contextualising the present study in background research concerned with disparities in health and the social and ethnic gradients which reinforce disparities. A variety of presented evidence then provided justification for the thesis research topic. This next chapter features an extensive review of the literature that informed the current research topic: the healthcare access of Māori solo mothers. The broader research areas which underpin studies of solo mothers' health are explained and the literature search strategy is given. Reviewed literature represents the broader body of knowledge regarding solo mothers' health and healthcare access. This extant solo mother literature is presented as international studies, followed by the limited New Zealand research. Section 2.6. will summarise the literature review and the research gaps regarding Māori solo mothers' healthcare access. First, an overview of the research literature review is given.

2.2. An Overview of Solo Mother Research Review

The previous chapter presented the background to the current study which was concerned with disparities in health, social and ethnic gradients of health, and the multiple disadvantages faced by Māori solo mothers in accessing healthcare (Worth & McMillan, 2004). The literature review now focuses on extant solo mother health research which informed the present study. The search for relevant solo mother studies revealed a significant gap in knowledge regarding the health needs, and healthcare access and experiences of solo mothers. The lack of research-based knowledge is not only in the New Zealand context, but internationally (Sarfati & Scott, 2001). Section 2.5. will present the limited extant international research which predominantly relates to solo mothers' health, and to a lesser extent their healthcare access and utilisation. Thereafter, the limited, but significant national solo mother health research is featured; solo mothers are an under-researched group in New Zealand with limited knowledge generated regarding their health and even less is known about their healthcare access. Literature searches did not locate studies investigating the health or healthcare access of Māori solo mothers as a specific research group of interest. Figure 2-1. Provides a visual overview of the literature review undertaken in this chapter.
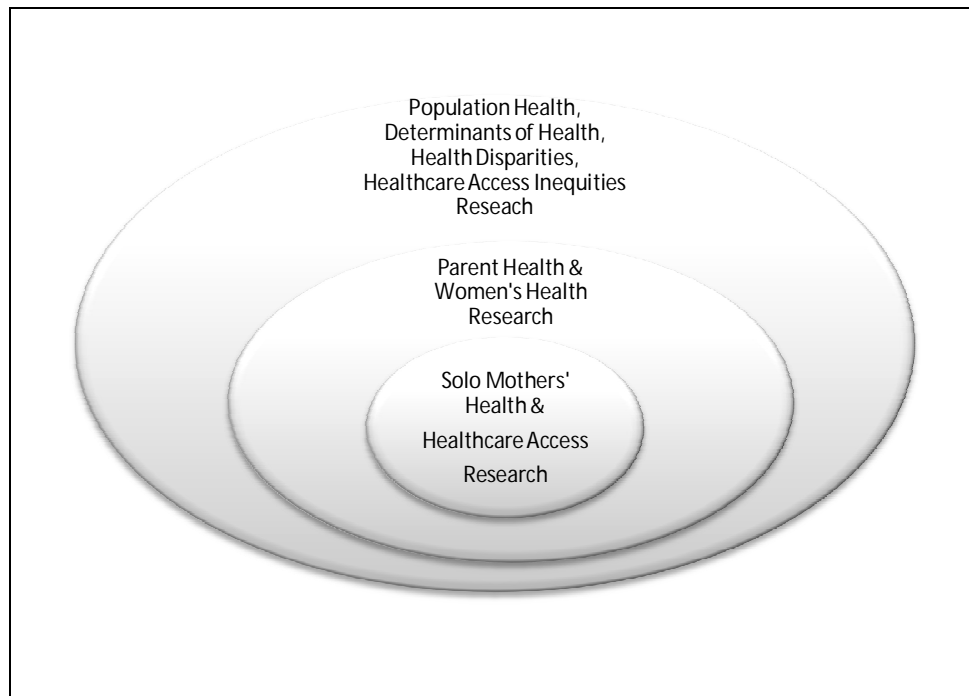
Figure 2-1. Summary of Literature Review

2.3. Literature Search Strategy

A thorough systematic search was undertaken of numerous academic, medical, and health sciences databases. As literature related to solo mothers' health was retrieved through this search, various online journal databases were similarly searched for related articles. A variety of keywords and MeSH terms and combinations of these were used for searching; as new terms were discovered databases were rechecked again for literature. This systemic search process was performed several times throughout the research period to ensure relevant material was located to inform this study.

Key Search Terms Used

The keywords and MeSH terms used were dependant on the database being searched and used in various combinations, of the following:

- Single parent family / single parent* / single mother*
- Lone parent* / lone mother*
- Sole parent* / sole mother*

- Solo parent* / solo mother*/ Māori solo parent* / Māori solo mother*

- Women's health / Māori health / Māori women's health

- Health / healthcare / healthcare access / health services / health service accessibility

- Health disparities / health inequalities / health inequities

The use of * indicates a variety of suffixes that the database may apply to the keyword.

Databases Searched

Wide varieties of databases were searched to facilitate location of relevant literature and included the following sources of material:

- University of Auckland Library and National Library of New Zealand

- Index New Zealand (INNZ) and Google Scholar

- PubMed and Science Direct databases

- Scopus and PsycINFO databases

- Web of Knowledge and ProQuest

- EBSCOHOST Online Research Databases

- Sage Journals and Springer Link

- Journal Storage (JSTOR) Online Journal Archive System

- Wiley Online Library

- Statistics New Zealand online database

- Ministry of Health and Māori Health online publication archives

- World Health Organisation (WHO) online publication database

Online Journal Archives

Several medical, social and health sciences journal offer online archived issues; several of these were searched using the keywords:

- Journal of the American Medical Association (JAMA) online archive

- Canadian Journal of Public Health

- Social Science & Medicine

- Health Promotion Practice

- Journal of Health Economics

- International Journal of Social Welfare

- Journal of Family Issues

- Journal of Family Psychology

- Social Psychiatry & Psychiatric Epidemiology

- Social Policy Journal of New Zealand

- New Zealand Medical Journal

- Australian & New Zealand Journal of Psychiatry

2.4. International Solo Mother Health Research

Health systems are key to reinforcing or removing inequitable socio-political structures that reinforce social and ethnic gradients of health, as they reflect social values of nations (Gilson, Doherty, Loewenson, & Francis, 2007). The dynamic interplay of health determinants, health status, healthcare, and health outcomes is illustrated in Figure 2-2.
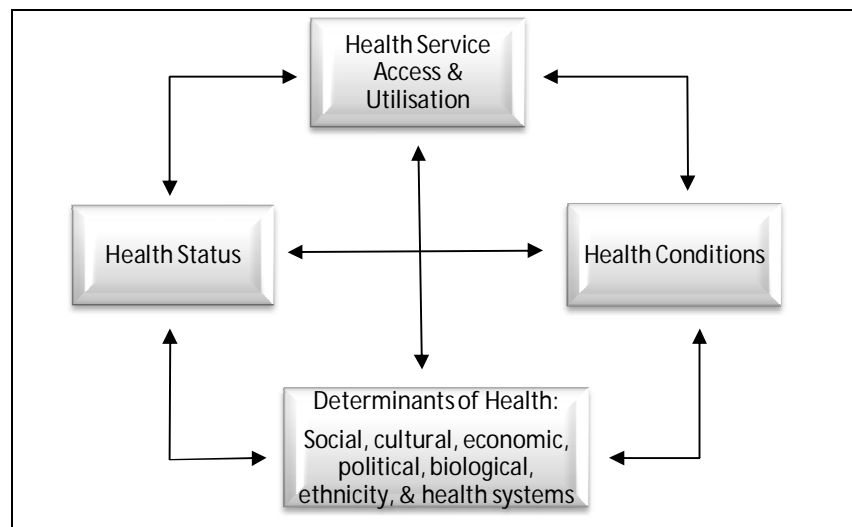
Figure 2-2. Model of Dynamics Underpinning Health & Healthcare Access
(Ministry of Health, 2008, p. 5)

The reviewed solo mother literature, in sections 2.4. and 2.5., is presented according to the type of health system underpinning each sample's healthcare provision. The reason for this is because different health systems feature different sources of funding which in turn determines the solo mothers' required level of financial contribution for accessing healthcare. Therefore, the findings of extant literature are located in the socio-political and cultural context of healthcare provision for the solo mothers studied.

Insurance-based User-pays Types of Funded Health System

Nations such as the United States of America and Mexico have limited social welfare systems which promotes excessive socioeconomic disadvantage for vulnerable groups like solo mothers, especially when child support is not forthcoming (Landero et al., 2009). These nations also have insurance-based user-pays type of health system funding, whereby citizens need private medical insurance or welfare-based Medicaid to access healthcare. There is a very limited public health system in these

countries. For low income populations, private medical insurance may be unaffordable, preventing access to healthcare (Kaestner & Kaushal, 2003; Kaushal & Kaestner, 2005; Seccombe et al., 2007). The Australian health system uses a similar type of insurance-based funding for healthcare, but also provides limited government-funded subsidies and public health services.

Firstly, a lone Australian study explored the health of solo mothers on welfare and barriers to work-activation programmes; solo mother were found to be a vulnerable and excessively disadvantaged group compared to the general population. Data was collected in the 1997 National Survey of Mental Health and Wellbeing and barriers to measured for included: human capital; mental health; substance use disorders; physical conditions and disability; and experience of traumatic events (physical and sexual). Findings revealed that compared to married mothers, solo mothers had: poorer education; three times more risk of mental health issues; four times more risk of substance abuse; twice the risk of physical barriers; and three times more likely to have experienced a traumatic event (Butterworth, 2003).

Several American studies have explored the impact of poverty and social welfare reforms on the health of solo mothers and their access to healthcare. Researchers were concerned that a 62% reduction in beneficiaries as a result of work-activation welfare reforms would force many solo mothers into low-income jobs that do not provide health insurance and they would also lose welfare-based healthcare aid (Kaestner & Kaushal, 2003). An investigation into the rates of health insurance coverage for these solo mothers leaving assistance revealed a substantial increase in the proportion of uninsured, low-educated, single women/solo mothers after welfare reforms. Several research projects report that social welfare reforms in the United States have resulted in low income families, many of which are headed by solo mothers, living without health insurance within a user-pays health system; potentially, reduced healthcare utilisation and subsequent health problems will be the outcome for disadvantaged solo mothers (Kaestner & Kaushal, 2003; Kaushal & Kaestner, 2005).

Medicaid and managed healthcare for single mothers was studied to investigate utilisation of linked health funding and provision. Managed healthcare services were established in California for Medicaid recipients; service clients were asked to rate service satisfaction on a variety of care aspects. Solo mothers reported less satisfaction with both services and practitioner-patient relationship. Waiting times for appointments were also rated as unsatisfactory. The researcher concluded that managed care health services were not the best fit for solo mothers (Pina, 1998).

In another related study, an investigation was made into the impact of United States welfare reform and access to abortion services on increased numbers of solo mothers and their rates of childbearing. Government welfare cuts had sought to reduce childbearing among poor unmarried women. Such punitive measures were considered to potentially increase demand for abortions; however, access to abortion services had decreased over the same period as welfare reform.

Researchers investigated the accessibility of abortions for unmarried women by looking at factors of geographic access, required parental notification, and restrictions on Medicaid funding. The 1980s reduction in abortion services availability attributed for a significant (2%) rise in solo mother families. Restrictions on Medicaid-funded abortions constituted approximately half the increase in African-American solo mothers' and parental notification requirements modestly influenced the rise in white solo mothers. The researchers concluded that concurrent welfare reform and reduction of abortion availability was counterproductive with inaccessibility of abortion services likely to contribute to the number of solo mothers and further childbearing (Lichter, McLaughlin, & Ribar, 1998).

Recognising a socioeconomic gradient in cardiovascular disease (CVD), and identifying solo mothers as a socially and economically disadvantaged group in society, one study investigated the nexus of solo motherhood and heart health. Compared to partnered mothers, solo mothers sampled were found to be: older than partnered women; living in poverty; of low income; smokers; overweight; self-identified as an ethnic minority; 4 times more likely to report lack of social support; marginalised by marital status and ethnic group; 3.3 times more likely to have experienced a CVD event; more likely to experience clinical risks for CVD, like hypertension; likely to report a lack of food in previous 12 months; and twice as likely to report poor/fair health. It was concluded that solo mothers are at higher risk of cardiovascular problems than partnered mothers. This increased risk was believed to be attributable to the adverse socioeconomic conditions of solo mothers. The recommendation was made that health professionals should consult with solo mothers to collaboratively design programmes and policies that would reduce their risks of heart disease and improve their living conditions (Young et al., 2005).

Seccombe et al. (2007) investigated the impact on healthcare access in the aftermath of the welfare reforms. The research sampled families leaving Temporary Assistance for Needy Families (TANF) welfare assistance; there was concern that national and state-level evaluations focused on employability of the families and neglect to assess their health, healthcare access and health insurance status upon leaving TANF. The researchers posit that in the United States healthcare access is inequitably distributed, rendering healthcare a resource of social inequality. Mixed methods were used to telephone survey families, some of whom were then interviewed. Qualitative data was thematically analysed using a grounded theory approach. Low income families without health insurance reported: irregular health checks; reliance on emergency department treatment; suffering of pain; non-treatment of acute and chronic ailments; non-filling of prescriptions; and forgoing of primary healthcare visits. Lack of income rendered uninsured families as: twice as likely to postpone medical checks; four times more likely to forgo healthcare; and likely to experience preventable suffering, morbidity and mortality. In addition to inadequate income, other barriers to healthcare access included: distance to healthcare; lack of transport access; lack of access to a telephone; lack of childcare; cultural insensitivity of healthcare providers; and feeling stigmatised by healthcare providers.

A qualitative study with low-income, Hispanic, immigrant solo mothers explored their health needs and interactions with healthcare providers. Thematic analysis captured several themes that describe the solo mothers' health concerns and issues. Family and community support were reportedly important for solo mothers' wellbeing. Cultural insensitivity and distrust in mainstream medicine also emerged as important cultural barriers. Additionally, financial difficulties, transport problems and isolation emerged as singular, but interrelated barriers: lack of transport hindered health access as did financial issues; and both transport and financial difficulties exacerbated social isolation. The study concluded that poor, immigrant solo mothers have difficulty gaining social support and health information due to lack of social networks and access barriers (Campbell-Grossman, Hudson, Keating-Lefler, Yank, & Obafunwa, 2009).

A Mexican sample of 33 solo mothers and 107 partnered mothers were quantitatively researched to better understand the influence of family structure on quality of life and depression. The research built upon evidenced links between poverty and health risks as well as between solo mother status and depression. The research was concerned with national changes in family structure which resulted in 2 million solo parent families (10% of households) and up to 90% of those were solo mother families. Findings revealed that the challenges and poverty faced by solo mothers were more prolonged and severe, generating stress, depression, and subsequent health problems: solo mothers were found to have lower quality of life, greater depression and lower income than their partnered counterparts. The solo mother families sampled were poor and expected to experience poverty due to the loss of spousal support. The researchers emphasised that economic, political, social and cultural changes underpinned the increasing breakdown of nuclear families and ill-supported solo mothers; as such, the psychological distress associated with solo mothering needed to be addressed politically, with particular attention to reduction of gender inequalities. Without intervention at the socioeconomic level the effectiveness of health programmes in meeting the solo mothers' health needs was doubted (Landero et al., 2009).

Tax-funded 'Universal Cover' Types of Health Systems

Nations such as Great Britain, Canada, Sweden and Finland offer their citizens universal cover healthcare that is taxpayer-funded. These systems provide free access to primary and secondary health services as well as dental health services (Beaudet & Perez, 1999; Fritzell et al., 2007; McGrath et al., 2002). The World Health Organisation considers this type of health system to be the most equitable in terms of removing cost barriers to access which affords the poor equal opportunity to seek healthcare as needed (Gilson et al., 2007).

Canadian health survey research has revealed through longitudinal national studies that health status of solo mothers is consistently worse than partnered mothers, with progressive decline in self-

ported health status with prolonged solo parenting. Canada's universal healthcare facilitated equitable healthcare access for solo mothers, but their health, especially mental health, remained inferior to national data as evidenced by higher rates of health service utilisation for emotional and mental health concerns among solo mothers compared to partnered mothers. The researchers concluded that prolonged time as solo mothers and the exposure to burdens associated with solo parenting had a negative on perceived health status (Beaudet & Perez, 1999).

Another Canadian study (Cairney & Terrance, 2002), also drawing on National Population Health Survey 1994-95 data, compared the rates of mental health service utilisation between solo and married mothers. Results showed that solo mothers were significantly more likely to have seen a health professional about mental health concerns in the previous 12 months and on a more frequent basis compared to married mothers. Although diagnosis of a mental health condition would have a positive effect on service utilisation, controlling for major depression and sociodemographic factors did not explain frequency of access. The authors suggest the unexplained frequency may be attributable to mental health issues, like drug or alcohol addiction, which were not covered in the survey.

Building upon the findings regarding solo mothers' mental health, Wang (2004) sought to investigate factors influencing differential prevalence of depression between married and solo mothers and their mental health utilisation.   Data from the 1996-97 Canadian National Population Health Survey (NPHS) ensured a large nationally representative sample. Findings revealed differences in major depression prevalence between married and solo mothers was age-specific, with higher rates for women aged 25-50 years; within this age range, solo mothers of ethnic minority and with one or more jobs had increased risk. Solo mothers were also found to be more likely to access health services for mental and emotional health problems compared to married mothers.

Acknowledging how policy and socioeconomic circumstances shape cardiovascular health, another Canadian study undertook qualitative research to explore heart health experiences from the perspective of solo mothers. Thirty-eight welfare-dependent solo mothers aged 17 to 53 years participated in focus groups and interviews. Thematic analysis revealed participants reported stress as a major concern for heart health. The stress was reportedly arising from financial responsibilities, humiliating social standards, and lack of family or social support. The researchers posit that social policies are essentially health policies in that social status and marginalisation have negative effects on solo mothers' heart health. Research exploring the ethnic status of solo mothers and their heart health was recommended (Higgins et al., 2006).

Drawing upon evidenced links between poverty and health-related problems, Curtis and Pennock (2006) explored under-researched dynamics between solo motherhood, social welfare assistance, and health status with the intention of generating more investigations in this under-researched area. In the results the Canadian solo mother sample emerged as a critically high risk group, vulnerable to negative impacts of both solo parenting and poverty, and deserving special health policy

consideration. Notably, variations in inter-territorial social policy execution were found which suggested need to assess health implications of social welfare policies and practices. Concern was expressed that funding for solo mother research was not forthcoming through usual health research channels and few studies were published in academic journals. The study's authors were concerned that major tensions exist between policy-makers and academics regarding dissemination of findings into solo mothers' health. Academics were criticised for lack of qualitative participatory solo mother research and policy-makers of seeking to control research outcomes especially when findings contradicted government agendas. Recommendations were made to increase research into the health of solo mothers and remedy barriers to dissemination, and to undertake mixed-method studies for meaningful data.

Reeves et al. (1994) identified the growing international trend in lone-parent families and noted most research focused on the health of children from these families. Building on trends in lifestyle surveys of self-reported health status, the findings from the British 1992 Trent lifestyle survey revealed British solo mothers reported: lower socioeconomic status; higher prevalence of smoking; poorer health; and less likelihood of owning a home, having access to a car, or being employed. The solo mothers also reportedly perceived themselves as less happy, and having lower levels of social and practical support. Additionally the solo mothers reported relationship stress, financial problems and sexual harassment. The solo mothers felt they would be healthier if they reduced weight and went to a doctor for regular checks; they indicated a desire for better information about maintaining health and where to go for healthcare, which was perceived to assist them to get healthy. The researchers concluded that poverty and health needed to be addressed through policy to improve solo mothers' health; however, they acknowledged health-related reports recommending increased income and childcare, and housing support for solo mothers, are politically ignored in general.

Similar research has revealed significant poverty-driven differences in Great Britain's population health status, with solo mothers self-reporting worse general health than partnered mothers, despite universal healthcare coverage through National Health Services (NHS). Analyses were carried out on data collected by two General Household Surveys to investigate solo mothers' health and living conditions over time. A distinct widening of a poverty gap between solo mothers and coupled mothers was evidenced. Solo mothers were consistently more likely to report poorer health and long-term health conditions that were limiting and were significantly more vulnerable to poor health than coupled mothers. The researchers recommended addressing of socioeconomic disadvantage and stress of solo mothers through social and health policy to increase income and provide more support (Shouls et al., 1999).

Solo mothers perceptions of access to a health visiting service was identified as a research gap by Knott and Latter (1999). They conducted qualitative research, using semi-structured interviews, to better understand solo mothers' experiences with NHS Community Trust home-based health visitors. Thematic analysis of the 12 participants' accounts revealed several themes. Firstly findings showed

the solo mothers assumed health visits were catered on their baby's wellbeing and not for any broader purposes. Clinics were viewed as opportunities to weigh the baby's, but not as contact sites for the health visitor. Some participants reportedly perceived health workers to be judgmental and impersonal towards the solo mothers; solo mothers felt stigmatised and discriminated against and wished to be treated the same as coupled mothers. In contrast, the participants expressed an expectation that health visitors be friendly, enthusiastic, encouraging and informative. The authors acknowledged that health visitors may be under-utilising their role to provide optimal care.

In a cross-cultural comparative study, the health of married and solo mothers from Britain and Finland were compared. Both nations have similar universal cover type health funding; but differ significantly in social policy. Finland has a generous social welfare system providing an equitable income and government-funded public childcare; consequently, high numbers of Finnish solo mothers are employed full-time. Conversely, British solo mothers receive less social welfare support resulting in lower socioeconomic status. Using nationally representative survey data from both countries, self-reported health status and limiting long-term illness prevalence were compared. Findings showed solo mothers across samples had worse reported health than married counterparts; but Finnish solo mothers had poorer health overall. While low socioeconomic status accounted for much of British solo mothers' poorer health, the Finnish results may have reflected the burdens of solo motherhood (Lahelma, Arber, Kivela, & Roos, 2002).

Similarly, McGrath et al. (2002) found universal healthcare cover did not translate to equitable access for solo mothers compared to partnered mothers. The qualitative research revealed British solo mothers were not accessing NHS dental services as often as partnered mothers; interview data showed younger age of solo mothers (16 – 24 years) and having more than two children significantly reduced dental attendance patterns, except for dental emergencies. The findings showed that partnered mothers were 58% more likely to have accessed dental health services in the previous year than solo mothers. The researchers concluded that solo mothers, in taking care of their children, are underutilising health services, which requires further investigation to identify and overcome barriers to access.

Recent British research conducted through NHS maternity care services examined ethnic and social inequalities in women's encounters with maternity care. Data was collected using a 2007 national survey of maternity patients. Women were asked about: antenatal care; care during labour and birth; post-partum hospital care; post-natal home care; and overall evaluation of care. Findings show ethnic minority women were more likely to delay access to services, delay having scans until 20 weeks gestation, and experience complications in pregnancy and birth; they were also more likely to breastfeed by choice and reported being treated with respect and dignity. Solo mothers experienced more complications and responded less positively to survey questions compared to married women. In particular, solo mothers were less likely to: access services prior to 12 weeks gestation; access scans at 20 weeks; attend NHS antenatal classes; receive postnatal checks, breastfeed by choice. Authors concluded that women of ethnic minority and solo mothers tended to access services late,

had poorer outcomes and perceived experiences more negatively on some aspects of care (Raleigh, Hussey, Seccombe, & Hallt, 2010).

Rejecting self-reported data, Swedish researchers (Weitoft, Hagland, Hjern, & Rosen, 2002) chose to investigate the health impacts of long-term solo motherhood by analysing hospitalisation records, discharge documents, and mortality data. Results showed that despite Sweden's comprehensive welfare and healthcare funding, the lone mothers were at increased risk of total mortality, suicide and attempted suicide, drug and alcohol addiction, lung cancer, injurious violence, traffic injury, accidents and psychiatric illness. Welfare-dependent solo mothers were also found to be at significantly increased risk of ischaemic heart disease compared to employed solo mothers. Healthcare access did not appear to be a factor in these risks, but the researchers did suggest lack of household resources and housing needs could be contributing to these poorer solo mother health outcomes.

In another Swedish study, a comparative investigation was undertaken to analyse the health and healthcare utilisation of differences between couple and solo parents and also between solo father and mothers. Data collection employed a postal questionnaire, which sampled 150 solo parents and 891 coupled parents. The results revealed that both solo mothers and solo fathers reported poorer health status than coupled parents. However, solo fathers were found to access general practice services more frequently compared to solo mothers. Moreover, the solo mothers reportedly avoided access to needed healthcare more often than married mothers did. The researchers suggest socioeconomic imbalances may account for differences in health status between married and solo parents; likewise socioeconomic imbalances were potentially underpinning the healthcare utilisation differences between solo fathers and solo mothers (Westin & Westerling, 2006).

Moreover, Fritzell and colleagues (2007), conducted research into the health of Swedish solo mothers and also found barriers despite Sweden's comprehensive social welfare system, highly subsidised childcare, and universal healthcare cover. Solo mothers receiving social assistance don't experience the levels of poverty found in other countries due to substantial state help with housing, childcare and health. Yet Swedish research has found solo motherhood itself is associated with poorer health, more hospitalisations, and risk of mortality; in particular, solo mothers are more likely to experience distress, stress, depression, addictions, injuries and violence. Although universal cover is available to all citizens, researchers found solo mothers had reduced rates of access to GPs, specialists, and outpatient services than partnered mothers. Lack of economic resources and time was generally reported as the main barriers. Of concern to the researchers, is that the lack of primary and outpatient care would potentially prevent early detection of medical problems, which could become serious inpatient health problems in future. Recommendations for future research include, study of solo mothers' health in varying social welfare contexts, in association with social support factors, and in relation to complex ethnic issues.

2.5. Māori Solo Mothers in the New Zealand Health Research Context

New Zealand uses a mixed-model approach to health sector access and funding. Primary healthcare is based on a user-pays system, with limited subsidies available to beneficiaries and high users of health services. The taxpayer-funded subsidies are approximately 60% and patients must enrol with a regular primary healthcare provider to access subsidised care/treatment. The universal provision of secondary healthcare is publicly funded through tax and delivered through hospitals, clinics and community-based services; however, access to private health professionals may be subsidised, but still requiring part-payment. Dental health for adults aged 18 years and over is not subsidised and not publicly-funded, but uses a user-pays model for access. There is a limited private sector of health services funded and accessed through private health insurance coverage although such medical insurance schemes usually cover a pre-determined percentage of cost and the insurance-holder must provide the shortfall (Jatrana & Crampton, 2009; Malcom, 2004).

In New Zealand, four key studies have investigated health of solo mothers with findings reflecting the international evidence. Sarfati and Scott (2001) undertook the first population-representative study of solo mothers' health, using the New Zealand Health Survey 19996/97 data. The national Health Survey had reported that 27% of all families were headed by a sole parent; with the vast majority of those sole parent families headed by mothers, on low incomes or government benefits, and living in high deprivation (Ministry of Health, 1999).

Following release of these findings, the Sarfati and Scott (2001) conducted their comparative study into the health of solo mothers and partnered mothers. Participants were compared on sociodemographic profiles, lifestyle risks, and three prevalent health conditions (asthma, hypertension and diabetes). The quantitative research involved administering SF-36 Physical Functioning and Mental Health questionnaire scales in order to identify factors contributing to health disparities between the two groups. Findings revealed that solo mothers were more likely to be: living in high deprivation areas; of low income or government benefits; and having lower educational qualifications. Solo mothers were found to have higher prevalence of smoking, problem drinking, treated hypertension, and significantly poorer general mental health than partnered mothers, which was tentatively attributed to higher stress levels. Notably, the researchers found solo mothers were more than twice as likely to be Māori. The researchers concluded that solo mothers health was poor, making them a vulnerable sub-group of the population requiring special consideration. Acknowledging their research as the first of its kind in New Zealand to specifically explore solo mothers' health, further research was recommended to better understand health problems of solo mothers better and address health inequalities.

Following on from this pioneering New Zealand study, two studies emerged as a result of a two year Health Research Council (HRC) study which investigated the relationship between beneficiaries, health and work-activation policies. Initially quantitative data was collected from 244 solo mothers living on the domestic purposes benefit (DPB) using SF-36 health questionnaires; then 120 interviews were conducted and transcribed for qualitative data. Worth and McMillan (2004) utilised the survey data to investigate the self-reported health status of solo mother beneficiaries. Drawing upon the qualitative data collected in the HRC study, Baker and Tippin (2004) analysed solo mothers' transcripts to explore the health of solo mothers receiving a government benefit and how their health impacts readiness for and sustainability of employment.

Underpinning the Baker and Tippin (2004) research was a concern that government research focused on solo mothers' employability but neglects well-evidenced links between poor health and poverty when justifying welfare policies. Firstly, the quantitative survey revealed that solo mother beneficiaries reported poorer physical and mental health, including depression and lack of emotional wellbeing, in association with socioeconomic. The analysis of interview data yielded two major findings: that solo mothers' poorer health status constitutes a significant barrier which is under-appreciated in their transition into the workforce; additionally, it was found that the beneficiaries poorer health is a significant determinant in the psychosocial context of the solo mothers' lives and not a mere employment barrier. Other findings provide insight into the delicate balance of solo mothers' health and their circumstances. Some perceived stigma as beneficiaries and tension existed in interaction with Work and Income New Zealand. On the positive side, the DPB allowed mothers to cope with their illness or sick children without income loss; on the other hand the low income meant mothers could barely exist. Food budgets often fell victim to other expenses resulting in poor nutrition and comprised health. Solo mothers reported high stress when faced with unexpected healthcare expenses and stressful periods were linked to decline in general health; many beneficiaries struggled to afford subsidised primary healthcare costs on the low DPB income.

Furthermore, the solo mothers reported a wide range of health issues including, problems with physical movement, respiratory conditions, gynaecological ailments, cardiovascular conditions. Mental health issues reported included, depression, substance abuse, anxiety, insomnia and stress; emotional problems were often related to stress from relationship breakdowns and ex-partner issues. Family support was variable among participants, but children were prioritised; however, nutritional deficits and substandard housing promoted chronic illness in children. Also reported was a lack of health-related information and intersectoral connectedness in dealing with welfare case workers. The researchers made recommendations related to improving solo mothers' health outcomes. Firstly, it was suggested that DPB incomes be adequate for solo mothers to afford unanticipated healthcare expenses for themselves and their children; additionally, it was argued that primary healthcare for beneficiaries children ought to be free. There was also a recommendation that social welfare staff be trained to be sensitive to addressing clients health needs by connecting them with services,

discussing health concerns, and fully disclosing all health-related financial help available (Baker & Tippin, 2004).

Complementing the previous study, Worth and McMillan (2004) undertook analysis of the survey results yielded in the HRC study on health, domestic purposes beneficiaries and transition to work. The researchers sought to present the quantitative self-reported health results as well as initiate a discussion concerning work activation policy and its consequences on DPB-dependent solo mothers' health and wellbeing. The survey sampled beneficiary's residing in urban and rural settings of both high and low deprivation. Findings revealed that beneficiary solo mothers had poorer self-reported health status than national data for women. Also, participants had lower social and physical functioning scores compared to national data; but, the greatest disparity was shown to be in emotional functioning, suggesting emotional health of solo mothers living on a government benefit is significantly undermined. Additionally, the results revealed that residing in a low deprivation area did not reduce beneficiary's disadvantaged health. Based on these findings the researchers questioned welfare assessments of 'fitness for work' and warned employment may exacerbate solo mothers' health problems. The stress of managing employment responsibilities with the burden of solo parenting is considered likely to undermine solo mothers' health further. Drawing upon international evidence of income-related health, the researchers suggest increasing the DPB income to improve solo mothers' health outcomes. It is recommended that policy-based assumptions of improved health through paid employment not be utilised dislocate alternative interventions for improved access to healthcare.

In another key study, Tobias, Gerritsen, Kokaua and Templeton (2009) used 2004 National Mental Health Survey data to compare the mental health of solo parents with partnered parents. The research objectives were to quantify high risks of mental illness in solo parents and examine the effects of socioeconomic status, social and practical support through co-residence, and physical health status on mental health risks. Sample analysis revealed solo parents were most likely to be: female; young (25-44yrs); Māori or Pacific Island ethnicity; of low income or receiving a government benefit. The quantitative findings revealed solo parents were more than twice as likely (43%) to have experienced mental illness than partnered parents (19%); solo parents were three times (9.8%) more likely to have co-morbid mental illness than their partnered counterparts (3.3.%). Solo parents receiving a benefit and those aged 25 to 44 years were more likely to experience a 12 month mental health issue than solo parents in employment and those aged 45 to 69 years. The researchers found that solo parents had excess risk of suicidal ideation, anxiety, mood disorders and substance abuse problems which were associated with low socioeconomic status and lack of social support, as provided through co-residence with other adults.

Moreover, these results were viewed as confirming need for improved access to mental health services, including drug and alcohol treatment, for solo parents. But the researchers warn these findings do not support work-activation policy and clinical response to solo parents' mental health issues would neglect to address the socioeconomic disadvantage underpinning their risks.

Recommendations highlight need for social and health policy to reduce risk and improve healthcare for solo parents. Specifically, it is suggested primary healthcare providers need to screen vulnerable solo parent patients and effectively treat or refer to community-based services, for mental health issues. It is suggested that 25% of mental health risks could be eliminating by increasing the DPB income and providing free or subsidised childcare. Moreover, the role of stigmatisation and discrimination in solo parents mental health is considered and recommendations made to reduce stereotyping and stigma in addition to improving access for this heterogeneous group to primary healthcare, including mental health services (Tobias et al., 2009).

2.6. Summary of Review

 In sum, solo mothers' self-reported health status is shown to be consistently worse than married or childless counterparts. Potential factors contributing to the health disadvantage of solo mothers include: poverty, living in areas of high deprivation, low income or government-benefit dependence, unaffordable childcare, stress, lack of access to health services and support, discrimination, and lack or social support. Across varying levels of national healthcare provision, from user-pays systems to universal cover, international studies reveal solo mothers' healthcare access is significantly reduced in comparison to partnered mothers and national populations. Barriers and facilitators of healthcare access for solo mothers are complex and influenced by personal circumstances as well as social, economic, cultural and political determinants. These determinants underpin the social and health sectors of any given nation which in turn produce the environment and conditions solo mothers live in.

   The New Zealand studies in section 2.5. failed to explore or reveal ethnic inequalities within the solo mother samples, despite demonstrating sociodemographic inequalities in health status. In contrast, international research revealed solo mothers' health status and access to healthcare consistently reflects both social and ethnic gradients. As such, solo mothers are commonly considered to be disadvantaged in multiple ways: solo parenting, poverty, and often ethnic minority. The healthcare experiences and access issues for New Zealand's solo mother population is an under-researched area worthy of investigation. Considering the significant proportion of Māori solo mothers in New Zealand's population, it is possible this subgroup of solo mothers face double or multiple disadvantages in health, making their access to healthcare a significant public health issue for exploration.

   With government obligations to the Treaty of Waitangi, and its inherent protection of Māori health and rights to equitable health system access, there is considerable need for research-based knowledge to identify any inequities in Māori solo mothers' healthcare access. Thus, in light of extant literature, there appears to be a significant research gap in terms of Māori health, women's health and solo mothers' health. Research that explores Māori solo mothers' health and documents their

experiences may reveal healthcare access inequities that in turn will inform policy and strategies to improve access for this vulnerable group and lead to better health outcomes.

Furthermore, an over-reliance on quantitative research, using census and survey data or mixed methods, and a lack of qualitative or indigenous approaches to research, revealed by the reviewed literature indicates a methodological gap in solo mother research. As the body of knowledge regarding solo mothers' health grows, the knowledge gaps around solo mothers' health care access and ethnic complexities influencing health outcomes illuminate the need to research these issues in meaningful ways that do not further marginalise solo mothers. The research topic of the present study attempts to contribute to a research gap in knowledge, concerning the healthcare access or Māori solo mothers. By adopting a qualitative approach, and moreover an indigenous Kaupapa Māori framework, this study also contributes to a methodological research gap in both solo mother and New Zealand health research. The Kaupapa Māori framework and qualitative approach selected for use in this study will be described and justified next, in chapter 3.

Chapter 3. Methodology and Methods

3.1. Introduction

Previously, Chapter 2 presented an extensive literature review of international research on solo motherhood in relation to health. Despite the growing body of knowledge, extant research revealed gaps in knowledge related to solo mothers' healthcare access. Additionally, the research review of New Zealand's solo mothers' health studies highlighted a scarcity of knowledge and apparent lack of investigation into the health of Māori solo mothers. Chapter 3 describes the methodology underlying this qualitative investigation of the healthcare access of Māori solo mothers and provides justification for methodological choices; methods used to collect and process data are explained and evidenced. Chapter 3 is organized around several key topics: research objectives; theoretical underpinnings; political, cultural and ethical considerations; recruitment and participants; data collection procedures; and general inductive thematic analysis of data.

3.2. Research Objectives

The present research project set out to answer the question:

What are the experiences of Māori solo mothers in accessing healthcare for personal health needs?

The objectives of this research were:

- To document the experiences of solo Māori mothers' experiences with access to healthcare within New Zealand;

- To identify both barriers and facilitators to solo Māori mothers' accessing healthcare in New Zealand; and

- To make recommendations regarding improved access to health services for Māori solo mothers.

The current research project sought to explore Māori solo mothers' health and document their experiences; data was hoped to reveal healthcare access inequities that could potentially inform policy and strategies to improve access for this underprivileged group, leading to better healthcare

and health outcomes (Sarfati & Scott, 2001). An overall commitment was made to undertake relevant research in order to contribute to the health of the significant Māori solo mother population in New Zealand.

3.3. Theoretical Underpinnings

The present study, undertaken for a Master of Health Science, was informed by and thus reflects many of the researcher's personal lived experiences. Apart from my role as a student and researcher I am also a woman and a mother of three children. Moreover, for the last ten years I have been raising my children single-handed as a solo mother. This period of solo-parenting has involved the challenges of raising a family on a low income; more specifically, a Domestic Purposes Benefit. Furthermore, I self-identify as mixed Māori-Pakeha ethnicities; my iwi is Te Aitanga-A-Mahaki, from the Te Tai Rawhiti region of North Island's east coast. Combined, it is these facets of my own identity and lived experienced that underpin my interest in Māori health, healthcare access, solo motherhood and women's personal health needs. Drawing upon my own health needs, healthcare access experiences and insights as a Māori solo mother, I was interested in conducting research with other Māori solo mothers as a marginalised and under-researched group in order to explore their healthcare access experiences; such research was intended to empower participants, provide meaningful findings, and better health outcomes.

The subsequent research, presented in this thesis, sought to investigate the experiences, barriers and facilitators of access to healthcare in New Zealand for Māori solo mothers. Relevant research underpinned by sound and appropriate methodology was needed to better understand the healthcare access experiences of Māori solo mothers. The wellbeing of this underprivileged sub-group of Māori and their healthcare access equity is an important public health issue, worthy of culturally-appropriate exploration, with the aim of reducing health disparities by informing policy. As this study sought to specifically explore the healthcare access experiences of Māori solo mothers, a Kaupapa Māori methodology was believed to be most appropriate epistemologically for promoting culturally safe research and valid, meaningful findings (Bishop, 1999; Smith, 1998, 2005). Moreover, the emancipatory nature of Kaupapa Māori research supports Māori, especially the underprivileged subgroups of Māori, in expressing their 'voice' (Alcoff, 1991; Denzin, 2005; Walker, Eketone, & Gibbs, 2006), making this approach well-suited for research exploring healthcare access and potential healthcare inequalities for Māori solo mothers.

Increasingly, Kaupapa Māori methodologies inform health research, facilitating relevant and accurate knowledge-creation for Māori communities and policy-makers with potential benefits including, better understanding of Māori health and healthcare needs, and addressing of embedded inequalities in access (Jones, Crengle, & McCreanor, 2006). Therefore, design of this study employed

a general inductive approach within a Kaupapa Māori framework to explore Māori solo mothers' healthcare access issues and experiences. Common themes in participants' experiences would expose gaps in current healthcare delivery and accessibility (Jones et al., 2006{Kerr, 2010 #67; Kerr et al., 2010), to reveal potential areas for improved accessibility and better health support. Reflecting on the emancipatory stance of Kaupapa Māori philosophy, the intent was that this information would help address health and healthcare inequalities for solo Māori mothers in New Zealand whilst contributing to evidence available on solo mothers' healthcare experiences in general. In sum, this research sought an in-depth understanding of Māori solo mothers' healthcare access experiences, in order to identify potential areas for change that may be implemented by providers and/or policy-makers to better inform targeted health policy and support (Kerr et al., 2010{Sarfati, 2001 #3; Sarfati & Scott, 2001).

3.3.1. Kaupapa Māori Methodology

Emerging as a form of resistance and methodological strategy, Kaupapa Māori initiatives have emerged as representative of Māori discontent with Pakeha worldviews and norms being applied to Māori and Māori-relevant issues. Providing forums and focus for Māori voices, and giving discursive direction to Māori people (Jones et al., 2006; Walker et al., 2006), a Kaupapa Māori approach can be summarised as: related to being Māori; connectedness to Māori philosophy and principles; based on the assumption of validity, importance and legitimacy of Māori culture and language; and concerned with fighting for autonomy regarding cultural well-being (Bishop, 1999; Cram, Phillips, Tipene-Matua, Parsons, & Taupo, 2004). As a collective philosophy, it is indicative of the shared vision, preferences, practices, aspirations, and concerns of Māori communities (Bishop, 2005), and representative of initiatives that are definitively Māori-driven in purpose and agenda (Gibbs, 2001). As a vehicle for self-determination, a Kaupapa Māori approach facilitates research by Māori, with Māori, for Māori betterment (Bishop, 1999).

Not always regarded as an epistemology, Kaupapa Māori research exists within a Māori worldview paradigm; Smith (1998) argues that legitimised by Māori customs, language and knowledge, Kaupapa Māori has epistemological validity, as meaningful from within cultural contexts. Emergent as emancipatory action, against research of Westernised frameworks and methodologies which frequently misrepresented and minimised Māori cultural practices, values and preferences, the Kaupapa Māori approach represents philosophical methodology underpinned by cultural constructions of knowledge creation and validation, and Māori worldviews (Cram et al., 2004; Denzin, 2005; Mahuika, 2008; Smith, 2005). As such, Kaupapa Māori practitioners address research issues of accountability, initiation, representation, validation and benefits within the cultural context of the co-researching participants (Bishop, 1998, 1999).

Authority of Kaupapa Māori discourse and practice is validated within the cultural context of Māori

practices that determine what is or is not culturally acceptable forms of research practice and process (Walker et al., 2006). Traditional criteria for evaluating cultural consistency and value are taonga tuku iho, 'messages of kawa,' collected as wisdom over the ages. As stable guiding principles, the kawa protocols inform and monitor tapu (sacredness) and tika (correctness) of cultural products, processes and practices in the past, present and future (Bishop, 1999). These protocols of Māori cultural practice underpin Kaupapa Māori research methodologies, to inform and reinforce key principles of matauranga Māori (Māori knowledge), tikanga (customs) and Te Reo Māori (Māori language) (Smith, 1998, 1999).

Matauranga Māori is premised by the Māori worldview that recognises dynamic interconnectedness of all things with knowledge generated from interaction between people and the natural environment (Durie, 2005). Knowledge is considered taonga (treasure), and thus tapu (sacred) (Cunningham, 2000), requiring respectful and careful treatment (Gibbs, 2001). Tapu conceptualisations guide Kaupapa Māori research respect for Māori people, korero (communication), and the sharing and amalgamation of knowledge (Jones et al., 2006). The principle of tikanga encapsulates customary practices, tribal lore, obligations and behaviours governing Māori social practices. Tikanga informs Kaupapa Māori research powerfully as it concerns ability to operate within the cultural system and make interpretative contextual judgments of cultural events. Tikanga can operate as rigid rules judging actions as tika (correct) or not.

Thus, Kaupapa Māori research must be consistent with cultural ethics according to tikanga (customs) and kawa (cultural protocols) for culturally appropriate engagement. Such cultural ethics are embedded in key cultural principles, which collectively constitute Kaupapa Māori research methodology and validate research practices and findings (Cram et al., 2004; Smith, 1998). Principles of Māori cultural practice, like concepts of whānau (extended family), tino rangatiratanga (self-determination), whānaungatanga (engagement and connectedness), whakawhānaungatanga (establishing relationships), and whakapapa (genealogy) guide researchers and inform research processes as Kaupapa Māori methodology (Bishop, 1998, 2005; Cram et al., 2004; Smith, 1998, 2005).

Identity according to whakapapa (genealogy) is fundamental to Māori worldview (Cram et al., 2004); for Kaupapa Māori researchers and participants, whakapapa contextualises Māori people individually and collectively. Kaupapa Māori researchers are frequently expected to meet kanohi ki te kanohi (face to face) with research communities or consulting groups, to be challenged and evaluated, which can assuage some distrust in research (Jones et al., 2006). Key to Kaupapa Māori research is mastering the principle of whakawhānaungatanga (establishing relationships) (Bishop, 1998); skilfully building and maintaining relationships with Māori communities and developing Māori research networks is fundamental to effective research and future projects (Jones et al., 2006). Methodologically, whakawhānaungatanga requires Kaupapa Māori practitioners to relinquish control and personal agendas in order to enter a participatory mode of consciousness fundamental to equalising researchers and participants while building relationally within cultural contexts (Bishop, 1998; Gibbs, 2001).

Whānaungatanga, the principle of engagement recognises the connectedness required to advance Māori agency and voice. Whānaungatanga qualities are reflected in relationships between researchers and participants as well as consulting and supervisory relationships (Bishop, 1998). Kaupapa Māori practitioners frequently spend quality time building kin-like relational bonds with communities and participants to foster engagement, build mana (power) (Jones et al., 2006), and cultivate deep interconnectedness between researcher and participants (Gibbs, 2001). Underpinning whānaungatanga, the principle of whānau is recognised as the cornerstone of Māori society. In Kaupapa Māori methodology, the whānau concept is an organisational principle, guiding researchers in: consultation protocols, structuring of supervision, delegating responsibilities, constructing common understandings, supporting participation, and providing a communication forum (Bishop, 2005; Smith, 1999).

Founded upon cultural customs, practices, and preferences, these principles of Kaupapa Māori research operate dynamically as methodology, woven throughout research processes and relationships (Bishop, 2005; Smith, 1998, 1999). Paramount to Kaupapa Māori research, the principle of tino rangatiratanga (self-determination) prioritises Māori control over cultural practices and research processes (Walker et al., 2006). Essentially a discursive practice, Kaupapa Māori methodology operationalises tino rangatiratanga (Bishop, 1998, 1999) through a struggle for emancipation, defined by resistance and critiquing of underlying assumptions of societal power imbalances (Mahuika, 2008). Increasingly applied through health research, Kaupapa Māori research methodology facilitates the self-determination of Māori communities over their health issues and research participation to generate accurate, relevant, and culturally-valid knowledge (E Curtis et al., 2005; Jones et al., 2006). In sum, Kaupapa Māori methodology seeks to unmask and deconstruct Pakeha social constructions about Māori, used to justify ongoing disparities and oppression (Smith, 1999), making this an appropriate approach for research with marginalised Māori.

3.3.2. Qualitative Research Approach

In New Zealand, health research in general continues to misrepresent Māori health status and fails to explain health disparities or remove health inequities (Bishop, 1999; Jones et al., 2006). State-funded explanatory health research has persistently underrepresented Māori in policy-informing national cohorts causing Māori health issues to be overlooked or distorted (Levy & Te Kingi, 2004). Extant research fails to capture Māori health realistically because of its individualistic focus on disease and causation, and government research which ignores *why* inequalities exist (Barnes, 2008; Jones et al., 2006). To discover *why* inequalities exist, research must be exploratory with a focus on which variables exist within the research issue. Exploratory research is qualitative, essentially asks research questions about the 'what', 'who' or 'where' of a research issue, and generates description and or discussion (Perry, 1998).

Thus, the present research adopted a qualitative approach to better understand *why* solo mothers' health outcomes are particularly poor compared to their married and single counterparts (Sarfati & Scott, 2001). As shown in Chapter 2, New Zealand research reveals solo mothers are more than twice as likely to be Māori as other ethnicities which suggests social and ethnic variables may underpin solo mothers' health disparities (Sarfati & Scott, 2001). The lack of research on the health or healthcare access of Māori solo mothers renders this research project exploratory. To gain knowledge and explore the variables at play in solo mothers' health outcomes this research asked *what* the healthcare access experiences of Māori solo mothers are, with the intention of describing and discussing any facilitators, barriers and issues revealed. In sum, the lack of knowledge regarding Māori solo mothers' health outcomes and minimal understanding of their healthcare access as a marginalised group suggested a qualitative study, exploratory in nature, would be most appropriate for investigating why health disparities exist and how to improve outcomes for this disadvantaged group.

Several key philosophical assumptions differentiate qualitative inquiry from quantitative approaches (Creswell, 2009). Firstly, on an ontological level which concerns the nature of reality qualitative inquiry reality is characterised by belief in multiple realities as viewed by participants; researchers may seek to illustrate and evidence these multiple perspectives through the use of textual quotes and themes from participants' data. Epistemologically, qualitative researchers reduce distance between themselves and the participants through collaborative, participatory or field research. The axiological assumption underpinning qualitative inquiry is that research is value-bound and biases, including those of the researcher exist; researchers acknowledge the value-laden nature research by locating themselves in their studies and may openly discussing values that shape interpretation of data. Rhetorically, qualitative researchers have the space to write informally in the personal voice in a narrative literary style. Lastly, methodological approaches employ the inductive logic of the researcher, contextualisation of the study topic, and an emergent design (Creswell, 2007).

These philosophical assumptions inherent in qualitative inquiry reflect the researcher's worldview, or paradigm. Qualitative researchers have multiple perspectives to choose from, but whichever worldview(s) is adopted it will shape the research in practice (Creswell, 2009). My choice of stance was determined predominantly by the exploratory nature of the under-researched study topic and research group of interest. However, the decision to research from within a Kaupapa Māori framework also strongly influenced my selection of an appropriate paradigm to inform my research methodologies. Increasingly, Kaupapa Māori approaches are being applied to health research for accurate exploration of relevant health issues and inequalities for Māori betterment (Cram et al., 2004), mainly because Māori have unique conceptualisations of health and wellness which are captured best within the holistic Māori paradigm (Cram, Smith, & Johnstone, 2003). Māori worldview considers mātauranga Māori (knowledge) to be dynamically generated, arising from interpersonal interaction within social and physical contextualisations and relationships (Durie, 2005).

Social construction theory is a worldview used in qualitative inquiry that aligns well with Māori worldview of knowledge generation and the exploratory nature of this study. Social constructivism

represents a worldview that desires to understand the world in which we live and relate, using an inductive approach to generate patterns of meaning; understanding is sought through complexity of subjective meanings. Aligning well with Kaupapa Māori philosophy, these subjective meanings are acknowledged to be negotiated in that participants' views are shaped through social interaction and exposure to historical and cultural norms. Moreover, researchers from this stance locate themselves within the research context in order to openly acknowledge how their own social and personal experiences as well as historical and cultural background inform the research and shapes interpretation of meanings. For this reason qualitative research is commonly considered interpretive inquiry (Creswell, 2007).

Adoption of a social constructivist worldview will shape the type of participants, the research objectives and questions, method of data collection, approach to data analysis, and utility of findings for social change or justice (Creswell, 2007, 2009). Qualitative researchers may also select from a variety of interpretive lenses through which they can conduct research processes, for instance feminist theories or critical theory (Creswell, 2007); such interpretive communities could have been applied in the current research, but I decided to apply a general inductive lens that simply reports the findings as based upon the participants' meanings and understanding of the research topic (Thomas, 2006).

However, as qualitative project taking a social constructivist stance, certain interpretive elements still hold true for this Kaupapa Māori research; for example, like interpretive studies this research represents an under-researched and marginalised group in society. The research topic and issues under investigation relate to the sociocultural conditions, like socioeconomic inequities that serve to disadvantage and depower this vulnerable group of women. Also, as a researcher I sought to conduct empowering participatory research that would not further marginalise the solo mother participants; I acknowledged power imbalances as the researcher and sought to minimise these by recognising participants as co-constructors of data and joint owners of findings. Furthermore, use of textual excerpts to illustrate findings is a powerful way to give marginalised groups a 'forum for their voice'; like interpretive studies, this project had the goal of making recommendations and seeking publication of findings with the intention of driving change through exposure and evidencing of inequities (Creswell, 2007).

Moreover, social construction theory is manifest in empirical phenomenological research. In this approach, the researcher may take a phenomenon, which is an abiding concern of which the researcher has lived experience, and seeks to investigate the phenomenon by describing the meaning of the phenomenon as experienced from multiple perspectives. The researcher locates themselves experientially in the research, but then sets aside their own experiences to focus on collecting data from a limited sample of other individuals who have experienced the same phenomenon (Creswell, 2007). The researcher uses textual excerpts to find commonalities in multiple experiences to generate themes in order to describe 'what' the participants experienced and 'how' it was experienced (Thomas, 2006). The type of research topics explored using phenomenological approaches are those where understanding a topic or issue from several

perspectives is important in order to apply the common or shared experiences to understand the phenomenon better to improve practice and inform policy (Creswell, 2007). In sum, an empirical phenomenological approach underpinned by social construction theory was suitable for the Māori solo mothers' healthcare access research topic, the research objectives of describing participants' experiences, identifying access facilitators and barriers, and the researchers own lived experienced of healthcare access as a Māori solo mother.

3.3.3. Theoretically Informed Procedures

Kaupapa Māori methodology is pragmatic with methods for data collection and data analysis selected for appropriateness according to the research topic, study objectives and utility of findings (Jones et al., 2006). All principles underpinning Kaupapa Māori methodology operate dynamically, weaving in and out of the research processes and relationships, informing research design regarding methods of data collection, analysis, and dissemination of findings (Bishop, 1999; Smith, 1999); being subject to participatory negotiation, procedures used in Kaupapa Māori research is potentially modified from consultation to publication (Barnes, 2008). Method deployment is ultimately guided by appropriateness to Kaupapa Māori methodology, the research context, cultural ethics and collective consensus to better capture Māori experience and yield richer findings, community empowerment and cultural validity (Walker et al., 2006).

In this study, Kaupapa Māori methodology was applied as a framework. As such, the research procedures for data collection and analysis were not restricted, but were gauged for appropriateness against cultural protocols. The whānaungatanga principle governs ways key research questions are answered, creation of realistic objectives, participant selection, research procedures, desired outcomes, and research ownership and beneficiaries (Gibbs, 2001). Appropriately, full Māori consultation was undertaken, and the Māori participants were offered opportunities to participate in optional participatory research activities, like member checking. My commitment to applying Kaupapa Māori methodology to this study led to cultural consultation which shaped the research topic, question, and objectives; this ensures the research undertaken as Kaupapa Māori is relevant, needed and beneficial for the Māori participants, Māori health, and the Māori population.

Furthermore, the participant recruitment strategy was informed by Kaupapa Māori methodology as a culturally appropriate approach to potential recruitment sites and contacts was vital. Much consultation occurred prior to and during the recruitment procedures: flyer design, distribution of flyers, communication with local contacts, and snowball recruitment. Importantly, Kaupapa Māori philosophy formed a framework for the data collection procedures outlined as a protocol; a practice interview provided a platform for review and critique of my interview skills to promote cultural competence, prior to collecting data from Māori participants in the field. The principle of whanau underpinned procedures that guided data collection interviews: mihimihi (formal meeting) prior to

interviews, facilitating the presence of support persons for participants, provision of koha and kai (Bishop, 1998).

However, it was the inherent characteristics of qualitative inquiry that predominantly informed research procedures for sampling strategy, data collection, data analysis, and reporting findings (Creswell, 2009). Qualitative research characteristically deploys research procedures that are emergent and inductive, built from the bottom up, and shaped by researcher's experience and understandings; more specifically, the social constructivist worldview informed the purpose sampling of participants, research questions, approaches to data collection, data analysis, and utility of findings for sociopolitical change. The purposive sampling of specific participants was guided by phenomenological studies, underpinned by social construction theory which commonly seek approximately 5 to 25 participants who have lived experience with the phenomenon under investigation (Creswell, 2007).

Similarly, data collection procedures for in-depth interviews using broad open-ended questions were based upon social constructivism which employs broad questions which allow participants space to construct meanings of situations or experiences. Open-ended questions are particularly effective as the researcher is able to be more attentive in listening as participants respond (Creswell, 2007). As exploratory research, the questions used at the start of an interview should be designed to uncover the participants' subjective meaning of the topic; the research issues should only be raised further into the interview using probes if the topics have not been elicited and discussed earlier by the more unstructured questioning (Perry, 1998). Qualitative data analysis features systematic analyses of data by the researcher to increasingly develop deeper knowledge of the research topic (Creswell, 2007). Data analysis in this study was informed by social constructivist approaches whereby transcripts are repeatedly analysed for textual descriptions of the 'what' and 'how' of participants experiences. By adopting an inductive thematic approach the findings are descriptions of participants' common or contradictory experiences of the phenomenon, illustrated with textual excerpts (Thomas, 2006).

Importantly, Kaupapa Māori methodology supports investigation and understanding of socially constructed experiences within the cultural context they are experienced. Qualitative methods, such as semi-structured interviews and thematic analyses are well-suited when utilised according to cultural ethics and context to reveal structural and ethnic inequalities. Increasingly, qualitative methods are used to gain understanding of experiences from rich, meaningful data which enables culturally-relevant research to tap experiences of Māori groups of interest (Jones et al., 2006). Interviews are frequently used in Kaupapa Māori data collection, aligning well with Māori customs and preference for face to face communication and whānaungatanga (relational interactions). Data analysis employing general thematic analyses are also increasingly used in health research and Kaupapa Māori projects. Themes related to barriers, facilitators and experiences of healthcare illuminate common issues and trends. Potentially, subsequent benefits of qualitative research methods include: better understanding of Māori health and healthcare needs, and addressing of embedded inequalities (E. Curtis, C. Wright, & M. Wall, 2005; E Curtis et al., 2005; Jones et al., 2006).

3.4. Political, Cultural and Ethical Considerations

In choosing to research with Māori solo mother participants several political, cultural and ethical considerations were identified; after consideration, and in consultation with supervisors, these issues were addressed as appropriate. The following sub-sections 3.4.1. to 3.4.9. present the key research considerations, explain the inherent issues and describe choices I made and action I took. The considerations presented in this section relate to the participants sought for participation and the issues that arose from intending to research with them as: a marginalised group in the population, Māori research participants, and human participants in research. The research issues identified for consideration include: Treaty of Waitangi obligations, supervision, consultation, ethics approval, privacy and confidentiality, intellectual property, cultural sensitivity, minimisation of harm, and informed consent.

3.4.1. Treaty of Waitangi Obligations

As the indigenous people of Aotearoa, any research undertaken with human participants in New Zealand will potentially impact Māori. The Crown's recommitment to its obligations under the Treaty of Waitangi recognises the impact that societal agendas and endeavours may have on Māori and provide a framework for Māori rights, including in the domain of research (Health Research Council of New Zealand, 2010; University of Auckland Human Participants Ethics Committee (UAHPEC), 2010b). Kaupapa Māori research is underpinned by culturally validated principles and protocols, of which the Treaty principles of partnership, protection and participation are incorporated. As such, research within a Kaupapa Māori research framework, such as this present study, is effectively a vehicle for operationalisation of the Treaty principles and makes explicit their inherent commitments to Māori wellbeing (Bishop, 1999; Durie, 2005; Smith, 1998).

Article 1 of the Treaty of Waitangi is defined as the Principle of Partnership, highlighting the collective Māori goal of increased tino rangatiratanga (self-determination) through partnership with the state in social, health, and education sectors at all levels, including the domain of research underpinning policy-making in these areas (Bishop, 1998; Health Research Council of New Zealand, 2010). Essentially, Kaupapa Māori research constitutes a vehicle for Māori to exercise partnership and tino rangatiratanga in all aspects of research projects: research by Māori, with Māori, for Māori (Bishop, 1999; Edwards, McManus, & McCreanor, 2005). However, some Kaupapa Māori researchers allow space for Pakeha researchers genuinely concerned with betterment of Māoridom, to support Kaupapa Māori researchers and teams under the Treaty principle of partnership (Bishop, 1999; Gibbs, 2001).

Through this study I embraced the principle and spirit of partnership through Kaupapa Māori research philosophy which equalises researcher and participant as co-researchers and co-creators of knowledge (Bishop, 1999; Durie, 2005). As a Master's researcher, I was notably supervised in part by two supervisors, Māori and non-Māori, which recognised the spirit of partnership between cultures and relational building within academic domains. My research processes were guided through cultural consultation in recognition of the partnership principle to review and advise regarding appropriate research design for the healthcare access topic and Māori solo mother participants.

Similarly, Treaty Article 2, redefined as the Principle of Protection, offers Māori greater tino rangatiratanga (self determination) through increased control, protection, and development of Māori property rights, including cultural and intellectual property. Cultural property such as Māori tikanga (customs), methodologies, matauranga Māori (knowledge), cultural identity, and Te Reo Māori (language) are actively and fully protected by this principle (Durie, 2005). Adoption of a Kaupapa Māori approach in research is underpinned by the principle of protection: Kaupapa Māori research proactively seeks to embody, protect, and validate cultural values, customs, and worldview, and is in turn validated by these cultural properties (Smith, 1998, 1999).

As a Kaupapa Māori research project, my study sought to provide a culturally protective form of research that supported the Māori participants and aimed to contribute positively and relevantly to the body of Māori health knowledge and betterment of Māori health outcomes. Intellectual property in this study was recognised as the knowledge shared by participants and the new collective knowledge generated by combining knowledge contributed by participants and myself with research-generated knowledge (University of Auckland Human Participants Ethics Committee (UAHPEC), 2010b).

Article 3, representing the Principle of Participation recognises Māori principles of whakawhānaungatanga (relational building) and whānaungatanga (connectedness), so Māori enjoy full citizenship rights, of full participation in society, receiving all benefits of other New Zealanders, without disadvantage. The participation principle encompasses the right of Māori to participate equitably in all aspects and roles in the domains of research, science and technology (Durie, 2005; Glover & Robertson, 1997; Health Research Council of New Zealand, 2010).

This principle underpins the optional participatory aspects of my research design: member checking and editing transcripts as well as reviewing and reporting back on the thematic summary and summarised findings. The topic and objectives of this study also considered and embraced this principle in that I recognised Māori have a right to health and healthcare without disadvantage or disparity (Bramley et al., 2004). Considered a disadvantaged societal group, my study sought to empower and include Māori solo mothers in creating better health for them. By revealing areas of inequity in taking care of their health through this study, my intention was to make relevant recommendations that inform better healthcare support and access so as to improve health outcomes and promote wellbeing.

3.4.2. Supervision, Consultation & Ethics Approval

As a Māori-Pakeha researcher, I was committed to ensuring a Kaupapa Māori approach underpinned research design, participant recruitment, data collection and analyses as well as interpretation and dissemination of findings. Māori input was sought from preliminary planning stages, through supervision and consultation, to align all research processes with Kaupapa Māori methodology, prior to applying for ethics approval. As a Master's research project, my study required academic supervision, including specialised supervision by an experienced practitioner of Kaupapa Māori research. In addition to University of Auckland standards for conducting Master's research, supervision from academic cultural consultants aligns the study with Kaupapa Māori methodology by underpinning the project with Māori cultural protocol; the principle of whānau, recognises the familial structure inherent in traditional whānau with older, experienced whānau members overseeing the activities of younger, inexperienced whānau members (Bishop, 2005; Smith, 1999; Walker et al., 2006).

Subsequently, my research was jointly supervised by a non-Māori senior academic and a Te Kupenga Hauora Māori academic staff member, to enable Kaupapa Māori research. In keeping with New Zealand's research ethics requirements for researching with Māori (University of Auckland Human Participants Ethics Committee (UAHPEC), 2010b), consultation with appropriate Māori must be undertaken and evidenced. Generally, Kaupapa Māori researchers are expected to meet face-to-face with consultation groups or cultural consultants to discuss issues, such as research topic and design as well as recruitment and data collection procedures (Gibbs, 2001). Initial consultation facilitates primary feedback on tentative Kaupapa Māori research proposals and negotiation includes evaluation of proposals and researcher's intentions and commitment to the research process (Jones et al., 2006; Walker et al., 2006). Consulting parties look for topic relevance for their community and betterment of Māori with maximisation of benefits from research, to ensure participation is worthwhile (Gibbs, 2001).

Therefore, consultation with my Te Kupenga Hauora Māori supervisior began in the very preliminary stages of planning to generate a relevant and culturally appropriate research topic and objectives; thereafter, the research design was formulated from the research topic and objectives by applying Kaupapa Māori framework. Both supervisors advised and assisted with development of my ethics application; they also provided guidance with the ethics application processes. Prior to ethics committee submission, the research project received support from the Office of the Tumuaki at the Faculty of Medical and Health Sciences (see Appendix A). Ethics approval to proceed with the research was granted on 16 May 2011 by the University of Auckland Human Participants Ethics Committee, who also commended thoroughness of my ethics application (see Appendix B).

Thereafter, all aspects of the recruitment process, interview guide development, and data collection procedures were guided by ongoing cultural consultation facilitated by my Kaupapa Māori supervisor, to ensure correct application of Kaupapa Māori methodology as the research progressed. Although Māori solo mothers are a significant group within the Māori population, they constitute a culturally and socio-demographically diverse group; as such, identification of a particular consulting group was unlikely. Moreover, due to the small-sized sample and diversity of participants sought, and a research topic not restricted to a definitive area or group (eg. iwi or hapu) of Māori, regional or community-based consultation with Māori did not seem appropriate for this project. Thus, wider consultation was undertaken with appropriate Te Kupenga Hauora Māori academics willing to korero (talk face to face) with me and advise on many aspects of the study and my cultural awareness to encourage cultural competence and safety for myself and the participants during the research process.

According to ethics standards for researching with Māori and Kaupapa Māori methodology, ongoing consultation allows Māori to claim cultural space and right to control research, in order to protect the access, definition, representation, and development of Māori knowledge, culture and people; consultation makes manifest Māori rights in refusing to be restricted, inconvenienced, illegitimated, invalidated and inappropriately measured according to Western beliefs, standards and methods (Bishop, 1998, 1999, 2005; Cram et al., 2004). In the same way, supervision seeks to ensure correctness of cultural protocols and tikanga (customs) which is essential in Kaupapa Māori research and requires broad skills and sensitivities in Māori culture (Smith, 1999; Walker et al., 2006). Unfortunately, the Te Kupenga Hauora Māori academic supervision was withdrawn unexpectedly during the data collection phase (see Appendix C); thus, Kaupapa Māori methodology could not be utilised for data analysis and interpretation.

3.4.3. Cultural and Social Sensitivity

Pragmatically, Kaupapa Māori methodology utilises a range of Te Reo Māori (Māori language) skills for orientating research processes and communicating with participant communities; many Kaupapa Māori practitioners and Māori participants speak minimal Te Reo so both Māori and English are commonly used in Kaupapa Māori research (Walker et al., 2006). Sensitive decision-making is required regarding recruitment materials, data collection, and research publication in Te Reo Māori, English, or both; researchers must acknowledge diversity in Te Reo Māori skills and comfortableness. Balance is needed in order to collect data and publish knowledge in linguistically meaningful forms, while also preventing any embarrassment or alienation of Māori less-competent in Te Reo Māori (Smith, 1999).

Additionally, the key principle of tikanga encapsulates customary practices, tribal lore, cultural obligations and behaviours governing Māori social practices. Tikanga informs Kaupapa Māori

research powerfully as it concerns ability to operate within the cultural system and make interpretative contextual judgments of cultural events. Tikanga can operate as rigid rules judging actions as tika (correct) or not; incorrectness can be embarrassing, offensive, or carry negative consequences (Smith, 1999; Walker et al., 2006). Thus, key kaumatua, liaison, and supervisory roles include supportive attendance with Kaupapa Māori researchers in formal domains, mentoring, supervising, and overseeing of ritual and spiritual dimensions of tikanga (Smith, 1999; Walker et al., 2006).

For Kaupapa Māori researchers, including myself, undertaking consultation and research highlights several important tikanga protocols that need to be considered and addressed (Bishop, 2005; Jones et al., 2006; Walker et al., 2006). Firstly, the tradition of koha (gift-giving) is a meaningful custom for Māori especially where time and knowledge are shared (Smith, 1999); for my research project, I decided provision of a small, but helpful koha for participants would be appropriate. Secondly, sharing of kai (food) is foundational in Māori culture, particularly in situations of whānaungatanga (engagement and connectedness) to develop aroha (mutual respect), rapport and comfortableness with participants (Bishop, 1998; Jones et al., 2006; Walker et al., 2006); symbolic of the sharing of kai, I decided it would be appropriate, and show minaaki (generosity and sharing) and aroha, to give each participant a packet of chocolate biscuits before commencing data collection. Thirdly, the Māori protocol regarding participation is for researchers to mihimihi (meet formally face to face) with participants prior to proceeding to data collection (Jones et al., 2006); I therefore allowed time for formal introductions and sharing of personal details and background with each participant, and proceeded to data collection with participant's approval. In order to fulfil the aforementioned aspects of cultural protocol, I applied and was granted, University of Auckland funding which helped with costs for koha ($20 Pak'n'Save voucher) and travel expenses to mihimihi and kanohi ki te kanohi (meet face to face) for data collection.

Social sensitivity through removal of power imbalances (University of Auckland Human Participants Ethics Committee (UAHPEC), 2010b), is promoted by the participatory nature of Kaupapa Māori methodology which locates researchers within the project as co-researchers with the participants (Bishop, 1999). The principle of whakawhānaungatanga underpins Kaupapa Māori research strategy to holistically join participants during research; this participatory manner is fundamental to building relationally within cultural contexts and supporting tino rangatiratanga (Bishop, 1998; Gibbs, 2001). In my research I sought to facilitate social sensitivity and equalisation of power within the research experience by being transparent with participants regarding my own solo mother experiences, through honest admission of my personal cultural limitations, by giving appropriate time to mihimihi with participants properly, and through participatory research processes.

3.4.4. Informed Consent

In accordance with ethics requirements for research involving human participants, all of my participants were required to give written informed consent prior to participation in the research

(University of Auckland Human Participants Ethics Committee (UAHPEC), 2010a, 2010b). Potential participants were provided with a Participant Information Sheet and I encouraged them to ask any questions they had regarding the research and participation (see Appendix D). The Participant Information Sheets contained key information pertaining to myself as the researcher, the research project, and participation requirements. Topics explained in detail in the document included: researcher's name, iwi, academic history, personal background, and reason for conducting the research; the research topic, objectives, period, intended outcomes and use of findings; participation requirements, right to withdraw, and optional participatory aspects; data collection process, data storage and destruction; privacy and confidentiality.

Prior to participation in data collection, Consent forms were then presented to informed participants for review and signing (see Appendix E). Consent forms required participants name and signature and indicated consent related to key aspects of research processes and participation. In order to participate the participants had to confirm that they were: giving informed consent to participate in a digitally-recorded interview; aged 18 years old or over; aware the research was for Master's examination; and findings may be published. Participants were also asked on the Consent Form to indicate their desire to receive a copy of their transcript, a provisional thematic summary, and a summary of findings. The signed forms were held securely in my home-based office during the research period. As stated clearly on the Consent Form, the signed consent forms were lodged with the University of Auckland's School of Population Health where they are to be held for 6 years, prior to being destroyed.

3.4.5. Privacy and Confidentiality

Privacy and confidentiality were placed in high priority in order to protect privacy of participation and confidentiality of data contributed by participants according to the University of Auckland's Human Participants Ethics Committee (University of Auckland Human Participants Ethics Committee (UAHPEC), 2010b) standards. To best insure this, the data collection interviews and transcription were conducted by me only. Supervisors were not given the identity of participants and no participant's name featured on transcripts; I used my own codes to identify participants' transcripts and other information that may have identified participants, such as children's names, was removed from transcripts. Thematic analysis of transcribed data was undertaken primarily by me, and consultation with supervisors only occurred as needed. To further protect participants from identification during the thesis examination process and potential publication of the research, I considered the use of pseudonyms in presenting the findings was most appropriate.

Throughout the research period all digital data files, electronic and hardcopy forms of transcripts, and data-related documentation were void of personal identification with codes used to identify each participant/interview. Digital files and electronic documents containing data were coded and securely

stored on my password-protected computer; upon completion of the research, these files were saved onto CD, removed from my computer, and stored at the appropriate University of Auckland's School of Population Health facilities. After a period of six years, all stored research items will be destroyed according to ethical standards for research (University of Auckland Human Participants Ethics Committee (UAHPEC), 2010b).

3.4.6. Intellectual Property

Negotiation and consultation with participants was a crucial aspect of undertaking this Kaupapa Māori research project in a respectful, empowering and culturally safe manner. In keeping with the participatory nature of Kaupapa Māori research (Bishop, 2005), participants were given the opportunity to check and retain a copy of their personal data transcript, review a provisional summary of thematic analyses, and receive a copy of summarised research findings (Cram et al., 2003). Participants were welcomed to edit their transcripts, and provide feedback on summarised themes and findings, which was considered in further data analyses, interpretation of themes, and reporting of findings. These optional participatory aspects of the research allowed participants self-determination over their desired level of participation.

Moreover, the participatory nature of these optional involvements, acknowledges the Māori worldview that data contributed by participants is knowledge owned and freely shared; it also recognises that knowledge is generated dynamically, by participants and researcher, through the data collection process as well as subsequent data analyses and interpretation phases (Bishop, 1998; Durie, 2005). The reporting back of findings, as a summary document, recognises the principle of whakawhānaungatanga which encourages the building of research relationships and participants' mana (personal power) beyond study completion and publication (Bishop, 1999).

3.4.7. Minimisation of Harm

Aligning with Kaupapa Māori philosophy, protection of participants in all dimensions was paramount and I endeavoured to make the research a positive experience. Although the topic of healthcare access was not intended to elicit any discomfort I acknowledged that any research involving human participants had the potential to cause harm (Health Research Council of New Zealand, 2010; University of Auckland Human Participants Ethics Committee (UAHPEC), 2010b). In consideration of this, the participatory processes were employed during data collection and analyses stages in an effort to provide participants with a culturally safe and empowering research experience. Additionally,

I acknowledged personal cultural limitations, undertook consultation to ensure my cultural awareness, and sought to ensure language presented no barrier to participation.

Prior to data collection, I decided that any sign of participant-discomfort, would indicate that I should suggest the following: moving to another question, taking a break, turning off the digital recorder, or ending the interview. I asked participants pre-interview to immediately report any discomfort experienced to me and to exercise their right to: choose to not answer a question, request the digital recorder be stopped, end the interview, and withdraw their participation or data at any time without explanation. All participants were provided with a list of selected southeast and central Auckland Māori and mainstream counselling services at the conclusion of interviews (see Appendix G), in the interests of reducing any harm that may have occurred from distress experienced post-interview. Fortunately, there were no incidents of distress either during or after data collection interviews. In the spirit of the whakawhānaungatanga (relational building) principle, and facilitated through the optional participatory aspects of the research, I have maintained intermittent communication during the post-interview phases of this research and participants have all indicated participation was a positive experience.

3.5. Participants and Recruitment

Methods for recruitment, data collection and data analysis were selected according to the research question: What are the experiences of Māori solo mothers in accessing healthcare for personal health needs? The research question required a recruitment strategy that would effectively find Māori solo mothers to facilitate data collection and analysis that would elicit and examine experiential data in a meaningful and culturally appropriate fashion. To meet the research objectives of identifying facilitators and barriers to the participants healthcare access, in order to make beneficial recommendations, the methods used needed to examine data and identify patterns in participants' experiences. Underpinning the methods employed was the Kaupapa Māori methodology which provided a cultural framework and required recognition of correct protocols.

3.5.1. Participants

Seven participants were recruited for participation in the presented research. There are no pre-set sample sizes in qualitative inquiry, but rather the number of participants is determined by the resources and time available, the purpose of the project, and the interests of the researcher and participants (Patton, 2002). As a qualitative study, and within the scope of a Masters thesis, the number of participants sought was limited. Approximately, eight participants was deemed sufficient for

an exploratory study of general themes related to Māori solo mothers' healthcare experiences, while providing a sample suitable in size for Masters level research with a sole researcher undertaking all recruitment, data collection, transcription and data analyses (Suzuki, Ahluwalia, Arora, & Mattis, 2007). In addition to my research project workload, time constraints of a Masters research period were recognised, with the consultation processes of a Kaupapa Māori methodology impacting time for data collection. However, the final number of seven participants was ultimately determined by my supervisor and myself as reasonable thematic saturation regarding participants' healthcare access experiences had been reached (Creswell, 2007).

3.5.2. Purposive Sampling

Purposive sampling was employed to recruit Māori solo mothers as the specific ethnic and sociodemographic group of interest (Suzuki et al., 2007). Inclusion criteria had to be met for five key aspects of participant suitability; these criteria for eligibility to participate were stated clearly on the recruitment flyer (see Appendix G) and in the Participant Information Sheet. The initial phone contact made by myself to potential participants facilitated the screening of interested individuals according to inclusion criteria. Those participants who met inclusion criteria were invited to participate and arrangements were made for mihimihi (formal meeting) and an interview; at the time of face to face meeting, the researcher rechecked participation eligibility. Potential participants not meeting the inclusion criteria for participation were excluded from the research.

 Inclusion criteria for potential participants included:
- Self-identification as Māori;
- currently a non-partnered solo mother with dependent children;
- aged 18 years or over;
- comfortable with interviews in English; and
- residing in the Auckland region.

Inclusion Criteria Definitions

Self-identification of participants as Māori was defined according to NZ Statistics   census-definitions of ethnicity (Statistics New Zealand, 2005). Potential participants were posed the 2001 and 2006 census ethnicity question at the time of initial phone contact to determine self-identification as Māori. Eligible participants indicated Māori was their sole ethnicity or one of their multiple-ethnic groups. All seven participants self-identified as Māori or indicated mixed ethnicity of Māori and Pakeha.

Aligning with extant research and census definitions (McGrath et al., 2002; Statistics New Zealand, 2009), a solo mother was defined as: a currently non-partnered woman providing sole care for dependent children; solo mothers may or may not reside with other adults (eg. boarders, whanau, friends). All participants met the criteria for the defined solo mother status.

Dependent children were defined as solo mothers' children aged less than 18 years and not employed full-time (McGrath et al., 2002; Statistics New Zealand, 2009). All participants met the criteria for having dependent children who were not employed full-time.

The last three criteria, shown above in section 3.5.2., were included to make the research a more comfortable and convenient experience for participants and researcher. Participants were required to be aged 18 years and over to avoid the need for parental consent to participate. I also considered adult participants over 18 years of age were more likely to be solo parenting without the financial support of parents or other whanau.

Comfortableness with interviews in English was set as an inclusion criterion for practical reasons and cultural sensitivity considerations. I am not fluent in Te Reo Māori and recognised participants would also have diversity of Māori language skills; therefore, interviewing in English avoided potential language barriers, prevented embarrassing participants less competent in Te Reo Māori, and reduced the risk of offending those participants more fluent in Te Reo than myself.

Finally, participants were restricted to those residing in the Auckland region to reduce the cost and time needed to travel further afield for data collection; as a full-time Masters researcher and solo mother myself, travelling beyond Auckland would have been challenging. I also expected that recruiting all participants from a common urban context would render common themes or differing experiences in data analysis more comparable.

3.5.3. Recruitment Strategy

Consultation

Consultation processes strongly focused on consulting with Māori who were experienced culturally and academically to advise on recruitment strategies to sample the diversity of the group of interest, in alignment with a Kaupapa Māori approach. Recruitment of Māori participants for research is fraught with cultural concerns regarding over-research of Māori communities, cultural distrust of research, and the need to follow cultural protocols in accessing Māori groups, as a researcher (Bishop, 2005). Cultural competence in researchers adopting Kaupapa Māori methodology is of utmost importance and consultation was sought to assure cultural safety for both myself and my potential participants.

As such, consultation was facilitated for me with two Te Kupenga Hauora Māori staff members: one a community and cultural liaison; the other a staff researcher. These consultants met with me, individually and collectively, to discuss matters such as: cultural awareness, the importance of mihimihi (formal introductions), culturally appropriate recruitment, and potential entry sites to Māori communities. In consideration of the research topic and participants sought, the consultants recommended the targeted distribution of flyers within Māori groups and communities, such as marae and community-based organisations, via local contacts; the consultants also strongly recommended the use of snowballing methods to recruit participants. Both recruitments methods were considered appropriate for Kaupapa Māori research as they would be most effective in locating potential participants through application of relational cultural principles, such as whakawhānaungatanga (relational networking), whanāungatanga (engagement) and whānau (extended family).

Subsequently, consultation facilitated communication with Māori groups known by the consultants, for help with flyer distribution; key members of three Auckland marae were therefore contacted regarding recruitment. I was also advised to make contact with local Māori to request assistance with further contacts or flyer distribution; email communication and contact with these local Māori was overseen by the community and cultural liaison consultant.

Distribution of Flyers

The use of flyers was intended to facilitate indirect recruitment which would allow interested participants to initiate contact with me in the first instance, in order to receive further information. I designed the flyers with help from a University of Auckland Faculty Services graphic designer and content was negotiated with my academic supervisors; the Te Kupenga Hauora Māori cultural consultants and Human Participants Ethics Committee approved the flyers. Information provided on the flyers included: the research question, Kaupapa Māori methodology, participant inclusion criteria, my contact details and iwi, koha details, and minimum participation requirements.

Facilitated through recruitment consultation, contact was made with three Māori marae members each holding key positions at their respective marae; one of these contacts was able to distribute flyers through involvement with a branch of a Māori women's organisation. As advised by the Te Kupenga Hauora Māori consultants, I made email contact with the secretary/treasurer of an east Auckland marae komiti (committee); after meeting in person the komiti member agreed to distribute flyers via the marae committee, to other Māori groups and potential participants. Similarly, a teacher at an east Auckland school who oversees a Māori enrichment programme was contacted, consulted regarding recruitment, and provided with an electronic flyer. Small quantities of flyers were also distributed to several local Māori contacts, parents of school-aged children, and whānau in the greater Auckland area to facilitate distribution to other Māori groups and individuals who may know of potential participants.

Recruitment of participants using targeted flyer distribution through Māori groups and individuals likely to facilitate further distribution to potential participants is an effective method used in Kaupapa Māori methodology; such recruitment strategy draws upon the relational networking, group engagement and extended family principles the underpin Māori culture and provide a feeling of connectedness which is important in researching with Māori (Bishop, 1998). Unfortunately, Māori preference for connectedness was revealed by the lack of response to flyers distributed through marae and other community-based Māori groups.

However, the flyers distributed via local and academic contacts generated more interest from several potential participants and eventually facilitated contact with three participants. Potential participants provided their phone contact details to the person who distributed the flyer, who in turn passed on the phone numbers to me. Soon after, I made phone contact with the potential participants to make introductions, explain the research further, answer any questions, screen for inclusion criteria, and where suitable, arrange a time and place to meet formally.

Snowball Techniques

Snowballing methods, commonly employed for recruitment of participants in qualitative studies (Creswell, 2007), also draw upon Kaupapa Māori concepts of whānau, whānaungatanga and whakawhānaungatanga (Bishop, 1998; Gibbs, 2001). The Te Kupenga Hauora Māori cultural consultants strongly recommended the use of snowballing methods to recruit participants, because in Māori culture, relational connectedness is regarded highly and provides a level of comfort and trust for Māori considering research participation. Potential participants are more likely to consider participation in research if they are provided with a flyer or informed via word of mouth from someone they are relationally familiar with, initially (Jones et al., 2006).

Therefore, snowball recruitment methods were employed to request referral to potential solo mother participants by early participants; it was arranged that potential referrals would be given my details, so contact could be made if desired. Flyers and participant information materials were supplied in cases where participants knew of other potential participants and were prepared to pass on the recruitment information. In all snowball recruitments, the solo mothers interested in more information or participation, gave permission for their phone numbers to be given to me so I could make contact via phone. This preference may have been due to most participants lacking a landline phone and only owning a cell phone; by requesting contact to be made by me the potential participants would have saved credit. Again, I used the initial phone contact to formally introduce myself, explain the research further, screen for inclusion criteria, and arrange to meet contacts suitable for participation.

3.6. Data Collection

3.6.1. Consultation

As the research progressed towards the data collection phase, ongoing consultation guided method choice and appropriate adjustments to ensure a culturally safe and participant-benefitting research experience. Several members of the Te Kupenga Hauora Māori staff acted as cultural consultants providing guidance and assistance for data collection materials and technique that aligned with Kaupapa Māori research methodology. Consulting staff approved my choice of semi-structured interviews for data collection and a process of consultation and negotiation generated a culturally appropriate interview guide; the interview guide is discussed fully in subsection 3.6.3.

Qualitative methods, including interviews, narratives, imagery, and collaborative interpretation are well-suited to Māori participants and support Kaupapa Māori research by facilitating understanding of phenomenon and giving voice to minorities (Edwards et al., 2005). The cultural consultants were satisfied that the use of interviews to collect data would be appropriate, because interviews facilitate the Māori preference for kanohi ki te kanohi (meeting face to face) interaction, between researcher and participant. The use of face to face interviews also supports Māori preference of korero (verbal communication) for sharing of experiential knowledge with the researcher and participant engaged together in the knowledge-creating research process. According to Kaupapa Māori methodology, the utilisation of interviews as a data collection method, supports the cultural principles of whakawhānaungatanga (relational collaboration), minaaki (sharing), matauranga Māori (Māori knowledge creation) and whānaungatanga (engagement and connectedness) (Bishop, 1998).

3.6.2. Semi-structured Interviews

Eligible participants interested in participation, were invited to meet face to face for mihimihi (formal introductions) with a view to continuing with an interview if desired. All participants found this suitable and convenient, with all mihimihi arranged from my initial phone contact, being followed immediately with data collection. I offered flexibility with social support and data collection venue with the intention of facilitating self-determination as well as promoting social sensitivity and cultural safety for participants.

In consideration of the principle of whānau (family), the recruitment flyers and participant information sheet explained that participants were welcome to have whānau or friends support them during interviews. One participant chose to have a friend present during most of the interview; this

support person did not participate in the data collection. Another participant had a friend on hand to watch the participant's children in another part of the residence during data collection. Two participants who reside with whānau members had those whānau caring for children during their interviews. The remaining three participants were unaccompanied for the interview and children were in care elsewhere.

In the same way, participants were given the opportunity to choose a setting of most comfort, convenience and support for the interview with suggested locations including: the participants home, whānau residence, or the University of Auckland's School of Population Health meeting rooms. Five participants chose to have their interviews conducted at their own residence. One participant gave her interview at the nearby home of a whānau member. One participant chose to give her interview in a private meeting room of her tertiary education provider. Flexibility with social support and data collection venue was intended to facilitate self-determination and promote social sensitivity and cultural safety for participants.

The night before an arranged mihimihi I would make phone contact with the potential participant to confirm they were still available to meet; I would also confirm that the arranged time was still convenient. This served to remind participants about the arranged meeting and provide an opportunity to cancel, reschedule or change meeting place arrangements. Upon arrival at the predetermined meeting place, while still in my vehicle, I would use a checklist to ensure I had all necessary documents and koha; I would also check the digital recorder was functioning correctly. Once satisfied my equipment and other resources were in order I would head towards the arranged meeting location.

I was greeted warmly by each individual potential participant, exchanged names, and was welcomed inside. On entering their residence/meeting room I would thank the participant for their willingness to mihimihi and gave them a packet of chocolate biscuits. This token koha was very well received and served as a good accompaniment to hot beverages offered. I would spend a little while at this stage just chatting with the potential participant about their residential area, home, children etc to encourage comfortableness and build rapport. The participants would then direct me to a lounge or dining area where we could talk privately.

At this point I would show potential participants a copy of the recruitment flyer and go through the inclusion criteria for participation; the flyer also provided a platform to begin telling participants information about my academic and personal background and how I came to be conducting this research. I would then present a copy of the Participant Information Sheet and ask the participant if they would like to spend some time reading through the document. When the participants indicated that were satisfied with the information I would verbally take them through the key points of the Participant Information Sheet; specifically, the participation requirements and optional participation aspects, the use of digital-recording, the privacy and confidentiality considerations, the future examination of the thesis, and potential publication of findings. At this point I would ask the solo mother whether she would like to participate and continue on with an interview if it was convenient, or

whether they would like time to think about participation. All participants chose to continue on from mihimihi with an interview.

Next I would present the participant with a Consent Form. Participants are required by University of Auckland's Human Participants Ethics Committee to provide informed written consent prior to participation. The Participant Information Sheet informed participants about the research and the Consent Form requires the participants' signature and name as written consent, pertaining to a list of research and participation requirements. Additionally, the Consent Form prompted participants to indicate their desire to receive their data transcript, a provisional thematic summary, and a summary of findings upon completion of the research project. Importantly, participants were informed this research was being conducted for a Masters thesis and could potentially be published in an academic journal; prior to participation the participants were required to give informed written consent regarding this use of the research.

With informed written consent obtained, I would show participants the digital recorder and explain that recording would start when they were ready. Because the participants had diverse backgrounds that had led to differing periods of time solo mothering I asked them reflect on their time as solo mothers when responding to the healthcare access questions. Then I would begin recording and start the interview with the broad context questions of the Interview Guide (see sub-section 3.6.3. below for more detail) which collected some basic demographic information and self-reported health status while endeavouring to make the participant comfortable with the interview progress before addressing healthcare access experiences.

Thereafter, the body of the interview encompassed broad healthcare access questions seeking positive and negative experiences as well as experiences of stigma or non-access. The probes were used as needed to prompt participants for additional experiences, which may have arisen through various kinds of health services; for example, General Practice, hospitals, afterhours care, maternity services, prescription filling, specialists, mental health, or screening programmes. After the broad healthcare access questions, the interview was concluded with three broad questions designed to allow the participant to add any relevant information and finally to express their preferred research outcomes. The interview guide was used systematically for each interview to ensure all broad questions were covered with appropriate and relevant prompting, before recording stopped.

The seven data collection interviews ranged in duration from 40 minutes up to 1 hour and 7 minutes; the interviews were digitally-recorded in entirety to allow for transcription and analysis of accurate raw data. Fortunately all participants were willing to have their interview recorded with no requests to stop the interview; one interview was paused temporarily due to the unexpected arrival of a visitor, but the interview resumed soon after. Digital audio-recording of participants' interviews allows for transcription and analysis of accurate raw data, not the researcher's perspective of the stories told (Alcoff, 1991; Poland, 1995).

In conclusion of the interview, I gave participants as koha a $20 Pak'n'Save voucher to recompense for time and knowledge-shared; they were very appreciative of this gesture of recompense. I finished the interview process by presenting participants with a printed list of local and central counselling services and encouraged them to make contact with an appropriate service if they experienced any delayed discomfort or distress related to participation in the interview. Then I took time to thank the participant for their willingness to participate in my research, explained the next stage of transcription, and collected necessary details for emailing or posting of transcripts and summaries.

Soon after each data collection interview, while a meeting was still fresh in my mind, I spent time quietly reflecting on the interview process noting any relevant thoughts or observations. For instance, I made notes about the participant's general demeanour, attitude towards me, the depth of the interview, and the general response to questions. Similarly, I reflected upon my own feelings throughout the interview, the ease or challenge of data collection, my skill as an interviewer, and my competency as a Māori researcher.

3.6.3. Interview Guide

An interview guide with dual purpose was developed in consultation with cultural advisors and Kaupapa Māori practitioners working at Te Kupenga Hauora Māori. The final version of the interview guide used in all seven data collection interviews was developed over several drafts that underwent rigorous consultation and approval (see Appendix H). Generation of the interview guide focused on key cultural protocols and development of effective broad questions and prompts that would elicit data needed to answer the research question and meet research objectives. A commitment was made by the student-researcher to consult further during the data collection phase in order to review the interview guide and make any adjustments needed.

Firstly, the interview guide was intended to provide the student-researcher with guidance through the interview process using culturally appropriate stages: mihimihi (introductions and welcome); the data collection interview; and poroporoaki (closing of interview). Cultural competence in researching with Māori participants is of vital importance in Kaupapa Māori research. The interview must begin with mihimihi in order to make formal introductions, establish whakapapa (genealogy) of researcher and participant, and share relevant personal background information in order to build rapport. This culturally-critical process of mihimihi is not a rushed stage as due time and care taken will build relationally and create comfortableness.

Semi-structured interviews were intended to tap participants' healthcare access experiences through the use of a 'critical incident' style of inquiry. The data collection questions were hoped to allow participants to korero openly about their experiences in a relaxed, thorough manner while also

keeping the interview focused in the research topic. The interview guide finishes with poroporoaki (conclusion) that allows participants to share additional knowledge and express their personal preferences of research outcomes. Semi-structured interviews, featuring broad questions, are believed to potentially generate rich descriptive data (Cram et al., 2003) making this a popular data collection method in contemporary health research (Baker & Tippin, 2004; Worth & McMillan, 2004), which aligns well with Kaupapa Māori methodology underpinning the study design (Cram et al., 2003; Edwards et al., 2005).

Secondly, the interview guide was designed to guide me through set interview questions and suggested prompts. It was very important to make interviews systematic in style and order, to cover all broad questions with the help of prompts, in a similar way for all interviews; systematic posing of questions and consistent style of questioning and prompting was expected to elicit meaningful data for later analysis and comparison. The interview guide featured ten broad questions reflecting five dimensions of healthcare access.

Firstly, three broad context questions requesting information about the solo mother, her current situation, and current health status were used to start the interview. The aim of this phase of the interview was to ease the participant into the interview process and generate some freely shared personal information about her solo mother situation. These broad starting questions also elicited and explored the participant's self-perceptions of their health and current health concerns, ready to lead into healthcare access experiences.

Following on, the use of broad, open-ended questions was expected to elicit rich information, facilitate participants' self-determination in information-sharing, and accommodate Māori perspectives and preferred ways of communicating (Cram et al., 2003). The interview guide therefore featured four broad 'critical incident'-inspired questions expected to elicit positive and negative encounters with healthcare, barriers to healthcare access, and any perceived experiences of stigma or discrimination. The potential data from such experiential inquiry was hoped to facilitate the identification and description of healthcare access facilitators, barriers and issues for Māori solo mothers. The prompts were flexible and intended to guide and facilitate responses, and therefore varied according to participants' answers and comfortableness. Prompts allowed the student-researcher to repeat the broad questions in relation to different healthcare access events and settings.

During the data collection phase, after the fourth interview, I consulted with my supervisor regarding the participants' responses to the interview guide questions. I expressed concern that the terms "helpful" and "unhelpful" were not really resonating with the solo mother participants; most would ask me to repeat or clarify the questions. In consideration of wanting to employ language appropriate to the participants in order to collect meaningful data, it was decided that I should reword the 'access experience' questions. Thereafter, the remaining participants were asked to describe "good or helpful" and "unhelpful or negative" experiences of healthcare access. This simple rewording with more common terms enabled participants to respond more easily. The dual terms were therefore applied in the data analyses phase to ensure comparable themes.

Closing questions were broad and allowed the interview to close in a relaxed manner and collected any information not covered by the middle phase. Participants were asked to add any information about their health, ways of caring for their health, healthcare access, or health service experiences. The concluding question asked participants what they would like to result from the research; included at the suggestion of a cultural consultant, this recognises participants' right to express self-determination and preference for research outcomes.

3.7. Data analysis

For Māori, knowledge is considered taonga (treasure), and thus tapu (sacred) (Cunningham, 2000), requiring respectful and careful treatment (Gibbs, 2001). Transcribed into writing, research data and publications containing knowledge become tapu, possibly restricted in access (Smith, 1999). Tapu conceptualisations guide Kaupapa Māori research respect for Māori people, korero (communication), and the sharing and amalgamation of knowledge (Jones et al., 2006). Respectful data processing, including transcription and analyses, recognises the tapu nature of Māori intellectual property which protects the mana (personal power) of research participants (Jones et al., 2006).

Subsequently, interviews were transcribed throughout the data collection phase of the research; data was securely stored and respectfully handled. As the researcher and interviewer I believed personal transcription and data analysis would promote continuity in data processing to promote meaningfulness and authenticity of findings. Transcripts were then coded and analysed for themes and categories using a general inductive thematic approach to data analysis. Major and minor themes were generated from the collective data.

3.7.1. Transcription of Interviews

To ensure the tapu (privacy and respect) of participants' data, their intellectual property, I personally transcribed all interviews as soon as possible after each data collection session. Post-interview I would immediately save the digital audio file of an interview from the digital recorder onto my personal password-protected computer; each audio file was named by a code (eg. M8) only to protect the participant-interviewee from identification. Transcripts produced are verbatim accounts of each interview, including both my communication as interviewer and the participant's responses; in addition to words spoken, relevant non-verbal information was recorded on the transcript (eg. [laughing], [pause], *emphasis*). As I transcribed each interview I removed names of children and other adults as an extra precaution against identification of participants; no participant names appear on electronic or

hardcopy versions of transcripts. The transcription phase was prolonged as I made every effort to ensure confidentiality, protect the data as tapu, and promote the integrity and authenticity of raw data.

At the time of giving informed consent participants indicated whether they wanted to receive a copy of their transcript. Offering participants a copy of their transcript acknowledged their right to own and retain their intellectual property; six of the seven participants requested to receive a copy of their personal transcript. Participants were offered the opportunity to check their personal interview transcript for accuracy and edit their transcript if desired; no participants withdrew data or edited their transcript.

3.7.2. General Inductive Thematic Analysis

Method selection for data analysis drew upon extant Kaupapa Māori research, such as the Hauora Tane Project which used qualitative interviews and thematic analyses to explore Māori men's health (Jones et al., 2006). Similarly, I aimed to utilise emergent themes from the interviews to describe and understand Māori solo mothers' healthcare access experiences in taking care of their personal health. Being exploratory, the data and findings of this project were not theory-driven, but sought to describe the undocumented experiences of an under-researched group; thus an inductive, or data-driven driven, approach to analysis would preserve the integrity of the raw data (Boyatzis, 1998).

Increasingly, general inductive techniques for analysing data are used in health research, especially when researchers want to analysis data without the constraints of theory-driven procedures (Thomas, 2006). As such, for this exploratory research I employed a general inductive design within the overarching Kaupapa Māori approach. A general inductive approach to analysing the qualitative data collected was considered suitable for the purposes of this study and the Kaupapa Māori framework. Themes emergent from the data were used to describe experiences (Creswell, 2007), to meet research objectives (Thomas, 2006), to further theorising of Māori health and healthcare access (Jones et al., 2006), and suggest future research directions (Cram et al., 2003).

General inductive thematic analysis provides an easily utilised and systematic set of analytic procedures for efficient and defendable data analyses and findings. Inductive approaches are useful for transforming raw textual data into summarised data sets; this enables researchers to establish clear links between research objectives and data condensed into summarised findings. Furthermore, a general inductive approach facilitates the development of a framework that reflects the structure underpinning the experiences emergent from the raw data. Inductive analyses allows complex data generated from objective-focused questions to be categorised thematically into meaningful findings; the generation, labelling and textual representation of themes is considered an effective and engaging style for reporting the findings of qualitative research (Thomas, 2006).

Certain analytic strategies underpin inductive data analysis. Firstly, data analysis is guided by the research objectives which highlight topics to be explored; analysis occurs over multiples readings of raw information. Secondly, the primary goal of analysis is to develop categories into key themes. Thirdly, findings are inexorably shaped by the experiences and understandings of the person conducting the research and undertaking data analysis. Research objectives limit the range of interpretations and thematic findings, because the researcher's focus is on key aspects of raw data. Ultimately, inductive analysis seeks to organise raw data into meaningful categories that generate a framework of key themes (Thomas, 2006).

Thematic Coding

The transcribed data firstly needed to be reduced to a more manageable amount of raw information. The most effective way to begin this reduction was to take each participants account and outline the information; this outline format should be consistent across all accounts (Boyatzis, 1998). Initial coding of accounts requires thorough reading of transcripts and consideration of potential meaning. Categories are identified, defined and labelled with appropriate words or phrases. Upper-level broad categories are usually derived from research objectives; lower-level categories usually emerge from rereading accounts, and commonly reflect actual phrases or meanings of excerpts (Thomas, 2006).

All transcripts were formatted the same and printed to produce hard-copies. Using colour questions and relevant data were highlighted to correspond with the interview guide. I went through each transcript and outlined the raw data into six key information themes to make handling the accounts easier. The most effective way to systematically outline the seven accounts was to use the Interview Guide questions as preliminary themes. So, upon a first read-through of the transcripts data was highlighted into the broad categories which were labelled in the left margin as follows: Personal Health; Good/Helpful Access; Negative/Unhelpful Access; Non-access; Stigma/Discrimination; and Research Outcomes.

A second read-through further reduced the data into sub-categories of the broad categories to make the accounts even more manageable (Thomas, 2006). Using the first three questions of the interview guide, relating to broad context personal health, the Personal Health themed-data was further themed into sub-categories labelled in the right margin as follows: Self-reported Health; Perceptions of Health; Health Concerns; Health Strategies. The broad Good/Helpful Access, Negative/Unhelpful Access, and Non-Access categories were reduced further in two distinct ways, according to the type of probing used. So the data relating to both Access and Non-access categories was sub-categorised into specific healthcare services accessed and then into specific helpful/unhelpful factors in access. The healthcare service sub-categories were labelled for the Helpful and Unhelpful Access and Non-Access data as: GP, Hospital, Māori Health Services, Mental Health, Dental, Afterhours, Cervical Screening, Maternity, Specialist, Sexual Health, Drug/Alcohol Treatment, Community-based Services, and Prescriptions. The broad Access and Non-Access data also was further reduced into sub-categories formed by probing into helpful/unhelpful factors and

barriers which were labelled as: Easier Access, Cost, Transport, Childcare, Whanau Support, Accidental Connection, Cultural Appropriateness, Financial Help, and Poverty.

Thematic Analysis

Once the raw information was reduced into more manageable labelled categories and sub-categories the individual accounts could be analysed for themes; then themes from each account could be compared and analysed for common or exceptional themes/experiences. As themes evolve with identification of patterns and links between themes and accounts the themes labels and definition should be developed to protect the honesty and accuracy of the raw data (Boyatzis, 1998). I then re-read each account, already labelled into the broad categories, and sub-categories of health services and factors/barriers noting specific experiential themes and links between sub-categories. To compare the individually themed accounts against all the other accounts I created a table of overarching themes; the themes from each account were listed down the left-hand column of the table and the accounts were labelled 1-7 and placed on the top row. I then plotted an "X" for each theme as it related to each account.

This summarised table of inter-account thematic analysis revealed the major and minor themes; summarising the themes from each account in this way allowed me to see which themes were common to several participants suggesting shared experiences. The table also allowed analysis of thematic patterns among participant accounts; in some cases, a theme was found to be common across several accounts elicited from participants with similar socioeconomic conditions. Such analysis of the inter-account themes in relation to the participants' personal circumstances allowed for the amalgamation of apparently minor themes into broader themes. As analysis progressed emergent minor and major themes were reworded and redefined to better retain the meaning and context of the raw data. The tabularised and summarised themes informed the Provisional Thematic Summary that was provided to interested participants for review and feedback.

Textualisation of Tabularised Themes

Rereading the original transcribed accounts is of utmost important to ensure integrity and accuracy of data for meaningful findings. Taking developed themes back to the raw data allows the researcher to check honesty of themes against the contextualised data; this is a critical process when utilising an inductive approach in analyses (Boyatzis, 1998). A common assumption in inductive analysis is that some text will be irrelevant to research questions and will not be categorised; additionally, some data may be relevant to more than one category and may be coded into any relevant categories. Continuing review of categorisation of data should include recognition of contradictory viewpoints and unique insights. Text excerpts should be selected to best represent a category and categories should be linked or merged in conveying similar meanings (Thomas, 2006).

To check the contextualised raw data against my categorisation I used a tabularised technique. I wanted to ensure my themes truly represented the data collected and captured the thematic patterns

and links emergent through analysis of individual accounts and inter-account summaries. So I created an electronic document to table all themes using the original broad categories described in sub-section 3.7.2.1.; then, within the broad categories I tabled in the lower-level sub-categories that represented healthcare services and access factors/barriers.

With those broad categories and sub-categories in place I then went through each transcript rereading the account and transferring relevant data as textual excerpts into the appropriate location(s) on the thematic table. Wherever possible, participants' responses to broad questions and probes were left as large chunks of textual data. I found this process very effective as many such chunks of data contained information relating to more than one theme so it was important to not oversimplify the experience but to capture all aspects relevant to themes and patterns. I systemically reread through all the accounts double-checking my understanding of the data and placing it appropriately into the themed table. As textual excerpts were copied into the tabled document I would place the corresponding code (1 – 7) in a left-hand column to identify which account had generated that data; this step also allowed me analyse the commonality of themes across accounts by summing the accounts which had textual excerpts corresponding with each theme.

In sum, this process of tabularising text confirmed the designation of themes as minor and major; the themes and diversity of experiences highlighted by the summary table and illustrated with text informed the writing of the Findings in Chapter 4. The use of a systematic inductive approach to data analysis enabled clear links to be made between the research objectives and the summarised findings. The summary of findings provided to interested participants was also generated from this summary document; however, no names or textual excerpts were included, just collectively generated themes and descriptions were given.

3.8. Assuring Rigour

3.8.1. Trustworthiness

I made every effort to ensure data was authentic and thematic findings sound. By conducting all interviews, transcription, and data analyses myself there was continuity in the handling and understanding of data to preserve integrity and meaningfulness. Performing transcription personally supports the integrity and authenticity of transcribed data for analyses which lends rigour to findings. Giving participants the opportunity to review, edit and critique on the authenticity of transcripts and provisional summarised findings increases the validity of this research. Rigorous and systemic reading of accounts and location of text into tabularised themes ensured true representation of data themes. Presenting findings as emergent themes and evidencing themes with rich, meaningful textual exemplars ensures findings are true to the data collected and not the product of my own interpretation of participants' experiences.

3.8.2. Transcript Checking

Member checking involves allowing stakeholders, such as participants, to check and edit their personal interview transcript before data analysis; checked and correct raw data is considered to ensure authenticity of data and adds rigor to findings (Poland, 1995). Six of the seven participants in this study requested on their Consent Forms to receive their transcripts; no participants made any corrections to their transcript. When using an inductive approach to data analysis, the use of member checking of raw data transcripts is considered to lend dependability to thematic findings. By conducting all data analysis myself, there was no need to evidence inter-rater reliability as consistency of coding was assured (Thomas, 2006).

3.8.3. Member Checking

Member checking involved offering participants an opportunity to receive a thematic summary of the provisional findings, and to report back on authenticity according to participants' experiences. Feedback from participants was considered in further analysis of the data. By offering the participants the opportunity to review a provisional thematic summary enables more participatory data analyses affords which empowers and builds participants' mana and further aligns research processes with Kaupapa Māori methodology and adds validity to findings (Cram et al., 2003; Kerr et al., 2010). Furthermore, allowing participants to review provisional findings facilitates an opportunity for participants to provide feedback on which themes resonate or not which authenticates thematic findings and strengthens rigour (Poland, 1995). Importantly, for research involving inductive thematic analysis the facilitation of review and feedback by participants on provisional themes and summarised findings promotes credibility of findings (Thomas, 2006).

3.9. Summary

In conclusion, a detailed outline of the approach used in this study has been provided. Chapter 3. began with an explanation of the Kaupapa Māori framework and qualitative social constructivist approach underpinning this study; these theoretical choices and the research procedures they informed were identified and justified. Recruitment strategies were explained and data collection methods using semi-structured interviews were detailed. The inductive thematic approach used for data analysis was outlined and rigour discussed. Employing these inductive methods the following chapter will report on the research findings.

Chapter 4. Findings

4.1. Introduction

Using the research procedures described in the previous chapter, Chapter 4 reports on the findings from in-depth interviews with seven solo Māori mothers. Chapter 4 has been organised around the research questions with the key findings presented as major themes: Self-reported Health Status, Health Concerns, and Taking Care of Health; Action Taken to Address Health Concerns; Barriers to Accessing Healthcare; Moving Around the Barriers to Access; Improving Māori Solo Mothers' Healthcare Access; and Being Māori, A Solo Mother and A Beneficiary. Reflecting the research objectives, thematic findings describe participants' healthcare access experiences, facilitators, and barriers; each theme is defined and illustrated with text segments from participant interviews. It is stressed however that the information reported in this chapter represents the viewpoints of the small sample of participants and is not generalisable to all Māori solo mothers. To protect the privacy of participants and their children pseudonyms have been used, and the names and locations of health services have been removed. To introduce the findings, the demographic and background profile of the study participants is first described to contextualise the healthcare access experiences of the participants.

4.2. The Participants: a Profile

The Women

All seven participants self-identified as being of Māori ethnicity or mixed Māori and Pakeha ethnicity. The participants are urban dwelling and most have been living in the Auckland region throughout their time as solo mothers. The seven female participants ranged in age from 19 to 34 years old. Their period of time as solo mothers' ranged from 1 to 13 years, an average of seven years as a solo mother. Although sharing similar characteristics in terms of ethnicity and residence, there were differences between participants: they reflect diverse personal backgrounds, different circumstances leading to their solo motherhood status, and diverse cultural experiences.

The children of the participants all qualified as dependent, with no children over 18 years of age and/or employed full-time. Dependent children residing with the solo mother participants ranged in age from 2 to 13 years; the number of dependent children residing with each solo mother participant ranged from 1 to 5 children per household. Collectively, the participants' biological children ranged

from 2 to 16 years of age; however, four participants had only some of their children living with them, as some children were cared for elsewhere.

At the time of interviews, none of the participants lived with a partner, as specified by the inclusion criteria. Few participants revealed past relationship details relating to their children's father(s); however, from information that was shared, there were differences among participants. Some participants had left long-term relationships, others had only had short-term partnerships resulting in children, and others have had unstable on-again-off-again unions during which the women perceived themselves to be solo mothers throughout. Only one participant shared custody with her ex-partner, and she had the child two-thirds of the time and received no financial or other support from the father.

All residents of Auckland, the participants were currently living in south, east, and central Auckland suburbs; some of these areas are low deprivation while others are high deprivation locales. Three participants resided in state-owned (Housing NZ) properties, while the remaining four participants were living in market rentals. Five participants are the only adults of their residence, two had family living at the same address, one had a cousin boarding with her and one was living temporarily with her children at her mother's home.

Although beneficiary status was not a recruitment criterion, it just so happened that all seven participants were receiving the Work and Income New Zealand (WINZ) Domestic Purposes Benefit (DPB) as their main source of income. However, one participant had just started permanent part-time employment in the education sector and another was studying full-time with a tertiary education provider.

4.3. Self-reported Health Status, Health Concerns & Taking Care of Health

When invited to comment on their current health status, the majority of participants described it in positive terms. Five participants described their health globally in terms such as "good", "fine" and "healthy as." Just two participants reported their health status as "unhealthy" and "not good." Self-reported "good" health seemed to reflect a lack of illness, an absence of serious conditions, an ability to function, and no need for healthcare. Self-reported "poor" health, in contrast, was linked to perceptions of 'unhealthy' lifestyles and neglecting preventative health checks. To illustrate, the participants elaborated on their self-perceived health status with statements such as:

> I see it as good health because I don't really go to the doctors. I don't really need to. (Mary)
>
> It's just like I haven't been sick, as in going to the doctors, you know, other than having the flu and then the cold and that… (Kimberly)
>
> ...to be honest, I don't feel very healthy at the moment. (Cassandra)

66

I don't feel unwell and the last time I went to the doctor, which was very recently, the doctor said that, 'You're perfect'. (Stella)

However, a different picture emerged when participants were asked to report on any current health concerns or issues they had. Despite almost all participants having previously claimed that their health was good, six of the seven participants revealed various concerns about their health. These health concerns included problems related to untreated conditions, diagnosed health problems, dental health, lifestyle concerns, mental health issues, and a lack of health checks.

...I think I do need to go [to the] doctors though for like, I don't know, a check-up of something. Only because like I think...I sleep a long time. In the mornings, I'm like really tired in the mornings. Like...my cousins...get up at 8:00 or something. I get up like at 9:30 or something and when I do get up I feel real like drowsy and tired. Yeah, I better go doctors. (Kimberly)

Five participants were particularly concerned about the impact of their lifestyle on their general health. These participants perceived their lifestyle as "unhealthy" in relation to lack of exercise, diet and eating habits, smoking, stress, and weight gain. These participants' perception of unhealthy factors reflects their socially-constructed awareness of 'healthy' lifestyles.

Well, I'm not doing much. I'm at home a lot and I'm not getting much exercise and I don't feel healthy and I smoke too much...and I don't eat very healthy as well. (Tia)

I was smaller, you know. And I wasn't...putting on weight, but now I eat and I put on weight, heaps. But I think it's because of the medication I take. (Cassandra)

The participants displayed considerable awareness of targeted health promotion messages, often aimed at groups of lower economical status and poorer health.

Yeah, I'm probably not really that healthy because I'm overweight, you know, and they see that as unhealthy. (Mary)

Reflecting government health targets, frequently delivered as preventative care through GP services, the participants commented on health-promoting actions they perceived were needed improve their personal health.

Yeah, probably stop eating sugar and rubbish. Try to cut down on my smoking and yeah those sort of things, but as in getting to the doctors - no. (Tia)

I'd actually just like to become really healthy and fit, really, if there was any, you know, cheap places where they could actually help you out and give advice on, actually not so much on eating, but like exercise-wise. I'd love to yeah be really fit and healthy. (Chloe)

[I'm not accessing] smears and that, and going to the doctor, and I'm not doing exercise…and [not eating] the right diet. (Cassandra)

Although health promotion messages were received, and apparently internalised, by the participants such tactics may hinder access to healthcare. Participants' accounts revealed a tendency to delay

access to healthcare if there is a risk of eliciting criticism from health professionals and perceived pressure for change.

> Probably those sort of things, but like I said I haven't really [done anything about my health concerns]…I forget about them, because I never, you know, but that is probably thinking about all the things, being so unhealthy at the moment and all the stress that I'm going through and all the smoking, constant smoking, you know. I should probably go to the [tertiary educator] doctor then they'll tell me I should *give up smoking*...having more money I wouldn't want to smoke. But smoking is my one release from stress, you know. If I didn't smoke I'd eat more…I know that's one of the main arguments: If you're so broke why do you smoke? But it's like it's my *one thing* that takes away some of the stress for five minutes. (Tia)

However, when delayed access results in health concerns progressing to health problems or serious illness, the participants are then more inclined to seek healthcare.

> ...I'm wondering about diabetes at the moment...it's because of the little like symptoms: my arms are falling asleep all the time and, but the main thing that came up in the last few days is the sweet taste in my mouth. I don't know if that's a, you know, my mother's just been diagnosed with diabetes and yeah I smoke too much and all those things... So, I probably will watch it, see if anything gets worse, and then actually do anything about it. (Tia)

The participants' self-reported health status and admissions of health concerns, indicated participants weighed their ability to function in everyday life and lack of illness when judging the seriousness of health concerns, and need for healthcare. Additionally, the participants revealed concern about lifestyle factors and changes they perceived to be necessary according to health promotion messages and interactions with health professionals. However, responses indicated the participants may not be willing or able to implement these healthful changes.

4.4. Action Taken to Address Health Concerns

In the previous section 4.3., the participants' health concerns, ranging from dental health issues through to the need for specialist services, were reported. Some participants stressed that their health concerns were just *concerns* and did not require health service access. However, other participants indicated a desire to address their concerns through access to healthcare if other barriers, like cost, were removed. When asked about experiences in accessing healthcare services some participants reported that they regularly utilised health services, while others did so infrequently: this next section reports on where the participants had sought healthcare and why they accessed particular services.

Dental Care

Firstly, dental health emerged across accounts as a major concern. The majority of the participants indicated an awareness of the need for regular dental checks and several reported a current need for dental treatment.

It's rotten and that and they just said you need to go to a dentist and they'll fix your teeth, but I can't afford it. (Cassandra)

Like I went and had some dental done and it didn't last very long. I'm going to need work again,...I think they're going to say, 'pull it out,' and I'm 31 years old and I've still got all of my teeth and I'm not going to start pulling them out. So I'm trying to preserve it. (Stella)

All seven participants expressed the desire to maintain dental health through regular dental care, but did not because they could not afford to.

Um, nowadays, I don't like going to WINZ because...everything is harder. So I try not to go there. I haven't even been to the dentist for, like, two years now. And it's because everything's getting harder. (Dorothy)

Most participants have reportedly suffered with painful dental problems, poor gum health, or rotten teeth because the funds are not available and dental care and treatment is too costly.

Oh yeah. Like painful, not only then, but all through that time when [you've]…been waiting. And the next minute you just can't [wait], it's unbearable. (Dorothy)

Subsequently, the participants reported limited access to dental services, which was overwhelmingly for emergency dental treatment only.

I haven't been to the dentist since intermediate. Yeah, and I've got no fillings, but now my teeth are just starting to get yellow and I'm starting to get concerned, because I smoke. (Kimberly)

Only if my teeth need attending to, other than that I would not go to see them. I actually don't go see them. I don't see them on a regular basis. That's all I'm going to say. Only if I really need to! (Chloe)

All participants, being recipients of the DPB, were familiar with WINZ facilities for financial help with dental treatment costs and their dental service access was inextricably linked to the accessibility of WINZ advances and grants.

It's expensive. I don't go. I'll go to WINZ and get them to pay, help. (Dorothy)

Dental care, yeah that's a big one, aye. Well, WINZ paid for my last one otherwise if WINZ wouldn't pay for it I wouldn't even bother going. It would need to be a matter of life or death, you know. (Mary)

Applications for benefit advances or emergency grants require an initial dental consultation to obtain a quote, and evidence of emergency status and treatment needed.

I would go to the dental, but it's just expensive these days. So I would go to the dentist, get a quote and take it to WINZ, and then, yeah, get them to do my teeth. Like, you know, at least get them to help pay the fee or something, you know. (Kimberly)

If WINZ approves an advance on the solo mother's benefit it must be repaid from her benefit payment each week.

I spent $600 on a couple of fillings and for x-rays... That was through Work and Income, but I still have to pay that back. Yeah, so that's the only thing about money-wise there. (Chloe)

69

Oh yeah, I've had WINZ help like to get my teeth done. Twice they did it and in amounts of $1000 and up. (Stella)

Additionally, WINZ provides emergency grants of $300 annually, which is not repaid and can be topped-up with an advance to cover dental treatment costs.

No, I think they pretty much understand when it's a toothache. 'Oh my gosh, I feel sorry for you.' Stamp, stamp, stamp! I'm like, 'Aaaahhhh aaahhh.' (Dorothy)

However, the participants cannot rely on this financial help. Benefit advances are subject to limitations of the amount that can be borrowed; or advances may be needed for other emergencies, such as car repairs. Non-access to advances further restricted participants' options which led some participants to forgo dental treatment entirely or to access hospital-based tooth-extractions.

I've only been to the hospital to get my back teeth out...My advances were used. [I] only had $300 [emergency grant available]. (Cassandra)

I'd have to use up all of my grant from WINZ to get a tooth fixed from any dentist and the only other option that you have is [to go to] the hospital to pull it out and give you antibiotics...the hospital dentist. The [location] hospital does dental work: $40 for extraction...I've [had] four teeth removed and the first would have been when I was about 21 – 22 [years old]. (Tia)

Access to hospital-based dental clinics involved prolonged waiting and strict protocols regarding treatment.

...I went to the hospital and sat there for about two hours, and then when I got in there, I told them that I know it's an abscess coming on and can I have some antibiotics. Well they said, 'No,' and that I needed to go to a dentist. That's the first time that they've actually said no, and I don't blame them because, you know, I was trying to *prevent* it, [but] it was a front tooth. I couldn't handle losing it...So the next day, I went to the dentist at the hospital for the thing, and they said they only do extractions...I finally got to see the doctor and he said 'I'm sorry, we only pull the teeth out,' and I said "I waited here for four hours can you just look at it? See that it's infected and give me antibiotics." He looked at me and I said, "Please don't take it out, I don't want to lose my front tooth." So he looked at it and said, 'Yes, it is infected' and he goes, 'I'll do a bit of a clean-up' and he scraped the back of my teeth as well, he gave me a scraping, and he prescribed some antibiotics for it…and I've still got it! So that was one time that I had to really beg. Yeah, and I did. I begged for my teeth, front teeth. (Tia)

Tia was fortunate to have received curative dental treatment; however, tooth extraction ought perhaps to be a last resort, not a standard of dental healthcare for low income populations. It could be argued that low-cost dental healthcare for regular checks, cleans and treatment would be a better utilisation of healthcare resources, and could prevent deterioration of dental health and high-cost treatments for impoverished solo mothers.

General Practitioners (GPs)

As reported previously in section 4.3., several participants indicated current health concerns and need to access a general practitioner (GP). It appears from participants reports that self-perceived urgency

of health concerns, and the juggling of other daily demands as a solo mother, influences the participant's likelihood of accessing GP services.

> Yeah, it is a real concern for me because I want one more child and I keep telling like my cousins and that ...and then when I do want to go [to the doctor for a] check up it's like other things come up, [but] yeah it is a concern for me. (Kimberly)

All participants reported GP services as their main source of healthcare. Access was predominantly for treatment of sickness, but pain was also a motivating factor in accessing GP services.

> I don't go to the doctor. I just don't go unless I'm in bed sick. I just don't. I can't afford it. (Stella)

> After I had my son I got haemorrhoids...They were really painful for me, but that time I think I waited a bit too long before I went to the doctors. It was at its peak...[but] they gave me the medicine for it. I was hoping, you know, they could do something right then and there to stop it because I was scared to go to the toilet...because I was in pain, yeah. (Chloe)

At other times, the need for prescriptions, contraception, or preventative care, like cervical screening checks, motivated the participants' access to GP services.

> I've always just had one doctor that I just go to, so if I needed anything I'd ask him, like with you know if there's any extended [care needed], like if he can help me [he will]. He was quite helpful. (Dorothy)

> Well, when I go to [the GP for cervical screening checks], like I haven't been to one since I've [last] been pregnant, but like before then when I was going. I was going to see one doctor and that was in [locality]. So, she was a female so I was okay with her taking swabs and that. So yeah, I was just a bit [shy]. (Kimberly)

Most participants indicated awareness that GPs are the gateway to secondary healthcare and would access GP services in order to get a referral to other services.

> I think access to healthcare out these ways are good...good prices and sometimes no charge at all...It just depends who's referring you…You can go and they'll write a referral and then they'll send me a letter if it's got to do with my kids and if it's got to do with myself you can just basically ring up, make an appointment and then as long as you keep that appointment. (Dorothy)

Sometimes GPs were accessed because the participant felt overwhelmed and was not coping with life circumstances.

> [My mother] went back to work and I...just couldn't cope and then I went to the, I went to the doctors and then you know I just bawled my eyes and then he stuck me on Aropax! (Mary)

Different types of GP services were reportedly accessed by the participants, including: private practices, Māori health providers, private accident and emergency centres (A & Es), and integrated family health centres.

> Well, my doctor is only a little doctors'. It's private - it's a husband and a wife - there's only two. (Chloe)

It's the [organisational name] accident and medical down [location]...we've been with them for oh just over a year, but used to go and see them because they're, you know, an accident and medical so you know I used to go see them when our doctors' weren't open or other doctors that I used to use weren't open, yeah. (Mary)

Several participants regularly accessed Māori healthcare services and preferred such services. Large clinics, offering multiple healthcare services and professionals at the one location, were particularly popular with participants.

Um it's a Māori organization, but they have different doctors: they have Island doctors and Indian doctors, but other than that...they're Māori...But the last one, they had x-ray there. They had dental. They had blood tests and everything there, but I just didn't need them...only when I was pregnant...there's like [physiotherapy], dentists, x-ray and adult general practice and then under stairs, underneath, was A & E. So that was all in one...So if we went upstairs even though that was our doctors, if we had an accident they'd say, 'Go downstairs, because this is just your doctors.' And I'm like, 'But, you know but, I had an accident.' And they'd say, 'Yeah, but you go down stairs because they deal faster with all that ACC stuff.' (Dorothy)

Hospital emergency departments (EDs) were also reportedly utilised as "free" primary healthcare by some participants in order to avoid unaffordable GP fees.

I know they know I'm only there because I can't afford the doctor. I know they know and I have to wait a long time, but they're okay. They still yeah, they don't treat me bad or anything like that, yeah... because they just take care of me. Well, they...do all the checks, you know, give me antibiotics, you know, do everything that doctors do, but they don't...[say], 'Well, it's going be a long time here!' or something like, anything that makes you [feel bad]. Well sometimes they mention, 'You should go to your GP' you know or, 'Next time you should see your GP first,' but they still are really nice, yeah. (Tia)

After-hours Care

In contrast, participants reported limited access to after-hours GP services. Closeness of services to participants' residence and low-cost fees facilitated access for some of the solo mothers.

Oh, I could [access after-hours care], our A& E over here shuts at ten o'clock...I would go straight to the A & E, definitely. (Chloe)

Cost was reported to be the main barrier to GP access after-hours. Although some participants reported local access to low-cost after-hours care, other participants reported after-hours fees were financially beyond them.

No, the only thing was that if you went to the A & E after-hours, you had to pay like, I don't know…not that much, but a little bit more than you would pay your normal doctor. (Dorothy)

… so I had to take [my daughter] to A & E, the closest A & E that was available and it was going to cost me $52! Yeah, and you know, for me I was in shock [because] that's subsidised, it's $52 and we get a $100 for food a week and they expect us to take [our children to doctors]. (Tia)

For Tia, utilisation of a hospital emergency department (ED) was a "free" after-hours healthcare option.

> Probably hospital. It'll probably, definitely be hospital after-hours. To know that it's $52 for [the A&E after-hours] ...the last time was I had a tooth pulled out and it got infected and my face swelled up and yeah I went straight to the hospital for [after-hours care]. They're my doctors. I'm sure they hate seeing me. I mean they're all emergency departments and everything, but they're free. (Tia)

However, regardless of the cost of after-hours services - expensive, low-cost, or "free" - utilisation was reported to be also dependent upon availability of transport and childcare, which are discussed more fully in section 4.5. For Chloe, the 24-hour Healthline phone-based service was a free and convenient option for after-hours healthcare.

> Um through my midwife…it was actually an after-hours thing you know…yeah someone to talk to, just to [put] me at ease while I was pregnant...I was really pregnant and I couldn't sleep. So I rang up Healthline and told them, 'I can't sleep' and she told me to read a book or something like that, or go watch some [television] and yeah relax. (Chloe)

Community Pharmacy

The solo mothers had all accessed community pharmacies in order to fill prescriptions. The actual pharmacy is selected for reasons of convenience and cost. Participants preferred to fill their prescriptions near home, or near the prescribing GP services. Pharmacies offering free prescription items were helpful; but sometimes prescriptions were only partially filled due to cost.

> Yeah, probably bringing down the cost of the scripts [would help, but] there's a chemist up the road there that they do scripts for free. (Mary)

> Oh yeah of course I do. That's why I say, if I can't afford [all prescription items], 'Well, I'll have that one and that one and I don't want that one.' (Dorothy)

Women's and Sexual Health Services

Several participants mentioned the need for women's health check-ups, such as cervical screening checks, as current health concerns. Although some participants indicated a preference for accessing such checks with a regular GP, other participants preferred specialised clinics, such as Family Planning and at some public hospitals.

> I prefer to go to a clinic because I feel comfortable when I go there... that's where I get all my [sexual health] check ups... I just get a bit iffy, you know. No one wants to go in there and get checked, but you have to for *our* safety, you know. (Dorothy)

Some participants have self-referred to such clinics to access cervical smear checks, sexual health checks, contraception, and termination procedures.

> Well, actually the last time I got my smear test done at the hospital they gave me like about six boxes of condoms and I've still got them in my cupboard. (Tia)

Other participants were referred to Family Planning services by other health services, such as GPs, for specialised procedures.

73

My own doctors referred me to Family Planning... And so that's why I did go to [sexual health clinic]...I remember the lady, she was good, she typed up all my information, and she set up my appointments, she also, you know, just told me what's going to happen. She took me through the whole thing...The procedure of having the abortion: what's going to happen, when it's going to happen. And all these doctors I saw, social workers, they told me exactly the same thing: all of them...I went to my appointment and they told me I had to go out by myself…I had to go by myself and actually make another appointment with the scanning place to go there and get a scan. Ok, and while I was at my first appointment they made me another appointment to go see them with my scans. So that was me go to the scan place, make an appointment and I think I had a appointment a couple of days later, so that was all right. So I had to hold my scans for I think I had another week to go back for my second appointment and then after that they made me an appointment to go to the actual hospital in [locality] and that's when I saw a social worker and a doctor and then after that they made the actual appointment for me to get, for termination. (Chloe)

Abortion Clinics

Two of the solo mothers revealed that they had accessed termination procedures in the past year: Chloe had her first and Stella had her third termination. Both women accessed a public hospital abortion clinic after going through pre-termination assessment processes with Family Planning.

…having the termination, it was really quick. It was done and dusted. It was like 'in-and-out.' That's what it felt like to me and you know it was really fast. I think, they told me what to expect, they told me how you'll feel, you know. Some people don't feel that, they feel fine and then go straight home. As for me, I didn't feel very well because you were – I was on gas while I was getting the termination and I felt really drowsy - sleepy for like just a half an hour. That's it. After the half an hour went by I was absolutely fine. I think I bled for a little bit, but I was fine. (Chloe)

Moreover, Chloe and Stella received contraception advice from clinic staff and were given free access to implantation of long-term contraceptives, intrauterine devices (IUDs), at the time of their terminations.

Okay and I think one of the doctors there asked me would I like to go on [a contraceptive] and they, you know, explained a range of contraceptives to me. I chose... [an IUD], because it was for five years...Straight after the abortion they implanted it...I did find that helpful because I wouldn't have been in any, you know, any state or had motivation to go to the doctors and actually sit there and get it done, yeah, again I would've been too lazy to go to the doctors and get that. (Chloe)

Optometry

Only Tia reported access to optometry services and indicated cost-barriers underpinned her delayed access to prescription eyewear.

I can't see, yeah, I can't see. I'm near-sighted. I can't see pretty much as far as my arms, out...it took me probably 10 years to get glasses. I needed glasses since I was 20 [years], but I didn't actually get glasses until I was 29 [years], and that was because, one, I was vain and didn't want WINZ to be in charge of what glasses I got to choose and so I saved, when my kids went to their father for one time, and I think it took me two months to save up for. It cost me $500 for all the glasses, the optometrist, the - all of those things that go in with getting my eyes tested and those sorts of things. When the optometrist tested me she freaked out that I actually drove. (Tia)

Tia's eventual access to vision health services was facilitated by family support and short-term respite from solo-parenting.

> Yeah, [locality] optometrist. I was living with my mother at the time, didn't have the kids so I able to put all my money into saving for my glasses and yeah. It all cost $500. Paid for it and got these glasses. (Tia)

WINZ reportedly provides around $100 towards glasses frames, but financial aid was not available for optometrist costs or prescription lenses.

> Yeah, my glasses are all scratched and I would love to have new glasses, but again, I'm afraid of what WINZ might give me. So, yes, they'd probably give me good enough glasses to see, but yeah I am a bit vain. I just need money. That's my main problem. There's no money to get me some more decent glasses...Yeah, and I think they give, I think $100 or something. I think the last time I saw them it was $100 and when I went into the shop to look at $100 glasses, yeah, they weren't very good...[So I'll] wear scratched glasses until I get a better job and try - or until I get a job - and then I might possibly be able to finally get new glasses. (Tia)

Tia reported a current concern regarding her need for new glasses, but could not afford to replace her current unsatisfactory glasses.

> Ha, not being able to see, yeah. I need new glasses now. My glasses that I have - I'm 34 [years] - are 5 years old and they're quite scratched and they're flimsy and floppy and [need replacing]... Definitely cost. It's only cost when it comes to teeth and eyes. And health!...but when it comes to my teeth and my eyes it's a constant [concern] always there in your face, you know, with my glasses always falling off all the time, those things I'm constantly aware of... (Tia)

Specialist Services

Undiagnosed and untreated health concerns emerged as issues for one participant. Stella reported this current health concern:

> I've got this thing on my back, but I just haven't been to the doctors and the last time I did go to the doctors it was for maternity so I didn't want to ask them, yeah. (Stella)

Furthermore, Stella had a problem with her foot, for which she been referred by a GP, to a podiatrist; but, the podiatrist fees were financially beyond her means.

> I asked [WINZ] to, I've asked them to help me with a podiatrist fee, because I've got something on my foot, that needs to be taken off, but they said unless I'm working or have proof that I, you know, they can't help. But it's a day to day menace. Like if I'm on my feet all day by the end of the day I'm limping. It's that bad...but you've got to pay $52 [podiatrist fee]...even with a referral, yeah. (Stella)

Another participant, Chloe, reported on a need to see a specialist about her current concerns regarding her ears health.

> I was born with 'glue ear' and I had operations when I was little, but I have a problem with a habit. I play with my ears a lot. I think I, I know I need to go and see the doctors, but I haven't. I need to go see the ear clinic. (Chloe)

Chloe had consulted her GP about her concerns, but the GP insisted nothing was wrong, and she had lost faith in their care.

> Well, when I was last at the doctors...I always tell them check my ears. They always tell me, 'It's fine'. Yeah. Sometimes they ring, [because] I put things in it. I think I need to actually go to a [specialist], someone who specialises in ears, so they can tell me properly what's wrong with it, [because] I think the doctors, if it's not red or looking pus-y, they just say, 'Ah it's looking fine.' Yeah, they don't really know I reckon. I need to go see a specialist. (Tia)

An unexpected opportunity to attend a mobile ear clinic confirmed the need for referral to a specialist.

> ...I think it's only in the summer holidays. They have those clinic buses for the ears...they checked my ears and they said I needed to see a specialist. So yeah I wrote down [my contact details], they said they'd send...me an appointment. I waited for a long time and they never sent [a referral]. Yeah, so I didn't go... I was kind of pissed off because I was waiting for it. I was actually waiting for it. Yeah, and that's the end of it...I think they put the paper in the rubbish. I was actually going to wait until they come back this summer and go tell them about the last holidays. Actually every holidays they go park up...Oh, yes I will. I'll go back to them and I'll let them know, yes. (Chloe)

Subsequent to the missed referral, Chloe was still concerned about her ears, but unsure how to proceed.

> I believe [my GP] can't help me...I want the doctor to give me information about my internal – internally about my ears...Yes I would, yes I would [like to see a specialist]. I don't know whether to go straight to my doctor to get referral or just go straight to the specialist. Yeah, I don't know which one. See I'm a bit confused there. I think that's probably why I haven't gone...[because] I would have to pay to go to my doctor and then, you know, just for my ears they'll refer me to there and I'll probably have to go pay again at the specialist. See I don't know how much it costs even if I go for a check-up I may have to pay them... (Chloe)

Mental Health Services

Four of the seven participants revealed they had accessed mental health services of some kind; one participant's access was in the past, but the other three were currently accessing such services. Stella and Tia are currently attending counselling for issues related to domestic violence and stress.

> I was really badly hurt [and] it got to the point where I was diagnosed with depression. It got to the point where he was literally stopping me from going and see my doctor and my psychologist, [because] he knew it would be my road to mend...It was 'reactive depression'. So basically just a cluster of horrible things happen and you just fall apart. (Stella)

> Well, that's the good thing, [with] what I'm going through at the moment, [tertiary institute] has a counsellor, and a free counsellor, and so I've been there a couple of times...It's not health-related. It's to do with stress that I'm going through with my kids' father about custody, those sort of things. No it's not, oh I suppose it's stress-related...[the counsellors] are awesome. The man I'm seeing, I've forgotten his name, but he's really good and, yeah. (Tia)

However, Mary's access to Māori Mental Health services dates back to an earlier episode. The immediacy of the access to these services was helpful, but Mary's experience highlights the potential tensions inherent in home-based help.

> Yeah, [my GP] probably could of, rather than putting me straight on [antidepressants], you know, tried other ways first and see what worked you know, because I'd only just gone and seen him that once

you know and he instantly writes me out a script for Aropax and, but the good thing in all that was, you know…is it the Mental Health, Māori mental health team they come out? They sent out this nurse - there's a, caregivers or nurses who looked after my son, you know, while I slept and stuff like that, yeah. But that was only for a week and then they realised that I didn't really need it. And some of the nurses were so dopey anyway, you know, and they were making things worse for me, you know! One nurse, you know because I've got my little oldest son you know, she's got the front door wide open and my son's running off down the driveway and you know! And then she's trying to [catch him] and I'm like, 'oh my gosh she's making things worse, get rid of this one!' you know. (Mary)

Cassandra was also currently accessing Mental Health services, but for treatment of her former drug use. In seeking healthcare for detoxification Cassandra had limited information about services and therefore limited options.

Oh, because I didn't tell anyone I was on [drugs]. Only my cousin...if I was straight-up with my doctor, yeah, he would've offered me the help...[but] I was paranoid...I just didn't go to him. That's the whole thing about it. I didn't go to him and…that's why I went to my cousin. I was going to see him, but I was like, 'Far out man I need to do something' and she goes, 'Oh, don't go to your GP. Go to the hospital.' And that was the wrong move I did, [because] I should've went to rehab. (Cassandra)

Cassandra unintentionally, and perhaps inappropriately, entered the Mental Health system as a result of going to a hospital for help, but had persevered through treatment and counselling.

I went into [a mental health unit]...like where people on, oh I don't know, off their brain, out of their mind [go]... they just gave [me]... Risperidone...it's to get off drugs or something like that. Ah, Mental Health just put you on it... they used to inject it in me [but]... I've just gone off the injection... Yeah [because] I'm doing good...but [I've] got to take tablets...[and] when you move you've got to see someone in the suburb...I got transferred to [community Mental Health services]...they're strict...they're good...they always check up on you. Ring up. (Cassandra)

Drug & Alcohol Treatment Services

Like Cassandra, Mary was also a former user of illicit drugs. In these cases the participant's parent and/or children provided the motivation to access health services that could help them to abstain from drugs, and maintain a healthy lifestyle thereafter.

Drugs. I was just on too much drugs...I just couldn't sleep, aye. Nah, I'd be up for like four days and I'd struggle to look after my kids...I just stopped hanging around those people and I just weaned off it, because I used to smoke *every day. Every day*. I'm not talking about [marijuana]. I'm talking about [methamphetamines]...I just thought about my kids. I had to get off it. (Cassandra)

I used to be, you know, I used to be a really bad drug addict...[and] it was because mum had lung cancer she nearly died and that sort of woke me up to everything. Yeah, because you know I just thought, 'if I don't spend time with her,' you know. I knew that she would eventually die you know. I knew that if I didn't eventually clean my act up – because when I was on the drugs I couldn't be bothered with her you know – and yeah and I knew that if I didn't clean my act up and spend some time with my mum that I was going to regret it and you know that sort of woke my eyes up to it and my children they deserve better than that, you know, and then we started going to church and you know I haven't gone back [to drugs] since. (Mary)

Coincidently Mary and Cassandra both accessed Community Drug and Alcohol Services (CADs) by self-referral. Mary's access to services was several years ago, but Cassandra was still receiving regular help.

I think I just went in there. Now why, why did I go in there? I just went. I've heard of them before. I can't remember how I heard, but I knew of them. I've known of them for some time before then…I did. I did go to CADS just one day a week and one day a week for four weeks, yeah, and that was a Māori service… No I just went in there and asked if I could have an appointment and that was after, not long after the incident with mum nearly dying, in the hospice, yeah. (Mary)

Yeah, at first [I accessed Mental Health services] and then I found CADs and got onto them, yeah… I found the [CADs] pamphlet and I rang them up…It was at [the assessment unit], at the mental health [clinic]… they talked to me and I told them all my issues and they said, 'Yeah. You need us.'…I used to go in like two times a month…[for] like drug and alcohol counselling…They were helpful man, awesome. They come over every week…[my care-worker] visits me now because I don't need counselling… we have talks. Like long talks. (Cassandra)

Additionally, CADs provided Mary with access to a Māori-oriented rehabilitation programme, which brought cultural understandings into treatment processes.

Whare Tapa Wha or something, oh no, was it that?…Yeah I think that's the programme that they run or something like that. I know it's got the 'Whare Tapa Wha' because it's got the four pillars that they talk about, yeah, and that was good. Yeah, but it's only for an hour or so, but still it brought out a lot, you know… and as Māori it's good because you know you identify with things that Pakeha don't identify with, you know. They don't see from you know because you're dealing with wairua [spiritual] and stuff like that you know and that's inside you, yeah know…Yeah, and somebody else told me, I can't remember who it was, that they went through CADs but they didn't get the same experience, but they didn't do the Māori part. (Mary)

Maternity Services

With all the participants being mothers the entire sample had had access to maternity services of some kind.

Oh one of them I had at home, but the rest I had in hospital. (Dorothy)

For some participants, maternity services for their children's births and related health matters, was the only experience they had of hospital-based healthcare.

Probably just for birth and that was the only experience I've had with actual health departments because I had never been like going to doctors or you know to get prescribed medicine or, yeah. But a couple of times like throughout my births, like with my children, it was all right, but not with Jay…I was in hospital and they didn't get…most of my placenta out. So that was the worst part of being in a health department for me was because I had dropped with him and we were at home and then about two or three days later I started getting stomach pains and then my son got sick, because he, his bowels were twisted. So we were both in there together. Like I couldn't help, I couldn't do anything, and then when I went for a check-up it was because they didn't get most of my placenta out and yeah. (Kimberly)

In general the participants had very positive encounters with maternity services, with access to scans, midwives, doctors, and maternity wards or units commonly reported.

When I had my son, I stayed four days at the [Location] Maternity Unit, and most mums when they have their baby they only stay there 2-3 days. I stayed there 4 days because I really enjoyed their hospitality, their food: it was yummy…they were good. They weren't in your face all the time. They gave you your space with your baby and they were there when you needed them…I really liked it at

the maternity unit...It was good [because] it gave me that like first 4 days with my son to relax with him and you know getting ready for what to expect when I go home...I would go back there. I would go back there. (Chloe)

No, it's all been really good. I think it's improved actually, a little bit, the maternity side of it. Because I had a daughter way back...a while ago, and it was different having her, than it was having Tama. Now they do actually soothe you through it rather than, 'harden up it's just how it goes'... with Tama I can honestly say that it might have been that beautiful experience that you see in the movies. Because, you know, you're older and you understand your body and yeah well it was the midwife made you feel relaxed and it was really nice. (Stella)

Most participants were very pleased with their chosen midwives illustrated, for example, in Kimberly using the same midwife for all three of her pregnancies.

Well it was, every time I had the same midwife throughout all my pregnancies: my sons, my daughter and she was [my cousin's] midwife as well. And yeah I never went out to see or went out to other midwives or other maternity services, she was coming to me...it is really good because she was really good. Like she, we actually got to know her properly, you know, like as if she was a friend taking care of us, yeah. She was the main 'young mum' midwife...like with me being young, she respected my privacy like me taking swabs and that. It was me you know who took…the swabs from her like, you know. She was a really nice lady overall. Just her nature and her job, you know, it was really good. (Kimberly)

Personal recommendations seem to enhance a sense of trust and familiarity for the participant towards the health professional.

[I met my midwife] through my cousin. She's had all three of her kids and she's seen that same midwife, and she referred [midwife] to me as well. Because yeah I went through her...Oh I was really keen because…just being pregnant, you know, I wouldn't know where to start with to find a midwife and because my cousin's had three kids and she knows me really well I trust her. And so yeah, I went with her and I like her. She was good. (Chloe)

Tia reported having very positive access experiences with her first three pregnancies, but with her fourth she reported unsatisfactory midwife services.

Well Kiri was my last and I've dealt with all other three pregnancies. I had perfect doctors, perfect midwives that all worked together well. They were a perfect team. And then to have on the fourth one this midwife who was really horrible. She'd never had kids as well. And then when I was giving birth she had no idea how to do it. I like practically pushed her out myself, you know, without any help and even though she was my fourth and I should know what I'm doing, it's nice to have someone that you feel knows more than you, when you're giving birth. (Tia)

In sum, the participants reported on accessing a wide range of healthcare services and professionals. Dental health and specialist services were reportedly the least accessed forms of healthcare. Conversely, GP services and maternity care were well-utilised. Mental health and related services had been accessed by most participants when needed. Participants' accounts revealed most access was for curative healthcare, rather than preventative. The reason for this appears to be cost barriers that discouraged the solo mothers' from accessing health services until health concerns had become serious or emergencies. Cost barriers and poverty impacted dynamically on participants' healthcare effectively reducing access options and sometimes preventing access to services.

4.5. Barriers to Accessing Healthcare

Previously, in section 4.4., the actions participants took to address their health concerns were described and illustrated. Of interest was where the participants go for curative and preventative healthcare and why they accessed those certain services. Repeatedly, in the experiences of access presented, the participants revealed financial, childcare, and transport factors that influenced their access options and choices. This next section explores the participants' actions and choices in accessing healthcare further, in light of these impacting factors.

Cost as the major barrier to access

Commonly the participants reported cost as the main barrier to accessing health services and treatments. Overwhelmingly, many healthcare costs are beyond the reach of the low DPB income the participants depended on. This poverty-driven pattern of being unable to access healthcare as needed and when needed, is captured by this 'cost as the major barrier' theme. For many participants, crucial GP services were too expensive to access, even when subsidised through Community Services cards.

> Those are the times when I've had to call my mother and my brother. One of them and they've had to come from wherever, whatever they're doing to bring me, what? [Doctors fees of] $15 or something. That sort of thing. (Tia)

Even very low-cost (under $10) access was at times beyond the reach of some participants. With after-hours GP fees substantially more than regular GP fees, healthcare access in weekends and evenings is well beyond most of the participants, financially.

> Ah, yeah, believe it or not the cost of $7 [GP fees] at one point was too much, you know, it just was. (Stella)

> Well, like I said, I mean they give us a hundred dollars, maybe just over a hundred dollars for food, and then they expect us to - and it's a struggle on just that ...feed all of us and then they expect to pay, something like for my daughter this weekend - $52 for [after-hours care] - that's half of our food for the week to go to a doctor and for me it's not an option. Not an option... [I'd probably not [go to the doctor], because of the money. I'll probably just sit there and wait until something actually happens. (Tia)

Even when they did consult a doctor, the costs related to filling a prescription were the next hurdle.

> I know that $3 [per item] isn't very much, but you know how if you've got like ten [prescription items] on there then that works out to be $30. (Mary)

> ...when I go to the hospital and if they happen to give me antibiotics at the time that I'm there, I might only have half the course and wait until the next time I'm sick, and I'll have the other half. (Tia)

Tia's experience with after-hours access illustrates and supports the cost as a barrier theme. The provision of Accident Compensation Corporation (ACC) cover, to pay for treatment of an "accidental injury," facilitated access to usually unaffordable healthcare.

> ...so I took [my daughter to the A&E] and when the receptionist told me it was going to be $52 I almost turned around and walked back out...I just stood there and said to them, 'You've got to be joking me - $52' and then...because my daughter also had a cold [and] ...a rash...as well as it did have a scratch...the receptionist said, 'So is it your…' - she sort of, kind of, directed me into - 'So you'd kind of say it probably is a cat scratch?' And then…'Cos if it is [a cat scratch] ACC is free.' And so I said, 'Yeah, I'll say it was a cat scratch,' so that we got to see the doctor. (Tia)

Conversely, without ACC cover for specialised health services, such a physiotherapy, participants had their access limited to GP consultations and prescribed medicines or lack of access altogether.

> Oh yeah when I was in bad back pain, yeah you know, and I couldn't afford to go [to the doctor], you know, and I couldn't afford to go so I didn't...[But when I did eventually] go they're like, 'Oh it's muscular.' So it's been like three times I've been [to the doctor] about my back, you know, and they're like, 'Oh it's muscular' you know, and…that's it. Then they give me more painkillers, you know, and they gave me these other things...they're muscular [anti-inflammatory], but they make me feel drowsy so I haven't touched them again...I just put up with it. If it gets really bad then I will...It's not [sore] now, but it was at one time. Yeah it was really bad...my brother's girlfriend said that physio's the best place because they're experts on backs, you know, but that's expensive too, you know. I said, 'Can they do ACC?' you know [but it's] only if you can you know really describe the accident, which I couldn't because I didn't know why my back was playing up anyway. (Mary)

Putting children's health first

Participants demonstrated great concern for their children's welfare and health, at the expense of their personal health needs. This commonly reported tendency to put children's healthcare first means participants regularly forgo access to health services.

> I think I'm always with my kids' [clinic], wherever my kids are. I think I'm always registered with them, but I've never been. Yeah. They know me through my kids, not through me seeing them. (Tia)

Several of the participants reported having children with ongoing health conditions which required frequent visits to GPs, after-hours clinics, pharmacies, and sometimes emergency departments (EDs). Meeting the costs involved in accessing children's healthcare regularly, and the children's health problems alone, created considerable stress for the participants.

> You know, because you know, the kids get quite sick and you don't want to be keeping them home, I mean away from the doctors, because you can't afford to pay for them. You know, like my son, he gets eczema and he goes through all this cream, and I tell him it's not good for him, you know, to use all the cream, you know. You know, and it's just hard because you don't want to take them to the doctor's, because you have to pay for them. (Mary)

> Yeah, because my son...he still had asthma and eczema and my other sons get sick and my daughter gets sick, you know. They need to go doctors... the daycares are going to tell me, 'Look he's got a runny nose,' [so] I'm going to take them to [the] doctors. And that's required by the kindergartens you know or where my kids go to kohangas that they need to know that my son's not that serious that he can go. (Dorothy)

81

As beneficiaries, the participants are a low-income group, and the costs of children's healthcare left little income for the solo mothers' healthcare.

> Oh, cost is always a factor, being a solo mum and on the benefit. Cost, it's always a factor, you know, because you put your own needs aside, because you have other things or your children need other things, you know, and you need food and stuff like that. So you put your own health aside for the… children and…for the house, you know... Yeah, yeah, you know, but then I suppose we have to learn that, you know, our own needs are just as important as everything else, yeah. (Mary)

Not only did participants put their children's needs before their own, they reported a willingness to do whatever was needed to meet their children's healthcare needs; Tia would beg her family for help, or access hospital EDs to get her children's healthcare needs met.

> If ever, say, if I couldn't - I can't remember it ever happening - but if by chance I couldn't get hold of anyone, [then I'd] go and beg people for money to take them to the doctors, then I'll take them to the hospital. There's no way my children will never not get medical care. (Tia)

However, the very low income provided by the DPB can restrict the solo mothers' ability to access healthcare even for the children.

> ...but if it's not just [my GP access], like my son, I didn't take him to the doctor a couple of weekends ago, because of the cost. (Mary)

> With my kids, what I usually do is give the script and say, 'Here, can you let me know how much before you put it through' and then they're like, 'Oh yeah, this one will be $3 and that one will be $8' and then I'm like, 'Ah no, give it [back], I'm going to go somewhere else. (Dorothy)

Difficulties with transportation

Even if a participant reported an ability to afford access to health services, a lack of transport emerged as a barrier to access in some participants' accounts. Stella reported on a time when she needed assistance: "Yeah, I had a midwife with my son who came and picked me up from my house because I didn't have any transport and she picked me up and took me to the hospital to have my son." The theme of transport difficulties as a barrier to access recognises the impact of not owning a car, costs to run and maintain cars, lack of support with transport, and problems with public transport.

> Yeah, well, I need a car and I've only just managed to get a [car]. I was three months without a car and it's impossible. Your children are sick and then if you've got no car to try and [take them to the doctor]. You can't carry them on your back to take them to the doctors and so I've now bought a $500 car and still paying my debts off from this $500 car and it has no warrant, no registration, the bumper's falling off. It's a piece of crap, but it goes really well and it gets the kids to the doctors as well as on rainy days gets them to school. But if I didn't have a car it's *impossible*. (Tia)

However, the cost of petrol and expenses involved with car registration, Warrant of Fitness, and repairs can contribute to transport difficulties even for car owners.

> Oh, that's a problem it's got no warrant or rego at the moment. Because I had to pay for something to be done on it. I was like, 'oh what a pain', and WINZ wouldn't pay for it, you know. (Mary)

Being unable to access a preferred and/or regular GP was also reported to be a result of residential relocation and flow-on challenges with a lack of transport and the distance.

> I just recently [moved]. I would [go to my regular GP] when I was living in [locality], but not now because I've moved too far and I couldn't afford to go see her. (Stella)

Public transport, including bus and train options, was reported to be helpful by some participants. But public transport would be unsuitable or impossible if fares were unaffordable or where healthcare was needed for: childbirth, serious illness, or after-hours care.

> …how many times do you fall sick on the right times? You know, the right time of day and those sort of things, and feeling all right to go on a bus for half an hour to get there?...[Yet] for some reason [WINZ] think it's okay to have us on public service. It is [under] normal circumstances, but once the kids get sick you can't be in public service and I don't have [family support]. Like I said my family live all over Auckland. (Tia)

Ambulance services were seen as a last resort for urgent health matters. For Dorothy a speedy labour and delayed help with transport created a need for emergency services.

> My sister actually pulled up because she was coming to watch my kids. While my other sister was coming to drive - take - me to the hospital, and as I was lying on the floor talking to the lady on the 111 waiting for my sister to come, or my *sisters* to come to do their jobs...my sister that was supposed to be there to watch my kids, she actually took my pants off and - because I couldn't get up - I was lying down by then...Yeah I just pushed and baby's head came out, and then I pushed again and he just came out...I was in labour for like about 50 minutes, 40 minutes, before that. So yeah…the ambulance came and took me because the baby was out and it would be safer if I went on the ambulance with the baby, yeah. Because they had to check the baby out...Yeah, and I was ok. (Dorothy)

Difficulties with childcare

A lack of childcare was also considered to be a barrier by most participants. Taking children along to GP appointments or accessing after-hours care with multiple children was considered stressful and sometimes unsuitable.

> …up here they close at 8 [pm], and you have regular hours [until] 8 [pm], so it's pretty good. Ummmm just money and being a solo mum really. You know? Sometimes you're sick and you don't want to drag your two children up to the doctors... (Stella)

When Tia needed to access hospital dental services, it meant taking her young daughter too; this was not the preferred option, but it made it possible for her to attend the clinic.

> Cost-wise my daughter had to miss this day, off at school, because we had to be sitting at the hospital at five-thirty in the morning and then I didn't get seen till approximately twelve o'clock in the afternoon...I had no choice but to take my daughter with me. (Tia)

Lack of childcare, when a solo mother needs maternity care around child birth, is a barrier to access and influences the underutilisation of health services.

Actually…we were down in [the] emergency side and they checked baby, checked me. All good. Then we went upstairs, they got us a bed and then by the next day just before lunch I was, I just wanted to get picked up and go home. Yeah I don't stay there and relax [after the birth]...[the next day] I went home and cleaned the house, you know, I didn't even have time to sleep. But I cleaned the house, cleaned the mess, done the washing, cooked dinner, and then the kids came home from school. (Dorothy)

Solo mothers would find health emergencies or hospitalisation extremely difficult to deal with if they had no help with childcare, as Stella illustrates:

Yeah, but I was in really bad pain, but there was no way I could ring an ambulance because I had my three year old son, you know. So, I had to drive all the way to [locality] in this mega-pain, track down my friend and then be driven to the hospital. (Stella)

For Mary the lack of childcare meant uptake of the services she had waited for was impossible. Better support of solo mothers' in overcoming drug and alcohol problems could be an effective targeted form of healthcare and use of health funding.

...and I couldn't do [drug treatment] because my mum had found out that she had lung cancer you know and she couldn't look after my kids. So, I couldn't do it, but you know, but if they'd have taken me at the time, you know, which is where I reckon they need the funding...with the drug scene. (Mary)

Mary revealed, however, there may be a fear that government help with childcare may result in removal of children from the solo mother's care.

I don't know about [CYFS] taking care of your children, because they end up keeping them, don't they, and you have to work hard to just to get them back. (Mary)

Low quality healthcare

Patterns of inappropriate, inadequate and unsatisfactory healthcare and treatments emerged across participants accounts of access. Where participants encountered low quality healthcare, or their children's healthcare was perceived negatively, such experiences can become barriers to future access of services. These collective accounts of substandard care or service provision are themed as 'low quality healthcare.'

Yes, it was a doctor. It was just like a quick in and out...But I actually wanted to know what it was. Why is it there, you know. Yeah, and he just told me, 'It's nothing to worry about.'...I don't feel like going back to...that specific doctor. (Chloe)

[My children] need to go [to the] doctors and from him I felt, when I did come in, it was either too serious or when I come in it was not serious enough. So I don't know why he was looking at me like I'm being an attention seeker...I'm like, 'Oh my gosh, don't even look at me like that.'...I probably like not want to go [back]. I still would have [gone] there, but only in like, you know, like dire straits. If I was like dying. (Dorothy)

Avoidance of undesirable pharmacological treatments and lack of alternative treatment options, can lead to untreated health problems, like depression, and non-access of GPs.

...I got post-natal depression with my son, my youngest. Yeah and they had me on these Aropax [anti-depressants] yeah you know, but when I got back into the drugs I didn't need them anymore. So you know maybe [depression] was an underlying thing and once the drugs were gone it got brought up again, but I didn't want to go to the doctors because I didn't want to go back on the Aropax. (Mary)

For other participants, negative experiences of primary, secondary, and maternity healthcare services were reported. Low quality healthcare can place immeasurable stress on a solo mother already overwhelmed by her circumstances.

...I suppose I had lost a lot of weight as well and when I had [an] appointment [with the midwife] she came to my house to do a check up to make sure everything was all right. She freaked me out and said I'm starving my baby and if I don't do something that they have to, that I have to get a scan and I probably have to be induced to bring the baby out...something like that, because I was about seven months pregnant. Anyway after all the crap I'd been through, to have to start worrying about and then I went to the hospital and they said she was perfect and healthy... Oh it was horrible, because I already felt horrible for the situation I was in, being pregnant again, and to have this woman to tell me I could be like starving my child or that she's going to have to be ripped out of me. Oh my gosh, I was devastated. Plus the hormones going on with being pregnant, you know. Yeah, I just remember being so scared being at the waiting room...then, they just said...'Your baby's beautiful, it's healthy, you know, the heart's beating all fine, perfect size dadadada.' And I walked out like, 'Cow!' All I could think of was she was a cow. (Tia)

Stella believed her experiences involving low-quality care were because the provider only cared about money. The perceived exploitation of beneficiary's access to WINZ financial aid would be entirely unprofessional and unethical in health service provision.

Yeah, I'd say quite a few times and it comes down to their nationality. Unfortunately, you know, quite a few dentists are [ethnic group] and things like that and so they don't really know our culture. You do get that feeling, you know, and you think that they're like, 'Yeah, we'll just write out however much it is because she's going to go to WINZ because she's on the DPB', you know? And it's not like that. (Stella)

Furthermore, Stella had lost a valued piece of jewellery while a patient in hospital, colouring her trust in the system.

I had a piece of jewellery at the hospital, like really nice 14 carat white gold, very precious to me. I was sedated under morphine most of the day. I had to go in for surgery, and for some reason this nurse...chose to give it back to me like minutes after I'd come out of surgery and I could barely hold the pen to sign the thing. It went missing... (Stella)

Judgemental and critical attitudes of health professionals

From several accounts emerged a pattern of unhelpful encounters with healthcare professionals and health service workers who did not convey a positive, caring, and helpful attitude towards the participants as patients, related by Stella as, "I kinda feel frowned upon sort of." Mary encountered judgemental attitudes when she sought treatment for drug use:

Yeah it did! It did hinder it, because you know I thought you know, all these places aren't very helpful, you know, why even bother. You know, here's someone who's trying to clean their act up and you know these people aren't even willing to help. But then you know I can see it from their side too because they help so many people and these people just go straight back into [drug use], and you know. But then they can't judge you know one person, a person, on all these other experiences. You know they've got to put all those others aside and you know they've still got to be able to obviously try

with someone you know and regardless of the outcome it's not their money they're spending you know. (Mary)

Several participants gave accounts of GPs who were hypercritical, failed to listen respectfully, or dismissed their concerns, all of which were troubling and insulting. A message that appeared to emerge was that participants held expectations of GPs to be family-oriented.

> Ah, my kids were jumping all over the place and he growled them and he pushed one of my kids. And I said, 'Don't you push my son,' you know. Don't you dare push my son. If you're a family doctor why don't you have a box of toys or something? All right they're going to play with your stuff because that just what kids do. What do you want me to do? Tie them up to the chair when we come in here? But then what will you do me for abuse? And if I leave them it's neglect. I feel like I have to leave my oldest son with the other three in the car and take the other two in, or the other one, because I can't bring all of them in because they just run riot....that's why I said, you know, 'I keep on coming here because I know I don't have anything to hide and that's why I come here. And even though you've rung the authorities on me, I still come here.' But then after a while I just didn't have faith in that doctor and his ability, his trust in me, as a mum. But yeah it's like doctors don't listen to the mothers. (Dorothy)

Another example of unhelpful attitudes encountered in healthcare involved a disgruntled receptionist at a sexual health clinic who disapproved of missed appointments. An attitude of understanding would be more appropriate, as the receptionist was not aware of the participant's personal responsibilities.

> I felt that because I had missed a lot of appointments and the lady at the desk wasn't very happy with me. And when I come I was like: 'Look,' you know, 'all right I missed some appointments,' you know, 'get over it,' you know, 'I'm here now so can I go see the nurse?' Then so she goes, you know, with a big attitude and saying, 'Oh so you just want a regular check, is it?' You know, because there was people in the waiting area who heard everything she was saying to me and I felt a little bit like... (Dorothy)

Waiting...waiting...

For participants, waiting times emerged as a commonly perceived problem in accessing healthcare. The theme of waiting as a barrier encompasses waiting in GP practices and clinics for appointments, waiting times for hospital-based healthcare, delayed access to health services, waiting for medical procedures, and delayed access to GP services. Waiting in GP waiting rooms for considerable periods of time, despite pre-booked appointments, was considered as highly negative and inconvenient.

> We go in, you know, but we could be sitting there for hours just to see a doctor, but you know, when there is time-appointments for seeing people. But, you know, it's like an hour later or something. (Kimberly)

Moreover, when accompanied by their children, participants reported that having to wait in full waiting rooms was stressful and may result in a solo mother not accessing GP services.

> Yes, when I have my son, yes. Sometimes I have him and I have to take him. My son is not easy to [get to] just sit in one place. He cannot sit in one place. Yeah. So that's a stress there for me, you know, having to manage him while waiting...it gets annoying waiting, but...if it's for me, I'm going there

for a reason so I don't mind, but if I have to wait longer than an hour, [then] I'm over it, you know, I'll probably leave, yeah. (Chloe)

Likewise, unavoidable waiting periods at hospitals were common complaints from the solo mothers who had accessed EDs and dental clinics. However, while waiting was inconvenient and extensive, solo mothers put up with it in order to access the urgent, free, or low-cost healthcare they needed.

> Yeah, the hospital dentist. The [locality] hospital does dental work: $40 for extraction and you have to be there by 4:30am in the morning, 4:30-5:00am in the morning, to wait out for - they give twenty...boards out with numbers on it and you have to be one of the first twenty to get one of these boards and then you get to have an extraction for $40. (Tia)

Another participant, Chloe, expressed considerable concern about the wait for a termination as it took her weeks to get through the system-required procedures and appointments.

> The delay, I think I was getting worried that, you know, the longer it took to get through it to see the doctor, you know, I was worried that I couldn't get a termination because you be a certain time to go for one. Yeah, you can't just go whenever you want. Yeah and I thought I was going to be...too far ahead...to go get one. But that's all that was going through my mind with that delay there...the only problem with [Family Planning] is you've got to have three appointments and they're not like a week, it could be two weeks apart, you know. Like something like that. That was the only negative with them that you have to wait for your appointment. Yeah, for the next three appointments really. (Chloe)

Mary discovered that there was a shortage of drug treatment facilities and services as well as delays for acceptance into detoxification when she tried to get help for drug use. Months of waiting for availability of and acceptance into treatment facilities were failure to provide healthcare when access was needed.

> ...when I was trying to find help out there it wasn't available, you know, and well it is available, but they need you to wait a certain length of time and I needed something there and then. Which is what
>
> it is like for a lot of people you know, but you know, they wait and the problem gets bigger, you know. That's the way I see it, and you know. Yeah, I went to this one place and I had to go into detox, but you know, I had to apply for it and then I had to wait, and it wasn't until about two, three months later that I actually got accepted in there and by then it was far too late, you know...(Mary)

In sum, section 4.5. presented barriers to access thematically as found across participants accounts. The main barrier to access is cost, because participants had low incomes which created impoverished living. Poverty and healthcare costs meant participants tended to put their children's healthcare needs before their own healthcare. The lack of transport and childcare emerged as barriers also; inability to get to services and/or childcare responsibilities sometimes prevented or limited healthcare access. At the service level, the participants reported low quality healthcare, unhelpful attitudes of health professionals, and waiting as unsatisfactory, disrespectful and inconvenient leading to minimisation or avoidance of access to certain professionals and services. This section illuminated the participants' expectations of fairness, quality and respect in accessing health services; although poverty reduced their options in many ways, participants attempted to exert their right to choice, even if that was limited to their refusal to access certain health professionals and services.

87

4.6. Moving Around the Barriers to Access

In spite of the barriers preventing or limiting access, the participants shared numerous examples of healthcare access experiences as solo mothers. These reported experiences were highly individual and yet commonalities emerged upon analysis across all interview accounts. The participants' healthcare encounters revealed the complexities of access as experienced by Māori solo mothers as they strategically navigate the various barriers to access. This section explores the limited options in access that confronted the participants and their perceptions and choices, if there were any, in achieving healthcare access. Emergent themes that capture the participants' healthcare experiences and preferred access outcomes are now presented, described and illustrated with participants' responses:

Having a Regular GP

Where transport and other factors allowed, participants overwhelmingly reported a preference for access to a long-term, regular GP. The main reasons given for this preference were that medical history is known, and trust was developed over time with healthcare professionals.

> Yeah, that's like [with] my cousin - I've asked her to come to our doctors, but she won't because she trusts her doctors and it's kind of like that trust. That trust feeling, yeah. (Kimberly)

The participants' accounts highlighted the qualities they commonly sought and valued in a regular GP: caring, gentleness, kindness, thoroughness and trustworthiness.

> Um he's just - he's just more mild and isn't so uptight and he's [ethnicity] yeah, but he's more calm... (Dorothy)

> I feel really comfortable there. I feel comfortable. Yeah, I kinda relax and feel comfortable and safe with that doctor and talking to them. (Chloe)

Familiarity also emerged as a strong factor in participants' preference for access to a regular GP. The long-term nature of the participants' GP-patient relationship, sometimes from childhood, meant the solo mothers' medical histories were well-known.

> Yeah, yeah, I would. I've been ever since I was little. But yeah I will carry on and my children are with them, you know. I'm happy with them. (Kimberly)

Long-term association with one doctor or practice was considered particularly helpful as it reduced repetitious consultations and minimised missed health problems through lack of historical knowledge.

> I'm a member up there and I'm going to go see a doctor tomorrow, her name is [doctor's name]. So, if she's the lady I think she is I might just get her card so I remember her name. Because that's another thing that's not pushed, to have a regular GP, which I think helps. A lot of these clinics are fine to put you in and put you through with anyone and my son, one of my children, has extensive health issues well has had extensive health issues, and you find yourself repeating yourself. And then that doctor

doesn't really quite grasp what you're getting [at] and the seriousness of what it could be and it's sort of dismissed and you sort of go home a bit [frustrated]. (Stella)

Additionally, participants often registered with a regular doctor on the basis of GP specialisation, which can reduce a solo mother's stress.

Oh, she's awesome. She's really awesome. My son has asthma and a lot of doctors don't know that much about asthma and she seems like a specialist because I've been dealing with his asthma since he was born so I know a lot about it and yeah, she knows, really well. A lot of doctors don't seem like specialists, but she's really good, love her. (Tia)

In contrast, it was reported that larger low-cost primary health clinics tended to randomly assign patients with 'the next available doctor,' which prevented participants from developing trust and familiarity with one specific GP.

A lot of times I've left doctors, like I said, worse than going in, you know. Even if they do treat me or my child, a lot of times with my children, they have no idea, you know, because I have different doctors they don't know their history and they see something and they think, 'Oh God' and the way they talk to you it's like, 'God, what are you doing to your children?' or something like that. (Stella)

Emphasising the *Care* in Healthcare

Many participants emphasised the importance of their GPs' attitude in helpful healthcare access. Participants valued caring GPs who consulted thoughtfully and thoroughly; a perceived 'caring' attitude is a strong factor in participants' selection of a GP and in remaining as a regular long-term patient.

I had a really good doctor out in [locality]. She was really good, [doctor's name], she used to - if I cancelled an appointment - she'd ring me up, you know, just to make, you know, 'are you all right?,' you know, things like that.(Stella)

GPs, and other health professionals, who were considered to be caring and helpful, impacted positively on participants by providing positive healthcare experiences, which promoted future access.

When she talks about things, it's her tone of, you know, she talks like she's talking with you she's not talking at you, you know, she's not…There's no undertone or anything, she's very honest, very common, the way she deals with you. Like I said, when my partner and I went in that day she handled both of us very well, you know, and she just makes everything go smooth and you feel reassured afterwards. Like 'I'm glad I went' rather than '*oh shame*' you know? (Stella)

Conversely, participants felt unsatisfied with health professionals with whom they perceived to be money-driven and too time-conscious; such healthcare was considered to be uncaring, low quality, impersonal and rushed.

I wasn't satisfied, you know. I think sometimes doctors are stressed out - not so much stressed, you know, they got other patients to see so they just deal with the patient they have quickly, just to get to the next one. Yeah, maybe that's what it was – I wouldn't have a clue –but I wasn't satisfied with walking in there with the information there. (Chloe)

Yeah, because it's just really in and out. They just ask you to examine and then prescribe you and you're out the door. (Kimberly)

Participants who had experienced "uncaring" healthcare tended to avoid accessing certain health professionals or services thereafter.

...I don't mean to rude, but it's a fact. I won't go to an [ethnicity] doctor or a [ethnicity] doctor because I don't believe they really care. You know, you just feel in and out and I know, I don't know if it's just the way that they are, but I don't like the way they are. Even with my children I don't like it. (Stella)

Achieving Access: Balancing the barriers

Participants commonly reported access problems due to: distance to and between health services; lack of payment options for GP services and prescription-filling; offering free screening checks on specified days; and lack of GP reminder systems. Accounts reveal that seldom is there a single barrier to access; rather, participants were often faced with multiple barriers and needed to juggle one barrier against another. Thus, sometimes the lowest cost service was forfeited because other factors impaired access.

Yeah because it was all there, you know, because and when the blood tests moved, then we had to go when I was pregnant and had to get bloods done, I had to go all the way to [location] to get them done. Because they had moved from - because they were all like in the same spot - I had to drive all the way to [location] with the form to get the blood tests done. (Dorothy)

...[tertiary education provider] has a doctor that's ten dollars for students, yeah, but yeah I should register with them. But it's the fact that it goes with study it kind of takes it away from where my children's are so that's why I haven't really registered with them...Yeah, I suppose I should, but it's always because I am a solo mother and because sometimes the financial things, of getting into the city to go to the doctors, those sort of things as well as I mean, if I'm sick to have to come all the way into the city to access it, is quite [difficult] and I can't drive here, because of the parking and all those sort of things in the city. So it's not - what's the word? *Easy*...I mean...how many times do you fall sick on the right times? You know, the right time of day and those sorts of things and feeling all right to go on a bus for half an hour to get there? So, but it is nice that it is there. (Tia)

Participants' accounts indicated that they were more likely to access healthcare when barriers, such as cost, travel distance and waiting time (see Section 4.5.), were reduced. However, examples were given to illustrate that participants' decisions may involve balancing one barrier against another. Costs and payment options, geographical location, and organisation of services are reported on individually.

Cost. Yeah. And then if it's free, if someone's going to come and tell me it's free it'll probably on the other side of Auckland. Or a ten hour wait to get seen. There's always those things - you can't just, you know, go to a doctor get your checks, those sort of things. It's always everything. (Tia)

In another example, free services could not be accessed because the day was not convenient.

Well it was free you know...because I was Māori it was free you know. Only it was lucky that I went to the doctors at that time because it was going to expire soon, so you know. Yeah, so that was lucky...I think the barrier for me, why I did put it off, was that it was only free on Wednesday and I was busy on Wednesdays so, you know, I didn't go there. (Mary)

Costs and Payments

According to all the participants, the availability of low-cost healthcare, including GP services, dental care, and prescription-filling, was commonly reported to be helpful in promoting access.

> So initially I registered with one doctor closest to me and it was something like, I don't know, $40-$50, not too sure, and then I got a advertisement in the local paper for a [Māori health provider further away] and it was probably about a fifteen minute drive to get there, but it advertised being free for children under 18 [years]. And so I thought, 'Well, that's the best' that I could get for where I was, being free. (Tia)

> I think access to healthcare out these ways [is] good... Yeah good prices and sometimes no charge at all. (Dorothy)

Inter-account analysis further revealed participants with local access to low-cost ($10 or less) primary healthcare, including GPs, after-hours, radiology, and pharmacy, reported easier and more frequent access to such services with less cost-based limitations.

> Ah with the Community Services card it's $8 for me to go and see my doctor...I don't not go. (Chloe)

> Um, it's $15...It's affordable. (Cassandra)

> Ah for adults: $10. That's like during the day. (Dorothy)

> Ah, yeah. $10. (Kimberly)

Additionally, when GPs and community pharmacies offered flexible payment options access to services and treatments was facilitated and discomfort for participants was reduced. Being on a low and fixed income, participants did not always have the cash available, especially close to benefit day.

> That and the other thing is allowed on our first visit to not have to pay because I had no money. So she allowed that as well and, which was really good. Ah, I think there was a $5 fee on top of it, though, but it still at least it got me through to Tuesday – [until] pay day... And if it happens to be on a day when I might not have any money and I've taken the kids, I've never come across the chemist not giving [the prescription] and then letting you pay [until] Tuesday. (Tia)

> Oh, you can book it up. Pay later...I just tell the doctor I can't pay and he says, 'Go and see the front desk,' and yeah. (Cassandra)

Location

Even though most participants own vehicles, they reported that the location of services in relation to their residence made access easier or more difficult. Health services situated locally or near public transport, including bus routes and train systems, were considered easier to access.

> ...if we move into an area I'll register them and probably the first is the closest. (Tia)

> No, no distance isn't a problem. It's just up the road. (Mary)

> Distance? Oh no, I'd train if I was to go [to public hospital] or something. (Kimberly)

Most solo mothers indicated a preference or need to access "local" healthcare; but low-cost healthcare is reportedly not available in many Auckland areas. For women in these situations, they

were faced with a trade-off between cost and geographical ease of access. Thus, the availability of low-cost healthcare services in the woman's local area impacts on her ability to access needed services.

> It's too - it's too difficult. I would have to catch a bus all the way there and I'd probably have to miss [classes] to do it, but then again I suppose I could [access healthcare] at the [low-cost tertiary institute GP] …those sort of things, but it's only just come up in the last weekend. So, I probably will watch it, see if anything gets worse, and then actually do anything about it. (Tia)

Furthermore, participants' accounts revealed that the lower cost GPs and Māori health providers are commonly located in areas classified as high deprivation, but solo mothers and their families don't reside only in high deprivation areas. Participants living in low deprivation areas reported more private practices which tended to charge considerably higher GP fees. Yet other participants on equally low-incomes resided in Housing NZ properties located in low deprivation areas with no local low-cost primary healthcare to access.

> I live in [locality] and it's quite a ponsy area with quite rich doctors in the area, [but] I just signed up, when I came back to Auckland, I just signed up with a GP that's quite reasonable I think. She's, I think, it's either $26 or around $26 which is really, *really* reasonable for a doctor...My neighbour, she told me [about] her, because she told me how cheap it was and …pretty local. She's about ten minutes away…oh yeah, [and] the kids are only $11 as well which is *really* good *and* I can see her on the same day. As soon as I ring up, like then she gives [me an appointment]. (Tia)

> Yeah, yeah. That's true. Um, there's a lot more access out south Auckland than there is out here. I've definitely noticed that. Because there are doctors out south Auckland who will pick you up if you need. (Stella)

Organisation of Services

Participants who were fortunate enough to reside near large primary care clinics, which offer multiple services at the one location, reported these "one-stop-shops" were not only convenient, but also saved time and money in travelling.

> [My GP is] part of a big clinic...They do ultrasounds, blood tests, ... a chemist,...He does a lot - smear tests and everything...Have you been to [location & health provider]? (Cassandra)

Moreover, the busy solo mothers' benefited from the convenience of service organisation which facilitated easier access to needed healthcare services.

> They had midwives there where my doctors were. They had the midwife come every Tuesday – Wednesday and we'd go on the other side of the room, beside the doctors, [they] would be there. So everything was there. Yeah, so when they had to do the bloods it was only across the road, which they'd get the results later. Just do the bloods, take the paper. Very accessible. (Dorothy)

Healthcare professionals and services that provided home-based healthcare or supported home-bound solo mothers was particularly convenient. Maternity care and services during post-natal periods, when participants are dealing with the demands of pregnancy and infants, and other young children, were highly valued.

> And yeah I never went out to [see] her or [go] out to other midwives or other maternity services, she was coming to me. (Kimberly)

Connectedness between social and health services

As beneficiaries, all participants were clients of social services, and connectedness between social and health services emerged as a facilitating factor in access even when the connection was accidental. Several participants had gained access to health services through referrals, self-referrals and recommendations from social services. This theme highlights how interconnectedness within health and social sectors can facilitate timely access to healthcare. Chloe reported health service information from WINZ:

> Ah, dentist[s], I just think it costs a lot of money, but I've actually been to a seminar with WINZ and they actually told me specifically, they told me there's a doctor here and they charge you $40 with a Community Services card just to pull teeth out. (Chloe)

Timely referrals to helpful health services, such as counselling and drug treatment programmes, were reported as arising from community-based organisations or government agencies. For Stella, it was "through the Police" that she accessed mental health services:

> ...I do group counselling and I do single counselling on my own as well. ... probably at the moment, it's my medicine. It really is...and something I should have been pushed into years ago...I wouldn't be where I am now...because it's something I feel very passionate about: womens' domestic violence [and] breaking the cycle [because] I've got four children to four different men and every single one of them beat me [but] mostly the last one. (Stella)

As an example of "accidental" connection, it was the Salvation Army's provision of food parcels that led to Mary accessing the drug addiction rehabilitation she was desperately seeking.

> And the lady that took me in, and you know I was sort of like rock bottom kinda then...I think I ended up just bursting into tears about things you know and I just went through for the assessment with them and then I got assigned an appointment...I went for a food parcel and then I was put onto the Strengthening Families and with the Salvation Army...And then they come out and then I got given a mentor and her name is [name] and she's one of my good friends now, you know. She's the one who took me to church and stuff, you know and then I moved on to the life skills programme, you know, everything sort of slotted into place as I was going along, you know. It was good timing you know because I couldn't be overwhelmed with too much then, you know. Because I wouldn't have stayed on track. Yeah, you know, so it sort of went slowly, yeah. (Mary)

In summarising section 4.6., one of the most significant findings to emerge throughout this section is the complex and proactive way the women approached access barriers; they weren't passive or unmotivated, but weighed barriers against another in an attempt to get desired access outcomes. Also of significance was the pattern within the health sector of establishing large low-cost clinics with interrelated services in areas deemed high deprivation; however, it became apparent through participants accounts that the low-income participants resided in areas varying from low to high deprivation. The seemingly imbalanced distribution of low-cost primary health services promoted access inequities among participants. With evidenced cost-barriers limiting primary care access participant accounts also indicated greater connectedness between social and health sectors could promote access of Māori solo mothers with health services.

4.7. Improving Māori Solo Mothers' Healthcare Access

Each participant was asked what outcome from this research would most help them to access healthcare so they could better take care of their personal health. Through the participants' responses emerged four main areas they perceived as crucial for improved health and healthcare access for Māori solo mothers. The themes for improving healthcare access, as suggested by participants, include: funding for GP services and dental care to reduce access costs; improving GP services by reducing waiting times and providing transport help; integration of dental services into primary health care; increased awareness of Māori solo mothers' healthcare needs; and better support for healthy lifestyle choices.

More Healthcare Funding

Several participants emphasised the need for increased funding for primary healthcare. The solo mothers feel primary care costs need to be reduced or removed so their low income is not a barrier to access.

> Easier access, you know, whether it be subsidy-wise or, you know, Māori clinics that get the, you know, the funding or whatever. (Stella)

They suggested a 'blanket' subsidy scheme, whereby all solo mothers access primary healthcare at the same low-cost regardless of local GP services; they were adamant WINZ should not be involved in the dispersal of funding.

> A blanket thing, to do with Community Services and subsidized. WINZ is just too much protocol. (Mary)

Moreover, funding to reduce the cost of healthy food and fitness facilities, so Māori solo mothers can make healthy choices, was considered important. Providing cheap gym membership and childcare facilities would facilitate access to regular exercise, which would reduce solo mothers' stress levels so they can care better for themselves and their children.

> Easier for me? If they...make the healthy food cheaper, and if gyms were like, gyms were much cheaper maybe. Yeah, because it's not that cheap. (Chloe)

Improved GP Services

Several participants mentioned pick-up and drop-off services would reduce transport barriers in healthcare access. Participants would like to see GP services and possibly pharmacies more accessible and responsive to users; this would provide easier access for solo mothers, which may reduce occurrences of delayed or non-access.

Anything, one, the main thing that's a really cool idea to have, for solo mothers, to pick them up to take them and that's the *only thing* that would stop me be able to take my kids to - and that is a *real*, a real issue...Maybe the doctors, if they had one of those [pick-up and drop-off] services for solo mothers, because WINZ doesn't give us anything for a car...[and] my mother lives on the [locality], my brother lives right down south and yeah, so those sort of services would be definitely helpful. (Tia)

Participants overwhelming rated waiting as a major inconvenience in accessing healthcare services, especially when accompanied by their children. If scheduling of appointments was improved so that waiting times in primary healthcare services were reduced significantly, occurrences of delayed or non-access may be reduced, particularly for solo mothers without childcare support.

They just need to be on time really, for us, for our appointments. (Chloe)

Dental Services within Primary Healthcare

Dental health is a major concern for participants and the cost of dental care is the main barrier to access. All participants would like to have regular dental checks and to access dental treatment as needed. Therefore, they suggested increased funding to integrate dental health services into primary healthcare for provision of subsidised low-cost access for low-income populations.

You know, the same sort of funding for doctors fees, you know, yeah. (Mary)

Under the primary healthcare system, dental services could be offered in family practices, rather than through the disconnected education and private sectors; this would enable solo mothers and their children preferred access to regular dentists.

Yeah, that you have one place. You know, like how you have a doctor that knows all your history about you. It would be good to have that with a dentist. They have portable dentists, dentists at schools, dentists over there, like none of them are connected together. (Dorothy)

Increased Awareness of Health

An 'increased awareness' theme encompasses Māori solo mothers' awareness about health and improving health as well as understanding the importance of accessing healthcare to maintain good health.

I hope that it helps, you know, solo mothers, like other people, other parents, in knowing that health is a big issue, like, for most of us. Yeah, just, I hope it just kinda gets to people, like treat yourself good and go to healthcare and check-ups. (Kimberly)

Furthermore, health professionals and social sectors need to recognise that solo mothers need help in taking care of their personal health.

> Like taking care of yourself, like diet, regular check-ups, go see the GP and that. Yeah, they got to take care of themselves so they can take care of their kids and that. (Cassandra)

Stella expressed a need for Māori women to gain insight into unhealthy aspects of contemporary Māori culture, in order to understand how unhealthy behaviour impacts on women's health, and indeed, on their lives. To achieve this Māori women need health education and support to overcome unhealthy situations.

> And a definite, you know, I think a look at the connection between health and domestic violence...how it can make you physically and emotionally, which affects everyone and everything, I think... Yeah, and not a lot of Māori women will admit that. Some Māori won't admit that, because they've been in it their whole lives...it's not healthy. And it's because there's not help there. I was brought up knowing different, but couldn't get out of where I was at, you know...I mean when it comes to crime or whatever, there's this Māori culture, well there's a Māori culture with your health and with life behind closed doors. You know? (Stella)

Emerging directly and collectively from the participants' lived experiences these suggestions provide definitive areas for needed change in order to improve healthcare access and health outcomes, for the Māori solo mother population. The key concerns expressed by the participants related to greater targeted funding to: reduce healthcare costs and make healthy choices the affordable choices.

4.8. Being Māori, a Solo Mother, and a Beneficiary

The participants as a group are marginalised in several ways: as Māori, as women, as solo mothers, and as beneficiaries. Māori women are demographically over-represented in the solo mother population and the participants' insights and experiences shed light on this complex, dynamic situation, why it continues, and the role of healthcare. According to participants, issues at the interface of culture, healthcare, and solo motherhood, include: cultural barriers; contraception options; expectations of Māori health providers; stigma and discrimination. However, it must be acknowledged that the information reported here represents the perspectives and views of the small sample of women only and cannot be generalised.

Risks to health of urban Māori solo motherhood

This theme captures the inter-relational aspects of contemporary Māori culture, imbalances in access to healthcare, and solo-parenting. The participants' accounts reflected interesting commonalities: benefit dependence, teen pregnancies, removal of children, and mental health risks. Analysis

revealed an emergent pattern among participants' profiles: four out of seven participants did not have all their biological children in their custodial care. Details regarding these absent children were limited, but this appears to be a pattern among Māori solo mothers as over half of the small sample has experienced the same phenomenon.

> Okay, I have, well I have three children, but I've only got two children living with me. I have two sons, they're 5 and 7 [yrs], and my daughter's 16. (Mary)

> Okay, I have two sons living with me: Tama aged 3, and Hohepa aged 9, and I see my daughter, who will be coming home soon, and she's 13. (Stella)

> Four [children]...Yeah, two with me and two with [their father]. (Tia)

> Well, like I don't have like all my children in my care: there's three. But then, say about two years ago, we had, I had a fall-out with my kids' dad and then I just ended up, I needed that break, not so much break – I turned to his parents and asked if they could help me.   And that was to take my kids into their care and I just had [my youngest] with me, you know, that kind of thing. I've been like handling it from there, you know, trying my best to just get back on my feet. (Kimberly)

Reasons underpinning the absence of these children, from their mothers' custody, were: teen pregnancy, fathers with custody, and not coping with solo-parenting. These participants also have teen pregnancies in common which could be related to later loss of custody. Stella shared her insights into the significant Māori solo mother population:

> I've seen it, I've seen it. They're having babies at 12. You know, I've got a niece who's, I think she's barely 18 [years], she's got 4 children, she looks older than I do. It's sad, you know. It's really sad...You know, like, 'It's all right to have a baby. Go on the DPB. Oh and yay, you know.' (Stella)

It must be acknowledged that experiences such as loss of child custody could increase mental health risks. Potential stress, grief and mental health strain could contribute to poorer mental health, unhealthy behaviour, and lack of well-being. Indeed three of the four participants without custody of all their children, reported mental health issues, including abusive relationships, drug use and stress. These potentially consequential issues were frequently missed by health services, as illustrated by Stella when her efforts to expose domestic violence at home were unnoticed or ignored by more than one health professional, suggesting unwillingness to acknowledge health-depleting issues beyond physical health.

> No, a Māori health nurse - the baby ones - come over to my house and normally I'd have the door closed and just answer it like that like everything was all good. On this particular day, *I was sick of it*, and I let my door swing open and tears were gushing down my face and she couldn't not see, you know, the holes in my wall, you know, at my old house. She kind of looked in the house, you know, and gave me this book and walked off and it was so obvious, you know. I hide things very well and I went out of my way to show this lady I needed help and she just gave a book and left. (Stella)

Participants self-motivated attempts to access help were hindered by a lack of information and support to escape unhealthy circumstances.

> ...I wasn't in the right frame of mind then, you know, it would have been, you know a better service for me would have been them ringing around, you know, and finding out what was available and what's not, you know. Well that's what I would do, you know. You know, as a counsellor. (Mary)

I eventually lost my children because of that...Well, not because of *that,* but just because help [to escape domestic violence] out there wasn't really there. (Stella)

Self-referred access or accidental connection to health services through the provision of health-related information and support services can positively impact Māori solo mothers' lives. As mentioned in section 4.4., Cassandra gained beneficial access to drug treatment services as a result of finding a pamphlet and self-referring herself to CADs. Through access to CADs, Cassandra was supported to stop using illicit drugs and to maintain a healthy lifestyle, which was further supported by connection to other helpful health services:

> Well, what is that [contraceptive] you put in your arm?...Is it [Jadelle] or something?...Yeah, well that's what I've got. That's something I've done so I can't get pregnant for five years...I just don't want to have a baby...CADs helped me through it and they paid for it. They paid my taxi to go all the way to [locality of Family Planning] from here and back. And [the CADs care-worker] explained it: She goes, 'Do you want [more] kids?' and I'm like, 'No' [so] she goes, 'Well, we can go and do this' and then, yeah, they helped me. (Cassandra)

As such, participants suggested information about healthcare and support services related to issues over-represented in Māori solo mother populations, such as domestic violence, drug addiction, unwanted or teen pregnancy, and depression could be visibly displayed in locations they routinely frequent, for example: Māori health providers, WINZ offices, Family Planning services, Plunket rooms, kohanga reo, and marae.

Aspects of reproductive health

Cassandra's aforementioned accidental connection to long-term contraceptives, which she had not known about nor could she ordinarily afford, is illustrative of a significant emergent pattern. Across accounts, participants gave diverse examples of not accessing healthcare because of a lack of information; but, a lack of contraceptive information and limited contraception options emerged as a common issue with far-reaching consequences. Some participants suggested contraception information needed to be visibly displayed and proactively promoted through primary healthcare practices.

> Yeah, oh well it's a start, yeah. It's a start yeah, you know, the pamphlets; if I wanted to know more I'd ask the doctor more questions. (Chloe)

> I wish that contraception had been pushed more to me years ago and I see nieces and that who it should have been pushed more with as well. (Stella)

However, in section 4.5., some participants reported underutilisation of primary healthcare which may prevent pamphlet displays and advocacy reaching the solo mothers. Moreover, GP services, sexual health clinics, and pharmacies for contraception advice and prescriptions were not always affordable or easily accessible.

Yeah, and the IUD is three years and costs $40 and still $40 is not something [I could afford], yeah. (Stella)

I'll get all the medication, but if it's something like contraception or, you know, condoms or something, I won't get that if it costs money: 'Oh nah, I don't need that, but I do need my antibiotics and my whatever else.' (Dorothy)

Moreover, many participants reported adverse affects from using commonly prescribed and/or government subsidised contraceptives such as the combined pill and Depo-Provera injection. Participants reported unwanted side effects and expense which sometimes resulted in lack of contraception altogether.

Well, it was just like I know the pill won't work, and the Depo[-Provera] can't afford it and whatever, because it's gone up even more now, you know. Yeah, so it led me to just chancing it I guess. (Stella)

I would be able to access [contraception] at that same time that they give me condoms, but my body doesn't do well with it. I either blow up with the pill - I put on heaps of weight or with the Depo-Provera I bled for a year. (Tia)

In view of the difficulties in accessing and using subsidised contraceptives, many of the participants had experiences of unplanned pregnancies and having additional children while solo-parenting.

I was quite stressed out when I was pregnant with my fourth, because I was pregnant again with another – with my fourth – and I even had gone through going to have an abortion with her and everything and so I wasn't really coping with the pregnancy very well. (Tia)

Paradoxically, although access to contraception comes at a cost, in terms of GP visits and prescriptions, the termination of pregnancies are free. For some participants, termination provided an alternative to having more children, and was used as a form of contraception.

[I had a termination] because I knew I couldn't afford to have another baby. That wasn't my only reason, but I don't want to talk about the rest. (Chloe)

Again, it needs to be acknowledged that experiences such as unwanted pregnancies and terminations may impact negatively on solo mothers' mental health and wellbeing.

Yeah and then keeping a child means so much. You know, time, money, everything, raising them right, and then having an abortion brings all the emotional strains. (Stella)

Illustrating the imbalances and irregularities of healthcare access, those who opted for terminations were then offered free access to long-term effective contraceptives, like intrauterine devices (IUDs), which can cost hundreds of dollars.

Well, I only got [an IUD], because I had a termination recently and that's my third one. I mean I would have *seven* children. (Stella)

Such contraceptives are, under usual access circumstances, beyond the participants' means financially.

I know with the IUD and the Mirena [IUD] it can be very, the Mirena is 300 and something dollars unless, unless you happen to be like I was, clever enough to say to them that my periods are really heavy to the point that I stay in bed for a whole day...Then they're like, you know, 'oh I'm sure you fit the criteria for this', but if you just go in there and say, 'I'd prefer that,' it's $365. (Stella)

Furthermore, most participants were not aware of such contraceptives until after a termination.

Yes, because it lasts for five years. Yes, I'm happy [with the IUD]. I think with the other contraceptives, you know, we hear these stories that if you go on the jab, you know, you get fat and all of that. And that's why I haven't gone on the pill or the jab or something like that. People say stories – there's stories going around that you put on lots of weight and that. (Chloe)

Providing free terminations and post-termination long-term contraceptives as a solution to unwanted children and future pregnancies, while failing to provide free long-term, effective contraception to the solo mothers in the first instance, is summed up by Stella as she reflects on her circumstances:

But I think if I had had one of those [IUDs] years ago I wouldn't have so many children now - *bless my children love my children*- but to me that's a part of healthcare, you know. I wouldn't be where I am now if maybe, I don't know, there were more options or it explained to me more. (Stella)

It appears that provision of free access to long-term contraceptives would be most beneficial for the participants and could prevent unwanted pregnancies and further hardship as solo mothers. However, non-cost barriers which could undermine such access do exist and would need to be addressed. Unfamiliar treatments, like the use of an IUD, can challenge cultural views regarding a woman's body and reproductive function. Potential cultural conflicts could be a barrier even to free access.

Yeah, because to a lot of Māori your period and stuff like that, is something you just don't mess with, you know, and it's just weird, you know; but, long-term in real[ity], in the real world, it's better to have something like that where you're not going to get pregnant and have children that you can't afford and, you know....So recently I've gone on the Mirena, and those sort of things were never, when I was younger, they were never, you know, they were sort of mentioned, but not really explained to you. And even now, when I've just had it put in, I was really scared about it, because, I don't know, and I think it's part of my Māori belief that it's a foreign object and it's going to be in your body, and, you know, freaked out until the hour before getting it put in, you know, 'Am I going to be all right? Am I going to be all right? Is it going to do something to me?' you know. (Stella)

Such cultural conflicts may be allayed by the recommendations of other women who have accessed IUDs or similar.

Yeah, and honestly, I didn't realize how much it was going to creep me out, but, it was really, and I spoke to a couple of Māori females and a couple of Pakeha and they said that they were wonderful, you know. (Stella)

Similarly, participants commonly reported personal barriers to accessing women's health checks, such as shyness with one's body, and discomfort regarding women's health issues and checks.

Yeah, to me that's a violation. I don't know, I know you have to get it done. (Stella)

Um, not so much cultural, but just in myself, I guess...Like I won't go to, like I quite rarely go doctors to go for swab tests and that because of the fact that, you know, like I'm shy of my body, yeah. (Kimberly)

For some participants, personal barriers were minimised by access to a regular GP or a female doctor whenever possible.

> …yeah, smear tests, yeah. I feel like that too, but I know I need to go, deep down I know I need to go. (Chloe)
>
> Yeah, sexual health...that's where I get all my check ups...a female [doctor] usually. (Dorothy)

It is possible that personal barriers may underpin the reported tendency for the participants to delay or avoid three-yearly cervical screening checks, despite reminders and free access.

> Yeah, yeah, well the only reason why I done my last smear test was because I went in about my back. Otherwise I would've put it off for a long time. You know, but yeah. (Mary)
>
> I get letters, but again it's just, I suppose, it comes down to being comfortable with my body and it's, I think I probably, I left this last one probably three years longer than I was meant to; but everything was fine, but you know, something that I guess. (Stella)

Preventative care programmes, or targeted promotion of contraception, for Māori solo mothers may require a different approach to increase access. Acknowledgement of underlying cultural beliefs and personal sensitivities is needed to approach Māori women's health safely and effectively to promote access of preventative care.

> Like I do feel like a bit discriminated against when we have to do, like down there checks. Or if I have to have a pregnancy test, and I don't want it, and then it's like they look at me funny like. (Dorothy)

With the study's participants representative of an already marginalised group, Dorothy's response highlights the importance of not further marginalising them in healthcare. Participants are possibly sensitive to perceived judgement because of social stigma attached to being a solo mother. Additionally, as Māori women, the participants may be sensitive to feeling pressured in relation to women's health issues and require culturally safe and respectful healthcare.

Marginalised and Stigmatised

As Māori solo mothers on the DPB, the participants are marginalised in society as well as disadvantaged, and healthcare access can be a platform for discriminatory practices. Some perceived experiences of stigma and discrimination were reported in response to a question about being treated differently, others were revealed unprompted. In each case, the participants felt a degree of being discredited by a health professional, as Tia suggested: "I can't think of [any discrimination], other than [at] that one in [locality], the [Māori health provider]. That [was] possibly because I was Māori."

Some participants received what they perceived to be inequitable treatment as a result of being a Māori, or a solo mother, or a teen mother, or a woman, or a beneficiary, or a combination of these factors. A consequence of perceived discrimination was avoidance of health care services unless

essential, summed up by Dorothy: "Oh, I felt like I didn't want to go to the doctors any more. I was like, 'We're only going to the doctors if we're all dying'."

> Sometimes, you know, at my old doctor, it's like I felt like he thought I couldn't cope. Because like I'd come in with my son who'd had an accident, and...I was pregnant, and I had a baby, and the older son. I had, like, two older kids, and then I had my son who had the accident, the third oldest, and I had a baby, plus I was pregnant. So he thought, you know, 'Why are you coming in so much when he's always...having accidents?...Maybe you're not coping,' and stuff like that. And I felt really like [he was] just judging me...I think it was because I had so many children, and because I was a solo parent, and because I was Māori and because I don't know. (Dorothy)

Chloe encountered what she perceived to be stigma and discrimination in relation to accessing a termination that she attributed to cultural values.

> I actually went to my own doctor, [but] at the time she was on holiday with her husband. So the husband's dad was there – he's a doctor as well...So I had to see him. I wasn't too comfortable seeing him, but I went to him. And I actually told him my situation and I was a bit disappointed, because what he said to me was he doesn't deal with that. He told me to go to Family Planning. Because they don't believe in those things, you know... it's not in their culture maybe. I'm not too sure. (Chloe)

Similarly, Stella reported an unusually rough procedure she believed was possibly due to the surgeon's cultural attitude towards women.

> I think this guy who did my last termination, honestly, I thought he had it in for women, to be honest. He was really rough and it was really painful! ...he was [ethnicity] or something... well, you hear stories about what their outlooks are on women... But that experience, should I get pregnant, will be a big factor next time whether I keep a child that I can't afford or not. You know, something like that will make me keep a baby because I don't want to go back and, you know. (Stella)

In another encounter of stigma and discrimination, Kimberly recalled being in hospital as a young teen with her first born and being mistreated by a maternity ward nurse.

> The only time I did feel uncomfortable was after I had my daughter. The lady, one of the nurses, like her attitude towards me kind of just like shocked me, you know. She was supposed to be there, caring, and you know, and her attitude towards me was a bit of a shock like, bitchy, and like rude.... You know, like I'm trying to be nice, but she's just giving attitude back you know. She was a [nationality] lady, but you know... It made me feel like going home, you know, like just get the discharge under way. Yeah I didn't. (Kimberly)

Some GPs will not allow time-to-pay leading participants to experience the embarrassment and stress of being unable to pay and being refused for delayed payment; this could be perceived as discrimination against low-income patients.

> Twice as shamed! It's shame enough that, you know, you have to ask and they say 'yes,' but when they turn me done it's like, 'okay, shall I turn around and walk out now?' Because what else can I do? (Tia)

> I just remember going to the doctor's and I couldn't pay for it, you know and because I didn't have any money [but] my son needed to go to the doctors. And, you know, I had a little bit of an argument with the lady at the desk. She told me that I'd have to go the hospital and I said, 'Well, you know, I can't afford to go there either because I can't afford to pay for the parking,' you know....Which is fair enough for them though. I see their side of things because they...probably have so many people who go in there and don't end up paying...but she [didn't] actually realise that they're actually my regular doctors. (Mary)

Stigma and discrimination have also been experienced in healthcare-related contact with community-based organisations. Mary encountered discouraging stigma at an organisation which ran a treatment programme.

> Well it just seemed to me that she thought that I was just another drug addict, you know, and I dunno, actually yeah, just you know, judged, as I'm just another drug addict, and here's another one that's going to, you know go [back to drugs]. Yeah, I don't know. (Mary)

Additionally, Mary felt discriminated against when requesting financial aid from a government service for health-related matters; staff had 'discretionary' power to approve grants. In this example, Mary indicated by her remarks about being "just another statistic" that she felt depersonalised and undermined as a human.

> As a person, I just feel like just another statistic to them, you know, I'm just another person who's there for another thing. And then some of them make you feel like it's their money their giving away, you know. Yeah, I just don't like it, you know, yeah. Yeah, no, but that's how I feel like I'm just another statistic to them and hopefully they haven't had a bad appointment before me, because otherwise they're in a bad mood and they're going to take it out on me...Yeah, yeah they're definitely different. You've got one person who will tick tick tick everything yeah, and then you've got another one who's asking all these different questions, you know, like oh my gosh give me the other lady! (Mary)

As indicated above, one potential response to experiences of being discriminated against was to avoid such services in the future, unless absolutely necessary. Another response was to lay a complaint, which several participants said they had done.

> I wrote it on their suggestion letter, that the surgery was really rough, you know. (Stella)

> Oh, there's just one doctor that I didn't like, but I made a complaint. (Dorothy)

> I complained to one of the other nurses. (Kimberly)

Stigmatisation by health professionals and further marginalisation through accessed healthcare is not best practice. In an attempt to avoid stigma and discrimination many participants reported a preference for Māori health providers, sometimes with the expectation of culturally safe and equality-based access to healthcare.

Preference for Māori health providers

In the light of negative experiences, because they were Māori (and solo mothers) some participants believed that by seeking care at Māori health organisations they would avoid such discrimination. However, in reality the participants' expectations of Māori health organisations were not always met. This was reflected in participants' diverse views on the place of Māori culture within the healthcare system and had different opinions about whether Māori services were right for them. These diverse yet insightful cultural perspectives developed into a broader theme of cultural barriers and issues, which reflects emergent issues at the interface of healthcare provision and culture. Although Mary found a Māori model of health useful in rehabilitation services, as mentioned in section 4.4., in other

contexts she did not want cultural support. During her daily hospital visits to a neonatal unit, Mary found Māori support workers overbearing and she felt culturally pressured.

> "I just don't like it when like I was up at the hospital with my son, you know, the Māori people they always come around and bug you. Yeah, you know, and I just prefer to you know get on with my own thing – yeah and if I need help then I'll ask... like I said up at the hospital you, these, you know, you get these Māori ladies coming around and they're like *vrroooommm* once they find out you're Māori. You know they're like, you know, they're there to help, you know, but they go a bit overboard you know, yeah.... I don't know, because sometimes I get put off by the whole Māori thing, yeah. You know, like I see the - yeah, sometimes I just get put off by the whole Māori thing...It's good to be able to relate to people in that sense, but like, I wasn't brought up Māori either, you know my mum was Pakeha-Māori, you know, and it's good in that sense I guess, yeah." (Mary)

Similarly, Stella expressed her satisfaction with consulting Pakeha doctors and with "mainstream" services.

> Yeah, I think, and this is just my personal belief - I believe that having Pakeha doctors, you know, having a mix in one place would be good. You know, having that option, because I think keeping the Pakeha, and I don't know really how to explain it, it kind of keeps things mainstream, you know. Māori have a culture about them. Do you know what I mean? I don't mean it to sound nasty. I just mean that to me, sometimes I prefer to go outside, just because sometimes you're told so often, or you know, it's around you so often, that things are 'this way' with whatever, and stepping outside of that, stepping outside of that can help, you know, see that maybe, you're not doing things right, you know? (Stella)

While Stella is comfortable with Pakeha doctors for some issues, she also wished to consult Māori doctors, better able to acknowledge things Māori, but was limited because "there's hardly any Māori" health professionals.

> Yeah, definitely, oh yeah, if they were available, definitely I would opt for a Māori doctor even if I had make an appointment...yeah, just because they're easier to relate to. Having said that, [GP name] was a Pakeha, but she was really good. But then I've had doctors who just do not understand... That's where the Māori thing comes in, I think – they identify more and know more about what goes on in our background and in our lives, and they're, like, the light at the end of the tunnel, you know. So maybe we would listen more if it's coming from them and because we know that they know what we're all about – all the whakamaa, the shame of it, is not there anymore. (Stella)

Tia indicated a preference for Māori health organisations and services where available on the basis that they are family-oriented.

> …if there's ever an opportunity for Māori services, even when it comes to [tertiary] studies and all those sort of things, I use it. I use them quite a bit.... That's because, like I quite often use Māori services. If there's an option to use Māori services I will use it, because they are family orientated. (Tia)

Most participants indicated a preference for Māori health providers, because they ran large clinics offering interrelated, low-cost health services within one location: GP fees were approximately $10 or less making these clinics substantially cheaper than other clinics and private practices.

> Oh [Māori health providers] are good, because they're cheap, you know, and they've got the good funding, you know. (Mary)

However, supporting Stella's aforementioned claim that there is a lack of Māori doctors, several participants reported Māori health organisations have very few if any Māori staff.

Yeah well the one that I am with are Māoris. Um it's a Māori organization, but they have different doctors: they have [ethnicity] doctors and [ethnicity] doctors. But other than that yeah, they're Māori. (Dorothy)

None of the participants reported having actual access to a Māori GP, but most participants are not concerned with the lack of Māori doctors at Māori health clinics as low-cost fees and caring attitudes were more valued than cultural affiliation.

Yeah, [my GP], is he [ethnic group]? Oh no oh some sort of [ethnic group] guy. You know they look [ethnic group], but some of them are from a certain other place. Yeah, yeah well he was working for a Māori health service. (Mary)

There is a doctor there that's Māori, but I don't see him. I don't know I just prefer somebody that's I don't know, I just like [my non-Māori GP]. He's a good doctor. (Dorothy)

In contrast, Tia expressed bafflement and disappointment towards a Māori health provider she repeatedly tried to access; reportedly all staff and patients were of other ethnicity and she as a Māori, could not get access.

Māori [health services] are quite family orientated services and they're really good and helpful and they have a lot of understanding when parents are on the benefit and I suppose I had expectations with that, with this [Māori health provider], but when I arrived there, there was no - they weren't Māori. The receptionist and the doctors and what I could see of the patients [were] not Māori as well and I could never get an appointment with them until the next day which was just stupid for me, for the kids, because when they're sick they go down really fast -if they get sick and you need to be seen straight away....when I started complaining, they gave me a card to go to the A & E...[which] gives me half price which is approximately $26 or something like that, and that makes it the same as all the rest of the doctors...I was really angry and I even brought it up with the A & E about, because I was going to the A & E more than I ever went to [the Māori health provider] – I don't think I ever saw the doctor ever - and I brought it up with the A & E and asked them, 'Do they get money for me being on their books?' Because I felt it was unfair that I've signed up to this place, they call it [a Māori health provider], they have all these Māori names, there's no Māori there, and they don't see Māori [patients]!...They said they were busy, but every time I went in there, like when I did actually wait until the next day...there were all [ethnicity]. The doctors were [ethnicity], the receptionists were [ethnicity], and yeah so they never gave me a reason why I was never seen on the day. (Tia)

The issue arising from these encounters with cultural barriers is concern that Māori Health providers are not providing the culturally safe and more affordable healthcare for Māori patients as intended and as funded. This theme captures insightful interpersonal differences and intercultural diversity in participants' attitudes towards culturally appropriate healthcare and the role of Māori health providers in their healthcare.

Whānau support facilitating access

A final theme running through the participants' accounts was the support of whānau (family). In the formal healthcare context that is the focus of this study, whānau support was frequently reported as helpful to Māori solo mothers in accessing healthcare when needed. Different types of whānau support were reported by participants, including help with transport, help with childcare, assistance

with costs, and provision of information. Helpful whānau members mentioned by participants included grandparents, parents, siblings, cousins and others.

> Yeah, yeah, no it's good to have your mother's support, yeah. (Mary)

> Always yeah. I've always got my family support. Like my cousins, one of the big supports, my children's grandmother, like she's always there. Yeah, they're just the main two, but they do come to help when I do need the support. (Kimberly)

In some cases, whānau provided free, trustworthy childcare, which allowed the participants to access healthcare service.

> Yeah, having family around, you know, that I trust with my son. Because I don't just - I think the only people I give my son to is her, and my mother and my mother-in-law and his father. That's it. That's the circle he goes in. So, yeah, that's helpful having my cousin here...When it comes to doctors and stuff like that, my mum's always there for me. I just need to drop her a text and she will come. Um, if it's for my son she'll shoot straight over. She'll do anything for my son. (Chloe)

Other cases involved whānau assisting with transportation to and from appointments, which enabled the participants to access health services and receive treatment. Chloe's mother helped with transportation to multiple pre-termination appointments.

> ...no I didn't have a car at that time. Um, my mother was helpful enough to drive me around...Oh it was a fair distance for my mother having her two babies and looking after my son. (Chloe)

Sometimes whānau were supportive by helping participants to seek information about healthcare services and access, or making recommendations regarding access.

> I heard about that years ago. One of my family said if you get toothache and it's rotten just go to the, um, hospital and pay $40 and bring your Community Services card. (Cassandra)

Financial support is another type of whānau support reported. Tia's whānau were able to help her with the cost of going to the GP, which enabled access.

> Oh, that's like I'd have to beg them to help me. They have helped me in the past...the last time I didn't know them so that wasn't the doctors that I knew. So I had to ask them to come and pay for it, because yeah. (Tia)

In sum, an understanding of interrelated social, personal and cultural dynamics could lead to better healthcare, targeted preventative care, and improved health status for Māori solo mothers. Contraception challenges emerged as a major theme with as a lack of information, cost-barriers, and unpleasant side-effects limited options. Free access to effective, long-term contraception would be advantageous in removing cost barriers to access. However, as evidenced by underutilisation of free women's health checks, cultural and personal barriers as well as transport, childcare and locality of services need to be taken into account. Several participant accounts referred to 'shame' (whakamaa) in response to healthcare encounters. In Māori culture, the concept of whakamaa is important and

ought to be recognised by health professionals and services. For Māori, to be shamed, especially through stigmatisation, is to violate a person's mana (personal power). It is therefore culturally unsafe for Māori solo mothers to be subjected to undeserved judgment and unfair discrimination while accessing healthcare services. The reported lack of preferred Māori health professionals at Māori health providers suggests Māori health work-force development could be prioritised in order to provide greater access to culturally safe healthcare.

4.9. Summary

The findings presented in this chapter illuminate commonalities and patterns emergent across participants' accounts of healthcare access. Participants' health concerns and healthcare access were reported and described. Barriers to access, factors relating to access, and participants' experiences and encounters in negotiating access to healthcare were presented as major themes, which were described and illustrated. Cultural and personal barriers and complexities were described and evidenced in the context of healthcare delivery and access. These thematic findings elucidate the main barriers, issues and complex circumstances impacting Māori solo mothers' ability to take care of their health through access to healthcare. The next chapter explores the themes as barriers and facilitators to access and presents a discussion of these findings in relation to extant literature relevant to the healthcare access of Māori solo mothers.

Chapter 5. Discussion, Conclusions and Recommendations

5.1.   Introduction

Chapter 4 presented the findings of the research thematically and evidenced emergent themes with textual exemplars from participants' accounts of healthcare access. This chapter will continue with a discussion of the main findings in relation to extant literature. Themes capturing the barriers, facilitators and issues that emerged from participants' accounts will be compared and contrasted with relevant solo mother research to illuminate findings that support, challenge, or go beyond previous research findings. Thereafter, conclusions of the findings will be made. Then recommendations for services, health and social policy, and evaluation of implemented changes will be presented. The limitations of the research are given next and recommendations for future research made thereafter.

5.2.   Discussion of Main Findings

This exploratory study set out to answer the question: *What are the experiences of Māori solo mothers in accessing healthcare in taking care of their personal health?*

Participant profile and health status

As a small group the participants were not homogeneous, but revealed very diverse backgrounds, lived experiences, and cultural perspectives. Additionally, their experiences, preferences and issues with healthcare and health services also reflected their heterogeneity. The solo mothers all self-identified as Māori as required for participation; however, two participants revealed mixed Māori-Pakeha ethnicity during the course of their interviews. The women also revealed different levels of cultural affiliation, knowledge, and experience as Māori. The mothers constituted a fairly young sample, ranging in age from late teens to mid-thirties, which contributed to the diversity of the small sample.

Similarly, the number of children in each participant's household ranged from one child to five; the dependent children's ages ranged from 2 to 13 years. Notably, four of the seven participants had lost or relinquished custody of one or two of their biological children; this knowledge was not prompted, but shared voluntarily in response to being asked how many children the mother had. The women then mentioned other biological children who did not reside with them, but most did not elaborate on the circumstances surrounding loss of custody.

However, it was clear that for these solo mothers losing custody of a biological child was sometimes distressing, but all too common. All seven participants resided in Auckland, in a variety of low, medium and high deprivation areas. Some of the solo mothers had tenancy of state housing; others were in market rentals, but none of the participants owned their own home. All participants were receiving the domestic purposes benefit (DPB) as their main source of income; this coincidence of an entirely welfare-dependent sample possibly reflects a high prevalence of solo mothers with young children receiving the DBP. In terms of socioeconomic status this welfare-dependence rendered all participants in a very low-income bracket at the bottom end of the social gradient of health. As such, according to literature the participants would be more likely to face multiple barriers to healthcare and to report poorer health (Ministry of Health & University of Otago, 2006; Tobias & Howden-Chapman, 2000).

When asked about their health status most of the mothers reported 'good' health. Most of the participants then justified what they considered 'good' health. It was perceived by the women to be an absence of serious illness or sickness, a lack of need for doctors' services, and an ability to function effectively on a daily basis. Several participants who had reported good health then presented self-perceived unhealthy lifestyle factors or personal issues, such as weight gain, nutrition concerns, or lack of exercise. Interestingly these after-thoughts by the participants reflected some of the recent and current government-driven health promotion messages revealing an awareness of healthy lifestyle factors.

Complexities and experiences of accessing healthcare

The majority of the women reported numerous current health concerns ranging from minor concerns to more serious unmet health needs and this was despite previously self-reporting good health. However, the women were not contradicting themselves, but rather this reflected the ways in which they cope and perceive health, and weigh up factors, such as function and pain, when judging their need to seek healthcare. Butterworth (2003) also found Australian solo mother beneficiaries were twice as likely to have physical problems as married mothers. Some women with access to low cost healthcare reported doing nothing about concerns as they seemed non-urgent. Conversely, other participants indicated they would like to see a doctor about their concerns and would if it was free or very low cost to do so. Several participants mentioned a lack of regular health checks which they felt they needed. Other participants were interested in information or advice about health or healthy practices, but did not know how to access this. A desire to be healthy and fit and make healthful changes was expressed by several participants, but a lack childcare and cost of gyms and nutritional food was a reported barrier. Similarly, British solo mothers also reported a desire to become more healthy, but lacked information and support (Reeves et al., 1994).

So, the main factors appearing to influence access to GP services were the sense of urgency or importance of the health concern as well as the cost involved to see a doctor; these were weighed up

by the solo mothers in deciding whether to access health services and where to seek healthcare, and when to access. It became apparent that very little was simple or easy for the participants in accessing healthcare. The majority of participants' healthcare access related to primary care services such as GP visits, prescription-filling, dental services, maternity care, and women's health checks which encompassed cervical smears, contraception and sexual health checks. Maternity care was reported as very positively by the participants except for negative encounters reported by two participants. Similarly, a NHS study found solo mothers and ethnic minority mothers reported overall care positively, but also have more likelihood of a negative experience (Raleigh et al., 2010).

To a slightly lesser degree several participants had had need to access mental health services for issues such as depression, domestic violence, ex-partner related stress, and drug addiction treatment. Australian solo mothers on welfare were similarly found to have three times the risk for mental health issues and four times the risk for substance abuse problems as married counterparts (Butterworth, 2003). Several studies on solo mothers' health have found these women are at increased risk of depression (Landero et al., 2009; Wang, 2004). Cairney and Terrance (2002) found Canadian solo mothers were more likely to access mental health services more frequently than married mothers. Only three participants mentioned use of or need for private sector specialist services; one participant had accessed optometrist services after significant delay and reported current unmet need with eye health. Three participants reported needing podiatrist, physiotherapist or ear specialist services, but had not accessed these as a result of cost barriers and lack of referral.

Cost as the main barrier to participants' healthcare access

Cost of health services was consistently reported as the main barrier to accessing needed healthcare. This cost barrier was inextricably tied to the participants' level of poverty as a result of very low DPB income. This finding supports New Zealand research that found Māori females, never married, with low income were more likely to defer primary healthcare access as a result of cost barriers (Jatrana & Crampton, 2009). For one participant, the need for after-hours healthcare was weighed up in terms of healthcare versus groceries; the high fees of after-hours GP access would have used up half her weekly grocery budget. So for her the decision to access health services forced a decision between accessing treatment and having enough food for her family. In a study of solo mothers and cardiovascular health it was found that lack of enough food was frequently reported (Young et al., 2005); this supports this experience of solo mothers having to reduce food budget for unexpected costs. Cost as a barrier impacted participants' access to a wide range of primary care services as well as private sector services. Numerous participants reported inability to access GP services on a frequent basis due to being unable to afford doctors' fees, albeit subsidised fees. In such cases, the solo mother would either do nothing about the unmet health need or would access hospital ED services for "free primary care." Low-income families were found, after welfare reforms in the United States, to report inability to afford doctors fees so no access occurred or the poor would go to EDs for treatment. In many cases, the low-income beneficiaries endured painful conditions and morbidity (Seccombe et al., 2007).

Similarly, participants reported that they frequently could not afford to fill prescriptions. Even the subsidised cost of items was too costly for some mothers, especially when there were several items needed. These findings are supported by Seccombe (2007) whereby low-income families were found to frequently forgo prescription-filling due to cost barriers. In response to cost barriers some participants simply did not fill prescription; alternatively the weighed up the importance of prescription items against each other to choose which items to fill and which to leave. One participant indicated she would choose to fill the medication items, but would leave contraception. Another strategy used by the participants when faced with unaffordable prescriptions was to "shop around" different community pharmacies as item charges and free items were variable across different services. New Zealand research also found that Māori patients were likely to defer prescription-filling due to cost (Jatrana & Crampton, 2009).

Lack of access to private sector health professionals was also attributed to cost of services. One participant had accessed GP services at a cost to get a referral for a foot problem; however, she had not accessed the referred treatment, because she could not afford the part-payment podiatrist fee. Another participant had suffered with a painful back problem, because she could not afford the cost of physiotherapy services and did not qualify for ACC injury cover. Seccombe (2007) also reported that low-income families on welfare live with health problems that go untreated due to cost barriers to access.

However, it was dental health services that were overwhelmingly reported as being underutilised and consistently beyond the participants in terms of cost. Every participant had experienced the need for dental treatment that required them to request financial aid from WINZ in order to afford the treatment costs. In most cases the treatment was quoted or charged in the range of hundreds or thousands of dollars. WINZ facilities in the form of emergency grants and benefit advances were not always accessible or sufficient to meet the costs of needed treatment. For those able to get funding, they accessed the dental treatment, and then repaid WINZ through weekly deductions from their already insufficient low-income. Other participants were not able to access WINZ financial aid and forced to either live with dental problems or go to hospital-based dental clinics for subsidised low-cost tooth extractions. All of the solo mothers indicated an unmet need for regular dental health checks and cleaning, but reported cost as a barrier to maintenance of dental health. New Zealand research recently found Māori females on low-incomes aged 15-44 years were most likely defer dental healthcare due to cost (Jatrana & Crampton, 2009); these findings support the solo mothers' demographics and accounts of deferred dental care.

Barriers to solo mothers' health care access

Participants' low incomes invariably generated impoverished living. Poverty and healthcare costs resulted in participants putting their children's health needs before their own healthcare. Several participants revealed some of their children suffered from chronic health conditions such as asthma and eczema which required frequent visits to GPs and hospitals and also required the frequent filling of prescriptions for children's ongoing medication needs. These costs related to their children's

healthcare negatively impacted the solo mothers' low income and her ability to afford to meet her own healthcare needs. One participant revealed she would meet her children's healthcare needs even if it meant begging, but her own health needs were consistently forgone. New Zealand research also found Māori women were more likely to defer their own healthcare in order to meet the needs of others in their care; these were seen as non-financial barriers to healthcare (Jatrana & Crampton, 2009).

Transport emerged as an important barrier for the solo mothers in accessing healthcare. In some cases the problem was a lack of transport, such as not owning a car. In other ways transport difficulties were a barrier in terms of the costs to run a car or pay for parking. Car ownership or access to a car was collectively considered an essential factor in being able to access health services. Public transport was reportedly a barrier in terms of cost, inconvenience of taking children, and limited hours of service; public transport was also considered highly inappropriate in situation where participants or their children were sick. Low-income families and solo mothers in the United States were also found to report transport difficulties and distance to services as a barriers to healthcare access (Campbell-Grossman et al., 2009; Seccombe et al., 2007). Help from family emerged as a way around transport barriers especially where transport was needed to get to healthcare at a distance from the mother's residence, or for after-hours access, or around the time of labour and childbirth. Not all participants had cars or support from family with transport which made healthcare access difficult if not impossible. Researchers have found solo mothers were less likely to have social support for needs such as transport (Young et al., 2005).

Similarly, childcare emerged as a significant barrier to mothers' ability to access healthcare in preferred ways or at times when needed. Seccombe (2007) also found low-income families on welfare reported lack of childcare as a barrier to healthcare. Inability to get to health services and/or their childcare responsibilities sometimes prevented or limited the solo mothers' healthcare access. For some participants needing residential or inpatient care, a lack of childcare and lack of family support, meant they could not access the service they needed, sometimes with very serious consequences. For one participant who had waited months for acceptance into drug treatment services, an unexpected family illness prevented her getting help with childcare; as a result she did not access the treatment she needed and then relapsed.

Issues for solo mothers in accessing healthcare

The participants reported perceived low quality healthcare as an issue that hindered access to health services or undermined their satisfaction with health service utilisation. Issues to emerge under this theme included feeling rushed through GP visits and feeling unheard or misunderstood by health professionals. Also mentioned as an issue was the tendency of some health professionals to be dismissive with the mothers regarding health concerns; this was especially unappreciated by the solo mothers when it was in relation to their children's health. Other examples of healthcare perceived to be low-quality involved ineffective or undesirable treatment of health problems with a lack of alternative treatment options offered by health professionals. Supporting these findings, New Zealand

Māori report 17% less time with doctors in consultations compared to non-Māori; they also report less adequate care, less effective treatments, and less effective health information (P Jansen & Jansen, 2010).

Similarly, waiting times at primary care clinics emerged as real issue for several participants. They perceived prolonged waits to be seen for appointments as inconvenient and difficult when they had small, sometimes unwell children with them. Expectations of long periods of waiting led some participants to delay healthcare access unless the access was needed for urgent reasons. One participant reported she would probably wait for up to an hour, but after that would probably just leave. As such, waiting emerged as a barrier to timely and satisfactory primary healthcare and was most frequently mentioned in relation to large low-cost clinics. In a study of Californian solo mothers' access to Medicaid-funded managed care clinics waiting was considered unsatisfactory and undermined access (Pina, 1998). New Zealand research also found Māori were more likely to not be seen on time or within their preferred time frame (P. Jansen, Bacal, & Buetow, 2011).

An imbalanced distribution of low-cost Māori health providers also emerged as an issue that prevented access to preferred and more affordable healthcare. This refers to the health sector tendency to establish large low-cost clinics which offer multiple interrelated services in high deprivation locales. A couple of participants reported a complete lack of low-cost health clinics in their areas of residence, which were classified as low deprivation, even though the participants were on low DPB incomes and in some cases residing in state housing. This unequal distribution of low-cost health services appears inconsistent with the distribution of beneficiaries and state housing throughout low to high deprivation areas. Moreover, according to participants' accounts, the limited availability of low-cost health clinics appears to promote health inequities within the solo mother sample. This finding is supported by Malcom (2004) who criticised inequitable distribution and utilisation of health funding, health resources, and primary health care organisations.

Factors facilitating access around the barriers

For all participants, access to a regular and preferably long-term GP was desirable and generated positive aspects for the healthcare access. Two positive consequences of accessing a regular GP were: trust and familiarity. Building trust with a GP over time increased participants comfort levels and promoted more frequent and ongoing access to GP services. These findings are supported by literature concerning the need for Māori patients to be comfortable in healthcare in order to better their access and outcomes (Mauri Ora Associates, 2006). The importance of trust in healthcare is supported research with poor immigrants that found distrust hindered access for solo mothers (Campbell-Grossman et al., 2009). Familiarity was seen as beneficial and arising from long-term access to a regular GP. Participants reported more satisfying health service access and better outcomes due to their regular GP knowing their medical history and personal circumstance, which promoted better diagnosis and treatment. The participants also appreciated not having to repeat themselves to several unknown doctors about the same health problem.

Moreover, the participants reported a theme of caring in their preferred healthcare. Health professionals who took time to consult and really listen to the solo mothers were considered more caring. Likewise, health professionals with kind and gentle demeanour and nonjudgmental toward the solo mothers were perceived as more caring and this promoted satisfaction with healthcare and future access. These findings are supported by Māori health research which found Māori patients prefer doctors who are friendly, communicate, take time, and provide information (Cram et al., 2003).

Another theme to emerge quite strong from participants' accounts was convenience. Several aspects of healthcare organisation and location increased the convenience of access making healthcare easier for the solo mothers. Low-cost clinics and other free services were considered very helpful and promoted access among participants, because cost barriers were reduced or removed. The availability of preferred services local to participants' residence was reportedly the most helpful facilitator for healthcare access as this reduced time and cost travelling to services. United States research on beneficiaries healthcare access found distance to services was a significant barrier (Seccombe et al., 2007). Organisation of services into interconnected multi-service service or services in close proximity of each other was also viewed positively as convenient and helpful in reducing transport needs and costs, and time travelling.

Lastly, participants revealed notable experiences of intersectoral help in accessing services and treatments. For instance, organisations like the Police, Salvation Army, and WINZ can effectively facilitate access for solo mothers to healthcare services. Therefore connectedness between social and health sectors plays an important role in linking solo mothers to health services.

5.3.   Conclusions about barriers, facilitators, issues and complexities

What became very clear with the participants were the complexities operating in even the most mundane aspects of healthcare. They were constantly weighing barriers against one another as they strategised and juggled resources in order to achieve access that would be insignificant and effortless to better resourced adults. For the participants burdens and barriers were moved and modified to achieve health goals, including taking children, organising transport, and allocating grocery money for doctor's fees and so on. Barriers to healthcare appear to be multiple for the Māori solo mother participants and dealing with these barriers can exacerbate stress already experienced from solo motherhood. Although some participants mentioned significant whanau (family) support, which provided transport and childcare help in accessing healthcare, there were others who did not appear to receive much help from family and had to deal with barriers independently.

Contraceptive needs and issues emerged strongly across accounts with most participants reporting difficulties in accessing effective treatments. Most of the women reported adverse effects from commonly prescribed or administered contraceptives; they also reported difficulty in affording GP fees and prescription filling cost which further hindered access. However, several participants had unexpectedly gained free access to long-term effective contraceptives and expressed satisfaction with the access to such treatment. Prior to receiving the superior contraceptive they reported a lack of information and options in contraception due to cost and health professionals not consulting about contraceptive needs. Issues with contraception had resulted in unwanted pregnancies, teen pregnancies and for some participants, abortions. One participant suggested contraption advice and access was a major issue for Māori females and needed to be addressed prior to Māori becoming solo mothers and benefit-dependent.

Complexities emerged from participants' accounts that reflect interconnected social, personal and cultural dynamics. These subtle nuances influencing the participants' healthcare were particularly apparent around women's health issues. What participants perceived to be personal barriers were actually reported collectively and may reflect subtle cultural beliefs which might be challenged by some treatments. Similarly, some participants referred to Māori concepts such as whakamaa (shame) and wairua (spirit) while relating their healthcare access experiences. These same participants had reportedly not been raised to be strongly grounded in Māori culture and te reo Māori and yet referred to the importance of wairua being acknowledged in their care, or expressed feeling whakamaa in accessing some Pakeha doctors despite reporting comfortableness with mainstream care.

Some of the women participants were particularly sensitive to perceptions of stigma, being judged or experiencing discrimination; such treatment was distressing and insulting which created barriers to future access or forced solo mothers to change practitioners or services. The multiple disadvantages operating in the participants lives – being women, Māori, solo mothers, beneficiaries, or mothers of numerous young children – seemed to evoke unfair stereotyping, criticism, and judgment from some health professionals. The participants did not consider this to be 'best practice' or 'culturally safe' and such experiences undermined the solo mother's trust in the health professionals and the system they represent. In sum, the participants' accounts revealed Māori solo mothers to be a very diverse group of women with frequently unmet healthcare needs, but a keen awareness of health and what type of healthcare and health services were right for them.

5.4.   Recommendations for Practice and Policy

Reflecting the key findings of this study, it is strongly recommended that cost barriers be removed as a barrier to Māori solo mothers' ability to access healthcare where needed, when needed. Although it

is acknowledged that free healthcare does not automatically translate into full uptake of services, due to other barriers such as childcare, transport difficulties and personal issues, it would be better to remove cost as the principal barrier to access. Subsidised primary healthcare fees and low-cost services are still financially beyond beneficiaries and low-income solo mothers. Free access to all healthcare would be equitable and may buffer some of the effects from the burdens of solo motherhood.

Similarly, it is recommended that dental health be integrated into the primary health strategy and receive at least the same proportional funding that GP services currently receive. Ideally, free access to dental health services would be beneficial for Māori solo mothers by removing financial barriers to access as well as the financial strain and stress from WINZ repayment burdens. Ability to regularly access dental services as part of taking care of their personal health would improve Māori solo mothers' general health and wellbeing, and quality of life.

Additionally, it would be beneficial for Māori solo mothers to have better, more convenient access, to preferred services sooner. It is recommended that more funding be channelled into Māori health organisations to encourage fairer distribution of culturally-appropriate services throughout the Auckland region, rather than the current pockets of Māori health services concentrated in high deprivation areas. However, it is imperative that Māori health organisations provide culturally safe high quality healthcare which requires employment of health professionals, healthcare workers, and support staff that are of Māori ethnicity. As such, it is recommended that greater funding and professional incentives be made available for Māori health workforce development.

Furthermore, at the service level, there is a need reduce waiting times in large primary care clinics to make access easier for solo mothers accompanied by their children. There is also need to provide Māori patients with the opportunity to see a regular preferred doctor as this builds the level of comfort and trust in a practitioner-patient relationship which promotes future access and improves health outcomes.

It has been expressed that social policy is in effect health policy and this appears to be the case for solo mother beneficiaries. Compared to other nations, New Zealand has a parsimonious social welfare system; not only is social policy punitive, but it has disregarded the Treaty of Waitangi. Māori solo mothers' receiving the benefit are extremely disadvantaged socioeconomically. There urgently needs to be proactive removal of stigma from both solo motherhood and benefit-receipt in addition to increased DBP income for more equitable standard of living. Importantly, Māori solo mothers need greater support through provision of low cost or free childcare to better support them as solo parents and to support with employment opportunities.

Lastly, it is recommended that any changes implemented at the practice level be effectively monitored and regularly evaluated for effectiveness in improving the healthcare access, health service experiences and health outcomes of Māori solo mothers as the group targeted for improved healthcare utilisation.

5.5.   Limitations

There are two obvious limitations of the current study. Firstly, the small sample size of seven participants means that although findings are authentic to the participants, they are not generalisable to the greater solo mother population. Additionally, the entirely urban sample could be viewed as a limitation. Auckland is a large, well populated, and well-resourced city. A sample of rural or mixed rural-urban participants may yield different findings due to geographical differences in healthcare resources and distribution of health funding.

5.6.   Recommendations for Future Research

A similar study to this current research, on the healthcare access of Māori solo mothers, but with a much larger sample would be beneficial. A large sample that better represents the Māori solo mother population would generate findings that could be generalised, increasing the potential utilisation of findings for informing policy and funding decision-making. Similarly, a larger sample of Māori solo mothers in a longitudinal study could provide greater insight into participants' healthcare access-seeking and utilisation-behaviour. In contrast, it is also recommended that a comparative study of solo mothers' of different ethnicities would be useful in exploring the ethnic differences in healthcare access and perceptions of experiences with health services. This would help to determine whether the current study's findings reflect experiences peculiar to Māori solo mothers or whether they represent other solo mother groups too. Lastly, a deeper investigation into some of the richer complex themes to emerge from this study may elicit greater understanding of Māori solo mothers' healthcare needs in order to improve access for them in ways that will be appropriate and beneficial. For instance, the participants of this study illuminated some interesting cultural and personal complexities in their perception and preferences for women's health which could be further explored to improve Māori access to preventative screening checks.

5.7.   Summary

The literature suggests solo mother populations are vulnerable and burdened by multiple disadvantages that potentially undermine their personal health and create barriers to equitable access to healthcare and through health systems. The present study of Māori solo mothers' healthcare access supports extant knowledge and evidence that social gradients of health exist and undermine ability to access even free or subsidised healthcare. Comparison of findings with international studies

highlighted the impact of user-pays primary healthcare types of health systems on low-income solo mothers. However, the findings, like international studies also elucidated dynamic complexities inherent in solo mothers' circumstances and ethnic minorities' experiences of dominant-culture healthcare provision. The present study reveals the interface of healthcare access, health, solo motherhood, Māori culture and socioeconomic disadvantage is far more complex than extant literature or health and social policies would suggest, and has set a foundation for further solo mother research to build a greater body of knowledge pertaining to this under-researched, but deserving group of Māori women.

Appendix A   Office of the Tumuaki Letter of Support

TE KUPENGA HAUORA MĀORI
Faculty of Medical and Health Sciences

THE UNIVERSITY
OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

Office of the Tumuaki
Level 2, 261 Morrin Road, St Johns
Auckland 1072, New Zealand
Telephone 64 9 373 7599 ext.86332
Facsimile 64 9 308 2307
Email: p.reid@auckland.ac.nz

8 April 2011

University of Auckland Human Participants Ethics Committee

Level 3, Building 438,

76 Symonds Street.

Auckland

The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

Tēnā koutou, tēnā koutou, tēnā tātou katoa,

Re: Associate Professor Nicola North

Title: Maori solo mothers' experiences in accessing health care for personal health
needs.

Associate Professor Nicola North has consulted with Office of the Tumuaki at the Faculty of
Medical and Health Sciences (FHMS), University of Auckland about the above project, and
the ethics application. We have read the application and advised accordingly on aspects of
Māori responsiveness.

We have no outstanding issues after this consultation and support the proposal before your
committee.

Noho ora mai

Associate Professor Papaarangi Reid
Tumuaki

Appendix B   Human Participants Ethics Committee Letter of Approval

Office of the Vice-Chancellor
Research Integrity Unit

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

The University of Auckland
Private Bag 92019
Auckland, New Zealand
Level 3, 76 Symonds Street
Telephone: 64 9 373 7599
Extension: 83711 / 87830
Facsimile: 64 9 373 7432

UNIVERSITY OF AUCKLAND

HUMAN PARTICIPANTS ETHICS COMMITTEE

16 May 2011

MEMORANDUM TO:

Associate Professor Nicola North / Rochelle Lee
School of Population Health

Re: Application for Ethics Approval (Our Ref. 2011 / 210)

The Committee considered your application for ethics approval for your project titled "Māori solo mothers' experiences in accessing health care for personal health needs".

Ethics approval has been given for a period of three years with the following comment(s).

1. The Committee commends that this is an extremely thorough and thoughtful application.
2. In the final bullet point of the Consent Form, "it" should be "they".

The expiry date for this approval is 11/05/2014.

If the project changes significantly you are required to resubmit a new application to the Committee for further consideration.

In order that an up-to-date record can be maintained, it would be appreciated if you could notify the Committee once your project is completed.

The Chair and the members of the Committee would be happy to discuss general matters relating to ethics approvals if you wish to do so. Contact should be made through the secretary in the first instance, Lana Lon, l.lon@auckland.ac.nz.

All communications with the UAHPEC regarding this application should include our reference number - 2011 / 210.

Lana Lon
Secretary
University of Auckland Human Participants Ethics Committee
c.c. Head of Department / School, School of Population Health

Rochelle Lee
1-55 Ennis Avenue
Pakuranga
Auckland 2010

Additional information:

1. Should you need to make any changes to the project, write to the Committee giving full details including revised documentation.

2. Should you require an extension, write to the Committee before the expiry date giving full details, along with revised documentation. An extension can be granted for up to three years, after which time you must make a new application.

3. At the end of three years, or if the project is completed before the expiry, you are requested to advise the Committee of its completion.

4. Do not forget to fill in the 'approval wording' on the Participant Information Sheets and Consent Forms, giving the dates of approval and the reference number, before you send them out to your participants.

5. Send a copy of this approval letter to: Manager, Funding Processes, Research Office if you have obtained funding other than from UniServices. For a UniServices contract, send a copy of the approval letter to: Contract Manager, UniServices.

6. Please note that the Committee may from time to time conduct audits of approved projects to ensure that the research has been carried out according to the approval that was given.

Appendix C   Change of Methodology Letter to Ethics Committee

Health Systems

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND
HEALTH SCIENCES

The University of Auckland
Private Bag 92019
Auckland
New Zealand,

Level 2
School of Population health
Gate 1 Tamaki Campus
261 Morrin Road
Glen Innes
www.health.auckland.ac.nz
Telephone: 64 9 373 7599 ext. 82931
Facsimile: 64 9 373-7533
Email: n.north@auckland.ac.nz

19 March 2012

Chair, HPEC
University of Auckland

YOUR REF: 2011/210: Notification of change to approved project

The above Masters research project received approval from the committee on 16th May 2011. I am writing to advise you of a change to the supervision team: I remain principal supervisor, but the second supervisor Dr Elana Curtis has withdrawn her involvement. Dr Curtis's role was principally in relation to guiding the student, Rochelle Lee, in kaupapa Māori methodology. We have been unable to find another supervisor with that particular expertise.

The change in the supervisory team has **not** affected procedures as set out in the application and approved regarding participant recruitment and interviewing procedures. This means there has been **no change** to the following procedures: participant recruitment, data collection through interviewing, feedback to participants (set out in Section B). There has been **no change** to the intended method of analysis employing general inductive techniques (pp.16 & 19 on the application).

Implications of the change in the supervisory team are in relation to data interpretation. The application refers to the employment of an "emancipatory stance" and "critical theory lens" in interpreting the data (p.20), reflecting a kaupapa Māori methodology. As the remaining supervisor (Dr Nicola North), I do not claim expertise in the employment of these stances in relation to Māori. Options have been fully discussed with Dr Papaarangi Read (Tumuaki) and, with the student's agreement, it seems best at this stage to employ general inductive techniques in analysis, but not to claim to be using the critical lens of kaupapa Māori in data interpretation.

Yours sincerely

Nicola North
Associate Professor Health Systems Section

Appendix D   Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Project: Māori solo mothers' experiences in accessing healthcare for personal health needs.

Researcher: Rochelle Lee

Introduction

Kia ora, my name is Rochelle Lee (Te Aitanga-a-Mahaki) and I am a post-graduate student at the School of Population Health, University of Auckland. I have a Bachelor of Health Sciences in psychology from Massey University and I have recently completed a Post-Graduate Diploma in Health Sciences with a specialisation in health informatics, at the University of Auckland. I am currently enrolled in a Master of Health Sciences programme, for which the present research project is being undertaken as a Masters Degree thesis. In addition to being a full-time student, I am a divorced mother of three children, residing in East Auckland. During 10 years of solo motherhood I have noticed differences in the way I take care of my health as well as specific experiences as a Māori solo mother in accessing healthcare. In considering my own perspective and experiences as a solo mother in New Zealand, I am interested to know if other Māori solo mothers of dependent children have similar or differing experiences of healthcare access in taking care of their personal health. The reason for my interest is to better understand the experiences of Māori solo mothers' healthcare access to inform health services and policy.

Research Project

The present project is a qualitative study undertaken as Kaupapa Māori research to explore the experiences of Māori solo mothers in taking care of their personal health. The aim of the research is to better understand the experiences of Māori solo mothers in relation to their health and healthcare. The study also seeks to understand and describe any barriers, facilitators and issues for Māori solo mothers in accessing healthcare services for their personal health needs. Data collection will involve the researcher audio-recording interviews with participants; the audio files of interviews will be transcribed by the researcher. Data analysis will involve the researcher analysing all interview transcripts to identify themes of participants' experiences as well as patterns between themes. Through this research, it is hoped that common difficulties and experiences will be revealed, with the goal of advocating for better support and improved access to healthcare services. Fundamentally, this study would like to give Māori solo mothers an opportunity to share their stories about health matters and experiences in accessing healthcare services, in a culturally safe, personally empowering and respectful manner.

123

Invitation to Participate

I would like to extend an invitation to you to participate in this research project. Participants invited to participate in this research are: solo mothers of dependent children; currently without a partner; self-identified as Māori; aged 18 years or more; residing in Auckland; and comfortable with being interviewed in English. The contribution you can make to this research, through the sharing of your experiences of personal healthcare and access to health services, would greatly benefit the limited body of knowledge related to Māori solo mothers and their health. The findings of this research will contribute to the knowledge and improvement of Māori health and possibly inform future research projects related to the health of solo mothers in New Zealand. The researcher has applied for funding for this research, from the University of Auckland, in the form of research grant.

Participation Requirements

Participation in this research project is completely voluntary. The study period of 7 months duration extends from 31 May to 15 December 2011. Research data is collected during an interview with each participant. To avoid undue inconvenience to participants, research participation will consist of a single interview of up to 1 hr duration, which will be digitally audio-recorded, with your consent. Interviewing will be conducted by the researcher at your home, another person's home by mutual agreement, or the University of Auckland Tamaki Campus, in Glen Innes. As a koha for participation, all consenting participants will receive a $20 food voucher. If you decide to participate, you have the right to not answer specific questions, to have recording stopped at any time, and to withdraw your participation or data. The interview process is not expected to cause any discomfort as participants decide the extent of experience they are comfortable to share. Rather the interview process is intended to be an empowering opportunity to share experiences and issues related to caring for your personal health. If at any time during the interview you feel uncomfortable or distressed, notify the researcher immediately, so steps may be taken to remove discomfort. You may choose to move to another question, pause recording, take a break from interviewing, or end the interview.

After the interview, participants are offered the opportunity to participate in the following if desired. Firstly, participants are offered the opportunity to receive a paper copy of their recorded-interview transcript to check, edit, and keep. Additionally, participants may review a provisional summary of the themes identified by the researcher; participants are encouraged to give the researcher feedback about the themes and accuracy to personal experiences, which will be considered in further analyses. Participation in checking the thematic summary and offering feedback to the researcher is welcomed, but entirely voluntary. Lastly, participants are offered the opportunity to receive a summary of findings and are welcome to report feedback to the researcher; such feedback may be considered in future publication and subsequent research.

Participant Data

Participant's interviews will be digitally audio-recorded, after giving informed, written consent. Even with consent given, you may choose to have the digital-recorder turned off at any point of the interview. Digitally-recorded interviews will be transcribed by the researcher; at this stage transcripts will be coded to remove participants' identity. Only the researcher will have access to the digital audio files, which will be securely stored on her password-protected computer. The de-named interview transcripts may be viewed by the research supervisors, Associate Professor Nicola North or Dr Elana Curtis, during the data analysis phase of the research. Participants will be offered the opportunity to receive and check a copy of their personal interview transcript; participants have the right to edit their transcript if desired. Participants choosing to check the provisional thematic summary will view specific themes identified by the researcher from all of the interviews, but the summary of themes does not identify participants.

Similarly, the summary of findings offered to participants after completion of the research will involve general or major findings, not specific data contribution. All data-related files will be stored securely by the researcher between 31 May and 15 December 2011 during data analysis; once the research project is completed all consent forms, data-related files and documents will be taken to the University of Auckland, School of Population Health and securely stored for 6 years, with consent forms and data stored separately. Storage of data for at least 6 years is expected for research, which

may be published and reviewed by other academics and researchers. After 6 years storage all research-related data will be destroyed through shredding or disposal in a 'confidential bin' at the School of Population Health.

Right to Withdraw from Participation

Participants are under no obligation to participate and may decline to accept this invitation. Additionally, participants are entitled to withdraw from the study at any time without explanation. Participants may withdraw any data traceable to them, from the research project at anytime without explanation, up until 31 August 2011. Withdrawal of participation or data is your right regardless of the koha given.

Anonymity and Confidentiality

All participants are assured of confidentiality and privacy regarding participation. Only the researcher will have knowledge of participants and their personal data contribution. Confidentiality is supported through researcher-only transcription. Interview data will have participant identity removed through coding to preserve anonymity. Digital audio-files and electronic transcripts of the recorded interviews will be securely stored on a password-protected computer locked in the researcher's office. Two research supervisors may be consulted during data analyses; however, data will have been de-named to ensure anonymity. The research will be reported back, to interested participants, as anonymous summarised findings. The research project will be written up primarily as a Master's thesis and will be viewed by University of Auckland examiners, who will have no knowledge of participant's identity. Thereafter, the researcher intends to seek publication of the research findings in a reputable peer-reviewed academic journal. No participant names or other information that identifies you or your data contribution will be used in the thesis or in any other publications. However, due to the nature of the data being your healthcare experiences, you or those close to you who know you well may recognise your contribution in the thesis even though no identifying information will be provided. Presentation of findings to interested parties through hui and academic seminars is also possible. It is hoped the findings of this research will inform health policy, yield knowledge for further research and build theory related to Māori health and solo mothers' health.

For any queries please contact:

Researcher: Rochelle Lee (BHSc, PGDipHSc)
Tel: 027 734 0199
Email: rlee092@aucklanduni.ac.nz

Supervisor: Associate Professor Nicola North
Tel: 09 373 7599 ext 82931
Email: n.north@auckland.ac.nz

Supervisor: Dr Elana Curtis
Tel: 09 373 7599 ext 86470
Email: e.curtis@auckland.ac.nz

Head of Department (Health Systems): Dr Tim Tenbensel
Tel: 09 373 7599 ext 89001
Email: t.tenbensel@auckland.ac.nz

For any queries regarding ethical concerns you may contact:
The Chair,
The University of Auckland Human Participants Ethics Committee,
The University of Auckland, Office of the Vice Chancellor,
Private Bag 92019, Auckland 1142.
Tel: 09 373-7599 ext 83711

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 16 MAY 2011 FOR 3 YEARS. REFERENCE NUMBER 2011/210.

Appendix E   Consent Form

Health Systems

The University of Auckland
Private Bag 92019
Auckland
New Zealand,
Level 2
School of Population health
Gate 1 Tamaki Campus
261 Morrin Road
Glen Innes
www.health.auckland.ac.nz
Telephone: 64 9 373 7599
Facsimile: 64 9 373-7533

CONSENT FORM

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project: Māori solo mothers' experiences in accessing healthcare for personal health needs.
Name of Researcher: Rochelle Lee

I have read the Participant Information Sheet, and have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction. I understand that participation in the research is voluntary.

- I agree to take part in this research and I am aged 18 years or over.

- I understand participation requires a single interview of approximately 1 hour or less.

- I agree / do not agree to be digitally audio-recorded.

- I wish / do not wish to receive a paper copy transcript of my interview.

- I understand that I am free to withdraw participation at any time without explanation and may withdraw any data traceable to me up to 31 August 2011.

- I wish / do not wish to check the provisional summary of themes.

- I wish / do not wish to receive a summary of research findings.

- I understand this research is for a Masters degree thesis, and will be viewed by University examiners.

- I understand the findings from the research may be published in an academic journal**.**

- I understand audio files of interviews and transcript-related documents will be stored securely post-   research for 6 years at the University of Auckland's School of Population Health, after which time they will be destroyed.

Name_____ Signature_____ Date _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 16 MAY 2011 FOR (3) YEARS REFERENCE NUMBER 2011/210.

Appendix F   Minimisation of Harm Information Sheet

Counselling Services

Friendship House Counselling Services (Manukau)
Friendship House, Manukau City
Ph: 262 2322
Email: friendshiphouse@xtra.co.nz

Pakuranga Counselling Service
Off Ti Rakau Dr, Pakuranga
Ph: 576 4248
(Income-dependant small charge)

Māori Mental Health Services
Counties-Manukau DHB
Ph: 262 9500
Email enquiry: http://www.cmdhb.org.nz/Feedback/enquiryform.htm
Website: http://www.cmdhb.org.nz/Funded-Services/Māori-Health/default.htm

Auckland Women's Centre (Greenlane)
Information, advice centre & counselling services
Ph: 376 3227
Website: www.womenz.org.nz

Māori Counselling Services
Waitemata DHB
Ph: 845 1818

Raukura Hauora O Tainui (Wiri)
Mental health services
Te Rangihaeata
Ph: 263 3800

Information Services

Citizens Advice Bureau
General enquiries - free local counselling services
Ph: 576 8331 (Pakuranga branch)

HealthPoint
Online guide to localized healthcare, including counselling services
Website: http://www.healthpoint.co.nz/

Mental Health Foundation
Ph: 300 7010
Email: resource@mentalhealthorg.nz   Website: www.mentalhealth.org.nz

Appendix G   Participant Recruitment Flyer

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Participants Required

Māori Solo mothers' experiences of healthcare access in taking care of their personal health

- Are you a solo mother of dependent (under 18yrs and not employed fulltime) children?
- Do you self-identify as Māori?
- Do you currently have no partner?
- Are you over 18 years and living in Auckland?

If you answered **YES** to these questions, I would like to invite you to participate in a research project aiming to understand Māori solo mothers' experiences in caring for their health and accessing healthcare services:

- This research is being conducted by a **Māori post-graduate student/solo mother**, for a Masters thesis through the School of Population Health, The University of Auckland.

- This project adopts a **Kaupapa Māori framework** as research by Māori, with Māori participants, for the benefit of Māori health.

- Participation requires **one interview of 1 hour or less**, with the researcher at location convenient for you – support from your whānau is welcome.

- All participants receive a **$20 Pak'nSave voucher**, but participation is voluntary and can be withdrawn at any time.

If you are interested in participating and wish to receive more information about the research, please contact the researcher:

Rochelle Lee (Te Aitanga-a-Māhaki)
Phone: 027 734 0199
Email: rlee092@aucklanduni.ac.nz

Approved by The University of Auckland Human Participants Ethics Committee on 16 May 2011 for 3 years, Reference Number 2011/210.

Appendix H   Interview Guide

Mihimihi (introductions, obtaining rapport within culturally appropriate)

- Establish tribal/local/whānau connections
- Provide participant with Participant Information Sheet (PIS)
- Offer any explanations needed and answer any questions regarding the PIS
- Obtain written consent for being involved in interview
- Obtain consent for audio-taping

Interview

Firstly, I'd like to thank you for agreeing to participate in this research by taking part in an interview. The interview consists of broad questions about your healthcare service access and taking care of your personal health; the questions are concerned with your healthcare experiences as a Māori woman and solo mother. Please answer questions with any relevant information you are comfortable with sharing, but you are not expected to share any information that makes you feel uncomfortable. It is also your right to asked for the digital recorder or interview to be paused or stopped at any time. If you are ready we will begin…

Broad Context:

- Can you tell me a little bit about yourself and your current situation?
- How is your health in general?
- Do you have any health concerns?

Discuss their current context as a solo mother, number of children, interest in being involved in interview.
Prompts explore their general feeling about their health, what their current health status is.

Description of experiences accessing healthcare:

- Can you describe an experience where you were helped in some way to access healthcare you needed? (Repeat as necessary)
- Can you describe an experience in accessing healthcare that was unhelpful? (Repeat as necessary).

Prompts explore multiple healthcare access settings (ED, GP, dentist, hospital, preventative services including screening etc). Participants identify an experience and interviewer will follow up to ensure the detail around the experience is obtained including health issue that needed attention, setting of healthcare provision, participant's thoughts as to why the experience helped or hindered (what actually led to the helping or hindering, who was involved in these actions), what effect the experience had on the participant, what was the outcome for the participant with respect to health, effect on whānau, effect on finances etc). This process will be repeated to explore multiple

Description of experiences where healthcare access was not provided:

- Can you describe a situation where you were not able to access healthcare?

Prompts ask participants to describe times when they have been ill and they haven't sought treatment. Prompts will explore the factors that may have lead to this for the participant (time, financial, cultural appropriateness of services, geography etc).

Description of feelings of stigma/discrimination

- Do you think you have ever been treated differently because you are a solo-mother, because you are Māori, because of your gender, because of your socio-economic position, or because of other reasons?

Aim to help participant identify situations where they feel they were treated differently and explore what their views are on why this occurred as per question above.

Poroporoaki (conclusion of interview)

- Is there anything else about your health or ways of caring for your health you'd like to share?
- Are there any other healthcare access or healthcare service experiences/issues you'd like to share?
- What would you like to see come out of this research?

Ensure process is drawn to a close appropriately, participant is asked to add anything else further they want to add, participant is thanked, voucher offered, appropriate farewell conducted.

Closing statement

I would like to thank you for participating in this interview and for sharing your experiences with me, for this research project. I hope you found your participation to be a positive experience. I have enjoyed meeting with you and appreciate the opportunity to talk with you today about your healthcare experiences as a Māori solo mother. I would like to give you this $20 grocery voucher as a koha to thank you for your time and willingness to share your personal healthcare experiences. I would also like to give you this list of local counselling services. If you feel upset at any stage later, because of the experiences raised in the interview, please make contact with one of these services or use the information services given [show on list] to select a preferred service. [If applicable] Would you like your transcript/summary emailed or posted to you? [Collect relevant details].

References

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