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Constraints to implementation of the 10 Steps to Successful Breastfeeding

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Research Report in partial fulfilment of the requirement for the degree Master of Nursing Science at the University of the Witwatersrand

Supervisor: Dr S. Armstrong

May 2014

DECLARATION

I hereby declare that the work contained in this research report is my own original work and that I have not submitted it, or part of it, for any degree at any other university.

All sources and significant contribution that I have cited have been indicated and acknowledged through out the report.

Signature

Date

ACKNOWLEDGEMENTS

I would like to thank the following people for the part they have each played in helping me to reach this point;

Paul, firstly for seeing the value in my venture and secondly for his unquestioning support and patience over the many weekends when I have claimed to be close to the end and yet never seem to reach the finishing line.

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ABSTRACT

Breastfeeding has been identified as an important method of improving health outcomes for infants in South Africa. South Africa is currently not meeting the **Millennium Development Goal** of reducing infant morbidity and mortality rates by the year 2015. The Department of Health has recognised the **Baby Friendly Hospital Initiative** as a means of improving breastfeeding figures and states that all maternity services should implement the initiative, through the **10Steps to Successful Breastfeeding.**

The midwives working with new mothers appear not to be incorporating the principles of this initiative into their practice and South Africa's breastfeeding has been described as poor. Dissemination of policy changes are poorly communicated to the midwives and consequently their breastfeeding practices are often out dated.

The purposeof this research was to investigate why midwives are not practicing the 10 steps to successful breastfeeding.

The study design was qualitative and exploratory and contextual in design. The study method was a modified nominal group technique. The population was all midwives working in the purposefully selected sites. Data collection ceased when data saturation occurred. Template analysis was carried out using Walt's Policy model i.e. using three themes namely, policy, players and processes and Tesch's open coded method to populate the three themes.

All ethical requirements were adhered to.

Validity and reliability were ensured.

Three main themes were identified from the study, these were; policy, players and processes with categories existing within these main themes.

<u>Policy</u>

The 10 steps policy has been implemented using a top down approach, which has not allowed for input from the midwives implementing the policy. The midwives may

lack the skills and tools necessary to effectively involve themselves in policy development.

The importance of having an effective breastfeeding policy was confirmed but it must be for all health care workers that work with mothers and babies.

Without effective communication of the policy to all healthcare workers the desired high standards of breastfeeding practice will not be achieved.

Through the process of implementation the policy will change from what is drafted on paper to what is put into practice, therefore continuous monitoring and assessment is needed.

Players

Two categories of players emerged from the study data.

Health care providers are those providing care for the breastfeeding mother. Health care users are anyone influenced directly or indirectly by the actions and knowledge of the health care providers. The health care provider is described as a consumer and as such will use certain strategies when making health care choices.

Both the health care provider and user will influence the outcomes of the policy through their interpretation and actions.

Process

Without improvement of the knowledge and skills of the healthcare providers the standards of breastfeeding practice will not improve. Poor levels of knowledge and low levels of interest were described amongst all areas of heath care providers. The professionaltraining the midwives described was poor and inadequate for their needs.

The importance of good antenatal education for women was emphasized. It is in the antenatal period that the majority of women form an intention to breastfeed, yet the antenatal education the mothers receive is failing to help them create a positive intention to breastfeed. The education given to the community and women must be meaningful and relevant to their needs. The community at large places little

importance on breastfeeding and this influences strongly on the mothers decision to breastfeed or not.

The midwives face time and resource constraints, some working in understaffed hospitals that keep their postnatal mothers for 6 hours. Poorly trained staff working in resource strained environments are not able to adhere to the most basic elements of the 10 steps.

The issue of advocacy emerged from the data. Midwives allow other co-professionals to undermine their unique relationship with the mother by allowing them to dominate the decisions and actions taken around breastfeeding. The mother has the ultimate right to choose how her baby is fed and this must be recognized by the health care providers.

The government and Department of Health have voiced support for breastfeeding and publically recognised the importance of improving the breastfeeding figures in South Africa, however they have not explored breastfeeding in its broader context and have therefore failed to provide midwives with the tools necessary to successfully implement the 10 steps policy.

Based on the findings of the study recommendations are made in relation to education, practice and research.

The limitations of the study are discussed in chapter five.

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CHAPTER ONE

INTRODUCTION

BACKGROUND

Breastfeeding is a cost effective way to improve health outcomes and prevent death. The Lancet neonatal survival series graded the effectiveness and efficacy of breastfeeding as “incontrovertible” (Darmstadt et al 2005). The importance of breastfeeding for the health and well being of the population is generally an undisputed fact, “the superiority of breast milk has been confirmed”(Kruger and Gericke 2001)

In September 2000 the Millennium Development Goals (MDG’s) were adopted by 189 countries, with the aim of addressing amongst other things global ill health. South Africa was one of the 189 countries that adopted the MDG’s. Of the 8 Goals, Goal 4 aims to reduce child mortality rates by two thirds by 2015, including infant and under five mortality rates (DoH 2007;United Nations 2010). In the Millennium Development Goals Country Report 2010 the target of reducing child mortality was described as “unlikely” to be met by 2015 in South Africa. “The current level of under-five mortality in South Africa is far higher than the international set target for South Africa (20 per thousand live births)” (MDG Country Report 2010).

These are deaths that could be prevented through exclusive breastfeeding. (Sanders 2010)

The Baby- Friendly Hospital Initiative (BFHI) is a global initiative of UNICEF and the WHO and was launched in 1991(UNICEF, WHO 2006). This initiative aims to promote, protect and support breastfeeding. The current BFHI package includes comprehensive guidelines and courses explaining the global criteria for BFHI for policy makers at country level through to administrators at hospital level. The Baby-Friendly Hospital Initiative has been proven to be successful in improving

breastfeeding outcomes, thus contributing towards a reduction in infant mortality(UNICEF,WHO 1998).

The Ten Steps to Successful Breastfeeding - the BFHI package describes the 10 Steps to Successful Breastfeeding that must be practised and assessed in order for a hospital to be accredited as a Baby Friendly Hospital. The hospital must pass each of the Ten Steps and be evaluated by an external inspection team. The steps are comprehensive and include recommended practices for the staff working in these hospitals and are collectively described as The Coalition for Improving Maternity Services 2007 (Lothian and Goer 2007). The initiative has been proven to increase breastfeeding initiation and longer length of exclusive breastfeeding maintenance. (WHO, Child Health & Development 1998).

The Department of Health supports the BFHI and in their Infant and Young Children Feeding Policy 2007 (DoH 2007) it states, “every health establishment providing maternity services should implement the Baby Friendly Initiative” by 2015.

HIV and Breastfeeding The HIV epidemic in South Africa has resulted in changes in infant feeding policies within recent years (DoH 2007). In light of research findings (WHO Kesho Bora Study 2010) the BFHI was revised and includes a handout that provides guidance for “Applying the Ten Steps in facilities with high HIV prevalence” (WHO UNICEF 2009).

Findings of a study in Gauteng– In a study of newborn feeding practices and support at healthcare facilities in Gauteng, Jordaan (2010) compared the practices around breastfeeding support in baby-friendly accredited facilities to non-baby friendly accredited facilities. Jordaan’s finding were in line with global trends and showed that health professional’s knowledge of breastfeeding is lacking although

successful implementation of breastfeeding programmes necessitates the staff interacting with the mothers to have a sound knowledge of breastfeeding (McInnes and Chambers 2008; Kronborg et.al 2007; Cantrill and Cooke 2004). Jordaan described breastfeeding practices in Gauteng hospitals, both accredited and non-accredited as sub optimal when measured against the 10 steps to successful breastfeeding.

PROBLEM STATEMENT

The success of any breastfeeding initiative is influenced by the knowledge, experience and attitude of the nursing staff (Jordaan 2010). Despite overwhelming evidence and government policies supporting the importance of breastfeeding as a cost effective method for helping South Africa to meet it's MDG target for child morbidity and mortality, the midwife working with new mothers appears not to be incorporating the recommendations into her practice. Jordaan's study revealed that practice levels are poor, when measured against the 10 Steps to Successful Breastfeeding although key factors appear to be in place to promote breastfeeding, such as government policy and research evidence. Factors that may influence this may relate to resources, capacity and knowledge. The key to successful breastfeeding still remains with the midwife and there is therefore the need to explore the constraints that affect midwives when implementing the 10 Steps to Successful Breastfeeding.

RESEARCH QUESTION

What constraints do midwives in Gauteng face when implementing the Ten Steps to Successful Breastfeeding in to their practices?

RESEARCH AIM

To determine the reasons for midwives not implementing the Ten Steps to Successful Breastfeeding through assessment of their knowledge and attitude towards breastfeeding.

RESEARCH OBJECTIVES

- Establish the opinions of practising midwives on the relative importance of each of the 10 steps to Successful Breastfeeding
- Explore the opportunities and constraints of practising the steps deemed to be the most important
- Develop an outline for an in-service programme for midwives addressing overcoming constraints related to implementation of the 10 steps.

SIGNIFICANCE OF THE STUDY

By building on the findings of Jordaan's research that shows breastfeeding practices in Gauteng are not in line with The Ten Steps, this research sets out to discover why breastfeeding practices amongst midwives are poor. This provides policy makers and educators with insight and information that they can use when planning policy and education programmes for midwives.

OVERVIEW OF METHODOLOGY

A Contextual, exploratory and a descriptive design was used to explore and describe the constraints facing midwives when implementing the 10 steps to successful breastfeeding.

The population consisted of midwives working in the purposefully selected sites from within both the public and private sector in Gauteng. The inclusion criteria were midwives whose work includes working with breast-feeding mothers in labour ward or postnatal ward. The midwives had to be employed at one of the selected sites and have a minimum of 2 years experience in their field. The midwives had to be willing to sign an informed consent form a to participate in the research process.

Sampling, data collection and analysis continued until saturation occurred. A Modified Nominal Group Technique was used to collect data. Guba and Lincoln's 1985 strategies for ensuring trustworthiness were used, as described by Shenton (2004). Template analysis was carried out using Walt's Policy model i.e. using three themes, namely policy, players and processes and data analysis was achieved using Tesch's method (Tesch1990).

The following ethical considerations were observed:

Consent from the Committee for Research on Human Subjects at the University of the Witwatersrand for ethical clearance was obtained.

Written permission from the Department of Health to carry out the research at the RahimaMoosa hospital was obtained.

Written consent was obtained from the management of Genesis Clinic.

Verbal consent was obtained from the matron at RahimaMoosa Hospital.

Written consent was obtained from the midwives participating in the study.

1.12 STRUCTURE OF THE STUDY

The research report is presented in the following chapters

Chapter One – Introduction and background

Chapter Two – Literature Review

Chapter Three – Methodology

Chapter Four - Findings

Chapter Five –Discussion, Conclusions and Recommendations

SUMMARY

This chapter serves to provide the reader with an overview of the study. The background to the study is described in order to provide the reader with a clear picture of the context in which the study took place. The research problems and aims are stated. The purpose, significance and objectives that guided this study are discussed.

CHAPTER TWO

LITERATURE REVIEW

BACKGROUND

Breastfeeding is essential for the normal growth and development of infants and as a means of reducing infant mortality it is a cost effective methodology. (Hoddinott 2008; WHO 2007 ; Darmstadt 2005). There is overwhelming scientific evidence to demonstrate the benefits of exclusive breastfeeding for all children. (Tshwane Declaration on breastfeeding 2011)

In September 2000 **The Millennium Development Goals** (MDG) were adopted by 189 countries with the aim of addressing the effects of poverty and global ill health. Of the 8 Goals, Goal 4 is Child Health and aims to reduce child mortality by two thirds by 2015, including infant and under five mortality rates (DoH 2007; United Nations 2010, MDG 2000). According to the 2008 South African Health Review, South Africa is failing to meet its target for MDG Goal 4. South Africa is one of only 12 countries worldwide where infant mortality is on the increase despite the large contribution of 8.5 % of the total GDP that the government allocates to health (OECD 2013.MDG Country Report 2012). The greatest contributor to child mortality in South Africa is HIV at 35% but illnesses such as diarrhoea and severe respiratory infections continue to claim a large number of lives – 16% (Sanders 2010). These are deaths that could be prevented through exclusive breastfeeding. The Department of Health (DoH) states that levels of exclusive breastfeeding in South Africa remain unacceptably low. In the Infant and Young Child Feeding Policy it states, "the promotion, protection and support of breastfeeding should continue to be the primary focus" (DoH 2007). Statistics show that in South Africa as few as 10% of babies are exclusively breastfed by 3 months of age (Swart et al 2008) with the figure dropping to 7% by six months (Doherty, Chopra 2006. World Health Stats 2010).

The Baby- Friendly Hospital Initiative (BFHI) is a global initiative of UNICEF and the WHO and was launched in 1991(UNICEF, WHO 2006). This initiative recognises exclusive breastfeeding as being central to achieving the United Nations' MDG Goal Four. The initiative provides an overarching framework of actions that aim to promote, protect and support breastfeeding. The BFHI is 20 years old and global figures for Baby – Friendly Hospitals are below target at 20,000 worldwide. The initiative is anticipated to work in industrialized and developing countries and to be implemented in private and public facilities.

The WHO/UNICEF Global Strategy for Infant and Young Child Feeding was developed in 2002 and defines the obligations and responsibilities of governments, international organizations and other concerned parties (Saadeh 2012). The BFHI is one of the operational targets of the Global Strategy for Infant and Young Child Feeding and calls for action to make all maternity hospitals adhere to the **Ten Steps to Successful Breastfeeding** (WHO 2009,UNICEF 2009) for them to achieve Baby Friendly status.

In South Africa the more encompassing term Mother Baby Friendly Hospital Initiative has been adopted but for the purpose of this report will be referred to as BFHI.

The current BFHI package includes comprehensive guidelines and courses explaining the global criteria for BFHI for policy makers at country level through to administrators at hospital level and guidelines on how each hospital can implement the **Ten Steps to Successful Breastfeeding** in order to be accredited as a Baby Friendly Hospital (UNICEF, WHO 2006). In order to gain this accreditation the hospital must pass each of the Ten Steps and be evaluated by an external inspection team. The steps are comprehensive and include recommended practices for the staff working in these hospitals.The initiative has been proven to increase breastfeeding initiation and longer length of exclusive breastfeeding maintenance. (WHO Child Health & Development 1998, Semenic et.al, 2012, Marais et.al 2010).

Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

1. *Have a written breastfeeding policy that is routinely communicated to all health care staff.*
2. *Train all health care staff in skills necessary to implement this policy.*
3. *Inform all pregnant women about the benefits and management of breastfeeding.*
4. *Help mothers initiate breastfeeding within half an hour of birth.*
5. *Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.*
6. *Give newborn infants no food or drink other than breast milk, unless medically indicated.*
7. *Practice rooming-in - that is, allow mothers and infants to remain together - 24 hours a day.*
8. *Encourage breastfeeding on demand.*
9. *Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.*
10. *Foster the establishment of breastfeeding support group*

Compliance to the *International* **Code of Marketing of Breastmilk Substitutes** (referred to herein as the “code”) is another key component of the BFHI. Since it’s adoption in 1981 by the World Health Assembly it has been in effect on a voluntary basis in South Africa until December 2012 when it became law (Unicef 2012). The code promotes and supports breastfeeding by protecting parents and health professionals from aggressive or inappropriate marketing of breast milk substitutes specifically marketed at infants and young children. In December 2012 the government legislated in favour of the code(Unicef 2012). The new regulations fall under the Foodstuffs, Cosmetics and Disinfectants Act,1972 (ActNo.54 of 1972).

The Department of Health supports the BFHI and in their Infant and Young Children Feeding Policy 2007 it states, “every health establishment providing maternity

services should implement the Baby Friendly Initiative" (DoH2007). By August 2008, 211 hospitals in South Africa had BFHI accreditation, 14 facilities in Gauteng were included in this figure (Jordaan 2010).

The Tshwane Declarationof support for breastfeeding in South Africa was delivered on the 22nd August 2011 by the Minister of Health Dr. Aaron Motsoaledi (Motsoaledi 2011) and clearly stated that South Africa's unacceptably high infant mortality rates and low breastfeeding rates needed to be addressed. The declaration stated that breastfeeding had been undermined by aggressive promotion and marketing of formula feeds, social and cultural perceptions, and the distribution of formula milk to prevent mother to child transmission of human immunodeficiency virus (HIV). The declaration called for commitment and action from government, community leaders, traditional leaders, healthcare workers, employers, the media and every citizen to support breastfeeding. It further stated that all private and public hospitals were to be Mother Baby Friendly accredited by 2015, that mothers with HIV should breastfeed for 12 months, that legislation must support the working mother in her endeavor to provide breast milk for her baby and that free formula delivery within South African hospitals would cease (Tshwane declaration of support for South Africa 2011).

Study Findings

Gauteng Study - In a study of new-born feeding practices and support at healthcare facilities in Gauteng Jordaan (2010) compared the practices around breastfeeding support in baby-friendly accredited facilities to non-baby friendly accredited facilities. She found that although accredited facilities fared better than non-accredited facilities, none of the 9 facilities passed all 10 steps.

Jordaan's finding were in line with global trends that show health professional's knowledge of breastfeeding is lacking although successful implementation of breastfeeding programmes necessitates the staff interacting with the mothers to have

a sound knowledge of breastfeeding (McInnes and Chambers 2008; Kronborg et.al 2007; Cantrill and Cooke2004).

Jordaan's study also found that midwives perceived breastfeeding to be time consuming, even in some of the Midwives Obstetric Units where the staffing levels were generally better with staff numbers occasionally exceeding patient numbers. Furber has noted how mothers describe midwives as "popping in" rather than spending time with them (Furber and Thomson 2007) and Reddin describes how midwives see breastfeeding as a "chore to get over and done with" (Reddin et.al 2007). Jordaan further comments that "if staff are not in the habit of helping mothers at times when it is busy, it is doubtful whether staff will help at times when it is quiet". Mothers express wanting "to be listened to: and they wanted more time" (Backström et.al 2010). Mothers want to be shown how to feed rather than it being done for them, which may be a result of time pressures (Mc Innes & Chambers 2008). Health professionals are often described as overworked and tired. The lack of proactive support offered by the midwife may add to the mother's reluctance to ask for help (Mc Innes & Chambers 2008). These findings compare with those made by Jordaan, where mothers claim they did not know they could feed or nurse because the staff was so busy. Jordaan states that the breastfeeding attitude of the midwives was influenced by "the emphasis put on breastfeeding support from top management as well as the nurse and matron in charge of maternity " (Jordaan 2010). There is published evidence identifying the lack of maternity service support for breastfeeding mothers (McInnes & Chambers 2008), yet without support within the maternity services it is difficult for the midwife to deliver or practice effective breastfeeding education to the mother.

Other study findings

Despite growing evidence to support the positive impact of the BFHI there have to date been few studies to investigate the barriers and constraints to the implementation of the policy (Semenic 2012, Schmied et al. 2011,Saadeh 2012, Daniels 2011).

These available studies share common themes;

Time and resource constraints: midwives recognized that the most important resource they needed was time and that the lack of it may force the midwife to take short cuts or seek a quick fix, such as give a bottle of formula to helpsettle the baby (Schmied et.al 2011). The same report noted that the priorities of the individual hospital also put time pressures in place, for example short hospital stays are not always conducive to establishing breastfeeding.

Reluctance to change old practices for new: Long-standing practices have made it difficult for staff to accept the concepts of the BFHI(Daniels 2011, Marais 2010). Staff also thought some of the practices in the 10 steps would be detrimental to the babies and the mothers (McKeever and St Fleur 2012), for example (step4) skin to skin contact would cause hypothermia in the baby and rooming in (Step7) would exhaust the mother by depriving her of rest. Inadequate knowledge and out dated practices were most commonly attribute to senior nurses or medical staff (Semenic 2102). However Daniels noted that once the staff had implemented the rooming-in step they actually found that they had more time to tend to other duties.

Involvement of all the health professionals working with mothers andnewbabies - medical staff were apprehensive about inducing guilt in mothers who did to wish to breastfeed (Mc Keever and St Fleur 2012). The BFHI has also been described as “something that is being forced on staff and women” (Schmeid et.al 2011) which indicates that it possibly is not seen in its wider context of a process to improve health care practices but rather as a series of tasks to be performed.

Breastfeeding educationfor all health providers and the women and the communitiesserve: observance of cultural and religious customs had to be taken into account and the community engaged in the initiative in order for it to work well in the Jersey Shore case study (Mc Keever and St Fleur 2012). Lack of education results in inconsistency of information, which in turn is described as being stressful for the mother receiving the conflicting information and for the healthcare worker who has to correct it (Schmied et.al 2012). The availability of mandatory and flexible breastfeeding education for all levels of maternity staff was commonly mentioned in an integrative review of barriers to implementation of the BFHI carried out by Semenic et.al 2012.

The value of the BFHI and the benefits to mother and baby were universally recognized but also that hard work and commitment were required for it to be realised (Mc Keever and St.Fleur 2012, Schmied et.al 2011, Semenic 2012).

Although the global rate of accredited hospitals is relatively low at 20,000 in 159 countries the progress towards adopting the 10 steps is positive (Semenic 2012). This confirms that the BFHI is a complex multifaceted programme requiring involvement from government bodies, health professionals, credible leadership and the presence of a central coordinating group(Schmied et.al 2011. Saadeh 2012). One paper described its implementation as a “slow drift” from traditional methods of care to evidence based and often-unfamiliar practices (Mc Keever and St Fleur 2012).

HIV and Breastfeeding The HIV epidemic in South Africa has resulted in changes in infant feeding policies within recent years (DoH 2007). In light of research findings (WHO Kesho Bora Study 2010) the BFHI was revised and includes a handout that provides guidance for “Applying the Ten Steps in facilities with high HIV prevalence”

(WHO. 2009). In April 2010 The DoH and National AIDS council released revised clinical guidelines for prevention of mother-to-child transmission of HIV (Clinical Guidelines: PMTCT 2010). These guidelines discuss the importance of exclusive breastfeeding for all infants and highlight the dangers of mixed feeding for this population group (Coovadia 2007). It is understandable that midwives are not always keeping up with the changes in policy on breastfeeding and HIV group. Midwives have been found to have specific knowledge gaps related to latest trends and research in relation to HIV and breastfeeding (Minnie 2006). Health professionals generally have been found to share the fear of HIV positive mother's breast milk with the mothers and have displayed anxiety when counseling the mothers about the new guidelines which in turn influences the mothers decisions to breast feed (Koricho et.al 2010. Chisenga et.al 2011).

HIV is not mentioned as a barrier or constraint to BFHI implementation in studies outside of Sub -Saharan Africa. To date there is no data available to indicate the effect of the implementation of the BFHI in areas of high HIV prevalence.

CHAPTER THREE

METHODOLOGY

2.1 INTRODUCTION

The methodology, the study design, the setting, the population, data collection, data analysis, validity and reliability and ethical considerations are discussed in this chapter.

2.2 DEFINITION OF METHODOLOGY

This refers to how the research was done and its logical sequence. According to Polit and Hungler (2004) methodology refers to ways of obtaining, organising and analysing data.

2.3 STUDY DESIGN

A qualitative method of study was used for this research because as Creswell (2009) stated “the researcher (is allowed) to keep focus on learning the meaning that the participants hold about the problem”. Qualitative methodology is dialectic and interpretive. The Qualitative method allows the participants world to be discovered and interpreted through the interaction between the researcher and research participants (De Vos 2005).

An exploratory and contextual design was used to explore and describe the constraints midwives experience when implementing the 10 steps to successful breastfeeding.

Mouton (1996) stated that the aim of contextual research is to produce an extensive description of the phenomena in its specific context. Therefore the researcher was allowed to explore and describe the constraints faced by midwives when

implementing the 10 steps to successful breastfeeding. The setting was discussed in chapter one.

According to Mouton (1996) the aim of an exploratory study is to establish the 'facts', to gather new data and to discover any interesting patterns that might exist within the data.

There is no literature available describing the constraints experienced by midwives in South Africa when implementing the 10 steps to successful breastfeeding and therefore use of an exploratory design allow for discovery of new facts about the phenomena.

2.4 RESEARCH METHOD

2.4.1 The Population

A population is the entire group of persons that is of interest to the researcher (Burns and Grove 2001). In this study the population is all midwives working in the purposefully selected sites.

Midwives were used because they are the healthcare workers that are trained in breastfeeding and are the primary educators of pregnant, labouring and postnatal women. They are the ones instructed to carry out the practices described in the 10 steps to successful breastfeeding and therefore the ones that experience at first hand the constraints of practically implementing policies.

2.4.2 Site Selection

The sites used for the data collection were purposefully selected to allow for better understanding of the research problem (Cresswell 2009).

The chosen sites were,

Rahima Moosa Hospital –is a non specialised mother and child hospital that does not have Baby and Mother Friendly Hospital accreditation. The hospital was included in the 2010 study carried out by Jordaan that looked at standards of practice as

measured by the then Baby Friendly accreditation tool. Jordaan found that the hospital failed to meet the standards required for accreditation. Rahima Moosa is yet to apply for formal accreditation by the Department of Health.

Genesis Clinic –is an eight-bedded private midwives obstetric unit. The clinic was not included in the 2010 study and is pending accreditation by the Department of Health for Baby and Mother Friendly Hospital.

2.4.3 The Sample

Midwives working in the selected sites were invited to take part in the study through participation in modified nominal groups of between 4 and 8 participants per group, in order to allow everyone the opportunity to participate (De Vos 2005). As this was a contextual study it was limited to the two sites.

Inclusion Criteria:

- Midwives whose work included working with breast-feeding mothers – labour ward or post natal ward.
- The midwives must be employed at one of the selected sites and have had a minimum of 2 years experience in their field.
- The midwives had to be willing to sign an informed consent form to participate in the research process.

2.4.4 Data Collection

Data collection refers to the process of gathering the information required to address the research question. In this study data were collected through modified nominal group technique. Data were collected between December 2012 and June 2013. The researcher experienced a delay in gaining access to Rahima Moosa Hospital.

Modified Nominal Group Technique – This is a modification of the Nominal Group Technique devised by Delbecq and Van den Ven in1986 as described by Kitzinger(1995). Participants are allowed to discuss and explore views using

everyday language rather than responding to a carefully constructed question, thus the researcher has the potential to ‘‘reveal dimensions of understanding that often remain untapped by more conventional collection data techniques” (Kitzinger 1995). Through a sharing of ideas and discussion the participants are able to combine ideas that can merge into a group consensus.

The purpose and outline of the methodology was described to respective managers and matrons of the research sites. Once their permission had been granted the researcher approached the midwives working within the sites to explain the purpose of the research and the format of the study. The researcher provided the potential participants with an information sheet that contained additional information about the study such as approximate length of time required from the participant and assurance of confidentiality and privacy in the research report. Through discussion all participants agreed upon a date time and location for the data collection to occur. Follow up calls were made to each ward the day before the groups were due to meet to serve as a reminder.

One group chose to meet in the training room of their clinic at 10:00. The second group chose to meet at 15:00 on a Friday afternoon in a tea lounge close to the wards. Before the groups began all participants completed consent forms. A brief overview of the proceedings was given, to refresh participants’ memories and also to allay any fears that they were to be tested on their knowledge of breastfeeding. The participants were assured that their experiences and opinions were of importance and that there were no right and wrong answers and that all contributions were of equal value. This also served to break the ice and ensure that everyone was ready to participate.

Each group was given 10 cards displaying one of the 10 Steps to Successful Breastfeeding.

- Through group interaction and discussion the participants rated the importance the 10 Steps to Successful Breastfeeding from 1 to 10

- The 4 highest ranked steps were taken and further discussion took place to establish;

    Why these steps scored a high ranking

    How practical these steps are to implement

    Constraints encountered when implementing the chosen steps

The researcher also took field notes during the data collection and reflective summary was used. Reflective summary is when the interviewers repeat in their own words, the ideas, opinion and feelings of interviewees correctly (De Vos 2005). The group sessions were recorded via tape recorder with the participants' consent and transcribed verbatim.

At the end of the interview all the participants were thanked for their involvement and assured that the findings would be made known to them.

2.4.5 Data Analysis

Template analysis was carried out using Walt's Policy model i.e. using three themes, namely policy, players and processes and Tesch's open coding method to populate the three themes.

Tesch described eight steps in the process of data analysis (Tesch 1990).

1. A sense of the whole was obtained by reading through the initial unstructured transcripts of the group discussions. Notes were made of immediate ideas that came to mind.
2. The first groups' transcript was selected and the following questions asked "What is this about?" and "what is the underlying meaning?" Attention was paid to the topic, not the content. The topics were noted in the margin.
3. A list of all the topics was compiled and each topic given a separate page. The topics were compared and similarities between identified, these topics

were then clustered together. A new list was then made containing three columns namely; major topics, important but rare topics and leftovers.

4. The list was taken and abbreviated into codes. The codes were written next to the appropriate section of the text. Additional notes were kept in the form of researcher memos. The second transcript was analysed in the same manner and similar codes identified as well as some unique ones.
5. Three descriptive words were identified that emerged in much of the data. Subcategories were identified and relations between categories were sought and highlighted by drawing lines between inter related categories.
6. The final decision on abbreviations for the codes was made and the codes alphabetized.
7. The data material belonging into each category collected together and a preliminary analysis was done. Commonalities of content, uniqueness in content and confusions and contradictions were looked for.
8. Existing data could be recoded at this stage but was not deemed necessary by the researcher.

2.5 VALIDITY AND RELIABILTY

Trustworthiness was ensured in this study by using Lincoln and Guba's (1985) strategies as adapted from Strategies for Ensuring Trustworthiness in Qualitative Research Projects (Shenton 2004).

2.5.1 Credibility

- Trusted research methods were used for data collection and analysis.
- Through her professional work as a midwife educator and lactation consultant the researcher was familiar with the culture of both the participating organizations and the phenomena under scrutiny.

- Inclusion in the study was voluntary and all potential participants were given the opportunity to refuse to participate in the study, thus ensuring that only those keen in contributing data were included.
- The use of different sites served to enhance credibility of the study.

2.5.2 Transferability

Detail of the context of the fieldwork is described so that the reader can decide whether or not the findings may be transferred to another setting. A dense description of the design, methodology and supporting literature maintained clarity.

2.5.3 Dependability

Through the achievement of credibility, dependability is to a degree ensured.

The detailed dense description of the study method ensured dependability.

2.4.5 Confirmability

Confirmability occurs in the presence of credibility, transferability and dependability as described by Holloway &Wheeler 1996 (Rolfe 2006). The researcher utilised the following auditing criteria;

1. Collected the raw data from the tape recorders
2. Analysed raw data and findings of the study through de-contextualization
3. Made a synthesis of the analysed data through re-contextualisation
4. Carefully planned each phase of the research process, research design, sampling design and data collection process.
5. Made sure that the conclusions of the study's findings were supported by the analysed data.

By keeping a detailed audit trail an observer would be able to trace the trail of the research, step by step.

The researcher held a discussion with some of the midwives from the chosen sites to discuss and concur on themes identified in the research.

2.6 ETHICAL CONSIDERATIONS

The research proposal was submitted to the Faculty of Health Sciences Postgraduate Committee of the University of the Witwatersrand and permission for the study to be conducted was granted.

The research proposal was submitted to the Committee for Research on Human Subjects at the University of the Witwatersrand and permission for the study to be conducted was granted.

Permission to conduct the study was obtained from the Department of Health in each of the chosen sites.

Verbal consent was obtained from the managers of the chosen sites to hold the discussion groups amongst consenting midwives.

In order to obtain an informed consent an information sheet outlining the background and aims of the study was provided for each prospective participant prior to scheduling the discussion group.

Written consent was then obtained from each participant prior to the discussion group and each participant was made aware that they could withdraw from the study, without penalty, at any time.

The participants were informed that all information collected through the study would be kept in confidence and that the written report findings would not singularly identify any of the participants.

To ensure anonymity and confidentiality the tapes and transcripts were kept by the researcher in a locked cabinet. Polit and Hungler (2004) state that confidentiality means that no information that the participant divulges is made public or available to

others. No names of participants or their colleagues were mentioned in the final report. All findings in this study were reported.

The researcher was cognisant of personal biases and values and remained objective as far as possible. During this study no harm came to any participant and ethical considerations were adhered to at all times.

2.7 SUMMARY

This chapter provided an explanation of the research methodology. The study design, population, sample, data collection, data analysis, trustworthiness and ethical considerations were described. Chapter 4describes and discusses the findings.

CHAPTER FOUR

FINDINGS

4.1 INTRODUCTION

The findings of the study are discussed in this chapter. Walt's (2000) model of policy analysis was used as a template for analysis and each of these themes is explained in this chapter using either Walt's own description or additional resources for understanding of what is understood by the three concepts or themes. The content analysis that was conducted using Walt's three themes viz. policy, players and process, as a guide generated nine categories as seen in Table 1. Walt's themes allowed the themes and categories described in this study to be placed into an existing structure that was used to describe health policy development. These emergent themes form a template for analysis and understanding of the data, thus allowing the relationships between the themes to be discussed (Walt et.al 2008).

The 10 steps to successful breastfeeding is a policy that requires the relevant players to perform processes in order for the policy outcomes to be met. The constraints that the midwives recognised with the implementation of the 10 steps are discussed using the themes policy, players and processes and all emergent categories are embedded into this framework.

4.2 RESEARCH FINDINGS

The themes and categories are discussed in detail.

Table1. Themes and Categories that Emerged from the Data

Main Themes	**Categories**
POLICY	1.The value of a breastfeeding policy 2.Communication of policy 3. What works on paper may not work in practice
PLAYERS/ACTORS	Healthcare Providers Health Care Users
PROCESSES	1.Knowledge and skills of healthcare providers 2.Intention of the mother to breastfeed 3.Time and resource constraints 4.Lack of Advocacy

4.2.1 POLICY

Policy is described as " A purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern" (Anderson 1975:3 in Walt). The Mother Baby Friendly Hospital Initiative requires implementation of the 10 Steps to successful breastfeeding and can therefore be described as following the "top down approach" model, Walt (2000). In this model policy formation occurs at international and governmental level and once devised it is " a largely technical process to be implemented by administrative agencies at national or sub-national levels". WHO devised the BFHI and Ten Steps and the South African Department of Health is administering its implementation in hospitals and community clinics across the country.

Top Down Approach - Once the politicians and bureaucrats have decided upon a health policy, it is communicated to planners in the health department who design appropriate programmes with guidelines, rules and monitoring systems.These are then transferred to local health authorities to be put into practice.Hogwood and Gunn(1984) call this top down approach the "perfect implementation model" that must adhere to certain preconditions if the policy is to reach its objectives as described in Walt.(Walt 2000)

The linear top down approach is in contrast to the bottom up approach where the implementers can play an important role in the planning of policy. Because they are closer to the problem they can provide information that can shape the policy and it's mode of implementation (Walt 2000).

Three categories emerged from within the policy theme.

1.The value of a breastfeeding policy

2.Communication of policy

3. What works on paper may not work in practice

1 .The value of a breastfeeding policy

The midwives acknowledged the importance of a breastfeeding policy and saw it as a source of information that could be practically applied to their practice. Some even saw it as the most important step of the 10 steps.

" (Policy) ***is the most important, the breastfeeding policy, so that we can discourage formula feeding and make sure that every mother is breastfeeding. Policy comes first" (Pu:1)***

It was also recognised that although the policy can be a useful tool for training it should not be confined only to the midwives but extend to all staff working with mothers and babies, including medical staff.

"***It is important to have a good breastfeeding policy in place for training midwives and all staff"(Pv:15)***

However comprehensive it may be a breastfeeding policy is unlikely to address all eventualities, thus allowing for some poor breastfeeding practices to continue. Without the direction provided by a policy the midwife may be forced to seek advice from the medical staff, whom are very unlikely to be familiar with hospital policies or favourable breastfeeding practices. The literature shows that the majority of doctors do not familiarise themselves with hospital policies on breastfeeding practices, viewing these to be for nursing staff alone (Bodribb et.al 2008).

The midwives were asked to get involved with the development of the policy but as one midwife expressed, there was no consensus of opinion.

"They are commanding us to have a consensus but we cant agree with one thing, some people are better than others at reasoning, I wish it could be modelled on a national policy so we could model it on that, which thing we can implement it on"(Pu:2)

This particular midwife was unaware that there is a national policy on infant and child feeding which could have been a useful tool for them to use. Playing an active role in the development of a hospital breastfeeding policy may not be familiar territory for many midwives and they may therefore lack the necessary skills. A bottom up approach to policy development may have allowed for the development of these skills by the midwives.

2. Communication of Policy

The midwives strongly recognise the need to communicate the policy to all healthcare workers to ensure that the policy is a working document and therefore a useful tool.

"Policy should be routinely communicated to all healthcare workers and staff, that really shouts to me" (Pu:2)

They describe how the policies frequently change and that the new elements of the policy are not effectively communicated to all the staff members to provide cohesion of practice.

"Every so often you hear about this thing, that this new thing came up, or this new part of the policy came up but it is not really sunk into the staff members or given that good in-service where all the staff members know about it and all understand what is happening here and we think now I really know about it" (Pu:2)

It was also highlighted that there are many policies that each need to be communicated to the staff and that there is not always the time in a busy unit to spend time familiarising oneself with policy changes.

"It's just that I feel that is meant to be read weekly to update ourselves….but to be honest with you I don't have the time…..and to have the breastfeeding

policy over all my other policies that need to be read, that is a constraint"(Pu:3)

"people don't read them" (Pv:2)

Effective communication of the breastfeeding policy is obviously challenging as midwives face time constraints and the turn over of staff is high and compliance amongst individuals will vary greatly. There is the risk of policies going unread with the result that the potential benefits of improved practice measures may be lost.

3. What works on paper may not work in practice

The midwives were aware that the implementation of a policy in the practice arena may lead to very different results from those envisaged in the planning arena.

"Because what works in practice is not the same…as what is on paper. But there must be guidelines" (Pv:2)

This awareness illustrates that the implementation of a policy is not a straightforward process and although the need for guidelines and policy is universally accepted there should be a process of monitoring and assessment to ensure both its correct implementation and efficacy.

"they might even read them but practical application of them is completely different" (Pv :2)

4.2.2 Summary of Policy Findings:

The 10 steps policy has been implemented using a top down approach, which has not allowed for input from the midwives implementing the policy. The midwives may lack the skills and tools necessary to effectively involve themselves in policy development.

The importance of having an effective breastfeeding policy was confirmed but it must be for all health care workers that work with mothers and babies.

Without effective communication of the policy to all healthcare workers the desired high standards of breastfeeding practice will not be achieved.

Through the process of implementation the policy will change from what is drafted on paper to what is put into practice, therefore continuous monitoring and assessment is needed.

4.2.3 ACTORS/PLAYERS

The actors or players are the people who implement the steps of the policy.

Walt describes the actors as those "who try to influence" the policy and includes amongst others professional groups and community structures including families.

Two categories of players emerged from the data;

- **Health care providers**
- **Health care users or health care consumers**

Health care providers are the professionals that care for the breastfeeding mother and were identified in many roles. See table 2.

Health care users incorporate all members of the community that are influenced directly or indirectly by the actions and knowledge of the health care providers. See table 2.

The number of actors illustrates the deeper complexity surrounding the issue of breastfeeding. Each player will bring influence to bear on the success of any breastfeeding policy.

Health Care Providers

Michael Lipsy (1980) coined the concept of street-level bureaucracy. He argued, "policy implementation in the end comes down to the people or individuals who

actually implement it" (Sutton 1999). She emphasises that the individuals are not simply cogs in the process, but have the ability to mould the policy outcomes". Street level bureaucrats are defined as individuals who on a daily basis interact with regular citizens and provide force behind the rules and laws in their areas of expertise (Sutton 1999). Examples given of street level bureaucrats include police, social workers and schools. For the purposes of this study the term can be applied to those health care providers working with breastfeeding women.

Lipsy went further and identified several problems with street level bureaucrats. As a result of time constraints and limited resources and other practical considerations the practical working out of a policy to produce an outcome may be quite altered from that originally intended by the policy makers, due to the influence of the street level bureaucrats. The influence can be described as professional discretion.

There is also the view that the exercising of professional discretion by street level bureaucrats is not inherently "bad" but can be seen as an important professional attribute. (Evans & Harris in Sutton 1999).

It has been argued that the street level workers "actually make policy choices rather than simply implement the decision of …official" .Policy implementation changes are a reflection of the individual value of each street level bureaucrat rather than the pure will of the policy makers (Maynard-Moody and Musheno 2003).

Health Care Users

A health care user is a consumer of the services offered by the health care provider and as such can be described as a health care consumer.

A consumer needs to recognise a need or use for a product before they will buy or make use of it, for example improved life style benefits. It is therefore logical to assume that the health care provider should recognise and understand the characteristics of the health care consumer they are serving. Through this

understanding the health care provider is better placed to market their service with improved efficacy.

Literature shows that health care users are more passive than previously assumed and that health choices are shaped more by economic and social forces than health warnings. (Wolf et.al 2005). This notion is supported by an article recently published in a UK newspaper (The Guardian 2013) that described a significant fall in breastfeeding figures despite an on going “breast is best” campaign run by the UK government since the mid 1970’s and the implementation of the BFHI. This reflects the consumers’ freedom to choose which in this example is the woman’s right to choose the feeding method for her baby that she deems most appropriate.

Payneet.al (1993) described some of the strategies that health consumers employ when making health related decisions and these illustrate that the price of a product is often considered before the quality. Health consumers show a tendency to be habitual and do what they did last time. They also establish which option has the highest number of good features and the benefits thereof.

Table 2.

Health Care Providers	Health Care Users
Midwives ***"start with midwives training"(Pv:15)*** Paediatricians ***"paeds are also health care staff" (Pv:3)*** Doctors ***" doctors are not interested" (Pv:15)*** Hospital staff **"training all healthcare professionals" (Pu:9)** Senior hospital staff Breastfeeding committee Matrons Dieticians Nursing sisters NICU staff Antenatal clinic Post natal sisters ***" didn't see one sister teach a mother tobreastfeed" (Pv:14)*** Community midwives Private clinics Night nurses Dhoulas	Women Post natal mothers Mothers ***"the mothers taught me" (Pv:21)*** Patients HIV+ve mother Sick mother Mothers of baby in NICU Primigravidas ***"Like primigravida mothers….not getting any information" (Pu:4)*** Mothers attending ante natal clinic Client Pregnant women Baby Baby with breastfeeding problem Sick child Family Husband ***"also support from the husband and family" (Pv:2)*** Grand-daughters Parents

Support groups Lactation consultants Well trained sisters ***"Every sister has a different technique" (Pv:16)*** Government ***"the government is not doing enough…need to take breastfeeding seriously" (Pu:9)***	Daughters Teenagers ***"The decision to breastfeed is made when you are a teenager" (Pv:6)*** Employers ***"Woman…will approach her employer " (Pv:9)*** Community ***"we have to change the attitudes of the…community" (Pv:5)*** School girls ***"Kids at high school should be taught that human babies should be fed human milk " (Pv:6)*** Restaurant owner

"Although we know that individuals do not always choose optimally a certain amount of rationality applied by healthcare users is assumed .This rational healthcare user would strive for an optimal combination of healthcare attributes at low costs "(Payne et.al 1993).
This would indicate that if breastfeeding was marketed favourably to the health care user that it would be chosen as the preferred method of baby feeding .

The cost of health to any nation is considerable and rising continuously. It is therefore important that health care providers and policy makers understand who is the user or consumer of their health service. Literature is beginning to emerge on this topic and the identity of the consumer has been profiled(Deloitte Center for Health Studies 2012).

4.2.4 Summary of Actors/Players Findings:

Two categories of players emerged from the study data.

Health care providers are those providing care for the breastfeeding mother. Using Lispy's street level bureaucrat model the likelihood of changes that may be brought to the policy was described.

Health care users are anyone influenced directly or indirectly by the actions and knowledge of the health care providers. The health care provider is described as a consumer and as will use certain strategies when making health care choices.

Both the health care provider and user will influence the outcomes of the policy through their interpretation and actions.

4.2.5 PROCESS

The actions or processes of the players bring about the realization of the objectives of the policy.

Walt describes process as follows;

"The implementation process involves the interaction between the community and the health service, as well as between provider and recipient. Poor-quality care or information, rudeness, lack of communication alongside human resource problems of incentives, motivation, support and supervision, can all intervene to make successful implementation of services break down, or lead to lost opportunities for intervention"

"policy implementation encompasses those actions by public and private individuals and groups that are directed at the achievement of goals and objectives set forth in prior policy decisions " Van Meter and Van Horn 1975from Public Policy by Sapru (2009)

Four categories emerged from the data;

1.Knowledge and skills of healthcare providers

2.Intention of the mother to breastfeed

3.Time and resource constraints

4.Lack of Advocacy

Each category is discussed in detail;

1.Knowledge and skills of healthcare providers

The midwife is often seen as the key to breast-feeding;

"It is important to start with the midwives training" Pv:15

The midwives are in a prime position to provide valuable information and support to the breastfeeding mother yet they are shown to have knowledge gaps, provide anecdotal advice and allow their own attitudes towards breastfeeding to influence the care they provide (McInnes 2008, Ebersold et.al 2007, Creedy et.al 2008, Jordaan 2010, Semenic 2012).

"'Some people (midwives) know and some don't that is frustrating" (Pu:3)

"There is so much more to it than your own experience…..I agree, it's about supporting and teaching the mother" (Pv:16)

"We have all had different experiences with breast feeding and maybe need to speak the same language"(Pv:15)

Although they are definitely at the front line the midwives require the support from the entire maternity health care team to achieve success and so breastfeeding knowledge and skills should be provided for all healthcare providers, not just the midwives interacting with the mothers.

"Training should be for all healthcare staff"(Pv:5)

The paediatricians and gynecologists must be included in the education process, as should the unit managers and nurses at every level of maternity care, from the community antenatal clinics to specialized areas such as neonatal ICU.

" Don't you think that right from the pregnancy stages is should also come from the gynaes?" (Pv:6)

Training and education for all healthcare providers are recognised as key recommendations according to a review published in 2012(Semenic 2012). In a policy statement from the American Academy of Paediatricians (AAP 1997) paediatricians were strongly encouraged to increase their competence in the physiology and clinical management of breastfeeding.

Inadequate staff knowledge and outdated practices, particularly among senior nurses or medical staff (Semenic 2012) are detrimental to successful breastfeeding.

"Its all about training all healthcare professionals, I might know but there may be four who don't" (Pu:9)

"All health care professionals have a responsibility to support breastfeeding though active lactation management" (Yngve and Sjöström 2001)

The midwives recognize the need to include all health care professional in education and training; otherwise the mother receives mixed messages through inconsistent information from different health care providers.

"Every sister has different technique and that can confuse the mother" (Pv:16)

These mixed messages lead to confusion and frustration for the mother and undermine the importance of exclusive breastfeeding. Through the education of the health care providers there is greater consistency in the information given to the mothers which Schmied et.al (2011) then believes leads to "happier staff" as their own self-efficacy is enhanced.

The midwives described the lack of support they received from the paediatricians and attribute it to their lack of training on the subject.

"Well paeds are also health care staff so they (should) also (be) included in training" (Pv:3)

Physicians have been found to often be unfamiliar with how to give appropriate breastfeeding support and management (Mc Keever and St Fleur 2012).

Research undertaken amongst Australian doctors found that only a minority felt confidence to assist breastfeeding women. The report found that doctors' confidence in their abilities was actually greater than their levels of knowledge (Bodribb 2008). Bodribb went on to describe that doctors who had breastfed their own babies displayed more confidence than those who had not. The report concludes that improving knowledge may not necessarily improve attitudes, strengthening the view that breastfeeding support is a multi faceted complex process requiring specialized knowledge and skills. This opinion is echoed by the midwives in the study.

"We know breastfeeding is complex" (Pu:3)

There is no formal requirement for medical staff to undertake specialized breast-feeding training.

"How do we get paeds to train? It's not compulsory "(Pv:21)

In September 2012 Stellenbosch University Faculty of Medicine and Health Sciences was awarded the contract to develop national breastfeeding training material for health workers (Stellenbosch University 2012). This follows the Tshwane Declaration but is not clear if this includes medical staff.

If doctors are not even aware of hospital feeding policies it may be understandable that they don't view themselves as part of the health care team that require breastfeeding training.

The actions of the medical staff are sometimes viewed by midwives as being detrimental to good breast-feeding outcomes.

"Doctors are not interested – they are always ready to tell the mother that formula is just as good"(Pv:15)

Supplementation of breast milk in the first few days is one of the strongest indicators of breastfeeding termination.(DiGirolamo et.al 2005,Perrine et.al 2012,Declercq et.al 2009).

Doctors are reported as not supporting breastfeeding over bottle feeding and have also been found to use their personal experience of breastfeeding as a basis for the advice and education they offer their patients (Bodribb 2008).

Some doctors continue to order routine blood sugars although this has a negative impact on breastfeeding and subtly undermines the mother's confidence in her ability to provide adequate nutrition for her baby.

"We should stop routinely testing blood sugars…….in the private clinics most of them are doing it after the first feed…."(Pv:3)

The midwives are continually faced with the medical staff intervening in the breastfeeding care of a mother and baby and although their recommendations are not necessarily reflective of up to date practice the advice given by the doctor is likely to be followed by both the midwife and patient.

" Everything can be right when it comes to breast feeding and the (medical) staff and the paediatricians can give us the hardest time. They don't include themselves as health care staff" (Pv:12)

As per Bodribb's findings the medical staff often deliver orders from a situation of authority although their knowledge of breastfeeding may fall below that of the midwife.

The importance of education for all health professionals working with mothers and babies was mentioned throughout the group sessions but when the midwives reflected upon the breastfeeding education they had received in their training it was

obvious that it was an area that had received inadequate attention. This applied to midwives who had trained over 20 years ago and more recently trained midwives.

" I worked six months at RM and not once did I learn how to educate the mums on breastfeeding or see one sister teach a mother to breastfeed, they were there for 6 hours (post birth), got health education on their wound care and then they went home. " Pv:14

They described their breastfeeding training as coming from the mothers they were supposed to be assisting or in some cases described total absence of breastfeeding training.

"In my training the mothers taught me" (Pv:21)

Breastfeeding education has lacked structure and expertise for many years and has resulted in general poor breastfeeding practices amongst midwives.

"There was nothing about latching and breast feeding, we did learn anatomy, we didn't even see the benefits of breastfeeding" (Pv:21)

This must impact on not only practice levels but also the attitudes of the midwives and an unwillingness to move from out dated practices.

"We are not properly briefed up, doing things that are old and some doing things that are new doesn't have a good flow. We are not given that really good in-service where all staff members know and understand what is happening and you think now I really know about it" (Pu:2)

Those who have attended courses since qualifying discussed how their new ideas were not always welcomed by colleagues when returning to their work place, further supporting the trend of resistance to change and general apathy towards changing practice methods.

"And you attend courses but when you get back to work and there is no support then you lose interest – unless you are here. Courses are oaky…but we don't need CPD points and most sisters cant be bothered to do what they learnt from the course"(Pv:15)

It is clear from these reflections that midwives recognize that their own training in breastfeeding was lacking the necessary knowledge and skills for them to be competent and confident when helping mothers breastfeed.

"When I did my nursing degree we probably watched one video where a baby latched on it's own and we did the anatomy of the breast and that's it – and we kind of went into the government hospital and there you sit and watch the mums and if a baby cries the nurse shouts "your baby's crying – feed your baby" and you go okay…and then you come here (Genesis) and it's the only place you do any breast feeding training and work one on one with the mothers and actually get that experience – that's where" (Pv:13)

Many midwives and doctors don't discuss breast-feeding when interacting with pregnant women and giving no information can be a powerful negative message to the mother. The mothers intention to breastfeed is likely to be established pre birth which increases the value of good antenatal education. (Gross et.al 2011)

"Lack of information – not speaking about it means you don't have to do it" (Pv:7)

Lack of breastfeeding education and support have been cited as reasons for lack of initiation of and early termination of breastfeeding (Gross et.al 2011)

It is well recognized that the most beneficial time for a mother to receive breastfeeding education is in the antenatal period or even prior to pregnancy (Gross et.al 2011). The optimum time to start breastfeeding education has been suggested as 12 weeks gestation (Renfrew et.al 2005).

The midwives in this study described a lack of antenatal education or fragmented late education being given to the mothers despite this being recognized as a key time for a woman to create an intention to breastfeed.

"I have been to a lot of antenatal consultations with a lot of different midwives and non of them speak about breastfeeding. It always comes at a later stage, when you get to 38 to 39 weeks then we will discuss it"(Pv:7)

"They don't give them intense information on importance of breastfeeding" (Pu:4)

A recent study in China shows that up to 80% of mothers who were not exposed to antenatal education were unaware of the WHO recommendation duration for exclusive breastfeeding and 40% believed that breast milk alone could not meet the nutritional needs of their baby (Jiang et.al 2012).

The absence of breastfeeding education is more likely to occur when healthcare providers are not equipped with the necessary skills or knowledge to educate or help the mother or if there is not a well-defined breast-feeding policy in place that has been communicated to all healthcare workers (Bodribb 2008).

"The importance of breastfeeding is not emphasized, they just tell them "mummy are you going to breastfeed or not?" and then they are done" (Pu:4)

Within this study the midwives described poor antenatal education practices pertaining to breastfeeding education in both the private and the public sectors. They also described the impact this has on their interactions with the mother in the postnatal period.

"You find that some of them are coming in and are undecided whether to breastfeed or not, yes, and that person has been attending clinic from 5 months, others are from the local clinics" (Pu:4)

The midwives face time constraints due to the short post birth hospital stay and instead of helping the mother with the practical elements of breastfeeding they are encouraging her to make the decision to breastfeed.

" Like primigravida mothers, they are not getting any information about breastfeeding - you find that it is busy and you are starting from scratch" (Pu :4).

The positive effect of antenatal education is that that the mother can establish an intention to feed prior to the birth and the post natal sisters are able to assist with the practical elements of initiating breastfeeding thus making optimal use of the short time they have with the mother. The poor or absent antenatal education was described as occurring in both the private and public sectors.

"Yes, as midwives on this unit our constraint is that the patient comes in with the ideas already in her head, and lack of information.

Well we don't get them when they are pregnant, we get them with pre-conceived ideas they have brought into labour" (Pv:10)

"If they (mothers) got complex breastfeeding information in the clinic it would make a difference, we (post natal) sisters wouldn't have to start afresh." (Pu:7)

The restricted time that is available is spent either encouraging the mother to breastfeed or correcting some of the false information that she has gained in her pregnancy that has the potential to have a negative on her impact on her decision to breastfeed.

"You find someone will come and say nothing is coming out, colostrum, we know colostrum doesn't project but they don't know, they will say "my milk is not enough" whereas they don't know that colostrum doesn't project, it shows that the education they get is not enough"(Pu:5)

The midwives display awareness about HIV and breast feeding practices, they know that the HIV positive mother must not mix feed and therefore establish what her intentions are in regards to feeding method. However when dealing with the HIV negative mothers the choice of feeding method is not always established and the baby may be given formula, without the mothers consent. This lack of consideration

of the mothers right to choose the feeding method for her baby is also seen in NICU, where the midwives routinely give formula to all babies of HIV negative mothers.

"When the baby is admitted to NICU they (midwives) just give formula. Sometimes they phone the postnatal ward to find out, but you know why, they find out if she is HIVpositive, because they can't mix feed, but with the others they don't ask they just give formula. HIV negative, they don't even bother"(Pu:6)

The policy for breastfeeding and HIV has been well communicated to all relevant staff members and results in the midwives acting in a positive cohesive manner. The same importance needs to be given to the BFHI and to respecting all mothers choice of feeding method.

The midwives in the private sector discussed what they thought should be taught to the mother and these included many of the most practical components of breastfeeding skills that a mother may need to use. They felt that hand expression was an important skill for the mother to learn.

"Mums should be taught hand expression before they go home so that if they have a problem they can express"(Pv:17)

Latching and positioning is a key skill for a breast-feeding mother to master and the midwives recognized in their discussion.

"It is important to have trained staff because mums battle with latching and positioning and feeding correctly. Mums are never shown properly"(Pv:1)

Latching and positioning is more than just a practical skill, the mother should also understand the principles behind what she is doing. There is a tendency for the midwives to "do" for the mother and not offer her the opportunity to learn the skills for herself. This may be attributed to lack of time and lack of skills to educate the mother.

"Yes, there is too much showing and not enough explaining why it is done or what is happening or what should be happening. We should ask sisters to watch a baby latch and feed rather than doing it."(Pv:16)

Nurses' attitudes and behaviours can have a positive or negative effect on the mother's breastfeeding experience and the mothers want to be shown how to feed and want the midwives to spend time with them and to answer their particular question. (Hong et.al 2003)

Skin to skin contact and demand feeding were also highlighted as important points with which to provide the mother with education. Both of these points are incorporated into the 10 steps.

"If you are going to tell them about breastfeeding you are going to teach them about demand feeding" (Pv:3)

"Training should also include benefits of skin to skin" (Pv:5)

The midwives describe "training" the mothers which implies that the individual needs of each mother may be overlooked in the desire to complete a pre designated agenda.

"Train antenatally and train them if their babies are in ICU" (Pv:5)

Although it is important that basics are discussed and understood the mother's individual needs should be met. This is not achieved through a training approach and highlights many health professionals' attitudes towards health education. Health care workers need to take into account what the mothers want as health consumers and provide them with the relevant education rather than satisfying their own policy driven tick list of what the mother should be told. It may also be indicative of the midwives' own experience of education where training and telling have predominated over a more inclusive approach to education.

Educating the mothers about the benefits of the 10 steps rather than just giving her the “how to” steps is more likely to increase the mothers confidence and self efficacy (Dennis and Faux1999, Maddux 2000).

Through the discussions it emerged that the midwives were aware of the need to ensure the mother gained confidence in her own skills in order for the mother to achieve independence. This sentiment was evident in both the public and private sector midwives discussions.

“Another thing with this training is to make sure the mother’s confidence is up and so that she feels confident that when she leaves the hospital that she can feed on her own” (Pv:5)

“When you tell them to breastfeed it makes it easier for them if you tell them that we are going to help you step by step until you are perfect on that one, until you can manage on your own (Pu:1)

Breast-feeding support is not just about imparting facts and knowledge to the mother but also about building confidence and independence in the mother, which requires skill from the midwife (Bäckstrom et.al 2010).

The need to involve the mother in the education process is recognized as is the need to make the both the information and the means of delivery relevant and meaningful.

“The mothers should be encouraged to ask questions and the sisters must be open to answer questions as well ” (Pu:5)

“Stuff for education needs to be relevant to the mothers- cartoons may be better” (Pv:16)

It was recognized that poor education from the midwives can result in poor breastfeeding practices.

“Poor education results in private mothers getting a night nurse for night time bottles” (Pv16)

The midwives are therefore aware of the important role they play in educating the mother not only in the short term but in her longer term breastfeeding practices. "Preparing the mother to go home after a birth confident in her ability to meet her own and her baby's needs should be the goal of every birthing centre professional" (Riordan & Auerbach,1999).

Intention of the Mother to Breastfeed

The midwives in the public sector described the constraints they face when many of the women arrive in the labour or postnatal ward and they still have not made a decision as to how to feed their baby. The midwives then spend time educating the mother on the benefits of breastfeeding at a time when they could be helping them master the skills necessary for successful breastfeeding.

"I think that is this is the first time they are hearing the information that it is not easy for me to impress but if they start in the clinic and get complex health education about breastfeeding it will make a difference, we wouldn't have to start afresh, here about breastfeeding" (Pu:7)

The midwives recognize that the intention of the mother to breastfeed is pivotal to the success of breastfeeding.

"I truly believe that breastfeeding will only be successful if the mother wants to breastfeed" (Pv:1)

The mother retains the right to choose the feeding method for her baby. Without the commitment of the mother, breastfeeding will not succeed far beyond her hospital stay when she complies with the pressures of the health professionals. Once at home with her baby the mother will exercise her right to choose which method she feeds her baby.

"They listen to you telling them the benefits of breastfeeding while they are in hospital, but you know that they are going to bottle feed this one when they get home"(Pu:7).

" I believe that I am quite well trained and can help them with breastfeeding and with breast feeding problems. If she is not going to do it she is not going to do it however well trained I am"(Pv:1)

The midwives described that because the HIV positive mothers get counseling antenatally they arrive with a positive intention to breastfeed or not, but that this service is not offered to the HIV negative women.

"And as a result you feel they are the ones who have a clear idea of whether they will exclusively breastfeed or formula feed" (Pu:5)

Research indicates that the mothers pre-birth intention to breast feed is a positive indicator of breastfeeding duration (Shahla et.al 2010,Yngve and Sjöström 2001,Perrine et.al 2012,Jiang et.al 2012,Stuebe and Bonuck 2011).

The mothers intention to breastfeed is pivotal , without the midwives face the greatest constraint to the implementation of the 10 steps.

The midwives realize that however hard they try to convince a woman to breastfeed that without her agreement they will never succeed, regardless of how much training they have received.

A literature review by Shahla in 2010 divided the factors that influence a woman's intention to breastfeed into three categories;

Socio-demographic factors

Biophysical factors

Psychosocial factors

Socio-demographic factors – young, under-educated, single, unemployed women are less likely to breastfeed their babies (Shahla et.al 2010).

In the public sector there are many young women who are single, unemployed and educated only to secondary level. They receive no breastfeeding education in pregnancy and live in a society that does not widely support the benefits of breastfeeding. Against these constraints the midwives the midwives encourage the mothers to breastfeed their babies.

"Mothers they don't co-operate, if you tried to show them how to feed, they are impatient. So mothers give up easily. So it is difficult for us to show them how to breastfeed and how to maintain lactation."(Pu:6)

The midwives are aware of the benefits of starting the education process at school level, which would target the demographic described as less likely to breastfeed.

"Kids should know from the start, it would make breast-feeding more normal" (Pv:15)

'It (breastfeeding education) should come from everybody. Information should be given at school level. Kids at high school should be taught that human babies should be fed human milk" (Pv:6)

"Inclusion of breastfeeding issues in school health education curriculum for children is supportive" (Yvenge and Sjöstöm2001)

"The decision to breastfeed is made when you are a teenager"(Pv:7)

This statement is supported in the literature. Bailey and Sherriff cited in Di Girolamo et al. 2005, states that 50 to 90 % of women will decide how to feed their child before becoming pregnant or very early in their pregnancy.

Bio-physical factors

The experience of the women during the birth and immediately afterwards effect breastfeeding intentions and outcomes. (Shahla et.al 2010)

The physical and emotional experiences the woman has during the birth and postnatal period impact on the woman's intention to breastfeed her baby. The woman in the public sector are birthing under stressful conditions. The average stay is 6 hours and sometimes this is cut short if there is no bed available.

"If it is full the patients will sleep on the floor, last couple of days we have been overcrowded, is someone has been discharged they must go and wait in the waiting room, because of the turnover"(Pu:9)

"Early discharge from maternity wards….could be seen as a threat to gaining those skills" (Yvenge and Sjostrom 2001)

" Babies are not breastfed in labour ward" (Pu:5)

This statement shows a lack of understanding amongst the staff about the physiology of breastfeeding.

"The importance of an early initiation for the success of breastfeeding and bonding between mother and child can not be over emphasized" (Widstrom 1987, Zetterstrom 1999 and Christensson 1995 in Yvenge and Sjostrom 2001).

The babies are routinely separated from their mothers immediately after birth for newborn checks. The mothers of babies that go to ICU don't see their babies.

The distance is also a problem because the mother is separated from their children, the neonatal ward is on the first floor and post natal ward is on the second floor – so it is a bit far"(Pu:7)

"If we don't put them together (mum and baby) they are not going to have a bond or closeness, it's not going to promote breastfeeding within that" (Pu:1)

Skin to skin contact is carried out intermittently, if at all.

"We don't even go there because our beds are so small, we are scared that the mothers will fall, so what we do is interrupted, we don't do it continuously" (Pu:7)

Skin to skin contact is an integral component of the 10 steps to successful breastfeeding as it is recognized as a positive factor in the initiation of breastfeeding. The WHO requirement is for the baby to remain in uninterrupted skin-to-skin contact with the mother for 1hour post birth.

Poor practices levels were described in both the private and public sector, although the only area where it is not routinely practiced in the private sector is in the operating theatre.

" I am even seeing it here, some of the midwives won't put the baby skin to skin in theatre, it annoys me terribly"(Pv:5)

The public hospital faces greater challenges in this regard as basic newborn assessment procedures are not carried out next to the mother but in a separate room, indicating obvious need to rethink existing hospital policies that are counter productive to the successful initiation of breastfeeding. The assessment of a newborn can easily be carried out while the baby remains in contact with its mother.

"Skin to skin is quite a challenge, it really is. We do it for 20 minutes and then the baby gets taken away for neonatal management" (Pu:8)

" A clinical practice that does not include supporting mothers to initiate breastfeeding when the baby is ready to suckle hinders breastfeeding "

(Yvenge and Sjöström 2001)

The mother may face separation from her baby, uncomfortable physical conditions, rushed service, inconsistent advice and unexpected after pains in addition to the routine recovery from childbirth and adjustment to the new baby and breastfeeding.

Psychosocial Factors

Support from the partner and family and the community at large. If breastfeeding is seen as the norm in the community then support for the process will follow and the mothers confidence in enhanced. (Shahla et.al 2010)

There are indications that breastfeeding is not seen as the norm in our society and consequently the breastfeeding mother is not guaranteed support within the community, as demonstrated by the story told by one of the midwives;

"A girl from my practice and her friends were in a restaurant , she was breast feeding. A customer went to the manager and said that if he didn't stop these women breast-feeding or tell them to go that he would leave the restaurant. These girls walked out and they had discreetly covered themselves"(Pv:9)

In a society where breastfeeding in public is not the norm it will be difficult for women to gain the self-confidence to feed their babies in public. Stuebe and Bonuck (2011) found that women who were comfortable breastfeeding in front of close friends, men and women, and in public were more likely to plan to exclusively breastfeed for longer.

It is understandable that many women choose not to breastfeed their babies when they live in a society that does not readily recognise its value. The health professionals are poorly trained and until recently the advertising of bottles and infant formula was prevalent.

"I think that formula in this country has been like… put on a pedestal, they don't think they are giving cows milk when they give formula. But they don't know" Pv:6

Many women will have been brought up in homes where breastfeeding has not been seen.

"You need to look at the people and their history behind them. They don't see it as a cool thing to breast feed"(Pv:9)

Having a mother who herself breastfed, or a friend who mastered the art of breastfeeding may be more effective than supportive health care staff
(Yvenge and Sjöström 2001)

Di Girolamo et al. (2005) found a significant correlation between breastfeeding intention, length of breastfeeding and the breastfeeding attitudes in her home.

The midwives expressed the belief that breastfeeding was not seen as the norm and that attitudes in the community at large need to be addressed.

"We need to normalize breastfeeding" (Pv:2)

"We have to change attitudes of patients and the community and health care community …" (Pv:5)

Breastfeeding to date has not been made a high profile issue and the midwives felt that the government should take responsibility for redressing this situation.

"The government is not doing enough- not implementing - not training midwives and don't understand the challenges, they (government) need to take breastfeeding seriously"(Pu:9)

Depending on the socio-demographic profile of the family there is likely to be more or less support for breastfeeding from the father. The father's support is viewed by some as more important than the professional support that the woman receives. This view was echoed in the midwives discussions although they also went on to describe how some men don't see it as something they should become involved in.

" Also the support form the husband and family in the early stages of pregnancy is important….for breastfeeding"(Pv:2)

"I think men see it as a woman's thing, as private and they shouldn't have to share it and the woman should be discreet"(pv:13)

This could be attributed to the sentiment expressed earlier that society as a whole does not support breastfeeding. The fathers may not have ever been exposed to

breastfeeding until the birth of their own baby. However the inclusion in fathers in education is important as they can play a vital role in the woman establishing a positive intention to breastfeed.

"We feel that we are in a society that does not support breastfeeding. It's not going to change in this generation." (P:v12)

Literature supports the importance of the father's support and encouragement from society in general as significant. "The attitude of the woman's partner to breastfeeding is crucial to both the woman's attitude and her breastfeeding behaviour" (Scott 2004 in Shahla 2010). ."Professional help cannot replace the day to day support that couples provide for each other" (de Montigny& Lacharite 2004 in Shahla 2010)

The perception of many woman is that they cannot continue to breastfeed once back at work and this influences their intention to breastfeed.

" I think that a lot of these girls are going back to work so early" (Pv:7)

Some will plan to breastfeed for the period prior to returning to work and then change to infant formula feeding.

"I don't think that makes them not want to (breastfeed) I think it makes them stop at three months" (Pv:7)

According to the Basic Conditions of Employment Act 1997 (Basic Conditions of Employment Act) employers must provide their employees with a clean safe space in which to breastfeed or express and they should be allocated two 30 minute periods for this purpose.

"The corporates have to make a room available for mothers to express"(Pv:9)

However many women will not be aware of this or feel intimidated or concerned about keeping their jobs and will not ask their employer for facilities to express or feed their baby.

A woman who is informed about her breastfeeding will approach her employer about facilities for expressing" (Pv:9)

Many women work in an unsympathetic environment when it comes to breastfeeding and expressing, which again reflects that breastfeeding is not valued in our society.

"I have had this conversation with lay people, my husband, men, a few friends and they all said "no" it would not be possible to do it in a corporate environment" (Pv:9)

The support for breastfeeding in the work place also helps to form positive intention to breastfeed and can be demonstrated where there is enforced and extended maternity leave options (Yvenge and Sjöström 2001).

A midwife describes her own experience with expressing and highlights how difficult it can be even in a breastfeeding friendly environment – the challenges in a less conducive environment must seem even greater for the working mother.

" You have to be super committed to express, I came back to 100% breast feeding environment but to sit in my office and pump is still a mission"

Prenatal intentions are among the strongest predictors of breastfeeding duration and intensity (Stuebe and Bonuck 2011,Bonuck et. al 2005,Bai et.al 2010, Scott and Bins 1999). It is therefore important that midwives at all stages of interaction with the pregnant woman are providing positive information about breastfeeding with special emphasis on what the mothers are exposed to in the ante natal period.

" If you can change the attitudes of the mothers while they are pregnant, encourage mothers and grandmothers to take them to support groups, then everything else will fall into place" (Pv:2)

3.Time and Resource Constraints

Observations made by midwives working in the private clinic where the average stay is 24 to 48 hours and staffing ratios are high reflected that they felt they needed more time to spend with the mother helping her with breastfeeding.

"Time can be a problem, if we are busy and the mum needs assistance, more staff would help" (Pv:16)

If the ward was busy time became a problem and they expressed a need for more staff. In the public sector the average stay is 6 hours and the patient turn over is high. Previous studies echo these findings. Universally midwives perceive there to be a lack of time and resources that negatively impacts on the assistance they can offer mothers with breastfeeding.

"I truly believe that we don't keep our mothers here long enough to be able to properly feed – if they go home in 48 hours, if the mother has had other babies she may be okay but some have their doubts"(Pv:16)

In a study carried out in Sweden the midwives perceived themselves as giving individual support to the mothers, which was in contrast to the mothers perceptions (Bäckströmet.al 2010). Women want to be listened to and to be recognized as unique individuals and have expressed a need for more time.

In her book **Breastfeeding in Hospital, Mothers Midwives and theProduction Line** (2006) Fiona Dykes uses the industrial model of time and production to describe current breastfeeding practices. She describes both the breastfeeding women and midwives as feeling like they are on a production line as they 'race

against the clock'. The midwives are short of time and staff and the mothers are aware that "breastfeeding and care respectively is experienced in terms of demand and efficient support".

This mirrors the current situation that many new mothers face who are in the public hospital for 6 hours post birth. During this time they have to receive information on discharge, wound care, family planning and infant vaccinations and at times are put in the waiting room to be taken home, even before the 6 hours has passed. The constraints on both the midwives and the mothers to establish breastfeeding are obvious.

"Patients come in large numbers, we have 22 patients in beds, we see this lot and they are discharged and maybe another 12 come along and you cannot share that information again, you are busy. There is such a high turnover" (Pu:4)

Early discharge from maternity wards is seen as a threat to the mother gaining the necessary skills to achieve confidence in her breastfeeding (Yvenge and Sjöström 2001).

Staff shortages and high staff turnover will negatively impact on breastfeeding practices. At any one time there will be new untrained staff who are require time consuming orientation from their colleagues and are less effective at providing the mothers will effective breastfeeding support.

"We are always getting new staff"(Pu:3)

4.Advocacy

Through analysis of the data the issue of advocacy emerged, although never referred to directly in the midwives discussions.

Three points pertaining to advocacy are described.

1.Lack of recognition for the midwives role

2.Midwives “making do”

3.Recognizing the right of the mother to choose the feeding method she prefers for her baby.

These three points are discussed in detail;

Lack of recognition for the midwives role.

Midwives allow co-professionals to assume an authoritative role on a subject about which the midwife possesses more knowledge and has a wider skill base. The midwife has educated the mother on the benefits of breastfeeding but allows the doctor or other authoritative body to undermine her authority on the subject.

“The breastfeeding committee had a day, they came around and talked about all the issues of breastfeeding. They found us sitting with the patients and started telling us about breastfeeding. Their way of distributing the information was not so well but if they had the whole day it would be very enlightening” (***Pu:3)***

In the discussion the midwives described the actions of the hospital breastfeeding committee that potentially undermined the relationship the midwives had with their patients by “telling us about breastfeeding”. This happened on one day, which further puts the value of the exercise into question.

The midwives also face the effect of the doctor’s orders that may be in direct conflict to the information that they have given the mother.

Health consumers instinctively put great trust in advice given by medical practitioners (Bodribb 2007). Often this advice from the doctors is not in line with current breastfeeding practices.

“The doctors tell the mother that formula is fine”(Pv:15)

An article published in Midwives ,the official magazine of the Royal College of Midwives discusses advocacy in midwifery and describes "a lack of recognition of the midwives role and the dominance of the medical profession " (Lucas 2011). "Notable status inequities and power differentials between nurses and physicians …effect the nurses ability to intervene effectively" (Tanner 2006).
By failing to intervene the midwife fails to gain professional recognition and potentially fails the mother.

2.Midwives "making do"

The midwives in the postnatal area, particularly in the public sector are faced with the daunting task of educating large numbers women on the benefits and skills required for breastfeeding, in a 6-hour period, while continuing with their other work. Throughout the study the midwives described factors that act as constraints in their breastfeeding practices, yet rather than speak out about these constraints they "made do", although they were aware of the shortcoming of their practice as a direct consequence of these constraints.

And that individual care and attention- you cant give that to large numbers of patients…you have to give information that the larger group needs" (Pu:4)

The midwives are asked to implement the 10 steps and yet the sustainment of outdates policies and practices by hospital management directly oppose the 10 steps. The literature supports that nurses are often caught in the "cross fire" of policy and practice."Nurses come face to face with issues associated with patient safety and satisfaction, access to services, clinic outcomes and health disparities…nurses have the choice to continue on trying to make do while feeling victimized by current changes or to motivate themselves and find opportunities to bring about changes in the health care system itself" (Abood 2007)

They appear to underestimate or fail to recognize their potential power as catalysts for change.

"If there is no interest or willingness to employ the power, it remains only a potential resource" (Abood 2007).

Midwives fail to see themselves as influential in the arena of health legislation. Midwives are all qualified nurses and as such offer the potential power of numbers and expert power in influencing health legislation. (Abood 2007)

3.Recognizing the right of the mother to choose the feeding she prefers for her baby.

It is important to recognize that the mother ultimately has the right to choose whether or not to breastfeed and she should not have to comply to a hospital policy on infant feeding. The midwives describe fighting with the mothers to breastfeed although they believe that she will ultimately formula or mix feed her baby once discharged.

"Because they always come and ask you for milk (formula), and they fight, you will tell them mummy you have to breastfeed and they fight"(Pu:7)

The findings throughout this study have indicated that the antenatal period is the time for the midwife to exert most influence over the mother's decision making in regards to breastfeeding and that the influence of the community is not to be underestimated. The time to have greater influence over the mothers decision to breastfeed her baby is in the antenatal period (Imdad et.al 2011).

Our mothers are more interested in the options they have to breastfeed or to formula feed" (Pu:5)

The midwife therefore faces the challenge of advocating for best health practices while respecting her patients need to have her choices acknowledged and respected.

This complex situation requires high levels of skill and self-efficacy on the part of the midwife. In the current situation the midwives seems to be unaware of their potential as experts that could influence health policy and practices.

The Nursing and Midwives Council U.K (NMC 2009) describes the midwife as an "advocate for women with responsibility for facilitating women" choices.

4.2.6 Summary of Process Findings:

Without improvement of the knowledge and skills of the healthcare providers the standards of breastfeeding practice will not improve. Poor levels of knowledge and low levels of interest were described amongst all areas of heath care providers. The training the midwives had received was described as poor.

The importance of good antenatal education for women was emphasized. It is in the antenatal period that the majority of women form an intention to breastfeed, yet the antenatal education the mothers receive is failing to help them create a positive intention to breastfeed. The education given to the community and women must be meaningful and relevant to their needs. The community at large places little importance on breastfeeding and this influences strongly on the mothers decision to breastfeed or not.

The midwives face time and resource constraints, some working in understaffed hospitals that keep their postnatal mothers for 6 hours. Poorly trained staff working in resource strained environments are not able to adhere to the most basic elements of the 10 steps.

The issue of advocacy emerged form the data. Midwives allow other co-professionals to undermine their unique relation ship with the mother by allowing them to dominate the decisions and actions taken around breastfeeding. The midwives work in low resource units that result in constraints on their abilities to implement the 10 steps, yet they "soldier on" and make do, instead of speaking out and drawing attention to the situation.

The mother has the ultimate right to choose how her baby is fed and this needs to be recognized by the health care providers. Rather than telling her what to do the

system should be geared towards steering her to the better option of breastfeeding and not enforcing policy criteria.

4.3 CHAPTER SUMMARY

This chapter gave an account of the analysis of data gathered from the modified nominal group technique with midwives in both the private and public sector. Themes and categories that emerged were discussed using Walt's model of policy analysis as a template for analysis. Supporting literature on the subject was given.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The findings and discussion of the previous chapter illustrate that the constraints faced by midwives in implementing the 10 steps to successful breastfeeding are broad and complex.

5.2. DISCUSSION.

The government and Department of Health have voiced support for breastfeeding and publically recognised the importance of improving the breastfeeding figures in South Africa (Tshwane declaration of support 2011). The Department of Health has adopted an active programme of implementing the 10 steps into all their public facilities and some of the private facilities. The government has also curbed the power of the formula companies aggressive marketing practices through enactment of the International Code of Marketing of Breast-Milk Substitutes (WHO2012). However they have not explored breastfeeding in its broader context and have therefore failed to provide midwives with the tools necessary to successfully implement the 10 steps policy.

The approach to the implementation of the 10 steps has followed a top down approach and as such the implementers of the policy, in this case the midwives working with the mothers, have not contributed to the policy planning although they are “closer to the problem” (Walt 2000). Without their input at planning level the department of health have adopted a “one size fits all” approach and not taken into account the nuances of each individual hospital and the community it serves.
It should be noted that the goal is to improve breastfeeding outcomes and that the Mother and Baby Friendly Initiative through the implementation of the 10 Steps is the

tool through which this can be achieved. Ensuring that each maternity facility in Gauteng becomes Mother Baby Friendly compliant will not be enough to ensure improved breastfeeding outcomes are achieved in a long-term sustainable fashion. The risk is that without regular assessments taking place hospitals will hold the baby friendly accreditation but not be practicing the 10 steps (Jordaan 2010).
This programme requires on-going assessment and re accreditation of the facilities, otherwise the accreditation becomes less meaningful and could be seen as being driven by political motives rather than health improvement.

The midwives appear to support the overarching goal of improving breastfeeding outcomes but identified key areas that make the implementation of the goal challenging and in some instances impossible for them.

Knowledge is an important tool to influence supportive breastfeeding behaviors among health professionals (Bernaix 2000, Kronberg et.al 2007).
The midwives described their own training and knowledge of breastfeeding and acknowledged that it was fragmented and out dated. Those working in the private sector felt that they had only improved their knowledge and learnt meaningful skills while working in their current location and this was due to the motivation and enthusiasm of the hospital management. Those in the public sector felt that some midwives were better informed than others but overall there were knowledge gaps and out dated practices that prevented them from carrying out breastfeeding friendly practices. For example, separating the baby from the mother to carry out “neonatal management”, namely the routine after birth checks performed on every baby, that can easily be performed while the baby is with the mother. The reason given for the separation was lack of space in the room. This type of practice suggests senior midwives who are reluctant to change routines through lack of knowledge and skills (Semenic et.al 2012. Ebersold et.al 2007).

The medical staff is not seen to be supportive towards the 10 steps and continue to prescribe practices that are detrimental to breastfeeding. Examples cited were; ordering routine blood glucose testing and formula supplements to new-borns, despite the fact that early supplementation of formula is one of the strongest factors for cessation of breastfeeding (Di Gorolamo et.al 2005). The paediatricians continue to use anecdotal evidence rather than evidence based practice when discussing breastfeeding with their patients. This is in keeping with global trends that show medical staff to be lacking in the skills and knowledge to effectively help mothers with breastfeeding (Brodribb 2007).

Many of the paediatricians continue to override and under value the breastfeeding knowledge of the midwives, although they are generally less experienced in the field. This was apparent in the private sector where the midwives who participated in this study are trained to a high standard in breastfeeding and are capable of managing the more complicated issues of babies who are reluctant to latch or mothers with a low milk supply. They receive instructions from the doctor that they recognise as detrimental to positive breastfeeding outcomes, however due to the autonomy of the doctor they are forced to carry out these instructions (Tanner 2006). The issue of advocacy arises here and will be discussed later in this section.

The literature supports the argument that education is one of the most important areas to be addressed when implementing any breastfeeding programme (Semenic er.al 2012). It must however apply to all the health care providers. The health care providers include all medical and nursing staff that interact with pregnant and post natal women. Currently, midwives are not required to receive Continuous Professional Development, however the department of health will not accredit any facility that has not sent 80 % of their nursing and midwifery staff on the 20 hour breastfeeding course that forms part of the WHO Baby Friendly Initiative. There are

no such guidelines for medical staff, which results in obvious constraints for midwives trying to achieve evidence base practice when faced with an authoritative but poorly skilled medical practitioner.

Education of the health care users is also important. The mother and the members of her immediate and greater community need to be educated about breastfeeding. The midwives described mothers who do not want to breastfeed, who are unaware of the benefits of breastfeeding or who feel they can't breastfeed because they are going back to work. When they described the community's attitude towards breastfeeding they spoke of mothers being unable to feed their babies in public and the of the average person being unable to see the feasibility of a breastfeeding mother returning to work. This is indicative of a community that does not put a high value on breastfeeding.

A woman's intention to breastfeed is most likely to be formed either prior to pregnancy or in the early stages of pregnancy and is strongly influenced by the support she receives from her partner and close family (Shahla et.al 2010). It therefore seems appropriate to target school children, young adults and ante-natal women with meaningful relevant health education that will turn them into positive consumers. Those women who have established a high intention to breastfeed may be confused and disillusioned by conflicting advice from members of the health profession and a lack of support in their greater community.

In the current situation the midwives are marketing a product to a reluctant consumer.

Both the midwives from the private and public sector described poor antenatal education practices, which result in women arriving in the hospital without having established an intention to breastfeed or with incorrect information.

It was interesting to note that the HIV positive mothers were given counselling and information in regards to feeding choices and they arrived in the hospital with a ready

formed intention to exclusively breastfeed or to formula feed. The midwives also described how these mothers are supported in the choices they make, for example, phoning from the NICU to find out if the mother of the HIV positive baby intended to breastfeed before giving the baby formula, whereas the HIV negative babies were reportedly given formula without first asking the mothers feeding preference. This example also shows that the mothers right to choose the feeding method for her baby is sometimes undermined by the health care providers.

Time is a constraint for the midwife, whether in the private or public health sector. Mothers want midwives to spend time with them and to watch them breastfeed (Backström et.al 2010) rather than to show them and do it for them. Due to increasing medical aid costs the average stay in the private facility is 24 to 48 hours during which time the mother has to adjust to the physical factors surrounding birth and learn to breastfeed her baby. For the average woman the transition from colostrum to breast milk will occur between 48 and 72 hours prior to which the majority of women will have been discharged home. Some women do receive postnatal follow up from their private midwives, who may or may not have received recent breastfeeding education. The private midwives are not part of the hospital staff and are not therefore obliged to attend breastfeeding education.
The patients in the public sector stay for an average of 6 hours and the midwives working there describe a situation of “bed block” and a high turn over of patients, coupled with low staffing levels. It is therefore understandable that they face major constraints in terms of breastfeeding practices. When preparing these women for discharge the midwives have to ensure the mother understands her own immediate physical care and that of her baby, when to return to the clinic for immunisations and family planning. Effective breastfeeding skills are unlikely to be taught in such circumstances and there is no time to listen to the mother and gain an understanding

of her personal situation and experience. This negative biophysical experience for the mother is a factor for cessation of breastfeeding (Shahla et.al 2010).

Resource constraints further include lack of educated staff. The staff turn over is described as high, which results in a high proportion of staff that are not educated "for every one who knows there are four who don't" as one midwife described it. The midwives spend their already pressurized time orientating new staff.

After discharge the women do not have access to adequate breastfeeding resources in either the private or public sector although it should be noted that the mothers from the private sector do have more resources at their disposal, however they are often unaware of what is available.

Throughout this study the midwives described the challenges and constraints they face when implementing the 10 steps but they failed to recognize their role as policy changers, "implementation always makes or changes policy to some degree"(Lindblom1980 in Walt 2000). Once a policy leaves the planning stages and starts being implemented changes will occur through the actions of the players, these players have expert and collective power to shape the outcomes (Lipsy1980). In this study the midwives recognised constraints but did not describe ways in which they could use their power to overcome the constraints, possibly because they remain unaware of this power. Implementation of any task without the correct tools is challenging and in this situation the midwives are expected to implement a policy that they have had no part in developing, coupled with a lack education and resources. They further lack support from health professionals or the mothers and the greater community that they serve.

The midwives have continued to "make do" even though they are aware that they are not achieving the desired results. This situation may have arisen as a result of there being no interest from the midwives in improving the situation or what seems more likely is that they remain unaware of their potential to bring about change by speaking out and influencing policy and practice in their own environment. In the

current hierarchical system the midwife continues to accept orders from doctors and hospital management that she knows to be detrimental to best feeding practices, she fails to implement her role as advocate for the mother. Possibly of more concern is that she therefore fails to advocate for her own profession, which can only have negative consequences as the expertise and specialised role of the midwife risks being eroded.

5.3 CONCLUSIONS

This study has met the aims of the research question and objectives by using the experience of the midwives to identify and describe the constraints they face and through further exploration provide reasons why the 10 steps are not being effectively implemented. Through the research undertaken to achieve the aims and objectives of this study a far greater understanding of the complexity of the issue has been described. The constraints faced by the midwives are more diversethan initially assumed and involve all stakeholders.

The findings of this study provide valuable insight into the constraints faced by midwives that will be of equal interest to policy makers, educators, health professionals and potentially health users.

The complexity of implementing an effective breastfeeding policy has gone unnoticed by the policy makers.

The top down approach had excluded the street level bureaucrats, in this example the midwives, from contributing to the policy development and sharing their expertise. The policy makers have failed to recognize that “nurses’ views and values inform their implementation of health policy” and that they feel excluded from the process of change (Walker and Gilson 2004).

Education of all health care providers is of paramount importance to the success of the implementation of the 10 steps policy. Without it there will continue to be the

delivery of mixed messages to health care users, which leads to confusion and poor practice standards.

The health care users, individuals and the community at large do not put sufficient value on the practice of breastfeeding and can therefore be described as “reluctant consumers. The promotion of breastfeeding in such an environment is challenging, especially when that environment is under resourced. The midwives face the constraints of lack of time and resources such as high staff turnover and bed shortages.

The midwife does not speak out and challenge the authorities that demand implementation of the policy, either because no platform is made available for such discourse or maybe because the midwife fails to recognize her important role of advocate for her patient and the profession at large.

The midwives alone cannot implement the policy; they face the constraints of lack of education and support amongst levels of breastfeeding health professionals. There is also insufficient support from the government, which manifests in poor awareness in the community and lack of resources within the hospitals.

5.4 LIMITATIONS OF THE STUDY

- Because this study was conducted only within Gauteng Province the findings cannot be generalized to the entire country.
- The study was limited to one public and one private clinic, which potentially gave a bias to the data from the private clinic as many more midwives are employed in the public sector than private, thus limiting the generalization of the findings.
- The use of purposive sampling ensured that midwives with the required understanding of the topic were included however it is recognised those with a higher level of knowledge may also have a bias toward breastfeeding. This

was not obvious to the researcher during data analysis but is worthy of mention.

5.5 RECOMMENDATIONS

Recommendations for Education

- A public health campaign aimed at increasing awareness of the value of breastfeeding for the whole population should be developed. This would assist in the normalisation of breastfeeding and result in women creating a positive intention to breastfeed that would in turn create a demand for knowledge and skills from health professionals and improved facilities for breastfeeding both at work and in the community.
- Universities and nursing colleges should develop a module on breastfeeding and incorporate it into their midwifery curriculum. Nursing education institutions also need to develop a module for trained staff and provide on going education.

Recommendations for Practice

- Antenatal education should be prioritized and effective programmes developed that serve individual communities. The midwives providing the antenatal education should work in conjunction with the department of health in creating the programme and the efficacy of the programmes measured.
- The government and department of health must ensure that the system used to award the Mother Baby Friendly Hospital status operates fairly and with accountability in order to maintain the credibility of the accreditation. Without on going assessment high standards of breastfeeding practices will not be maintained.

- Health policy development should be approached from a bottom up view, allowing the policy implementers, the midwives, to feel included in the process of policy change and development. They can provide great insight and perspective to the process that is otherwise lost.
- Support for the implementation of policy from all stakeholders and the analysis thereof on an on-going basis is vital to ensure the aims of the policy are met. Without this all-inclusive support only the political agenda is met and the policy then fails to actually benefit the people who it is intended to assist.

Recommendations for Research

- This study should be expanded to other provinces within South Africa to provide comprehensive findings that the government and department of health may use in future policy development as they continue to reassess the efficacy of the current policy.
- The role of the midwife as advocate needs to be addressed by all stakeholders involved in the profession. The South African Nursing Council, nursing education institutions and individual healthcare facilities must acknowledge this important of this role not only to protect the mother, baby and family in the midwives care but also to ensure the protection of the midwife as a specialized member of the health professional community. Currently there is limited information available on this topic from South Africa and there is a need for local research to address the issue.

5.6 SUMMARY OF CHAPTER This chapter contains discussion and conclusions drawn from the findings made in chapter four. Based on these conclusions certain recommendations have been made. The research question and objectives have been shown to have been met.

REFERENCES

Abood, S., 2007.Influencing Health Care in the Legislative Arena The *OnlineJournal of Issues in Nursing*.Jan, Vol12(1) Manuscript 2.

American Academy of Pediatrics. 1997.*Policy Statement; Breast-feeding and the useof human milk*. Pediatrics; 100(6):1035-9

Backström,C., Hertfelt Wahn,E., Ekstrom, A., 2010. Two Sides of Breastfeeding Support : Experiences of Women and Midwives . *International Breastfeeding Journal* 5:20

Bai,Y., Middlestadt,S.E., Peng,C.Y., Fly,A.D., 2010. Predictors of continuation of exclusive breastfeeding for the first six months of life. *Journal of Human Lactation*;26:26-34

Basic Conditions of Employment Act, 1997 Government Gazette Vol.401,No.19453, 13 November 1998. Available at: http://www.labour.gov.za
[Accessed 23rd October 2013]

Bernaix,L.W. 2000.Nurses' attitudes, subjective norms, and behavioural intentions toward support of breastfeeding mothers.*Journal of Human Lactation* Aug:16(3) 201-209

Bettman.J.R, Johnson. E.J,Payne ,J.W., 2000.Consumer Decision Making [online] Available at:
http://www.haas.berkeley.edu/courses/spring2000/ba269d/bettmanjohnsonpayne91.pdf
[accessed 3rd August 2012]

Bonuck, K.A., Freeman, K., Trombley,M., 2005.Country of origin and race/ethnicity: Impact on breastfeeding intentions. *Journal of Human Lactation*; 21:320-326

Bodribb, W., Fallon, A., Jackson,C., Hagney,D.,2008. Breastfeeding and Australian GP registrars-Their Knowledge and Attitudes . *Journal of Human Lactation*24(4):422-430

Burns, N., Grove S.K., 2009 . *The Practice of Nursing Research. Appraisal, Synthesis, and Generation of Evidence*. 6th ed.Philidelphia. W.B Saunders Company.

Cantrill,R., Cooke,M., 2004. Midwives' knowledge of newborn feeding ability and reported practice managing the first breastfeed. *Breastfeed Rev*. Mar;12(1):25-33 ABSTRACT

Coovadia,H.M, Rollins,N.C., Bland,R.M., Little,K., Coutsoudis,A., Bennish,M.L., Newell,M.L., 2007. Mother –to-child transmission of HIV-1 infection during exclusive breastfeeding in the first 6 months of life :an intervention cohort study. *Lancet* .Mar 31;369(9567):1107-16

Chisenga, M., Siame,J., Baisley,K., Kasonka, L., Filteau,S. 2011. Determinants of infant feeding choices by Zambian mothers:a mixed quantitative and qualitative study. *Maternal & Child Nutrition*. Apr;7(2):148-159

Creedy,D., Cantrill,R., Cooke, M. 2008. Assessing midwives' breastfeeding knowledge: Properties of the Newborn Feeding Ability questionnaire and Breastfeeding Initiation Practices Scale. *International Breastfeeding Journal* 2008,3:7

Creswell, J.W., 2009. *Research Design Qualitative, Quantitative and Mixed MethodsApproach*, 3rd ed., New York: Sage

Daniels,L., Knowledge, attitudes and practices of nursing staff regarding the Baby-Friendly Hospital Initiative in non-accredited obstetric units in Cape Town. *SouthAfrican Journal of Clinical Nutrition* 2011:24(1)

Darmstadt,G.L.,Bhutta,Z.A.,Cousens ,S., Adam,T., Walker,N., 2005. Evidence-based, cost-effective interventions: how many newborn babies can we save? *Lancet* , Mar12;365(9463)pp977-88

Declercq E., Labbock MH., Sakala C., O'Hara M., 2009. Hospital Practices and women's likelihood of fulfilling their intention to exclusively breastfeed. *American Journal of Public Health* 2009:99(5),929-935

Deloitte Center for Health Studies 2012, Survey of U.S HealthCare Consumers Consumer Quality Index .Available at: http://www.google.com/search?client=safari&rls=en&q=Survey+of+U.S+HealthCare+Consumers+2012.+Deloitte+Center+for+Health+Studies,+Consumer+Quality+Index)&ie=UTF-8&oe=UTF-8
[Accessed 27th September 2013]

Dennis., C.L., Faux, S.,1999. Development and psychometric testing of the Breastfeeding Self-Efficacy Scale. *Research in Nursing and Health*,Oct,22(5),pp399-409

Department of Health South Africa.2007. *Infant and Young Child Feeding Policy*. [Online] (2007) Available at http://www.info.gov.za/view/DownloadFileAction?id=94072 [26/08/2011]
[Accessed8th March 2012]

Department of Health. 2010. Clinical Guidelines:PMTCT 2010[online] (2012) Available at http://www.fidssa.co.za/images/PMTCT_Guidlines.pdf(22/02/2014)
[Accessed 8th March 2012]

De Vos, A.S., 2011, *Research at Grassroots*. 3rd ed. Pretoria: Van Schaik Publishers

DiGirolamo, A., Thompson,N., Martoel,R., Faden,S., & Grummer-Strawn,L. 2005. Intention or Experience? Predictors of continued breastfeeding. *Health Educationand Behaviour*,32(2),208-226.

Doherty,T.,Chopra ,M.,2006. HIV and Infant Feeding.In Ijumba . *South African HealthReview*. Durban.: Health Systems Trust;2006.pg221-34
Dykes,F., 2006.Breastfeeding in Hospital, Mothers Midwives and the production Line. 1st ed. Abingdon:Routledge

Ebersold,S.L., Murphy,S.D., Paterno, M.T., Sauvager, M.D and Wright, E.M., 2007, Nurses and Breastfeeding: Are You being Supportive?. *Nursing for Women'sHealth*,11:482-487.

Furber,C.M., Thomson, A.M., 2007. Midwives in the UK: an exploratory study of providing newborn feeding support for the post partum mothers in the hospital. *Journal ofMidwifery Womens Health* Mar,52(2)pp142-7

Foodstuffs, Cosmetics and Disinfectants Act. Act 55 of 1972
Available at ; www.info.gov.za/view/Download file Action?id 179244
[accessed 22nd November 2013]

Goss, J.D. & Leinbach,T.R., 1996. "Focus Groups as alternative research practice", Area 28(2):115-23.

Gross,S., Resnik,A., Nanda,J., Cross-Barnet,C., Augustyn,M., Kelly, L., Paige, D., 2011.Early Postpartum:A Critical Period in Setting the Path for Breastfeeding Success. *Breastfeeding Medicine* Volume 6, Number 0

Hoddinott P, Tappin D, Wright C. 2008.Breast feeding. BMJ ;336(7649):881-887. doi:10.1136/bmj.39521.566296.BE

Hong,T.M., Callister, L.C., Schwartz, R.,2003. First-Time Mother's View of Breastfeeding Support From Nurses. *The American Journal of Maternal/Child Health Nursing*. Vol 28(1) pp 10-15

Imdad, A., Yakoob, M.Y, Bhutta,Z., 2011.Effect of breastfeeding promotion interventions on breastfeeding rates, with special focus on developing countries. *BMC Public Health* 2,11(suppl3):24

Jiang,H.,Li.M., Wen,L.M., Hunter,C., He,G., Qian.X.,2012. Awareness, Intention and Needs Regarding Breastfeeding: Findings from First-Time Mothers in Shanghai, China. *Breastfeeding Medicine* December ;7(6):526-534

Jordaan,M.M., 2010.A Cross-Sectional Study of Newborn Feeding Practices and Support at Healthcare Facilities in Gauteng. [Thesis] Johannesburg: University of the Witwatersrand

Kitzinger, J.,1995. Qualitative Research: Introducing Focus Groups. *BMJ* Jul29; 311, 299

Koricho,A.T., Moland,K.M., Blystad,A., 2010. Poisonous milk and sinful mothers: the changing meaning of breastfeeding in the wake of the HIV epidemic in Addis Ababa, Ethiopia. *International Breastfeeding Journal*, 5:12

Kronborg,H.,Vaeth,M.,Olsen,J.,Harder,I., 2007 .Health visitors and breastfeeding support: influence of knowledge and self efficacy. *European Journal of Public Health* 18(3) 283-288 pp 283,287

Kruger, R.,Gericke, G. 2001. Breastfeeding Practices of Mothers With Children (aged 0-36 months) in a rural area of South Africa. *Journal of Family Ecology & ConsumerSciences*, Vol 29,pg 60 – 72

Lipsy,M., 1980. *Street Level Bureaucracy: The Dilemmas of the Individual in PublicService*. USA: Russel Sage Foundation

Lothian,J.,Goer,H. 2007.The Coalition for Improving Maternity Services. *Journal ofPerinatal Education* Vol 1.Supplement.

Lucas,A., 2011.Taking-the Lead. *Midwives* [online]
Available at: www.rcm.org.uk/midwives/features/taking-the-lead
[Accessed on 27th September 2013]

Marais, D., Koornhof, H.E., du Plessis,L.M., Naude, C.E., Smit,K., Hertzog,E., Treurnicht,R., Alexander,M., Cruywagen,L., Kosaber,I. 2010.Breastfeeding policies and practices in health care facilities in the Western Cape Province, South Africa.*SouthAfrican Journal of Clinical Nutrition*;23(1)

Maclntosh, J. 1981 "Focus groups in different nursing education", Journal of Advance Nursing 18:1981-85

Maddux,J.E., 2000. Self Efficacy: The Power of Believing you Can. Handbook of positive psychology. New York: Oxford University Press

Maynard-Moody,S., Musheno,M., 2003. *Cops. Teachers, Counselors - Stories fromthe frontline of public service*. Ann Arbor: University of Michigan Press.

Mc Innes, R.J.,Chambers,J.A .,2008 Supporting mothers: qualitative synthesis . *Journal ofAdvanced Nursing* 62(4), 407-427 pp 407,421

Mc Keever,J., St Fleur,R., 2012 Overcoming Barriers to Baby-Friendly Status one hospitals experience. *Journal of Human Lactation*28(3) 312-314

Millennium Development Goals www.un.org/milleniumgoals/
[Accessed 22nd October 2012]

Millennium Development Goals Country Report 2010 [Online] (2010) Available at http://www.statssa.gov.za/news_archive/Docs/MDGR_2010.pdf
[Accessed 29/08/2011]

Minnie,C.,2006 .The choice of baby feeding mode within the reality of the HIV/AIDS epidemic: health education implications . *Curationis* 29(4):19-27

Motsoaledi,A., 2011. *Address by the Minister of Health at the breastfeeding consultative meeting,* Centurion [Online] updated 28/08/11. Available at: http://www.polity.org.za/article/sa-motsoaledi-address-by-the-minister-of-health-at-the-breastfeeding-consultative-meeting-centurion-22082011-2011-08-22
[Accessed 2nd September 2011]

Mouton, J.,1996. *Understanding Social Research.* Pretoria:Van Schaik Publishers.

OEDC (Organization for Economic Co-operation and Development) 2013. OECD Health Data-How Does South Africa Compare with OECD Countries?
www.oecd.org/health
[Accessed 22nd October 2013]

NMC 2009 Standards for Pre Registration Midwifery Education. [Online]
Available at:http://www.nmc-uk.org/Documents/NMC-Publications/nmcStandardsfor Pre_RegistrationMidwiferyEducation.pdf
[Accessed 22nd October 2013]

Payne JW, Bettman JR, Johnson EJ: 1993.The adaptive decision maker. New York: Cambridge.University Press.

Perrine,C.G., Scanlon,K., Li, R., Odom,E., Grummer-Strawn, L.M., 2012.Baby Friendly Practices and Meeting Exclusive Breastfeeding Intention. *Pediatrics*, Jul,130(1):54-60.

Polit,D.F., Beck, C., 2014*Appraising Evidence for Nursing Practice*.8th ed. Philadelphia:Lippincott, Wilkins & Wilkins

Renfrew,MJ, Dyson L, McFadden, A., 2005.Evidence into practice briefing on the initiation and duration of breastfeeding: technical report. London: National Institute for Health and Clinical Excellence

Reddin,E., Pincombe, J., Darbyshire, P.,2007.Passive Resistance: Early Experiences of Midwifery Students/ Graduates and the Baby Friendly Initiative 10 Steps to Successful Breastfeeding. *Women Birth* Jun ;20 (2)pp71-6

Riordan,J., Auerbach,K. 1999 Breastfeeding and human lactation 3rd edition. USA: Jones & Bartlett

Rolfe,G., 2006. Validity, trustworthiness and rigour; quality and the idea of qualitative research. *Journal of Advanced Nursing*.53(3) 304-310

Saadeh, J.S. 2012. The Baby-Friendly Hospital Initiative 20 years On: Facts, Progress, and the Way Forward. *Journal of Human Lactation*28(3) 272-275

Sanders, D., Bradshaw, D., Ngongo, N.,2010.*The Status of Child Health in South Africa 2010* [Online] (2010) Available at http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2009-10/sa_child_gauge09-10_status_child_health.pdf
[Accessed 28 August 2011]

Sapru,R., 2009. *Public Policy*. 2nd ed. New Delhi: Sterling Publishers

Schmied,V., Gribble,K., Sheehan,A., Taylor,C., Dykes,F.C., 2011.Ten steps or climbing a mountain: A study of Australian health professionals' perceptions of implementing the baby friendly health initiative to protect, promote and support breastfeeding. *BMC Health Service Res*;11:208

Scott, J.A., Binns, C.W., Factors associated with the initiation and duration of breastfeeding: a review. Breastfeeding Review 1999; 7(1):5-16

Semenic,S.,Childerhose,J.,Laurziere,J.,Groleau,D., 2012. Barriers, facilitators, and Recommendations Related to Implementing the Baby-Friendly Initiative (BFI): AnIntegrated Review. *Journal of Human Lactation*; 28(3) 317-334

Shahla,M., Fahy,K., Kable,A.K., 2010.Factors that positively influence breastfeeding duration to 6 months: a literature review , Women and Birth, vol.23,no.4,pp.135-145

Shenton, A., 2004. Strategies for Ensuring Trustworthiness in Qualitative Research Projects. *Education for Information* 22 (2004) pp63-75

Stellenbosch University.2012
Available at:http://blogs.sun.ac.za/news/2012/09/19/south2south-awarded-contract-to-develop-national-breastfeeding-training-material/
[Accessed 22nd October 2013]

Stuebe, A., Bonuck.K., 2011.What Predicts Intent to Breastfeed Exclusively? Breastfeeding Knowledge, Attitudes and Beliefs in a Diverse Urban Population. *Breastfeeding Medicine*. December;6(6):413-420

Sutton,R., 1999.The Policy Process: an overview. Overseas Development Institute funded by World Bank. http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/2535.pdf [Accessed 12 August 2012]

Swart,R., Sanders,D.,Mc Lachlan,M., 2008. Nutrition: A primary health care perspective.In: Barron , P., Roma-Reardon,J., editors. *South African Health Review*. Durban. Health Systems Trust; pp129-147

Tanner,C., 2006. Thinking Like A nurse: A Research Based Model of Clinical Judgement. *Journal of Nursing Education*, June,45(6) 204-210

Tesch, R., 1990. Qualitative Research: Analysis Types and Software Tools, 3rd ed., Basingstoke: The Falmer Press

The Guardian 2013 Available at:www.the guardian.com>Life & style>Breastfeeding [accessed 9July 2013]

The Tshwane declaration of support for breastfeeding in South Africa 2011 www.sajcn.co.za/index.php/SAJCN/article/download/586/820 [Accessed 3rd February 2013]

Tshwane Declaration of support for breastfeeding in South Africa .2011.*SouthAfrican Journal of Clinical Nutrition*;24(4)

United Nations, 2010. *We Can End Poverty 2015* [Online] Available at http://www.un.org/millenniumgoals/childhealth.shtml [29/08/2011]

UNICEF, World Health Organization.1998. Evidence for the ten steps to successful breastfeeding. WHO/CHD/98.9

UNICEF, World Health Organisation. 2006. Baby Friendly Hospital Initiative, revised, updated and expanded for integrated care, Section 3, Breastfeeding Promotion and Support in a Baby Friendly Hospital, A 20 hour course for maternity staff, Preliminary Version.

UNICEF. Nutrition. UNICEF in action. Key publications and links.[Cited 2009 Jan16]. Available from http://www.unicef.org/proramme/breastfeeding/links.htm [Accessed 3rd June 2013]

Walker,L., Gilson,L., 2004. We are bitter but we are satisfied: Nurses as street level Bureaucrats in South Africa. *Social Science & Medicine*. 59(6) 1251-1261

Walt,G. 2000. *Health Policy An Introduction to Process and Power*. Johannesburg Witwatersrand University Press.

Walt,G., Shiffman,J., Schneider,H., Murray,S., Brugha,R., and Gilson,L.,2008. “Doing” health policy analysis: methodological and conceptual reflections and challenges. *Oxford Journals*, 23(5),pp308-317

WHO. 2010. Kesho Bora Study Preventing mother-to-child transmission of HIV during breastfeeding . Department of Reproductive Health and Research. WHO/RHR/11.01

WHO, Regional Office of Europe. Infant feeding, nutrition and food security. [cited 2009. Jan16] Available from www.euro.who.int/nutrition/Infant/20020808_1

WHO. 2007.Evidence on the long term effects of breastfeeding: systematic reviews and meta-analysis. Geneva:WHO;2007

WHO.2012. Code of Marketing of Breastmilk Substitutes . Available at www.who.int/nutrition/publications/code_english pdf [Accessed: 3 Feb 2013]

Woolf,S., Chan,E., Harris,R., Sheridan,S., Braddock,C., Kaplan,R., Krist,A., O’Connor, A., Tunis,S., 2005. *Promoting Informed Choice: Transforming Health Careto Dispense Knowledge for Decision Making*. American College of Physicians . 143:293-300

World Health Organization, 1998.Child Health and Development - Evidence for the ten steps to successful breastfeeding. Geneva : World Health Organization.

World Health Organization, UNICEF, 2009. BFHI Revised Updated and Expanded for Integrated Care. WHO

World Health Organization. The Baby- Friendly Hospital Initiative Monitoring and Reassessment: Tools to Sustain Progress.1999

World Health Organization, UNICEF. 2003. Global Strategy for Infant and Young Children Feeding. Geneva: World Health Organization.

World Health Organization, 1998.Child health and Development - Evidence for the ten steps to successful breastfeeding. Geneva : World Health Organization

World Health Organization, UNICEF, 2009. BFHI Revised Updated and Expanded for Integrated Care. WHO

World Health Statistics 2010 http://www.who.int/gho/publications/world_health_statistics/WHS2010_IndicatorCompendium.pdf?ua=1. [Accessed 25September 2012]

Yngve, A., Sjöström,M. 2001. Breastfeeding determinants and a suggested framework for action in Europe. *Public Health Nutrition* : 4(2B), 729-739

APPENDIX 1

INFORMED CONSENT FOR RECORDING OF THE DISCUSSION GROUP INTERVIEW WITH MIDWIVES

I have been given the information sheet on the project entitled: *Constraints to Implementation of The 10 Steps to Successful Breastfeeding.* I have read and understood the information sheet and all my questions have been answered satisfactorily.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is recorded, the recording will be destroyed two years after publication of the findings.

I understand that I can ask the person interviewing me to stop recording, and to stop the interview altogether, at any time.

Participant's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

APPENDIX 2

Code QLU

CONSTRAINTS TO IMPLEMENTATION OF THE 10 STEPS TO SUCCESSFUL BREASTFEEDING

INFORMATION SHEET FOR RESEARCH PARTICIPANTS

Introduction and background

Hello. My name is Claire Bracher and I am a postgraduate student from the Department of Nursing in the Faculty of Health Sciences at the University of the Witwatersrand. I am studying towards my master's degree in Nursing Science and as part of my studies I am required to write a research report.

The overall aim of this study is to explore the constraints that midwives face when implementing the 10 steps to successful breastfeeding into their practices. The information obtained will be helpful in planning the educational objectives for teaching breastfeeding to midwives. The midwives are key to promoting good quality breastfeeding practices and therefore the midwives are the primary focus of this research. We want to understand in depth the conditions in which they work, and the pressures under which they work, and the challenges they face when implementing the 10 Steps to Successful Breastfeeding.

We will be doing data collection in your unit, with those of you who volunteer to participate in the study.

You are invited to participate in a modified nominal group that will last between 1 and a half and 2 hours. This is similar to a focus group although it is more structured and requires the participants to share ideas and reach a consensus .The data collection will take place at your place of work at a predetermined time and will comprise 5 to 10 participants.
With your permission the modified nominal group will be recorded so that accurate transcripts may be made for analysis purposes. The data will be collected by myself and one research assistant.
You may withdraw from the group at any time without any consequences.
Refreshments will be served during the proceedings.

Confidentiality

The information that we collect will be kept locked in a safe and will only be accessed by the researcher and researcher's assistant. We will not feedback directly to your manager or charge sister. We will feedback the results in a general way but any identifying information will be changed. Your name will not be revealed in any feedback, written data or report resulting from the study. However, due to the nature of the modified nominal group and it's similarity to a focus group, full confidentiality cannot be guaranteed. The answers given by participants will be combined and

analysed to look for common themes and experiences. The combined information will be written up in the form of a report.

Consent

Permission to carry out this project was obtained from the University of the Witwatersrand Research Ethics Committees. We will ask for consent to record the interview as this helps us accurately record what you say. Members of the research team only, namely a co coder and myself, will view the recording. The recording will be destroyed two years after the study is completed and published, in line with our ethical responsibilities.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the study. There will be no negative consequences for individuals who do not want to be participate. You will not be compensated for taking part in the study. During the research project, you have the right to decline to answer any questions that make you feel uncomfortable, or to stop your participation at any time. We hope however that the study will give you a chance to get the reality of your everyday work and the pressures that you are under understood by a wider community – and therefore to impact on nursing policy.

Contact details

We will be happy to answer any question you have about this study. This research has been approved by the University of the Witwatersrand Research Ethics Committee. If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the ethics office on (011) 717 1234. If you have questions about the research, you may also contact me directly:

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GAUTENG DEPARTMENT OF HEALTH

RESEARCH PROPOSAL EVALUATION FORM

Researcher Name	Claire Bracher
Researcher's contact details	Email: bracher.claire@gmail.com
Institution	University of the Witwatersrand; Nursing Department
Research Topic	Constraints to implementation of the 10 steps to successful breastfeeding
Date Received by the Directorate PPR	04/07/2012
Date Received Reviewer	07/08/2012
Final Review Date	07/08/2012
Date Submitted to Director of PPR	07/08/2012
Research Site(s)	Rahima Moosa hospital and Genesis clinic
Type of research	Descriptive

CRITERIA	YES	NO	COMMENTS
1. Is this research project within the scope of the Department of Health key policy priorities/directives?	X		
2. Content of Research: ▪ Original work	X		
▪ New facts, ideas	X		
▪ Confirmation of uncertain data	X		
▪ Repetition of known data and consequently of limited importance		X	
▪ Insufficient research information		X	
▪ Confusion of topics/questions		X	
3. Is the title of the research project suitable?	X		
4. Are the objectives of the research project adequate?	X		
5. Could the objectives be limited to better focus on the project's main objective?		X	
6. Writing style			

CRITERIA	YES	NO	COMMENTS
▪ The text of the proposal is clear	X		
▪ The nomenclature used is correct	X		
▪ The references used are relevant, comprehensive and accurate	X		
▪ The spelling and grammar are correct	X		
▪ The language needs improvement		X	
▪ The research proposal needs re-styling and re-writing		X	
7. Are the research methods appropriate to the study?	X		
8. Is data collection method in line with the study design?	X		
9. Does the study have ethical approval? If yes, name the ethics committee.	X		M120407
10. Is the definition and measurement of variables consistent with the scope of the proposal?	X		
11. Is the time frame of the proposal adequate to meet the objectives?	X		
12. Is the method of dissemination of the results of the research project stated?		X	It is recommended that the researchers specify how the results will be shared / disseminated
13. Is any possible conflict of interests clarified?	n/a		
14. Are financial implications and financial support transparent?	x		

SUMMARY OF PROPOSAL

Background

Breastfeeding has been identified as an important method of improving health outcomes for infants in SA. SA is currently not meeting the Millennium Development Goal of reducing infant morbidity and mortality rates by the year 2015. The Department of Health has recognized the Baby Friendly Hospital Initiative as a means of improving breastfeeding figures and states that all maternity services should implement the initiative, through the 10 steps to successful breastfeeding. The midwives working with new mothers appear not to be incorporating the principles of this initiative into their practice and South Africa's breastfeeding has been described as poor. Dissemination of policy changes are poorly communicated to the midwives and consequently their breastfeeding practices are often out dated. The purpose of this study is to investigate why midwives are not practicing the 10 steps to successful breastfeeding.

Objectives

- Determine the opinions of practicing midwives on the relative importance of each of the 10 steps to Successful Breastfeeding.
- Explore the opportunities and constraints of practicing the steps deemed to be the most important.
- Develop an outline for an in-service programme for midwives addressing overcoming constraints related to implementation.

METHODS

It will be a qualitative exploratory and contextual study design. Midwives will be purposefully selected from Rahima Moosa hospital and Genesis clinic. Data will be collected via modified nominal groups. Each group will be given 10 cards displaying one of the 10 steps to Successful Breastfeeding. Through group interaction and discussion the participants will rate the importance of the 10 steps to Successful Breastfeeding from 1 -10. The highest ranked steps will be taken and further discussion will take place to establish: why these steps scored a high ranking; how practical these steps are to implement; Constraints encountered when implementing the chosen steps. The groups will be video recorded and transcribed verbatim by the researcher. The data will be analyzed by the researcher using the Open Coding method.

REVIEWER'S FINAL CONCLUSION

The proposed study will provide recommendations for more effective training guides to institutions that educate midwives and is recommended for approval.

Reviewed and Recommended by

Dr Bridget Ikalafeng, Research and Epidemiology

Date: 13/08/2012

Approved

S. le Roux, Director PPR

Date: 14/08/2012

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02 October 2012
Person No: 400905
PAG

Mrs CE Bracher
14 Gullane Road
Greenside
2193
South Africa

Dear Mrs Bracher

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled "*Constraints to implementation of the 10 steps to successful breastfeeding*" has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Mrs Claire Bracher

CLEARANCE CERTIFICATE	**M120407**
PROJECT	Constraints to Implementation of the 10 Steps to Successful Breastfeeding
INVESTIGATORS	Mrs Claire Bracher.
DEPARTMENT	Department of Nursing Education
DATE CONSIDERED	04/05/2012
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 18/06/2012 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Dr Sue Armstrong

DECLARATION OF INVESTIGATOR(S)
To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...