

Breastfeeding Practices of Healthcare Providers
at Capricorn District Level 1 Hospitals,
Limpopo Province

by

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DECLARATION

I hereby declare that the work herein submitted as a thesis for the Master of Public Health resulted from my own investigation, and that it has neither wholly nor partially been presented as a thesis for degree in this University or elsewhere.

Work by other authors, which served as sources of information have duly been acknowledged by reference to the authors.

Signature

Date

DEDICATION

I dedicate this work to my parents, mom Ngwatladi and my late father Nape, my brothers and sisters for their regular coaching sessions, my husband, Phogole a' Ngwato and my three children, Phenyo, Theto and Chegofatjo for keeping up with me and being glued to the computer when I'm home. You are a heavenly blessing to me!

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ABSTRACT

The Aim: The aim of the study was to assess breastfeeding practices of healthcare providers at level one hospitals in Capricorn District of Limpopo province.

Methods: Five level one district hospitals within the Capricorn district of Limpopo province were the study sites. Two focus groups with members ranging from three to nine members were conducted. Two managers per hospital were interviewed.

In both focus groups and in-depth interviews an audio tape recorder was used. This was transcribed and from the first transcription categories were developed. These formed a basis for data analysis, although the categories had undergone transformation as the analysis unfolded.

Results: The study found that there are three practices that are adopted with regard to breastfeeding practices. Most employees choose to breastfeed as the first choice in baby feeding. Majority succeeded in breastfeeding their babies for sometime. There are those who feed their babies' breast milk as the only source of milk during infancy. Others practice mixed feeding, where the baby is given breast milk and supplemented by formula. However, others fed their babies formula only. They indicate that this was not the initial choice in baby feeding.

Conclusion: Healthcare providers have the same needs as the rest of the population with regard to breastfeeding and work. Their challenges are more work-related; which affect their decision whether to breastfeed or not to.

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DEFINITION OF CONCEPTS

1. Absenteeism

It refers to a habitual failure to appear for work or other regular duty; which is usually unscheduled (The American Heritage Dictionary, 2000).

2. Allied Group

In terms of the Limpopo Department of Health and Social Development's organisational structure for district hospitals (2009), it refers to a group of health professionals who are registered with the Health Profession's Council of South Africa in the following professional boards: physiotherapy, occupational therapy, speech-language therapy and Audiology, radiography, dietetics and optometry. It also includes social workers in healthcare.

3. Artificial feeding

It means feeding a baby with breast milk substitutes. The baby is usually fed formula or other fluids, using an infant feeding bottle or baby cup (IYCFP, 2005).

4. Baby-Friendly Hospital

A Baby Friendly Hospital (BFH) is a health care facility where the practitioners who provide care for women and babies adopt practices that aim to protect, promote and support **exclusive** breastfeeding from birth. At the same time, Baby Friendly facilities ensure that women who choose not to breastfeed are supported in their decision and provided with unbiased information and advice (Baby Friendly Aotearoa, 2008).

5. Bottle feeding

It refers to feeding from an infant feeding bottle, whatever is in the bottle, including expressed milk, water or formula. The baby is said to be sucking from the bottle; which is different from suckling from the breast (IYCFP, 2005)

6. Breast milk substitutes

It refers to food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose. They include any liquids, fluids or semi-solids that may be purchased or prepared from home (The International Code of Marketing of Breast-milk Substitutes, 1981)

7. Cessation of breastfeeding

It refers to completely stopping breastfeeding, including any suckling at the breast. This could be in a progressive or abrupt manner (IYCFP, 2005).

8. Exclusive breastfeeding

An infant receives only breast milk and no other liquids or solids, not even water, except drops or syrups consisting of vitamins, mineral supplements or medicines. When expressed milk is given, the preferred term is breast milk feeding (IYCFP, 2005).

9. Healthcare provider

Any person providing health services mainly registered in terms of:

- Allied Health Professions Act, 1982 (Act No. 63 of 1982)
- Health Professions Act, 1974 (Act No. 56 of 1974)
- Nursing Act, 1978 (Act No. 53 of 1978)
- Pharmacy Act, 1974 (Act No. 53 of 1974) and
- Dental Technicians Act, 1978 (Act No. 19 of 1979) (IYCFP, 2005)

10. Infant

The Oxford dictionary defines it as a child during the first few years of life.

For purposes of this study it refers to any person from birth to 1 year (IYCFP draft, 2005)

11. Level 1 district hospital

For purposes of this study, it refers to a public hospital which offers primary and secondary healthcare, which does not offer specialist services. This classification is not based on the number of beds in that hospital (DoH, 2005)

12. Maternity leave

It is a leave taken by a woman on or around the birth of her child, for purposes of recuperation and taking care of the new born baby (BCEA 75 of 1997).

13. Mixed feeding

It refers to feeding breast milk as well as other milks (including commercial infant formula or home-prepared milk), foods or liquids (IYCFP, 2005).

14. New born

A recently born baby, especially who is less than a month old, the relevant medical term which may bear the same

meaning is neonate (Merriam Webster's Online Dictionary, 2008).

15. Productivity

Output per employee, either in financial or non-financial quantities (Heath, 2007)

16. Sekgalaka

A condition where a person develops sores any where in the body. It is believed that such sores may cause infertility and other ailments.

17. The Code

It refers to the International Code of Marketing of Breast-milk Substitutes.

18. The Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare 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 one half-hour of birth.
5. Show mothers how to breastfeed and maintain lactation, even 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 groups and refer mothers to them on discharge from the hospital or clinic (UNICEF, 2009)

ABBREVIATIONS

- 2. BCEA**
Basic Conditions of Employment Act of 1997
- 3. CEO**
Chief Executive Officer
- 4. DoL**
Department of Labour
- 5. ILO**
International Labor Organization
- 6. IBFAN**
International Baby Food Action Network
- 7. IYCFP**
Infant and Young Child Feeding Policy
- 8. NZ**
New Zealand.
- 9. UN**
United Nations
- 10. UNICEF**
United Nations Children's Fund
- 11. WHO**
World Health Organization

CHAPTER 1

1.1 Introduction

Healthcare providers play an important role in protecting and promoting breastfeeding in the everyday execution of their duties. They should therefore be motivated and have the right attitude to encourage a mother of a newborn in their care to breastfeed. They play a vital role in utilizing the Code of Marketing of Breast-milk Substitutes (The Code) as a valuable tool to protect and promote breastfeeding (International Baby Food Action Network, 2000).

South Africa is one of the countries having the highest number of hospitals that have been granted the baby-friendly hospital status. The success of this country can be credited to the hard work done by healthcare providers in teaching new mothers about the importance of breastfeeding. Healthcare providers are charged with a responsibility to promote exclusive breastfeeding of infants from birth to six months and successive breastfeeding until the baby is at least two years old (Allain & Chetley, 1999; Kuzwayo, 1991; Innocenti Declaration, 2005).

Healthcare providers are part of the general population or the community and they are also responsible to help new mothers to breastfeed. King (1992) alludes that healthcare providers should set an example by breastfeeding their own children. The author further stresses that patients must see healthcare providers' breastfeeding their own babies.

Most healthcare providers' work environment is characterized by staff shortages and longer working days, sometimes without regular lunch periods. Some healthcare providers may be discouraged to breastfeed as recommended in the various literatures. For instance, a nurses' working day may commence at 7H00 until 19H00. If we include travel time, this may be way over fifteen hours that a new mother may find herself spending away from her baby.

Legislation in South Africa benefits women in the employment world by making provision for four months paid maternity leave. It provides that the employer must protect a woman during her pregnancy and after the birth of her child. The employer should not allow a female employee who is nursing her child to perform duties that may be harmful to her or her baby. The main focus of such legislation is protection from harm while the mother is on duty. However, this does not include the indirect harm that a baby may suffer due to poorly mixed baby formula when mom is

busy at work (BCEA 75 of 1997; Unemployment Insurance Act 30 of 1966).

Breastfeeding exclusively for six months after the birth of a child is crucial for the mother and infant's health. It is therefore important for employers to support breastfeeding employees. The law makes provision for four months paid maternity leave, whereas it is essential for an infant to be exclusively breastfed for about six months. It then becomes apparent that though it is possible, it may not be so easy for employed women to successfully breastfeed exclusively for the whole six months (WHO/ UNICEF, 1989).

Breast milk contains all the nutrients that a baby requires for the first four to six months of its life. All these nutrients come in the right proportion and in the form that the baby's body can easily absorb. It even contains enough water for the baby, irrespective of how hot or cold the weather may be. It contains enough salt, calcium and phosphate for the growing baby. There is therefore no need for the mother to give a newborn baby any other food except breast milk for the first six months (King, 1992).

On the other hand, there is an increased risk of transmission of HIV from mother to child through breast milk if mixed feeding is practiced. The working conditions of most healthcare providers are such that mixed feeding is a norm rather than an exception, with shifts that stretch to as long as twelve hours, there is usually not enough time to express breast milk. This is compounded by the irregular lunch breaks that are associated with most healthcare providers' work schedule (Coovadia and Rollins, 2007).

1.2 Problem Statement

Healthcare providers feature in most publications as the providers of health but there is limited literature about their breastfeeding practices. There is also no record about the challenges they face if they choose to breastfeed their own infants. There is also no information about how those who succeed to breastfeed cope (King, 1992; IYCFP, 2005).

1.3 Research Question

What are the breastfeeding practices of healthcare providers at level one hospitals in Capricorn District of Limpopo province?

1.4 Aim of the Study

The aim of the study was to assess breastfeeding practices of healthcare providers at level one hospitals in Capricorn District of Limpopo province.

1.5 Research Objectives

- 1.5.1. To find out perceptions of healthcare providers and their managers regarding breastfeeding and work.
- 1.5.2. To find out if there are healthcare providers who managed to successfully breastfeed, and how they managed to do so.
- 1.5.3. To identify challenges faced by healthcare providers in terms of breastfeeding and work.

CHAPTER 2 LITERATURE REVIEW

2.1. Introduction

This review focuses on the following aspects: a) conceptions of breastfeeding, b) schools of thought in breastfeeding and c) experiences in other countries. We will also discuss the current legislation in South Africa and internationally with regard to breastfeeding and work.

2.2. Discussion

King (1992) alludes that healthcare providers are not fully practicing exclusive breastfeeding, although they are supposed to be exemplary in breastfeeding their own infants, this is usually not being practiced. There may be some factors that contribute to such a scenario, or to some extent it may be that they are more scrutinized, as they are custodians of breastfeeding promotion.

A study conducted in Kwa-Zulu Natal indicated that infants born of HIV positive mothers could benefit considerably from exclusive breastfeeding. An exclusively breastfed baby has a 4% risk of infection by the virus, whereas a mixed fed baby is eleven times more likely to contract the virus from breast milk. An HIV positive employee may be tempted to practice mixed feeding if the workplace is not supportive to breastfeeding. This may put that employee's baby at a higher risk of contracting the virus (Coovadia and Rollins, 2007).

There are risks associated with artificial feeding, risks that do not exist or exist in a lower rate among breastfed children. An artificially fed baby has a higher risk of malnutrition than a breastfed one; the same applies to gastrointestinal infections and obesity. If a bottle is used to feed the baby, this may contaminate the milk, which the baby may consume and get gastrointestinal infections. Bacteria grow more quickly in artificial feeds than in breast milk (King, 1992).

A study that was conducted in Nigeria indicated that exclusive breastfeeding could be increased through focused breastfeeding counseling. The prevalence of diarrhea was also significantly reduced. This further confirms the important role played by healthcare providers, as they are mainly the first people who come in contact with new-borns and their mothers. The same study indicated a 46% reduction in re-occurrence of diarrhea on exclusively breastfed babies, which is a significant reduction. Infants who were not exclusively breastfed experienced only 8% reduction (Adetugbo, Adetugbo, Orewale and Fabiyi, 1997).

An expectant employee may commence with maternity leave any time from 36 weeks of pregnancy or as the doctor or midwife deems fit. This may reduce the time spent by an employed mother with the new-born baby significantly, warranting the mother to return to work before the baby is even four months old. There is an apparent lack of coordination between the Basic Conditions of Employment Act 75 of 1997 (BCEA) and other legislations aimed at protecting and promoting breastfeeding; (The International Code of marketing of Breast-milk Substitutes, 1981; Infant and Young Child Feeding Policy, 2008; Innocenti Declaration, 2005).

The BCEA (Act 75 of 1997) makes provision for only four months maternity leave and a woman may commence with the leave four weeks before delivery. This may leave the mother with only three months to be with her newborn before returning to work. If the mother has to return to a hectic schedule characterized by staff shortages and longer working hours, which is the norm in the healthcare providers' work environment, the issue of breastfeeding may not become an option. If she chooses to breastfeed, it then becomes difficult.

A breastfeeding mother needs to breastfeed or express breast milk regularly in order to sustain adequate flow of breast milk. This is usually not practical once the mother is back at work unless there are policies in place to promote and protect breastfeeding in the workplace. The process of expressing breast milk must be carried out in a quiet and private environment where interruption is minimal (King, 1992; Biagioli, 2003).

Exclusive breastfeeding for the first six months of a child's life is important, but this is an exception and not a norm in South Africa. The National Demographic and Health Survey that was conducted in 1998 showed that only about 10.4% mothers exclusively breastfed their children during the first three months. Only 1.2% of mothers exclusively breastfed their children at the age of four to six months. The results of the study conducted in Kwa-Zulu Natal also shows that a disappointing 10% of mothers exclusively breastfed at three months (South African Demographic and Health Survey, 1998; Kassier, Maunder and Senekal, 2003).

One of the four most important reasons for termination of breastfeeding, given by 9% of women interviewed in the South African Demographic and Health Survey (1998), was returning to work. Having to return to work for financial reasons was also cited as the top most reason for women in the Pacific Island to terminate breast feeding. It was suggested that when employment

and breast feeding are in competition, it is usually breastfeeding which suffers (Work and Life Bulletin, 2002).

There is a significant association between maternal employment and early cessation of breastfeeding. Some of the challenges identified were lack of break time, inadequate facilities for pumping, and storage of human milk, lack of resources that promote breastfeeding and lack of support from employers and colleagues. There is an apparent conflict between paid work and breastfeeding, with increased paid work resulting in low breastfeeding rates among employed women. This is mainly because breastfeeding in the workplace has not been given enough attention. Most women view their return to work as a cause to end their breastfeeding regime (Philippine Pediatric Society Committee, 2004; Galtry, 2000).

The National Immunization Survey conducted in the United States in 2001 revealed that 62.5% of babies were exclusively breastfed for the first 7 days of life, but this figure declined to 7.9% at six months. In 1998, South African rates of exclusive breastfeeding were found to be at 10% for the first 3 months of life, and 1.2% at 4 to 6 months. Although these are figures taken in different years, they both indicate that there is a significant drop in breastfeeding rates somewhere between three months and six months of a baby's life. This period coincides with the time for the mother to return to work (Li, Zhao, Mokdad, Barker and Grummer-Strawn: 2003; SADHS, 1998).

The mother who chooses to breastfeed may return to her pre-pregnancy weight sooner because breast milk production consumes more fat. Breastfeeding also helps to stop bleeding after delivery. Frequent breastfeeding helps to protect against another pregnancy, as such, it gives the mother more chance to regain her pre-pregnancy state. Studies on female reproductive health have shown that the risk of breast and cervical cancer is significantly reduced through breastfeeding (Menon and Holla, 2004; King, 1992, Innocenti Declaration, 1990).

By creating a breastfeeding-friendly environment employers stand to benefit significantly. It saves on recruitment costs as more employees are retained, there will be less absenteeism because breastfed babies do not get sick quite often, which eventually boosts productivity. The company's image is enhanced and the community will know such a company as a good one since there is less resignations. A lot can be achieved by educating the employer as well as the public about the health economic benefits from high rates of breastfeeding (Department of Labour, New Zealand, 2005; Saxena, 2006).

There are four basic things that an employer can do to create an enabling environment for breastfeeding in the workplace:

2.2.1. Talking with the employee (communication as early as possible).

An expectant employee should communicate with her employer in an attempt to gain support and in order to negotiate working conditions that will support the practice of breastfeeding. On the other hand the employer should inform an expectant employee on any arrangements and policy issues regarding breastfeeding (Philippine Pediatric Society Committee on Policy Statements: 2004).

2.2.2. Time.

The ILO convention 183 (2000) indicates that breastfeeding breaks for a breastfeeding employee is a human right, although it makes provision for such, the number of breastfeeding breaks are left with national offices to determine. At least one breastfeeding break will be better than nothing (ILO, 2000).

2.2.3. Space (facilities)

The employer may provide a clean, comfortable room, with an electric outlet for breast pumps, a comfortable chair and a fridge for storing expressed breast milk. Interruptions must be kept to the minimum and as such, it is preferable if that room can be dedicated exclusively for breastfeeding purposes. Employees can then book such a room on various periods (United States Breastfeeding Committee: 2002).

2.2.4. Support

In a study conducted at university of Kwa-Zulu Natal, 57% of the working mothers who participated felt that the workplace provided no support for breastfeeding. They indicated affordable child care facilities at work, the option to work from home and extended paid maternity leave as ways the workplace could support breastfeeding. This is in support of the recommendations made in the ILO convention and by the Philippine Pediatric Society (ILO, 2000; PPS Committee on Policy Statements, 2004; Sayed, 2005).

Although there may not be a definite period for an employer to provide support to breastfeeding employees, WHO (2003) advises that workplace support should be made available for the first 12 months after the birth of a baby. South Africa has managed to comply with this directive through the BCEA, although it only offers protection for the first six months after the birth of a child. The Innocenti Declaration also recommends that all governments should adopt maternity protection legislation and

other measures that facilitate six months of exclusive breastfeeding for women employed in all sectors (ILO, 2000; WHO/UNICEF, 2003; Innocenti Declaration, 2005).

2.3. Conclusion

The various literature regarding breastfeeding and work has been discussed. In the following chapter the methodology that was used in this study will be outlined.

CHAPTER 3 METHODOLOGY

3.1 Introduction

In this study, a non-probability, purposive sampling method was used to identify participants. Ten focus groups with a total of sixty-three participants were conducted. Unstructured in-depth interviews were conducted with ten hospital managers, of which two were male and eight were female.

The focus groups were conducted in the boardroom of the hospital depending on its availability during the visit. Where the boardroom was not available, an alternative room which provided little interruption was provided. Managers were interviewed in the privacy of their offices. A Please do not disturb sign was placed on the door to ensure privacy during the interview session

3.2 Study Site

The study was conducted at five level 1 district hospitals at the Capricorn district of Limpopo Province, which has a combination of urban and rural areas. The map below shows the Capricorn district; which is situated on the central part of the province; it was called the central region prior to rezoning of the province. The portion colored in yellow on the third insert indicates the Capricorn district and its location in the province:

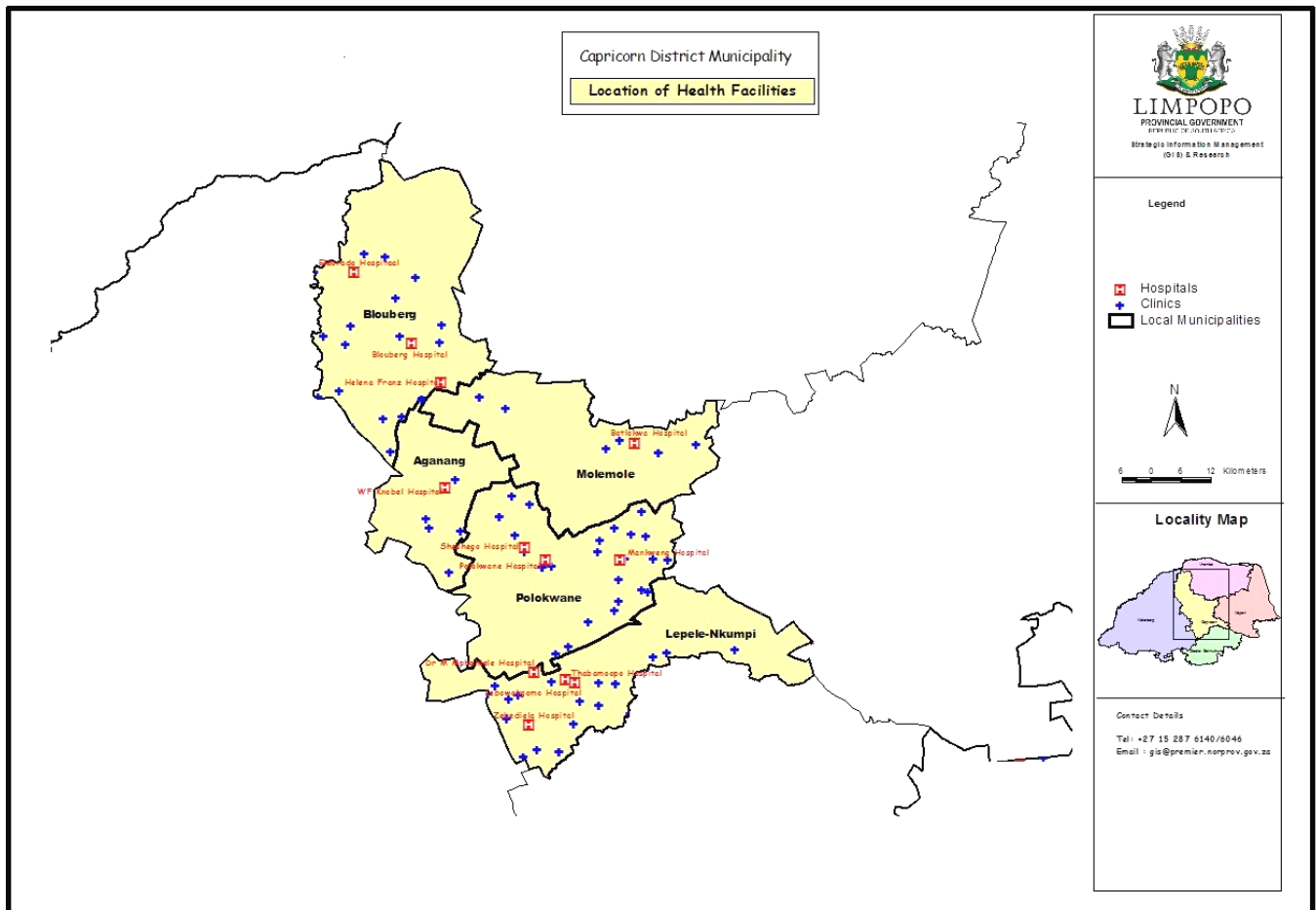


Figure 3.1 Capricorn District Map

Source: Limpopo Office of the Premier, Strategic Information Management & Research (2007)

3.2.1. Botlokwa Hospital

Botlokwa Hospital is a level one hospital situated in the area of Botlokwa within Molemole Municipality, Capricorn District, Limpopo Province, 57 km north of Polokwane along the Polokwane – Makhado N1 Road, 2km north – east along Ramokgopa road. It serves a population of 109 439, which is predominantly rural and there are farming communities utilizing the hospital's services. (Botlokwa Hospital Strategic Plan: 2006 to 2009)

This hospital has 88 authorized beds, of which 56 are usable. It had 67.69% usable bed utilization rate (UBUR) and the average length of stay (ALOS) of 4.34 days in the 2005 and 2006 financial year (Botlokwa hospital strategic plan, 2005-2009).

The vacancy rate at this hospital by the end of the 2006/2007 financial year was 50%, with a staff turnover of 0.5%. The total number of female healthcare providers at this hospital was 80 by June 2007. The clinical staff among this group is part of a team that offers support to 6 clinics at surrounding villages by conducting clinic visits; the Allied group also performs home visits at least once per week (Botlokwa hospital strategic plan, 2005-2009; Botlokwa hospital Workforce profile, 2007).

Botlokwa hospital was first assessed in complying with the ten steps of Baby-Friendly Hospital Initiative in 2003 and obtained a status as a Baby-Friendly hospital the same year. This hospital was further assessed in 2006 and was found to be complying (Limpopo BFHI database, 2009).

3.2.2. W.F.Knobel Hospital

W.F. Knobel hospital is a level one district hospital situated in Aganang Local municipality, with a population 149 922 in the Capricorn District Municipality. The community that the hospital serves is predominately rural. It is about 54 Km west of Polokwane (W.F. Knobel hospital Annual Performance Plan, 2006/2007 to 2008/2009).

This hospital has 214 approved beds and 120 usable beds, with the UBUR of 66% by the end of the 2006/2007 financial year; the ALOS of inpatients at this hospital was 5 days by the end of the same financial year. It provides outreach services to 8 clinics, with extra 5 clinics supported by their pharmacy (W.F. Knobel hospital Annual Performance Plan, 2006/2007 to 2008/2009).

The vacancy rate was estimated at 30% by the end of the 2006/2007 financial year. Female healthcare providers at this hospital was estimated at 141 by the end of the second quarter of

the 2007/2008 financial year (WF Knobel hospital workforce profile, 2007)

WF Knobel hospital's latest BFHI assessment was done in 2008 and was found to be a Baby-Friendly hospital (Limpopo BFHI database: 2009)

3.2.3. Seshego Hospital

Seshego hospital is a level one district hospital situated 15km northwest of Polokwane city. According to the 2001 census, the hospital serves an estimated population of 200 000, which is a combination of both rural and peri-urban community (Seshego Hospital Strategic Plan: 2006 to 2009).

This hospital has 180 authorized beds, of which 140 are usable. It had 71.2% usable bed utilization rate (UBUR) and the average length of stay (ALOS) of 4.28 days by the end of the 2005/2006 financial year (Seshego hospital strategic plan, 2005-2009).

The vacancy rate at this hospital was 31.6% by the end of the 2005/2006 financial year, with a staff turnover of 4%. The total number of female healthcare providers at this hospital was 149 by June 2007. The clinical staff among this group is part of a team that offers support to 13 out of 28 clinics at surrounding villages by conducting clinic visits; the Allied group also performs home visits at least once per week (Seshego hospital strategic plan, 2005-2009; Seshego hospital Workforce profile, 2007).

Seshego hospital was first assessed in complying with the ten steps of Baby-Friendly Hospital Initiative in 2002 and again in 2008. It obtained a status as a Baby-Friendly hospital during both assessments (Limpopo BFHI database, 2009).

3.2.4. Zebediela Hospital

Zebediela hospital is a level one district hospital situated in the Capricorn District at Lepelle-Nkumpi Municipality. It is situated 85 km south of Polokwane, 70 km east of Mokopane and 45 km north of Roedtan. Its population is estimated at 95 286 according to the 2001 national census, which are all rural. (Zebediela Hospital strategic plan, 2004/5 to 2009/10)

The hospital has 108 approved beds. It had 70.8% UBUR and ALOS was 4.25% in the 2005/2006 financial year (Zebediela Hospital strategic plan, 2004/5 to 2009/10).

The vacancy rate at this hospital in the 2004/2005 financial year was 56%, with a staff turnover of 2%. The total number of female healthcare providers at this hospital was 93 by June 2007. The clinical staff among this group is part of a team that offers support to 8 clinics at surrounding villages by conducting clinic visits; the Allied group also performs home visits to clients at surrounding villages at least once per week (Zebediela hospital strategic plan, 2005-2009; Zebediela hospital Workforce profile, 2007).

Zebediela hospital has not yet been assessed as a Baby-Friendly hospital (Limpopo BFHI database, 2009).

3.2.5. Helene Franz Hospital

Helene Franz hospital is a level one district hospital situated in the Capricorn District at Blouberg local Municipality of Molemole. It is situated 98 km north-west of Polokwane. It serves Blouberg, Aganang, Mogalakwena, Lephalale and Makhado municipalities. The population it serves is estimated at 161 321 according to the 2001 national census, it is mainly a deeply rural community. Lack of water, both for agriculture/gardening and for human use, was cited as one of the biggest problems at this area (Helena Franz strategic plan, 2005-2009).

This hospital has 149 authorized beds, of which 119 are usable. It had 77.8% usable bed utilization rate (UBUR) and the average length of stay (ALOS) of 4.9 days in the 1st quarter of the 2005 and 2006 financial year (Helena Franz strategic plan, 2005-2009).

The vacancy rate at this hospital in the first quarter of 2005 was 40%, with a staff turnover of 4.04%. The total number of female healthcare providers at this hospital was 119 by June 2007. The clinical staff among this group is part of a team that offers support to 16 clinics and 2 health centers at surrounding villages by conducting clinic visits; the Allied group also performs home visits at least once per week (Helena Franz strategic plan, 2005-2009; Helene Franz hospital Workforce profile, 2007).

With regard to Baby-Friendly hospital status, this hospital obtained the status in 2009 after it first failed its initial BFHI assessment. There were lactation management workshops going on in this hospital during the time of collection of this data (Limpopo BFHI database, 2009).

3.3 Research Design

A qualitative research design was adopted for this study. This was an exploratory study to provide a baseline for further

research in as far as breastfeeding trends of healthcare providers are concerned (Welman, Kruger and Mitchell: 2005).

A non-probability sampling method was used for the study and only female healthcare providers who have had a baby and are presently in the employ of the five district hospitals are the total population. These have significant expertise in breastfeeding since most of them have gone through a minimum of 18 hours lactation management course (Galloway, 1997)

A purposive sample of two managers per hospital for in-depth interviews was used and two focus groups comprising of about three to ten individuals in each group per district hospital were interviewed.

3.4 Data Collection

3.4.1. Instruments

3.4.1.1 Unstructured in-depth interviews

Unstructured in-depth interviews were conducted on two managers responsible for the rendering of healthcare services at each of the 5 district hospitals. Any two of the following hospital managers were interviewed because of their relevance to the research topic: The clinical manager, allied manager, the nursing manager, the Chief Executive Officer (CEO) and the corporate manager. The corporate manager is not directly involved in supervision of healthcare providers; he/she plays a key role as he/she is responsible for transport, training and infrastructure in the hospital. These are critical in breastfeeding support for employees. The CEO is the accounting officer and final decision taker in the hospital and as such, his/her role in support and promotion of breastfeeding is vital (Neuman, 2006)

3.4.1.2 Focus groups

In this study, the interaction and inquiry was in an unstructured manner. It was anticipated that such focus groups will serve to elicit responses between members of the groups (Welman et al, 2005)

3.4.1.3 Compilation of focus groups

The two focus groups at the hospitals were constituted as follows: one group comprised of nursing personnel and the other group consisted of clinical personnel. This was done to create homogeneity within the group in order to minimize intimidation, which could inhibit responses from some participants (Welman et al, 2005; Neuman, 2006).

Welman et al (2005) identified the following phases in conducting focus groups, and they were used as a guide in this study:

- The researcher introduced the topic to the focus group.
- The researcher set rules indicating, for example, that only one person should speak at a time.
- Each participant (in turn) made an opening statement regarding their experience of the topic.
- The researcher guided the open group discussion by asking questions such as “Most people here mentioned Z, but how does that fit with A?”
- The session ended with each person (in turn) giving a final statement that could not be challenged.

3.4.2. Procedure

The purpose of the interview was explained to the participants and their co-operation was sought. Participants were informed that the interview process will not take more than 30 minutes.

A tape recorder was used with the participant’s consent to record conversations. Field notes were taken by the researcher in order to record observation made, non-verbal behavior such as pauses in conversation, sitting arrangements and body gestures (Welman et al, 2005).

3.4.2.1 Materials

A tape recorder was used in all focus groups, and field notes were compiled to record any non-verbal responses and other gestures. A note pad was used to note any opinions and items that needed further discussion. Identity tags in the form of numbers were made for every participant to identify each member (Welman et al, 2005).

3.4.2.2 The location for collecting data

Managers were interviewed in the privacy of their offices; they were requested to choose the time that suits them for the interview. One manager was on maternity leave and agreed to be interviewed at home.

Focus groups were conducted within the hospital premises, preferably in the boardroom or any spacious room where interruptions could be minimized.

A note was placed at the door to indicate that there were interviews in progress and no disturbance was allowed.

3.4.3. Data Analysis

Welman et al (2005) indicate that the analysis of the information obtained from unstructured interviews and focus groups is based on the interviewer's records. The emphasis is placed on writing a summary of the proceedings as soon as possible after the conclusion of the interview(s). The report was progressively written after each encounter. The tape recordings were transcribed and complemented by the notes that were taken during the interviews.

De Vos, Strydom and Fouche (2005) indicate that there is no clear distinction between data collection and analysis in qualitative research. The first aspect of data analysis is done during collection. They allude that as data is collected, the researcher may look for alternative explanations and patterns that would invalidate initial insight, not necessarily focusing on confirming preliminary field hypotheses. Data analysis in this study commenced from the initial interview and focus group, it continued progressively throughout data collection. New insights were discovered throughout data collection and this formed the basis for analysis

De Vos, Strydom and Fouche (2005) identify 9 phases in data analysis, whereas Marshall and Rossman (1999) identify 6 phases in data analysis. The latter was used as a guideline in the analysis of the data collected in this study.

3.4.3.1 Organizing the data

The material used at various data collection points were labeled, with dates when the data was collected indicated. Field notes were then transferred to the computer and a verbatim transcription of the audio tapes was done. Cutting and pasting of the data collected was done on the computer. Data collected was copied and the master copy was kept in a safe place for reference whenever one needs to revisit the notes (De Vos, Strydom and Fouche, 2005).

3.4.3.2 Generating categories, themes and pattern

Words and themes that participants use formed a basis for formulating categories and sub-categories of concepts. In the analysis **experiences, feelings and needs** of both employees and their managers with regard to breastfeeding and work were used as three main categories developed by Van Zyl (1993) as cited in De Vos, Strydom and Fouche (2005). After close examination of the first data, sub-categories were developed out of the above three categories and these were regularly modified as the analysis progressed (De Vos, Strydom and Fouche, 2005).

3.4.3.3 Coding the data

Denzin and Lincoln (2000) allude that ‘coding is the heart and soul of whole-text analyses.’ This statement is further supported by De Vos, Strydom and Fouche (2005) who indicate that coding is the formal representation of analytic thinking. Most of the coding was done manually using highlighter pens of various colours and then entered on the computer after initial coding.

When coding the data the grounded theory approach was used. The emphasis in this methodology is that the theories generated emerged from the data. De Vos, Strydom and Fouche (2005) indicate that the grounded theory approach is relevant to the human service professions and it utilizes three methods of coding:

- **Open coding-** in this method the data collected is broken down, examined, compared, conceptualized and categorized. This involved close examination of the sentences and paragraphs of the first interview and focus group data. De Vos, Strydom and Fouche (2005) indicate that this approach to open coding is useful where there are several categories already defined.
- **Axial coding-** the data that has undergone open coding is now put together in new ways. Connections between categories were made, looking at the conditions, context, actions and consequences.
- **Selective coding-** at this stage a core category is selected and systematically related to other categories. Categories that need further refinement and development are filled (De Vos, Strydom and Fouche (2005) ; Dawson: 2007)

3.4.3.4 Testing the emergent understandings

This phase involved evaluating how reasonable and probable the researcher’s developing understandings are. De Vos, Strydom and Fouche (2005) indicate that a part of this phase involves evaluating the data for their usefulness and centrality to the story that unfolds. Irrelevant data was eventually discarded and only data that is central to the research objectives is displayed in this report.

3.4.3.5 Searching for alternative explanations

The categories, themes and patterns that seemed so apparent were challenged and a search for other explanations made. Marshall and Rossman (1999) indicate that alternative explanations always exist. Starting with data analysis as soon as the first data was collected assisted the researcher in this endeavor.

3.4.3.6 Writing the report

Marshall and Rossman (1999) and De Vos, Strydom and Fouche (2005) agree that writing about qualitative data cannot be separated from the analytic process. A matrix was used as one of the means to report the results of the study. This serves the purpose of making a comparison between responses by managers versus employees and inter-group comparisons. The cells of the matrix contain text, not numbers (De Vos, Strydom and Fouche, 2005)

3.4.4. Reporting of data and utilization of results

A comprehensive report outlining the findings of this study will be written to the Mother and Child Welfare and Nutrition directorate in the provincial department of health for consideration. The findings of this study will be presented at the provincial research symposium of the Limpopo Provincial Department of Health.

The results of this study will be published in the relevant journals and will form a basis for further research and improvement plan for the conditions of service of employees of the Limpopo Department of Health and Social Development who choose to breastfeed.

3.5 Significance of the study

The findings of this study will assist policy makers in the Department of Health and Social Development (Limpopo) to develop policies that address the needs of employees in as far as breastfeeding and work is concerned.

3.6 Limitations of the study

3.6.1. Minimum numbers in Focus groups

Two out of ten focus groups were conducted with three members mainly due to unavailability of participants. In one institution there were fewer female employees in the clinical care category such that the minimum number could not be reached.

3.6.2. Employees without children

A total of five employees who participated in the focus group did not have any children. The managers of various professional units relied on delegation to pass information to members of staff. This resulted in some of the selection criteria not being adhered to as the delegates were not given the original requisition. For ethical reasons it was not possible to dismiss these employees from focus groups once they were there. Most of the input they made was based on their feelings and perceptions regarding breastfeeding.

3.6.3. Various nursing categories

Combining all nursing categories under one roof for focus group created a situation where the facilitator/researcher had to coerce the lower categories as they were quiet in most discussions. Our focus group was not as homogenous as it was meant to be. Some members dominated the discussions; this needed the facilitator to control the situation.

3.7 Ethical considerations

Approval was obtained from the University of Limpopo Ethics Committee to conduct the study after approval of the research proposal by the Research Committee of the School of Health Sciences. Permission to conduct interviews was obtained from the Limpopo Provincial Department of Health's ethics committee. After approval was granted, the CEO's of the five hospitals were briefed about the study and their co-operation was sought.

Participants were informed that their participation is voluntary, that they have the right to abstain from participation and to withdraw from participation at any time if they do not feel comfortable to continue. They were also informed that the discussion will be recorded. Confidentiality of the information collected is maintained. Consent forms were issued before interviews and only those who completed them were included in the study.

CHAPTER 4 RESULTS

4. 1 Introduction

Data collected in this study was coded manually using highlighter pens. Four categories were initially identified and they formed the basis of initial coding. These categories are: Feelings, Experiences, Needs and Opinion/Factors. The latter included anything that was not falling within the first three but that appeared to have an influence on breastfeeding among healthcare providers. The four categories were further broken into seven sub-categories which will be identified later in this chapter.

Du Plooy (2002) alludes that a frequency count is the only quantitative type of data that can be obtained in qualitative data analysis. In this instance a tally sheet was compiled, wherein data was allocated to categories as outlined in the previous paragraph. The frequency of concepts was counted as they occurred during discussions in focus groups and also during interviews. The data will also be summarized and a comparison between the findings from focus groups with employees and interviews with managers will be made in order to identify areas of congruence and areas of conflict.

4. 2 Focus Groups Results

The results of the study indicate that participants in focus groups could easily talk about their experiences with regard to breastfeeding and work (317 responses) as displayed in Table 4.1 below. Opinions or factors that contributed to whether they succeeded to breastfeed or not were mentioned (177 responses). Feelings regarding breastfeeding and work reflected 154 times and needs were the least during conversations (103 times).

These figures are further presented diagrammatically in Figure 4.1. This diagram indicates the above frequency in the form of a chart. This shows what category dominated the discussions in the focus groups.

Table 4.1: A frequency table for responses in focus groups

Focus group	Members in group	Feelings	Experiences	Needs	Factors/Opinions
1	3	18	23	13	12
2	5	36	32	13	36
3	8	9	20	13	15
4	8	22	59	9	4
5	6	16	23	12	8
6	5	1	26	6	21
7	7	26	57	13	38
8	9	17	24	10	20
9	9	9	43	7	17
10	3	3	10	7	6
Total	63	157	317	103	177

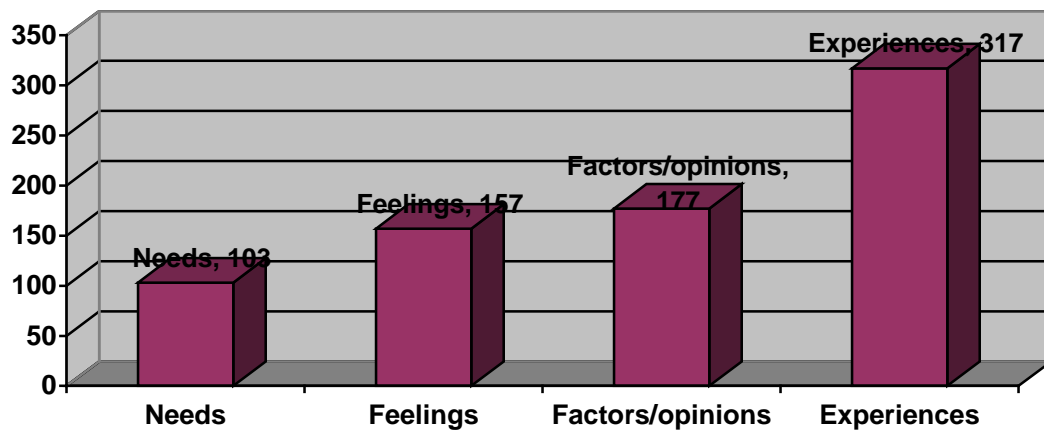


Figure 4.1: Focus groups responses

Table 4.2 represents responses made during nurses' focus groups

Table 4.2: Responses from nurses' focus groups

Focus Group	Members in group	Feelings	Experiences	Needs	Factors/Opinions
1	3	18	23	13	12
3	8	9	20	13	15
4	8	22	59	9	4
6	5	1	26	6	21
8	9	17	24	10	20
	33	67	152	51	72

Table 4.3 represents those that were made by clinical personnel.

Table 4.3: Responses from clinical personnel focus groups

Focus Group	Members in group	Feelings	Experiences	Needs	Factors/ Opinions
2	5	36	32	13	36
5	6	16	23	12	8
7	7	26	57	13	38
9	9	9	43	7	17
10	3	3	10	7	6
	30	90	165	52	105

The above responses were further broken down in an endeavor to develop meaning to the concepts generated during the focus groups. Sub-categories that were developed are: Positive feelings, negative feelings, positive experiences, negative experiences, factors and opinions. The category that was not further broken down is that of employees' needs.

Negative experiences featured most in the conversation, with negative feelings regarding pregnancy, breastfeeding and having to return to work forming a big percentage of the negative feelings. This was mainly in response to question one and question four of our guiding questions (see appendix C). Below is a table of the summary of responses under new sub-categories (Table 4.4).

Positive feelings featured as the lowest, with thirty six responses. On the other hand, employees could easily point out factors that contributed to the success or failure of their breastfeeding experience. Opinions include participants' knowledge and assumptions regarding breastfeeding, these may be factual, perceptual or even myths regarding breastfeeding and work.

Table 4.4: Summary of responses per sub-category

Sub-Category	Frequency of responses
Negative Experiences	207
Negative feelings	121
Positive Experiences	110
Factors	109
Needs	103
Opinions	67
Positive feelings	36

Positive Experiences

Table 4.5 indicates a breakdown of the positive experiences as they were shared across the focus groups. These results indicate that

some employees within the focus groups enjoyed breastfeeding and actually succeeded in it.

Twenty six participants (41.3%) indicated that they enjoyed to breastfeed. Eighteen participants (28.6%) indicated that they managed to breastfeed for two years and beyond. Ten participants (15.9%) indicated that they had supportive work environments, which include supportive managers and colleagues. Only six participants (9.5) indicated that they managed to practice exclusive breastfeeding for some time. Of all the positive experiences, only one participant (1.6%) indicated that she had a supportive nanny.

Table 4.5: Positive experiences with regard to breastfeeding and work

Number of participants	Experience	Frequency
26	I succeeded/enjoyed to breastfeed for some time	32
18	I breastfed for at least two years	29
10	I had supportive manager, colleague or workplace	12
7	I had enough expressed breast milk and my baby took it	8
6	I practiced exclusive breastfeeding for some time	6
5	I got support from family to breastfeed	9
4	I could well balance breastfeeding and work	6
4	My baby was happy and healthy	5
2	I could bond with my baby	2
1	I had a good/supportive nanny/caregiver	1
	Total	110

Negative Experiences

Table 4.6 below gives an overview of the negative experiences that were shared among participants. Twenty three (36.5%) participants across all focus groups indicated that breastfeeding was a disaster or it was painful. This theme includes pain due to sore nipples. This matter will be further discussed in chapter five. Twenty one participants (33.3%) indicated that they did not have a good work life balance, which included sleeping on duty and having no social life.

It is worth noting that unsupportive work environment featured as the third major negative experience. This was shared by seventeen participants (27.0%) across all focus groups. Fourteen participants

(22%) indicated that they had to use formula, and most of them also expressed the fact that formula was not their first choice in baby feeding.

Eleven participants (17.5%) expressed their challenges with nannies, with the most fascinating incident being a situation where a nanny left baby at the neighbors while mom was at work. Another eleven participants indicated that they had to choose between breastfeeding and personal development, as in all institutions there were no provision for babies and nannies in workshops and nursing colleges. Nine participants (14.3%) indicated that they had to stop breastfeeding because they had to attend to some work pressure or having to attend a workshop.

Seven participants (11.1%) indicated that they had to work long hours, could not breastfeed on demand and another group from the nursing profession indicated the issue of having to work night duty while their babies were less than a year. Other negative experiences as tabulated in will be further discussed in the next chapter.

Table 4.6: Negative Experiences with regard to breastfeeding and work

Number of Participants	Negative Experience	Frequency
23	Breastfeeding was a disaster/ was painful/ Sore nipples)	36
21	Poor work/ life balance	28
17	Unsupportive work environment	27
14	Had to use formula, which was not my first choice in baby feeding	16
11	Nanny/ caregiver problems	12
11	Had to choose between breastfeeding and personal development	12
9	Had to stop breastfeeding because of work or workshop	9
7	Long working hours	10
7	I could not breastfeed on demand/ I had to time feed	9
7	I had to work night duty while my baby was less than a year	8
6	I breastfed for less than two years	7
5	My baby was sick more often	7
4	I could not bond with my baby/ my baby bonded with the nanny more	8
5	I never attended lactation management workshop	5

3	Formula feeds were not well prepared	5
3	Not enough expressed breast milk	3
3	Baby did not like expressed breast milk	3
2	Poor hygiene at crèche	2
		207

Table 4.7 indicates positive feelings that participants expressed or recalled during focus group. Nine participants (14.3%) indicated a deep sense of determination to succeed to breastfeed. Seven (11.1%) expressed how they enjoyed or still enjoy breastfeeding their babies. Six (9.5%) were happy to be pregnant or to be a mom. Five participants (7.9%) expressed their sense of satisfaction at having succeeded to breastfeed their babies

Table 4.7: Positive Feelings

Number of Participants	Positive Feeling	Frequency
9	Determination	10
7	Loved/enjoyed breastfeeding/ it felt good	15
6	Happy to be a mom/pregnant	6
5	Satisfaction	5
	Total	36

Table 4.8 tabulates the negative feelings that were expressed in focus groups. Most participants, twenty (31.7%) shared with us the pain they had to endure when they had to leave their babies at home. Worry about the baby's safety, whether the caregiver was going to feed the baby correctly, including preparation of formula feeds was expressed by seventeen participants (27%). Twelve participants (19%) expressed their frustration at having to leave their babies in the care of other people, especially on the fact that they could not breastfeed their babies on demand. Another twelve participants expressed how difficult it was for them to actually leave their babies behind. Seven (11.1%) felt tired when they came back from work. Six participants (6.5%) expressed their sense of guilt at having to leave their fragile babies with someone else. The rest of the negative feelings as tabulated below will be discussed in the next chapter (Chapter 5).

Table 4.8: Negative Feelings

Number of Participants	Negative Feeling	Frequency
20	Pain	28
17	Worry	23
12	Frustration	19
12	Difficult	15
7	Tired	7
6	Guilt	9
4	Scared/Fear	4
3	Mixed Feelings	4
3	Anger	3
3	Stress	3
3	Sad	3
2	Don't like breastfeeding	2
1	Disappointment	1
63		121

Table 4.9 gives a summary of opinions that were raised in the focus groups. These formed a basis of decision making on the issue of whether to breastfeed or not to breastfeed for most participants. A striking feature is that most opinions as highlighted on Table 4.9 were pro breastfeeding. On the other hand one participant (1.6%) indicated that formula feeding prevents transfer of diseases from mother to baby.

Table 4.9: Opinions

Number of Participants	Opinions	Frequency
9	A breastfed baby is healthy/grows well	12
9	Breastfeeding saves money/ is affordable	9
8	Breastfeeding is important	12
8	Breastfeeding creates a bond between mom and baby	10
5	A formula fed baby is prone to sickness and/or obesity	6
5	Management is not compassionate/supportive	5
5	Breastfeeding prevents maternal diseases	5
4	Breast is convenient	4
2	A breastfed baby is more intelligent	2
2	Breastfeeding prevents pregnancy	2
1	Formula prevents transfer of diseases from mom to baby	1
	Total	67

Table 4.10 below describes factors that directly influenced employees' decision whether to breastfeed or not to breastfeed and the decision to continue breastfeeding for a certain period. Work was mentioned by eighteen participants (28.6%) as one of the factors that influence their decision whether to breastfeed or not to breastfeed. Mom's health status, which includes HIV/AIDS status, was cited by ten participants (15.9%) as one of the factors influencing baby feeding decision. Eight participants (12.7%) cited affordability and mom's knowledge on breastfeeding as some of the factors. Seven participants (11.1%) said that they were guided by the baby's growth and development whether to continue breastfeeding or to stop. Six participants (9.5%) cited aesthetics, social factors and family support respectively. Aesthetics was based both on the opinion that the breasts will shrink due to breastfeeding and others did not like "the constant oozing of milk from their breasts". Social factors include the participants' perceived lack of social life due to breastfeeding, they felt breastfeeding without supplementing with formula feeds "tied them down". Other factors as indicated in Table 4.10 will be discussed further in the next chapter.

Table 4.10: Factors

Number of Participants	Factors influencing breastfeeding	Frequency
18	Work	19
10	Mom's health status, including HIV/AIDS	16
8	Affordability	9
8	Mom's knowledge on breastfeeding	8
6	Aesthetics	9
7	Baby's growth and development, including teething	7
6	Social factors	6
6	Family support	6
5	Preparedness/ planning	6
5	Baby's eating habits	5
3	Counseling	5
3	Workshop/ school	5
3	Time factor	3
3	Nanny factor	3
2	Distance from work	2
		109

Table 4.11 describes employee's needs; all the needs may be fulfilled by the employer. It is worth mentioning that the feasibility of these needs falls outside the scope of this study. This may need a different study to establish.

Fifteen participants (23.8%) indicated the need for a crèche or day care centre within or near (a walking distance to) the workplace. Twelve participants (19.0%) expressed the need for an extended maternity leave with an additional two months to make it six months. The need for a breastfeeding room or expression room was voiced by eight participants (12.7%). The same number voiced the need for a better communication between employees and management as well as the need for breastfeeding breaks over and above the normal one hour lunch breaks. Proper accommodation within or near the workplace and a policy on breastfeeding and work, was expressed by seven participants (11.1%). Six nursing professionals voiced the need to work day shifts only, and where possible office hours for the first year of the baby's life. The rest of the needs as outlined in Table 4.11 will be discussed in next chapter.

Table 4.11: Employees' Needs

Number of participants	Employees needs	Frequency
15	Crèche/ day care centre	20
12	Extended maternity leave	15
8	Breastfeeding room	10
8	Communication/ management support	8
8	Breastfeeding breaks	8
7	Proper accommodation within or near workplace	10
6	Day shifts/ no night duty for a year after baby's birth	8
7	Policy on breastfeeding and work	7
5	Support from other colleagues	5
4	Six months exclusive breastfeeding	4
3	Flexible working hours	4
2	Sick bay for employees' sick babies	2
1	Training on breastfeeding	2
	Total	103

4. 3 Results for Unstructured In-depth interviews

Unstructured In-depth interviews were held with two managers in each of the five institutions as outlined in the previous chapter. On a general note, the results of the interviews indicate that managers were more comfortable to talk about their experiences and practices than expressing their feelings. This is despite the fact that all managers seemed relaxed and showed enthusiasm as they were making deliberations on the topic.

Table 4.12 outlines the results per interview. Eighty-four experiences and practices, forty-two opinions and factors, thirty-nine needs and twenty-six feeling were expressed. An interesting factor is that the nursing managers seemed to wear two caps when it came to dealing with a pregnant employee; that of a manager and a midwife. All nursing managers indicated that they start to talk with the employee about the necessity of attending ante natal care clinics as well as ensuring that the employee is well placed.

Table 4.12: A frequency table for in-depth interview responses

Manager Number	Experiences	Feelings	Opinions	Needs
1.	6	1	4	1
2.	18	8	8	5
3.	5	5	3	6
4.	6	3	4	6
5.	10	2	3	5
6.	8	1	3	2
7.	11	-	2	2
8.	7	2	8	4
9.	5	2	5	4
10.	8	1	3	4
Total	84	26	42	39

Figure 4.2 (page 31) displays managers' responses in diagrammatic form. Experiences, including practices were the most expressed and feelings were the least expressed.

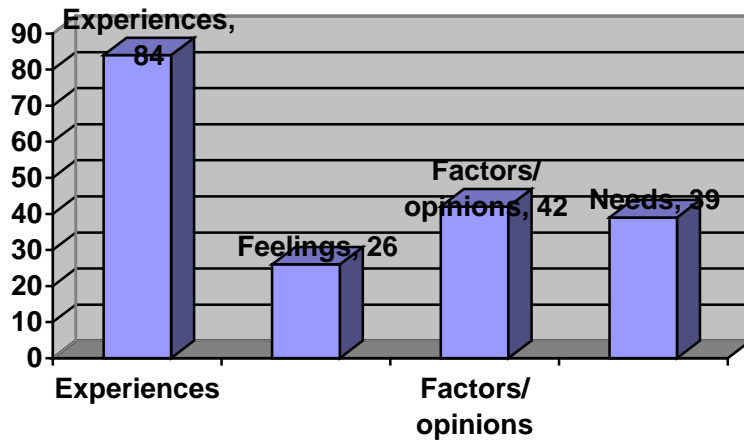


Figure 4.2: In-depth Interview Responses

The above four categories were further sub-divided into seven sub-categories. However, the category for needs remains unchanged; it is therefore recorded as it is.

Table 4.13 indicates the positive feeling that managers expressed. Four managers (40%) indicated, in response to the first guiding question (see appendix D) that they usually feel happy for the employee when the employee reports that she is pregnant. They base their feeling of happiness on the fact that they believe that a health professional usually plans for her pregnancy as such pregnancy is celebrated.

Table 4.13 Positive feelings

Number of Managers	Feeling	Frequency
4	Happy for the employee	5

Table 4.14 displays negative feelings that were shared by managers during the interviews. Six managers (60%) indicated that they are usually sad when an employee reports that she is pregnant because of the anticipated gap that the employee will leave whilst on maternity leave. This is aggravated by the fact that there is severe staff shortages in all institutions visited and as such the employee's anticipated absence produces a sad feeling.

Four managers (40%) expressed that they usually worry about the safety of the employee and the fetus. This includes worrying about the services as the employee will be away. Three managers (30%) indicated that they had mixed feelings when an employee reports of

pregnancy. They are happy with the employee whereas on the other hand they worry or are sad because of the perceived aggravation of staff shortage, however temporary. It is worth noting that nine (90%) of managers expressed negative feelings regarding employee's pregnancy or child birth issues.

Table 4.14: Negative feelings

Number of Managers	Feeling	Frequency
6	Sad because of anticipated staff shortage	6
4	Worry	8
3	Mixed feelings	4
9	Total	16

Table 4.15 outlines positive experiences or practices that were reported to be in place by the managers interviewed at the five institutions.

Five managers (50%) reported about positive experiences or practices at their institutions regarding management of employees during pregnancy and child birth. Three managers (30%) indicated that they move employees to a more pregnancy or breastfeeding friendly ward. This was reported by nursing managers since nurses are the only health professionals who sometimes rotate among wards.

Four managers (40%) indicated that they usually communicate with the employee to find out about their ante natal care practices before the baby's birth and to enquire about baby's health after birth. Three managers (30%) indicated that there is some effort, although it is minimal, to assist employees during pregnancy and child birth at their institution. Two nursing managers (20%) indicated that they have an internal practice of not putting the employee on night duty for the first year of the baby's life.

One nursing manager (10%) indicated that a breastfeeding employee is placed on night duty as a way of supporting the breastfeeding employee, for as long as an employee agrees.

Table 4.15: Positive Experiences/good practices

Number of Managers	Experience/ good practices	Frequency
3	Employee is moved to a more friendlier work station	3
4	Communicate with employee/ enquire about baby's health	4
3	Some effort/ minimal effort	3
2	No night duty for employee for a year	2
1	Put employee on night duty	1
5	Total	13

Table 4.16 outlines the negative experiences and practices reported by managers during the interviews. Six managers (60%) shared the negative experiences or practices. Four (40%) indicated that there is no form of support that is given to breastfeeding employees at their institutions. Two managers (20%) indicated that there are no policies that guide them to manage breastfeeding employees.

Table 4.16: Negative experience/ practices

Number of Managers	Experience	Frequency
4	No form of support for breastfeeding employee	7
2	No policies regarding breastfeeding and work	2
6	Total	9

Table 4.17 displays the managers' opinions regarding breastfeeding and work. These include their perceptions regarding breastfeeding employees' job performance. Most of the responses on this table were based on guiding question two and four (see appendix D)

Six managers (60%) believe that breastfeeding is important and should be priority baby feeding method. Five managers (50%) are of the opinion that breastfeeding has a negative impact on employee productivity, the same number believe that breastfeeding increases bonding between mother and baby. Another five managers believe that breastfeeding increases employee absenteeism. On the other hand, five managers (50%) are of the opinion that breastfeeding employees may put more effort to their work in an effort to "cover lost time".

Another opinion that was perpetually reiterated by managers in the nursing profession was that attendance of ante natal clinic as early

as possible is important and should be encouraged; three nursing managers (30%) indicated this during their interviews. Another three managers indicated that breastfed babies are healthier. On the other hand, two managers (20%) indicated that though breastfeeding is important, today's mothers do not make breastfeeding a priority because they leave their babies at home. The rest of the opinions as tabulated below will be discussed in the next chapter.

Table 4.17: Manager's Opinions on breastfeeding and work

Number of Managers	Opinions	Frequency
6	Breastfeeding should be priority feeding for baby	15
5	Breastfeeding has a negative impact to productivity	7
5	Breastfeeding increases employee absenteeism	6
5	A breastfeeding employee may put more effort to work	6
5	Breastfeeding increases bonding between mom and baby	5
3	Ante Natal Care is important and should be encouraged	4
3	Breastfed babies are healthier	3
2	Breastfeeding is not a priority	3
2	It is better to feed baby directly from breast	3
2	Breastfeeding does not hamper productivity	2
2	Four months maternity leave is enough	2
1	Formula fed babies are sick more often	1
10	Total	57

The factors that affect or influence employees' decision whether to breastfeed or not to breastfeed or the length of breastfeeding are tabulated in Table 4.18 below. Although there was no specific question that was raised to managers regarding factors affecting employees' decisions, these were raised by managers during the course of the interview in one way or another since our interview was unstructured. Managers were permitted to direct the interview the way they feel comfortable, as long as they were dwelling on the presented topic.

Four managers (40%) identified the work environment as one of the factors that may positively or negatively influence the employees' decision whether to breastfeed or not to breastfeed, including the length of breastfeeding. The issue of HIV/AIDS was raised by two

managers (20%) from the nursing profession as one of the factors. They both felt that once a woman is HIV positive she should not breastfeed, rather formula feed. Mom's general health status was also said to be affecting decision making, with poor health status increasing the probability of breastfeeding cessation.

Affordability was raised by two managers (20%) as one of the factors affecting breastfeeding. The same number of managers identified the distance between work and home as one of the factors. The nanny factor as well as employees' knowledge about breastfeeding were raised by one manager each (10%).

Table 4.18: Factors affecting breastfeeding

Number of Managers	Factors	Frequency
4	Work environment	6
2	HIV/AIDS	3
2	Mom's health status	3
2	Affordability	3
2	Distance between work and home	2
1	The nanny factor	1
1	Employees' knowledge on breastfeeding	1
9	Total	19

There are overlaps with regard to needs that are solely for employees and employers' needs. Table 4.19 displays these needs. Managers were able to describe both employees and employers' needs with a better clarity than employees during focus groups.

Five managers (50%) identified the need for a crèche or day care centre near or within the institution. Another five managers indicated that when an employee returns to work after maternity leave, she is expected to perform and as such the employer needs the employee's services or productivity.

Communication between employees and the employer was identified by four managers (40%), breastfeeding breaks were mentioned by three managers (30%). Another three managers (30%) identified the need for breastfeeding room and the need for a policy that will give direction on breastfeeding and work. Two managers (20%) expressed that employees should not perform night duty whilst still breastfeeding. Two more managers identified the need for proper accommodation near or within the institution. One manager (10%) identified the need for flexible working time for breastfeeding employees.

Table 4.19: Employees and Employers' needs

Number of Managers	Needs	Frequency
5	Nursery/crèche near or within institution	7
5	Productivity/ service	5
4	Communication	4
3	Breastfeeding breaks	4
3	Breastfeeding room	4
3	Policy on breastfeeding and work	3
2	No night duty	3
2	Accommodation within/near institution	2
1	Flexible working time	2
10	Total	34

4. 4 Conclusion

The findings of this study as displayed in this chapter indicate that both the employees and employer as represented by managers in the five hospitals in our study have areas of concern and areas where there is success with regard to breastfeeding and work. The above findings will be further scrutinized and discussed in the next chapter.

CHAPTER 5 DISCUSSIONS

5. 1 Introduction

The aim of the study was to assess breastfeeding practices of healthcare providers at level one hospitals in Capricorn District of Limpopo province. In this chapter the findings of this study will be scrutinized and discussed in an effort to gain understanding of what the experiences, feelings, opinions, needs as well as factors that are affecting healthcare providers with regard to breastfeeding of their own babies may be.

As indicated in item 3.4.3.3 (page 17), the process of selective coding involves identifying a core category and systematically relating it to other categories. In this study, employees' experiences have been identified as the core category from which relationship with other categories will be compared. Conclusions and recommendations will be based on this relationship (De Vos, Strydom and Fouché 2005).

5.2. Summary of the findings (Scenarios)

The above-mentioned results confirm that indeed healthcare providers do not practice what they preach as indicated by King (1992). This was also re-iterated several times by most participants in all focus groups that were conducted. It also appears that this failure creates a sense of guilt as they know that breastfeeding is the best feeding method for the baby, especially during the first six months. One focus group participant put it in her own words and said:

“We at nursing section, we as nurses don’t practice what we preach, especially on breastfeeding because most of us, we spend a long time at work and so... sometimes like when we... transfer patients we come late at home”

They went on to indicate that most healthcare providers feed their own babies formula whereas they encourage mothers to breastfeed.

Three scenarios could be identified in all the focus groups:

5.2.1. Successful breastfeeding experience- breastfeeding is a breeze

Twenty six individuals (41.3%) across the focus groups indicated that they enjoyed to breastfeed, most of them expressed that it was good or it is good to breastfeed. They experienced minimal or no pain during breastfeeding. The majority of those who indicated that they enjoyed to breastfeed credited their success to strong family support (9.5%), preparation for when one returns back to work (9.5%), a supportive work environment including supportive

managers and six (9.5%) had enough expressed breast milk and were able to leave some for baby when they go to work.

One focus group participant could be quoted when describing her breastfeeding experience saying:

“I just enjoyed every moment of breastfeeding to tell you the truth. I enjoyed everything!”

Counseling appeared to be one of the most common factors in employees who succeeded to breastfeed their babies. Three participants (4.8%) indicated that it is important for mothers to go for counseling before the baby is born so one can be ready psychologically. The issue of counseling occurred five times during focus group, whereas planning or being prepared occurred six times.

In as far as family support is concerned; employees indicated that they mainly got support from their spouses, their mothers and/or mother in laws and at times from siblings. They would plan together with family members around how the baby is going to be fed before birth of the baby. This ensured that when the breastfeeding employee entertains the issue of quitting, they are encouraged to carry on breastfeeding.

One focus group participant expressed the importance of family support when experiencing painful nipples:

“It is painful to breastfeed with sore nipples; but my mother said I should continue to breastfeed, they will eventually heal. And my husband reminded me that we planned to breastfeed and we must not change!”

Among these individuals there are those who indicated that it was tough to breastfeed the first baby but it got better with the second baby. It thus become apparent that that the importance of preparedness cannot be over emphasized if a working mother wants to continue breastfeeding.

5.2.2. Breastfeeding is tough but it is worth it to breastfeed against all odds.

Twenty three participants (36.5%) indicated that breastfeeding was a disaster. In one participant’s words:

“With the first child, breastfeeding was a disaster, I didn’t know what to expect. . .”

What is interesting is that although it was tough, they continued to breastfeed. Some indicated that they eventually decided to practice

mixed feeding, where the baby received breast milk in the mornings, evenings and during weekends or day offs when mom is home. This is how some focus group participants put it:

“Because of the type of our work, we just use all. When we are at home we prefer to breastfeed our babies and then when we are at work you teach your mother to prepare formula even if it is a risk.”

Another participant said:

“And to my side, I decided that ok; I’m going to use both of them! And I’ll be the one who is preparing the formula. So it was like that until I said ok, it’s enough!”

Others also shared about painful cracked nipples which made it very difficult to breastfeed. As another focus group participant put it:

“With me, the cracked nipples, I had to buy that shield, so when I’m giving with that shield on . . . hell would break loose!”

Majority of these participants are those who were breastfeeding their first babies. As indicated on the above paragraph, most participants who fall under this category went through the pain mainly due to lack of knowledge about breastfeeding. Some acknowledged that after attending lactation management workshops and learning about positioning the baby well on the breast, they wished they could turn back the clock so they can breastfeed properly.

One participant explained her breastfeeding experience this way:

“I was really disappointed when he stopped breastfeeding at four months. But then I told myself that other kids I will just breastfeed so the second born I breastfed until she was one year and then after one year I started with formula. Then the third born I breastfed her until she was two years. I only started with formula after two years. She stopped breastfeeding last December and I really regret letting her stop, but I had no choice because I didn’t have a nanny and she had to go to her grand parents.”

Most participants indicated that they continued to breastfeed mainly because of the benefits of breastfeeding. In this group of individuals there are those who indicated that breastfeeding interfered with their relationship with their partners. They said that their partners sometimes felt left out and it strained their relationship. They would then talk about it and the partner would realize that in the long run, the baby needs breast milk to be healthy and grow well and that

breast is affordable. They would then agree on the time frame for breastfeeding. This ranged from as early as two months to over two years. One focus group participant put it this way:

“I even had a meeting with my husband concerning this issue whether we compromise breastfeeding or we compromise our marriage. And then he said to me, we rather compromise our marriage for now. Just continue, breastfeed our child so that he can grow well. Compromise for now, for some few minutes, for some few months, for now . . .!”

5.2.3. Breastfeeding is tough-rather formula feed

Fourteen participants (22.2%) indicated that they opted to formula feed. This group includes some of employees in item 5.2.1. and 5.2.2. Some could only pull it off for a few weeks. Some individuals in this group were really eager to breastfeed, but circumstances could not allow them to. They then had to resort to formula feeding.

Participants indicated that they understood the importance of breastfeeding and wanted to breastfeed their babies. Unfortunately, the odds were against them or they felt that breastfeeding was too tiresome to proceed with it for longer. One participant indicated that when she was trying to breastfeed, she developed mastitis. She realized when the baby was burping that the baby’s vomit was mixed with blood. She realized that these came from her breast and then she decided to quit breastfeeding. The baby was only four months old when this happened. This is how the participant explained her situation:

“So I had to come back to work with those problems, the baby not adjusting well to the breast and everything. So it was difficult for me to breastfeed. I’m now trying during the night, but I can see the baby is not happy. Even if I’m drinking the maxolon they’ve been giving me, I’m drinking tea, I’m doing this, and because of the schedule, I have to work today, then during the day I don’t breastfeed. So it is not something which is ongoing, so the baby sometimes is fighting, not wanting the breast. So I think I must just stop breastfeeding!”

Some of the reasons included perception that the baby was not getting enough breast milk since the baby would be glued to the breast for lengths of time. This was tiring to the mom and she would opt to formula feed. Another reason cited by this group was that they were practicing mixed feeding and the baby eventually preferred formula over breast milk. One participant explained this experience this way:

“I have a son, I didn’t even think of breastfeeding until the day I gave birth. So they gave me the baby, I had to breastfeed him, I didn’t know how! They tried showing me but I didn’t know how. I think for about two hours I didn’t know how to breastfeed. So after two hours is then I was able to breastfeed. My son breastfed the whole night until the following morning, I didn’t want to see him. I just told the nurse just to take this baby, and let me sleep... then after some days he started not wanting to breastfeed. I started to prepare him formula. After tasting formula he never wanted my breast!”

Six participants (9.5%) cited aesthetics as one of the factors that made them choose formula feeding. They believed that if they do not breastfeed, the shape of their breasts will remain beautiful. The issue of aesthetics occurred nine times during focus groups, with some feeling that they did not like to have big breasts and flat tummies that is associated with breastfeeding. Among this group some believed that the breast will eventually shrink due to breastfeeding. One participant said:

“From my experience; the other thing with breastfeeding is this thing of forever wet breasts! That’s why I said maybe it will be better to stop breastfeeding. Instead of breast pads, you would rather buy milk or napkins. So those issues of appearance wise, breastfeeding will make the image a little bit disturbed.”

The fact that these statements are uttered by healthcare providers indicates that to some extent clients who come for their care may receive such views. As indicated elsewhere in this study, healthcare providers are custodians of maternal and child health and as such, their views on issue such as breastfeeding cannot be undermined because they have a bearing on how the general public will view breastfeeding.

5.3. Breastfeeding Scenario Game-Board

Figure 5.1 (page 43) gives a summary of the above scenarios using a Breastfeeding Scenario Game-board modified from the version by Ilbury and Sunter (2005) in order to describe the above scenarios in the form of a matrix. Breastfeeding practices of participants have been summarized based on their various reports regarding their breastfeeding experiences.

The vertical axis of the Game-board displays employees’ experiences regarding breastfeeding. The lower end of the vertical axis represents a disastrous breastfeeding experience and the upper part a pleasant breastfeeding experience. On the other hand, the horizontal axis displays participants’ perception of formula feeding.

The left being a positive perception on formula whereas the right hand end of the axis represents a negative perception.

Ilbury and Sunter (2005) indicate that a game-board that confers some control to the players themselves as to where they end up on the board is likely to get a positive reception. However, the report given by most participants regarding their breastfeeding experiences suggests that in most instances, due to their conditions of employment they do not have the legacy to choose the feeding method that they prefer to use on their babies. This could be one of the causes for frustration in most participants.

5.3. 1 Scenario A: Breast milk only

Most participants who fall in this scenario are described in item 5.2.1 (page 36 of this study) and these found breastfeeding pleasant and less strenuous. Some of the factors that contributed to this experience were described in item 5.2.1. Over and above these factors was the fact that they believed that baby formula is not as safe as it is put out to be and then they opted to feed their babies breast milk only.

The scenario A participants were able to breastfeed their babies directly from the breast, on the other hand, they had enough expressed breast milk to leave for baby when they are at work. Some babies refused expressed breast milk and they would breastfeed when mom returns home and during lunch breaks.

5.3. 2 Scenario B: Mixed Feeding

Most participants in focus groups could be placed in scenario B because as much as they knew the benefits of breastfeeding, they found themselves having to take a decision to use formula when on duty. One nurse described this scenario this way, with the rest humming their agreements, indicating that it is common practice:

“So I’d usually breastfeed after hours but not during the night. Because if you breastfeed mostly during the night, when you are on night duty the baby will cry a lot. So I decided to make the baby acquainted to the bottle during the night, then the breast during the day.”

This practice appeared to be common in the healthcare professionals’ breastfeeding practices. Some practiced mixed feeding for the sake of convenience. They felt that they get tight up to the baby a lot if they opt to breastfeed without supplementing with formula. One participant who was still breastfeeding her second baby explained it this way:

“The girl (her first born baby) was not taking any milk except the breast, so when I had a spare time I had to go and breastfeed. It was like my life revolved around my baby. So with the second child is at the morning and night only. So during the day is a bottle, he can survive.”

Given the various factors and opinions that were raised in these focus groups, it is no surprising to find the majority of participants belonging to this group. They are aware of the risks associated with formula as outlined elsewhere in this study. Mostly explain that they had no choice but to practice mixed feeding.

The risks associated with mixed feeding where the mother is HIV positive cannot be overemphasized. The fact that a large number of participants professed to practice mixed feeding is cause for concern.

5.3.3 Scenario C: Formula Feeding Only

As indicated in item 5.2.3 (page 39) of this study, participants in this scenario explain that it was not their initial choice of baby feeding method. Participants could actually move across all three categories when they return back to work. Some indicated that they failed to produce enough expressed breast milk and had to feed baby formula through a feeding bottle. The baby will then develop teat confusion and choose the bottle.

All participants who indicated that they formula fed their babies during this study indicated that the thought of feeding baby formula never came before baby was born. They had to feed them formula because their attempts at breastfeeding failed. Others indicated that they could not breastfeed in public and gave baby formula. Eventually the baby preferred formula to breast milk. One such participant put it this way:

“I couldn’t breastfeed in public...for me it was just breast only at home and I think I frustrated my baby a lot! I think she ended up saying: I have had enough mom, I’m not taking it, and I prefer formula!”

Over and above teat confusion, some participants were forced by medical complications to resort to formula. These complications could arise after the baby’s birth as in the case of the mother who developed mastitis (see item 5.2.3, page 39 of this study). Other complications arise during birth where mom does not recover from a caesarian section or a difficult birth as is the case with the participant quoted below:

“As a woman, I was pregnant before and the thought of not breastfeeding doesn’t come to mind at all. As a health professional you are thinking I will do exclusive breastfeeding and you know with all the benefits. But then there are challenges you know, like I was challenged not to be able to breastfeed, complicating after caesarian section and the baby getting used to the bottle!”

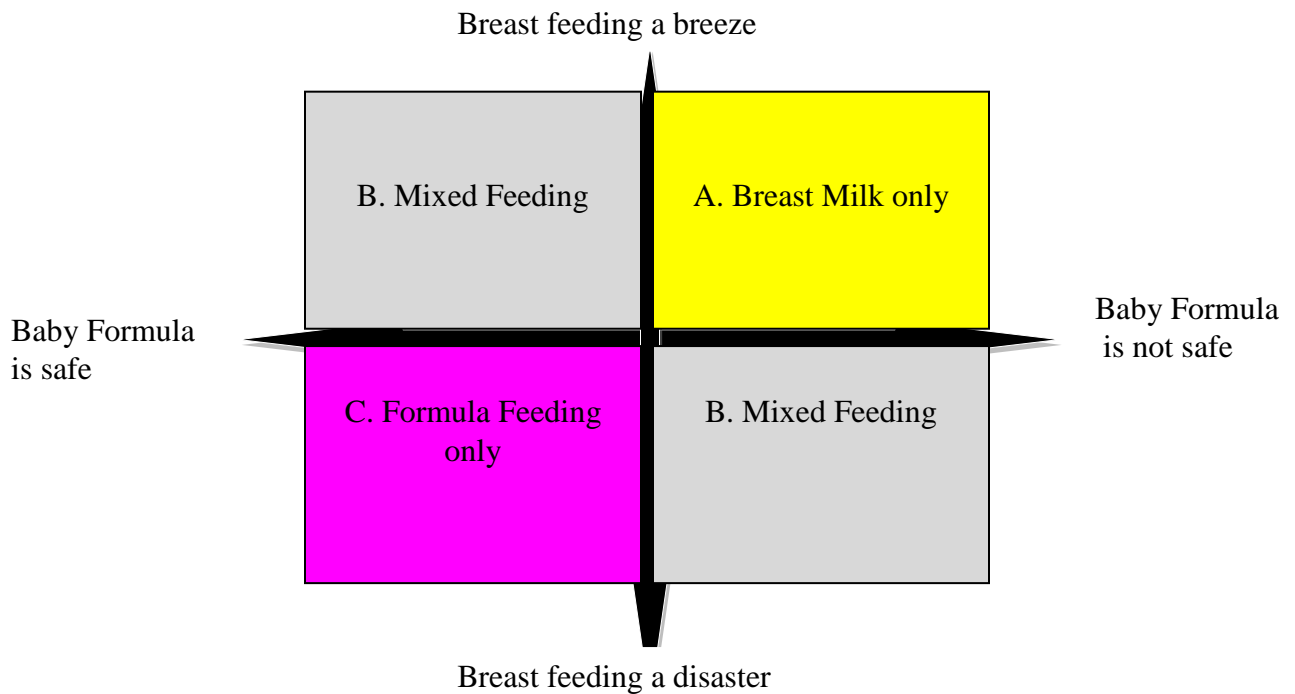


Figure 5.1: Breastfeeding Scenario Game-board

5.4. Comparison between Nursing and Clinical care Focus Groups

The atmospheres created by the two groups of professionals in their various focus groups were to some extent different. The focus group comprising of nursing personnel were formal and the responses given were mainly well thought. On the other hand, the clinical care personnel in all focus groups were more casual and the responses were spontaneous. As indicated in item 3.6.3 (page 19) of this study, the formality in the nurses’ focus groups could be because junior categories were grouped together with senior categories. This may have had an inhibiting effect especially because nurses adhere to certain etiquette with regard to how junior nurses should relate to their senior nurses (Vlok, 1988).

In terms of numbers (see Table 4.2 and Table 4.3 in page 21 and 22 respectively as well as figure 5.2 below), the nursing focus groups had the highest total number of members (33 nurses or 52.4%) and the clinical personnel focus groups had the lowest (30 clinical care personnel or 47.6%). This is understandable since the nursing profession is dominated by female employees and the clinical services had a mixture of both sexes.

Members in the clinical personnel focus groups made more responses than the nursing personnel focus group. The nursing personnel have a total of 342 responses whereas clinical care personnel have 412 responses. On average, each member of the nursing team made 10.4 responses whereas each member of the clinical team made 13.7 responses.

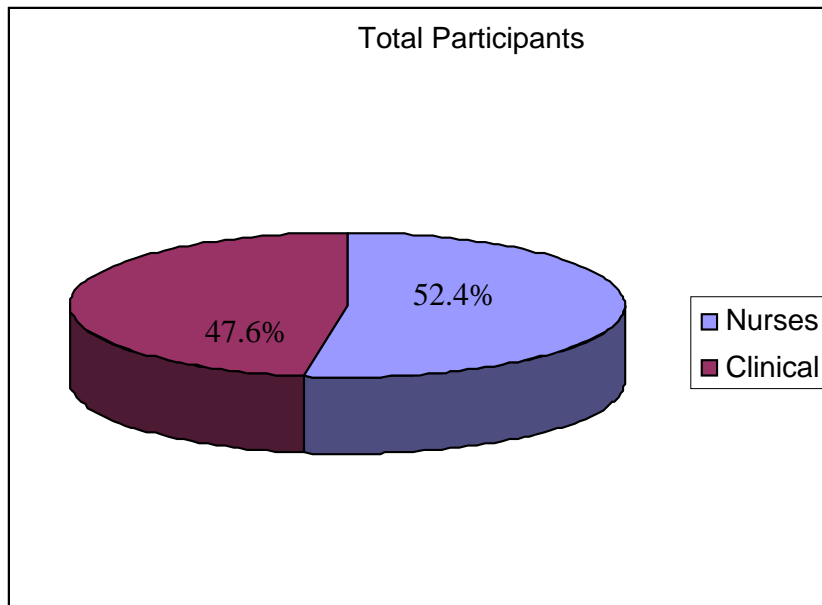


Figure 5.2: Focus group participants per professional group

5.4.1. Feelings

Table 4.2 and 4.3 indicate that the clinical personnel were more able to express their feelings (90 responses or 57.3% of the feelings) better than the nurses (67 responses or 46.7% of the feelings). This further supports the opinion that to some extent the nurses were not as open as the clinical personnel due to the limitations caused by seniors having been mixed with juniors. However, the most common feeling that was raised in both groups was that of pain and frustration in having to leave baby when mom had to return to work. One focus group participant from the clinical personnel focus group put it this way:

“It was frustrating for me; I even thought the maternity leave that I got was not enough. After coming back from maternity, for the first month I was always frustrated because I was always thinking about the baby. The one I left at home.”

Another member from the same group said:

“I’m telling you, you will miss your child! I’m from maternity now, so the first time when I arrived here, for the whole day I didn’t eat my lunch because I was just missing my child. How is the child coping? Then I missed him so much, only for breastfeeding. I wanted to see him breastfeed for that day. So now I’m coping because I know that when I go back I will breastfeed him a bit.”

Over and above the frustrations of having to leave the baby, the nurses had an added challenge which further instilled pain, fear and frustration to them. They had to deal with uncertainty of not knowing how the allocation list will turn out to be for them because their job entails rotation over a certain period of time. Their main source of fear is the prospect of being put on night duty or at a more strenuous ward. One nurse put the night duty problem this way:

“The other thing is the issue of night duty. We fight for day offs, we also fight for wards. Someone will say it is long that I was doing night duty; I want to work in that ward because they knock off at 16h30 so I can knock off early. You find that we are working in one ward being about four breastfeeding employees and we all don’t want to do night duty. Who then is going to leave her baby and do night duty? That’s the problem!”

In all focus groups for nurses there was at least one nurse who indicated that they had to work night duty when their baby was less than one year. They cited the challenge of staff shortages which compelled their superiors to request them to work night duty. This further supports what was mentioned in chapter one of this study about staff shortages that are characteristics of most hospitals in Limpopo. This further deepens the nurses’ pain and frustration over the baby’s health and well being.

Nurses expressed more than clinical personnel how difficult it was to leave their babies at home, especially when they were to go on night duty. Both groups expressed a sense of guilt at having to feed their babies formula when they know all the risks associated with formula feeding and all the benefits that breastfeeding provides.

Seven participants expressed how they would be so tired when they came back from duty. This feeling was one of the causes for

cessation of breastfeed among these employees. The nursing personnel indicated that the full day shift (which starts at seven am until seven pm) was the most tiring. This finding is in line with the results of other studies as indicated in chapter 2 (page 5 and 6 of this report); where participants in the South African Demographic and Health Survey (1998) and other studies have cited having to return to work as one of the reasons for cessation of breastfeeding (Work and Life Bulletin, 2002; Philippine Pediatric Society Committee, 2004; Galtry, 2000).

An interesting trend in most of the focus groups was the vicious circle that these feelings eventually created. When one negative feeling appears, there is another one that usually occurs as a result of the initial feeling. Closely associated with the above-mentioned feelings are sadness, anger and stress.

Four participants (6.3%) indicated that they are scared or afraid of how they are going to cope with having to balance maternal responsibilities and responsibilities as an employee. Of these four, two are those who were expecting their first babies, and the other two did not have babies at all, although they indicated that they would like to have babies one day.

One of the expectant women also expressed both verbally and non-verbally that she also has mixed feelings with regard to what to expect after child birth. This was further reiterated by two others who did not have babies. The prospect of having a baby appealed to them but they are scared that the baby may contract diseases if they are forced to feed their babies formula due to the hectic work schedule.

Besides the negative feelings that are highlighted in the preceding paragraphs, positive feelings like determination, love happiness and satisfaction at being able to breastfeed their babies were expressed. Participants also indicated that their babies inspired them to continue breastfeeding. The breastfeeding experience brought satisfaction at being able to provide much needed nutrition for the baby.

5.4.2. Experiences

In as far as experience is concerned, clinical care personnel still expressed more of their experiences than nursing personnel. Nursing personnel on the other hand had more bizarre stories or incidences that they shared regarding their experiences as working mothers. For instance, there is an incident where a new nursing mom had to stay with a baby and a nanny in a residence which was on the bushes. The nanny then informed her that she is going back home with the baby because they were scared. She had to start feeding the baby

formula because the baby was now far and there was no accommodation within the hospital.

Another nurse explained how she once found her baby and the nanny vanished from the staff residence where she lived. She later found the baby with neighbors. The baby was hungry with soiled nappies. Apparently the nanny left her there when she decided that she no longer wants to work for the nurse.

The fact that 41.6% of healthcare providers indicated that they enjoyed breastfeeding shows that some do succeed to breastfeed even beyond two years. It is also an indication that most healthcare providers are determined to breastfeed because most of these participants reported to enjoy breastfeeding their second babies. The very number indicated that they knew how important breastfeeding was, and this encouraged them to continue breastfeeding.

Factors that contributed to successful breastfeeding were cited in item 5.2.1 of this study.

On the other hand there are those who continued to breastfeed although they were feeling pain (36.5%) and this was mentioned thirty six times during conversations. There are several factors that contributed to the employees' painful breastfeeding experiences. These included hectic work schedule, mom's health status and improper positioning of the baby resulting in cracked and bleeding nipples.

The latter becomes a challenge in health service delivery because it may mean that even clients are not getting the support they need when they breastfeed their babies. One of the duties of healthcare providers, especially nurses is to assist breastfeeding mothers to position their babies well. It is unfortunate that some of the 36.5% indicated in the above paragraph had disastrous breastfeeding experiences mainly because of poor positioning of baby to the breast.

Particular to the nursing personnel's experiences was the issue of allocation list. In terms of common practice, nurses, especially those without specialty and lower categories usually rotate every three months. It was reported during focus groups that sometimes superiors just allocate without consulting the employees first. This further created tensions and dissatisfaction if a breastfeeding employee is allocated in a busy ward where she may not have enough time to express or to rush home to breastfeed. The worst experience is that at times they are allocated for night duty without being consulted.

Almost similar to this challenge on the side of radiographers in the clinical side, is the issue of after hour radiography services. One participant who was expectant at the time of the focus group indicated that she is presently taking calls for after hour radiography services and is not sure if she will be expected to take calls even when breastfeeding. Another officer reported that she had to take calls on a daily basis, from when her baby was around four months old. She went through lactation management course and she loved to breastfeed. The challenge was that she would be called in the middle of the night at any given day to render her services, leaving an infant with her mom.

Again on the clinical personnel side, the challenge that was raised was the issue of having to go for outreach services whereby clinics and clients' homes are visited on a weekly or monthly basis to render clinical care services (refer to item 3.2, page 10 of this study for number of clinics per hospital). This posed as a challenge for breastfeeding employees in that it was not possible for them to express when out in outreach. The lunch breaks are also not very clear because they are based on the area they are visiting. The issue of going home or to the staff residence to breastfeed is then ruled out during outreach.

On the nursing side, the issue of transfer of clients to the higher level of care posed as a challenge to successful breastfeeding. The time spend away from the baby is usually extended and at the same time there is no possibility to express breast milk while away.

From the enquiry made during this study there are no policies in place to address the issue of breastfeeding and work. This further makes the decision to feed the baby breastmilk only for the baby's first six months of life and continuation of breastfeeding up to two years of the baby's life difficult for healthcare providers to make.

5.4.3. Needs

Both nursing and clinical personnel shared the same needs with an exception of one need that is exclusive to nursing personnel. Their needs are similar to those indicated in chapter two (item 2.2.1 to 2.2.4, page 7) of this study. Their needs were not in the similar sequence as in the above-mentioned chapter but all were cited by almost all participants during focus groups. Employees' needs are tabulated in Table 4.11 (page 28). In this chapter we will only discuss needs that were raised by majority of participants. The number of participants given on the table excludes those who murmured their agreement in a chorus with the speaker because it was difficult to count how many they were.

5.4.3.1. Crèche or day care centre

This need was raised in both focus groups. It was also indicated that this may not necessarily solve all breastfeeding problems for employees but at least for those on day duty and those who work office hours a crèche will assist. It was discovered by interaction with employees that all hospitals that were visited during the study did not have such facilities within or at least a kilometer away from the institution. The issue of day care centre was voiced twenty times during focus groups.

5.4.3.2. Extended maternity leave

Twelve participants (19%) indicated that the current four months maternity was insufficient to practice exclusive breastfeeding. They felt that there is a need for the employer to add a further two months to the make it six months. This occurred fifteen times during focus groups. It was shared by both the nursing and clinical personnel.

Most employees indicated that they had to start maternity leave up to two months before the baby was born, mainly due to illness where you find that sick leave days are exhausted. This meant that they were going to return to work when the baby was still too young. They then opted to utilize any available leave days like sick leave and vacation leave in order to compensate for this. This did not go down well in most of the institutions because managers did not approve such practice, especially with vacation leave.

5.4.3.3. Breastfeeding Room

Eight participants (12.7%), from both nursing and clinical personnel indicated the need for a breastfeeding room. This need is in line with what was highlighted in item 2.2.3, page 7 of this study. It was indicated that employers may support breastfeeding employees with a room to breastfeed or express breast milk depending on whichever is possible.

In all the focus groups except two where we had three nurses and five nurses who were all junior category nurses indicated this need. Although only eight was recorded, this matter occurred ten times during focus groups and the rest of group members murmured their agreement with the speaker.

It seems as if a breastfeeding room is gaining some popularity in the district with one hospital already identified a space to that effect. However, the room is also used as a rest room and as such not suitable for breastfeeding purposes. On the other hand, those who do transfers and those who do outreach services raised a concern that a breastfeeding room may not necessarily cater for them.

5.4.3.4. Communication or management support

Eight participants (12.7%) identified the need for more communication between employees and managers regarding baby feeding practices and issues pertaining to child birth. Most participants from the nursing profession felt that if only their superiors could invest more time to discuss with them their plans regarding allocations and also regarding child care they will feel supported. This need is in line with what was reiterated in item 2.2.1, page 7 of this study.

The issue of poor communication appeared to further compound the level of frustration among expectant employees because they eventually feel uncertain of what to expect. Reference is made on two expectant employees from the clinical divisions who were left with less than two months to go on maternity leave but never had any discussion with their superiors regarding issues surrounding their pregnancy. The other officer was performing after hour services on a call basis. She did not know whether she will be expected to continue taking calls or she will be excused.

The issue of proper communication cannot be overemphasized. For any organization to perform optimally and that the members of staff may feel valued. Through proper communication managers will gain a deeper understanding of what is going on in an employee's life. Belker and Topchick (2005) indicate that one is better off communicating too much than communicating too little.

5.4.3.5. Breastfeeding breaks

Eight participants (12.7%) indicated the need for breastfeeding breaks. In their own interpretation, participants believe that there is a need for at least an hour breastfeeding break, which should be over and above the normal lunch hour. It was discussed in focus groups that this hour may be broken down depending on service delivery issues and the baby's eating patterns.

This need is in line with what was indicated in item 2.2.2, page 7 of this study, which is based on the ILO convention 183 (2000). It makes provision for national departments to determine the length of breastfeeding breaks. This convention also indicates that breastfeeding breaks for breastfeeding employees is a human rights issue, unfortunately, in the five institutions where the study was conducted there were no policies regarding breastfeeding breaks.

On the other hand, nurses indicated that utilizing breastfeeding breaks while on night duty was impossible because it is usually dark

outside and as such they cannot go home or to the rooms to breastfeed even if that would be provided for.

5.4.3.6. Proper accommodation within or near workplace

Seven participants (11%) indicated the need for proper accommodation within or near the workplace. This matter was cited ten times during conversation. In addition to that it was raised that sometimes institutions have a law that prohibits babies at nurses' residences because babies would make noise for night duty staff that are asleep. It was indicated during focus groups that accommodation should be provided, where possible according to individual needs.

Two participants further indicated that they would prefer to have a nanny for their baby than to take them to crèche or day care centre. According to them, proper accommodation means at least a two bedroom unit where a nanny should have her own room as they do not prefer to share a room or a bed with the nanny. The issue of proper accommodation as a means of support for breastfeeding employees was also cited by participants in a study conducted at university of Kwa-Zulu Natal (item 2.2.4, page 7 of this study).

5.4.3.7. Policy on breastfeeding and work

In all the institutions where the study was conducted it was discovered that there were no policies on breastfeeding and work. This eventually led to a situation where managers or supervisors use their own discretion on how to deal with breastfeeding employees.

This was further confirmed in several cases where at one institution breastfeeding employees are permitted to bring along their babies and nannies when going for workshops. An indemnity form would be filled for the baby and nanny to indemnify the institution in this instance. In other institutions, participants indicated that they had to choose whether to breastfeed or to attend such a workshop since they are not permitted to bring along babies and nannies.

Some participants from the nursing profession further indicated that this lack of policies also affected their training needs. When an employee is next in line to go for training and she falls pregnant, at some institutions she was permitted to continue with studies whereas in other institution she would then be skipped and another non-breastfeeding employee is sent.

The importance of policies in an organization cannot be overemphasized. It becomes clear from the above discussion that employees' need for policies on breastfeeding and work are founded on sound principles to ensure uniformity in hospital management.

5.4.3.8. Support from fellow colleagues

Five participants indicated the need for support from fellow colleagues. This is further supported by the fact that those who succeeded to breastfeed indicated that they would get support from their colleagues. Two participants indicated that their colleagues would at times remind them to go and express.

Participants indicated that it would become stressful if fellow employees did not support their breastfeeding endeavors. This was more serious for nurses as they relied on their colleagues' mercy to perform night duty on the breastfeeding employee's behalf. This is because managers leave it to the breastfeeding employee to look for a replacement for themselves if they feel their babies are still too small for them to perform night duty. Should there be no volunteer; the breastfeeding employee will have no choice but to do night duty.

5.4.3.9. Six months exclusive breastfeeding

Four participants (6.3%) indicated that they need to exclusively breastfeed their babies. Of this number of participants, two were expectant employees and one did not have a baby yet and was also not expectant. It appears that by listening to the conversations and also participating in them, these participants felt there is a need to exclusively breastfeed their baby for six months.

It is worth noting that from the conversations during focus group it was discovered that none of the participants were able to exclusively breastfeed their babies for more than four months. This need may have aroused from this discovery. The fact that the majority of participants who identified this need did not yet have babies should be of concern to policy makers.

5.4.3.10. Flexible working hours

Three participants (4.8%) indicated the need for flexible working hours for breastfeeding employees. Although this was captured as three participants, most members in the three focus groups where this need was identified murmured their agreements. It occurred four times during conversations.

This need was raised based on the fact that usually the baby would want an early morning snack from mom's breast and mom is supposed to wake up, take a bath and catches the early morning ride to work. They felt if there were flexible working hours, the day would start a bit later, perhaps around nine am and finish around four. This would give mom and baby ample time to breastfeed and bond, according to participants.

On the other hand, a discussion ensued in one focus group where this need was raised, one participant indicated that flexible working

time may be equal to flexible salary, rather opt for part time job. Some felt that this could negatively affect service delivery because most of clients are from rural community and they rely on public transport. It was indicated that flexible working hours could disadvantage these clients and this is not acceptable.

5.4.3.11. Sick bay for employee's sick babies

Two participants indicated the need for a sick bay for sick babies of employees. This included any employee's sick baby, whether breastfeeding or not. It was highlighted that many working hours are lost due to family responsibility leave because an employee's baby is sick.

This need was identified by one participant from the nursing and one from the clinical personnel. The basis for this need was on the fact that they are working at a health service institution and at least this would give employees peace of mind knowing that the baby is in good care and the employee could make regular checks on how the baby's condition is progressing.

5.4.3.12. Day shifts or no night duty for a year after baby's birth

Six participants (9.5%), all from the five nursing focus groups indicated that they would prefer to not perform night duty and where possible, office hours at least during the first year after the baby's birth. This was raised eight times during focus groups with some members murmuring their agreements.

From the expression on their faces and other body language, it was apparent that the issue of night duty for nurses who are breastfeeding is a nightmare. This is compounded by the fact that employees are usually not consulted when allocation lists are made in some institutions.

5.4.3.13. Training on breastfeeding

One employee from the nursing division indicated the need for training of all employees on breastfeeding. The present training that is going on (lactation management workshops), in her observation, was focused on nurses at maternity and pediatric wards. She felt all employees should be trained not only on how to support breastfeeding clients but also on how to breastfeed their own babies.

This was based on the participant's personal experience of a disastrous breastfeeding experience. She believes that if she were to breastfeed now after she was trained for breastfeeding it was going to be a breeze, hence the need for training of all employees in hospitals on breastfeeding.

5.4.4. Opinions

Table 4.9 in chapter four (page 26) indicates participants' opinions regarding breastfeeding and work. Nine participants (14.3%) indicated that breastfed babies are healthier and they grow well.

This occurred twelve times during focus groups. Most participants indicated that this is what makes them to decide whether they continue to breastfeed the baby or not. A baby who grows slowly is breastfed longer and a fast growing baby may be weaned off the breast earlier.

Nine participants (14.3%) indicated that breastfeeding saves money or is affordable. Most participants indicated that the high cost associated with formula feeding was enough to encourage them to continue breastfeeding even beyond two years. Some participants indicated that they had agreed with their partners on breastfeeding and could not quit because it would mean more cost to the partner who was not eager to buy formula.

Eight participants (12.7%) reiterated the importance of breastfeeding. They indicated that breastfeeding must be encouraged and supported. This occurred twelve times during focus group. Participants expressed that as much as breastfeeding is important, there is an impression that it is emphasized by their superiors for clients who come for health services in hospitals and not for them as employees to their own babies. This eventually leads them to feel like hypocrites, having to preach breastfeeding while they do not practice it themselves.

Eight participants (12.7%) agreed that breastfeeding creates a bond between mom and baby. In this regard there were some participants who indicated that they have a closer relationship with their grand mothers than with their mothers because they were not breastfeed because mom had to go to school or to work. They were determined not to make the same mistake with their own babies. Some of the participants indicated that they are now trying very hard to build a relationship with their first born babies because they left them with grandparents and did not breastfeed them. Some indicated that their babies have bonded with their nannies, especially with nurses because the baby sleeps with nanny when mom is on night duty. One nurse explained it this way:

“Nowadays our babies sometimes love the aunties (nannies) more than us because in six months or seven months you go on night duty. The baby will sleep with the aunty for seven days and will be with her during the day when you are asleep. At five o'clock you go back to work, she is with the aunty. I would feel pain when the baby talks and she will say aunty this and that even when the aunty is not there, instead of saying mama. It is because we spend

such a little time with our babies. . .” (Others participants hummed their agreements).

Five participants (7.9%) are of the opinion that formula fed babies are prone to sickness and obesity. Some related how they would struggle with a baby who would be suffering from diarrhea and vomiting. They believed that this may be due to failure by the caregiver to mix the formula properly. For those who work office hours this was minimized by making sure that they mix all the baby's feeds themselves before going to work. Some believed changing brands also helps

Another five participants (7.9%) were of the opinion that management is sometimes not compassionate or supportive to breastfeeding employees. Three of these participants are from the nursing focus groups. They base this opinion on the fact that management hardly ever communicates with expectant employees and offer any guidance. Participants felt that they were left to their own demise in as far as breastfeeding and work is concerned.

A further five participants (7.9) were of the opinion that breastfeeding prevents maternal diseases. This is in line with what was mentioned in chapter two (page 3) of this study. Breastfeeding is said to prevent breast and cervical cancers as well as other maternal diseases.

Four participants (6.3%) believe that breast is convenient. They do not have to carry lots of bags and bottles when they are traveling. They further re-iterated that even when the baby is crying you can easily give the breast which is ever ready.

Two participants (3.2%) indicated that a breastfed baby is more intelligent. Another two participants (3.2%) were of the opinion that breastfeeding prevents pregnancy. One participant went on to indicate that with her first baby she only breastfed for six months and she got pregnant with a second child the very same year. She believed that it was because she weaned her baby too early off the breast. She was then determined to breastfeed the second baby until the baby is over two years. She believed that breastfeeding helped her with child spacing.

One participant (1.6%) was of the opinion that formula prevents transfer of diseases from mom to baby. She believes that by feeding the baby formula, even if mom is sick, this cannot be transferred to the baby. An example was given that if mom is constipated or has diarrhea, so will her breastfeeding baby be. The issue of *sekgalaka* (sores) was also mentioned. It is believed that mom can transfer *sekgalaka* to the baby when breastfeeding.

5.5. Comparison between Employees and Managers Responses

As outlined in Table 4.12 (page 29), managers expressed fewer feelings than all other categories of responses. On the other hand, employees' feelings were second last in terms of frequency. Employees talked less about their needs with regard to breastfeeding and work. Managers were more focused on service delivery and the discussions during interviews were driven towards service delivery. In line with the objectives of this study, only responses that have any direct or indirect impact on breastfeeding practices of healthcare providers will be discussed.

5.5.1 Managers and employees' perceptions regarding breastfeeding and work

Question one in the guide for focus group as well as question one and two for in-depth interviews were meant to assist in identifying perceptions regarding breastfeeding and work. The responses for both employees in focus group and managers during interviews indicate that both parties harbored more negative feelings than positive feelings or perceptions regarding breastfeeding and work.

5.5.1.1. Positive feelings/perceptions

All the positive feelings that employees expressed during focus group could not be associated in any way to the work place. They explained their feelings to be related to the joy of motherhood. On the other hand, managers (40%) indicated that they would be happy for the employee for the anticipated joy of being a mother. The low number of managers who had such a positive feeling on being informed about breastfeeding is an indication of an underlying problem. It is not within the scope of this study to dig deeper into the matter.

5.5.1.2. Negative feelings/perceptions

Employees and managers had different reasons for the negative feeling or perceptions in as far as breastfeeding and work is concerned. Employees (27.0%) were more worried about how they were going to manage to look after the baby and at the same time fulfill their contractual responsibilities as employees. On the other hand, managers' (40%) worries were centered around how they are going to meet their target with the employee away on maternity leave. This further went down to worrying if the employee will still be productive and report on duty as regularly as expected.

The above-mentioned scenario creates an area of conflict, however ambiguous it may be. This may explain the seventeen participants (27.0%) who indicated that the workplace was unsupportive to breastfeeding employees. This was reiterated by participants from all five hospitals.

One of the main reasons for the high volume (40%) and frequency of negative feelings regarding breastfeeding and work as mentioned by all managers who were interviewed were staff shortages. Employees would also highlight staff shortages several times during focus group discussions.

Table 4.8 (page 26) indicates that negative feelings featured 121 times during focus group discussion 119 were directly related to employees' work environment. This shows the impact that the work environment has on healthcare providers who participated in focus groups with regard to breastfeeding. Nine out of ten managers expressed one form of negative feeling or another as indicated in Table 4.14 (page 31), occurring sixteen times during interviews.

5.5.1.3. Employee productivity

Question two of guiding questions for managers was aimed at identifying managers' perceptions regarding breastfeeding and employee productivity. Table 4.17 (page 33) outlines the various opinions that managers shared regarding breastfeeding. Although most opinions were based on breastfeeding in general, there are some that were directly related to breastfeeding and employee productivity.

Managers seemed to share divided views regarding whether there is a relationship between breastfeeding and employee productivity. Five managers (50%) believe that breastfeeding negatively affects employee productivity. They mentioned this seven times during interviews. They base their opinion on the fact that if an employee is to be given breastfeeding breaks, that employee's target will have to be reduced and as such, the employee is less productive than her non breastfeeding counter part.

These managers' perceptions are in line with employees' responses to question four of guiding questions for focus groups. When participants were asked how they attained a balance between work and breastfeeding, twenty one participants (33.3%) indicated that they did not have a good work/life balance and it was raised twenty eight times during discussions. This response cut across eight of the ten focus groups. Mostly related their poor work life balance as being the result of sleepless nights and the baby wanting to breastfeed when they are about to take a bath and report for duty. Some related how they used to doze off in meetings and therefore not contributing positively in discussion. Not willing to work beyond the normal knock off time was raised by others. One of the participants put it this way:

“During knock off, the time to leave ne, you will be the first one to leave! You will be the first one to leave, if there are other things,

maybe that disturbs you, you get irritated because you feel that these people they don't understand me. I find that these people they don't understand me. I have to be there, I have to be there for my child . . . so your time must be, like fixed time."

Five more managers (50%) believe that breastfeeding increases employee absenteeism. They believe that when a baby is sick the mother would take some day off to nurse the baby. This was further supported by employees' responses to question four. Some employees related how they would look for any excuse to stay home and breastfeed the baby. This went as far as the employee always being the first one to volunteer to attend any external meeting with a hope of knocking off early to go home and breastfeed. As an observation during discussion, it seemed most participants; including employees during focus groups could not draw a line between motherhood and breastfeeding.

Another five managers (50%) indicated that a breastfeeding employee may put more effort to her work in an effort to cover time lost when away breastfeeding. They did not necessarily say this as a matter of practice but as an opinion.

Two managers (20%) believe that breastfeeding does not hamper employee productivity. They base their opinion on the belief that it is up to both managers and employees to plan the employee's work taking into cognizance the employee's added role as a breastfeeding mother.

5.5.1.4 Maternity leave

In as far as maternity leave is concerned; there was no direct question that was aimed at addressing the matter in both focus groups and in-depth interviews. Managers and employees who participated in the study gave their inputs as supportive information in some discussion. As indicated in item 5.3.3.2 (page 45) of this study, employees feel that four months maternity leave is not enough. They feel it should be extended to six months. On the other hand, two managers (20%) believe that four months maternity leave is enough for employees to nurse their babies for some time. It is believed that employees should then focus on their work when they come back from maternity leave.

5.5.1.5 Other opinions

Managers during interviews and employees during focus groups had several common opinions as indicated in Table 4.9 (page 26) for employees and Table 4.17 (page 34) for managers. Both groups agree that breastfeeding is important (60% of managers and 12.7% of employees) and should be encouraged. They are also in agreement with regard to the opinion that breastfeeding increases bonding

between mother and baby (50% of managers and 12.7% of employees). Both managers (30%) and employees (14.3%) believe that breastfed babies are healthier and that formula fed babies are prone to sickness and obesity (10% of managers and 7.9% of employees).

If the above-mentioned opinions are anything to go by, it can be stated that there is enough areas of similarities for both employers and employees to communicate on a deeper level in an attempt to create a breastfeeding friendly work environment. One may be led to believe that, as some of the employees have highlighted during discussions, superiors are too focused on productivity and overlook the fact that employees have needs that sometimes have to be fulfilled by the employer.

5.5. 2 Factors contributing to successful breastfeeding

Table 4.10 (page 27) and Table 4.18 (page 34) give an overview of factors that are seen to have an impact on breastfeeding. As indicated elsewhere in this study, most factors serve a dual role in that it depends on how it is applied. For instance, one manager believes that by putting an employee on night duty they are supporting the employee to spend more time with baby during night off, whereas one employee indicated that she felt unsupported when she was made to go for night duty when the baby was less than a year old.

5.5.2.1 Work environment

An interesting finding is that both managers (40%) and employees (28.6%) agree that the work environment or having to go to work have some impact on successful breastfeeding. Both responses are in line with what was discussed in chapter two (page 6) of this study, where participants in two different studies, one in South Africa and the other in the Pacific Island indicated having to return to work as one of the reasons for termination of breastfeeding. Since this study was performed at a hospital setup, it was expected that the work environment would give cognizance to the importance of breastfeeding. Unfortunately, this is not the case from the report given by both managers and employees who participated in this study (the South African Demographic and Health Survey, 1998 & Work and Life Bulletin, 2002).

This further supports what was highlighted in chapter one of this study. The work environment of most healthcare providers did not create a good setup for successful breastfeeding. Those who succeeded, however, credited their success to good communication between them and their superiors as well as good planning.

It becomes apparent that if both the employees and the employer can work together in an effort to create a workplace that is supportive of breastfeeding, the number of employees who succeed to breastfeed will increase. Some of the needs as identified in 5.3.3 (page 45) do not necessarily have serious financial implications; they only need some form of innovation from both parties.

This includes the organizational culture of the institution. A simple approach of improved communication between employers and employees may go a long way in creating a positive work environment that will support breastfeeding initiatives. This was cited by both managers and employees indicating the need for improved communication. From the discussions in both focus groups and interviews, it was discovered that it seems as if managers expect employees to come knocking at their doors and start talking with them about their pregnancy. On the other hand, employees expect their managers to take the initiative and call them to their office and open the discussion. It is not within the scope of this study to prescribe what should take place, but from the responses of both parties, communication should be improved as this affects how employees view their workplace.

5.5.2.2 Mom's Health Status

The health status of the new mom occurred as the second main factor that influence breastfeeding. There appears to be a positive relationship between mom's health and success of breastfeeding. Both managers and employees indicated that there is a direct relationship between breastfeeding and the health status of the mother.

The issue of HIV/AIDS occurred as a concern in both focus groups and interviews. Some of the participants in the focus groups indicated that they would not breastfeed their babies for long for fear of transmission of the virus to the baby should they contract the virus during lactation period. Managers (20%) felt that once a person is HIV positive, she must not breastfeed, rather feed baby formula.

In order to promote and support breastfeeding, the workplace must create a healthy work environment for breastfeeding employees. Those who succeeded to breastfeed have partially credited the effort made by superiors as well as colleagues as contributors to that success. This included where managers allocated an employee to a less hectic ward for nurses and where employees were removed from doing after hour services so they can concentrate on breastfeeding the baby after work.

5.5.2.3 Affordability

It was revealed by two managers (20%) during interviews and eight employees (12.7%) that one of the factors that directly influenced success of breastfeeding is affordability. Some employees admitted that the high cost of formula would be enough to motivate them to breastfeed. Managers were also of the opinion that employees would opt to breastfeed if they considered the cost of formula and other items associated with it.

From the responses by both parties, it appears that there is a converse relationship between breastfeeding and affordability. One focus participant was more vocal in saying: “*if you can afford it, you better formula feed!*” She was open in indicating that she used to buy sixteen tins of formula per month for her son. However sixteen tins per month may not be within most people’s reach especially if there are other kids to feed and other responsibilities. Indeed, to some extent the relative cost of formula is enough to motivate a mother to breastfeed at no direct cost at all.

5.5.2.4 Distance between work and Home

Distance between work and home was cited by both managers during interviews (20%) and employees during focus group (3.2%) as one of the factors influencing breastfeeding. There appears to be a converse relationship between distance between work and home and breastfeeding. Those employees who stay far from work opted to formula feed. They would often leave the baby with their parents at home and only go home over weekends or month end.

Managers who indicated this also outlined that this affected staff retention because “*an employee cannot stay and relax when her four months baby is some 800km away in Bloemfontein or in Kwa Zulu-Natal*”, as one of the managers explained during interviews.

This goes on to support the need for proper accommodation within or near the institution, as indicated by both managers and employees in Table 4.11 and Table 4.19 (page 28 and 35 of this study). If the employer could create an environment where employees can have a home away from home, to some extent a positive impact on breastfeeding may be seen. Some of the employees who succeeded to breastfeed while working indicated that they had accommodation near the workplace or their previous employers had a crèche within or near the workplace. It then becomes apparent that the shorter the distance between mom and the baby, the longer and smoother the breastfeeding experience will be.

5.5.2.5 The nanny Factor

Three participants in focus groups (4.8%) and one manager (10%) indicated that the nanny plays a role in breastfeeding. A good

nanny, especially one who does not have a problem with feeding the baby expressed breast milk seems to assist in encouraging breastfeeding. This was supported by one employee who indicated that she succeeded to breastfeed because she had a good nanny. It is interesting to note that there was at least one manager who acknowledged the role played by nannies.

Nannies, according to the employees' report during focus group, affect their job performance in that should a nanny not show up on duty, then the employee will have to bank work too. If the nanny was staying with an employee in a room near the hospital, this usually forces the employee to quit breastfeeding and send the baby to grandparents. The formula feeding journey then begins. With formula feeding then another set of challenges start to join in. Most employees indicated that sometimes if the formula is not mixed well the baby may develop diarrhea or constipation. A vicious cycle then begins; more family responsibility days are taken to look after the sick baby. This problem is aggravated by the fact that most employees stay in rural or peri-urban areas and running water is not always available (see item 3.2, page 10).

From the above-mentioned discussion we can conclude that a good nanny may play a positive role in ensuring that breastfeeding is successful.

5.5.2.6 Employee's Knowledge on Breastfeeding

The more knowledge an employee has on the benefits of breastfeeding, the more they will persevere to breastfeed. This was mentioned by one manager (10%) and eight employees (12.7%). In as far as employees are concerned; the rest of the focus group members murmured their agreements when the issue was raised.

Some of these employees indicated that when they had thoughts of quitting breastfeeding, their knowledge of breastfeeding benefits kept them going. About four employees out of the eight indicated that with their first babies they did not breastfeed for long because they did not have the knowledge they have now. They indicated that they are now more determined to breastfeed because of that knowledge.

5.5. 3 Challenges

Table 4.6 (page 24) and Table 4.16 (page 32) indicate negative experiences or practices as expressed by employees during focus groups and managers during in-depth interviews. This will form a basis for identifying what the main challenges faced by healthcare providers may be.

5.5.3.1 Workplace related challenges

As indicated earlier, the workplace appears to play a major role in influencing the employees' decision whether to breastfeed or not to breastfeed, including how long they are to breastfeed. It can then be assumed that one of the main challenges is unsupportive workplace. Both employees during focus group (27%) and managers in in-depth interviews (40%) alluded to the fact that the workplace does not support breastfeeding employees. Most managers felt that their hands are tied because they cannot act without any policy directive even if they want to support employees.

The diagram below (Figure 5.3) indicates the various workplace related challenges as reported by focus group participants. We will not go into detail with them because they were all discussed in earlier discussions. Infrastructural problems refer to challenges related to lack of space to express and lack of crèche or day care centre.

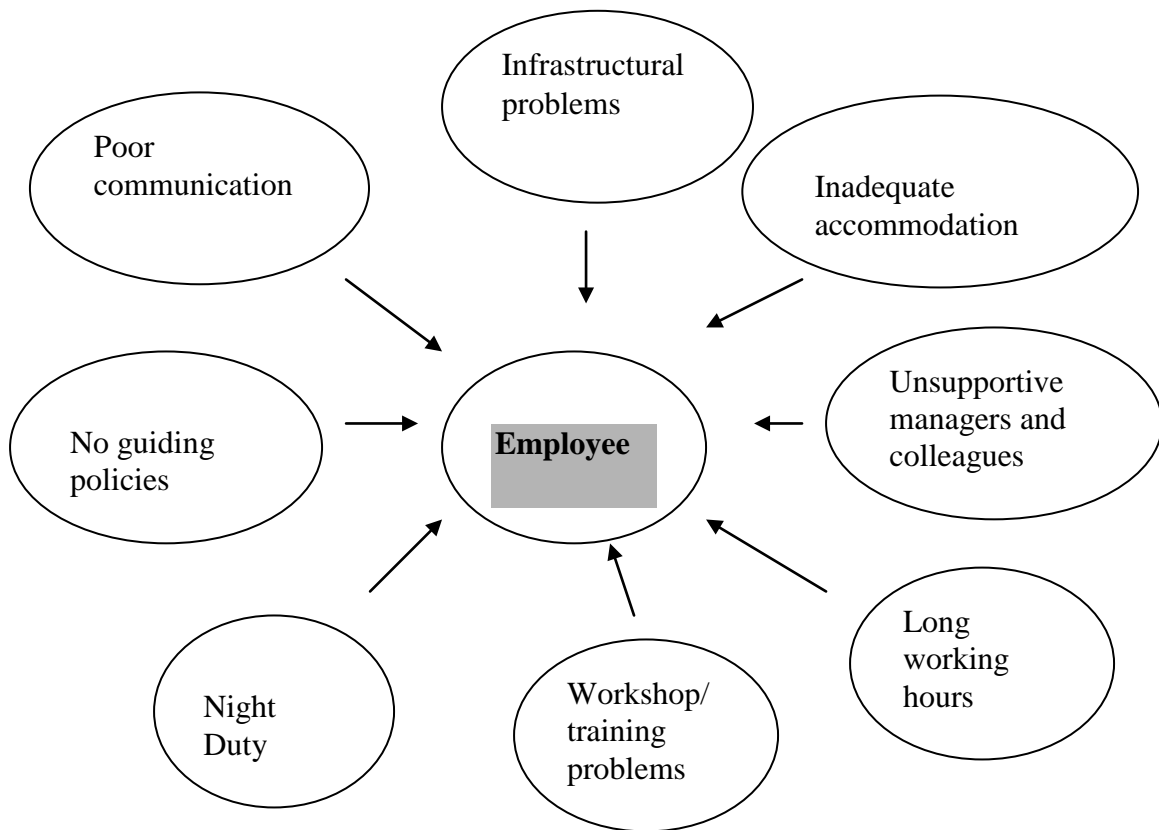


Figure 5.3: Workplace related challenges faced by employees

5.5.3.2 Social circumstances

Participants during focus group indicated challenges that are more related to social circumstances. Managers also confirmed this during interviews. In most cases, such challenges eventually lead to problems such as absenteeism and productivity issues. Below

(Figure 5.4) is a diagrammatic representation of challenges associated to employees' social circumstances.

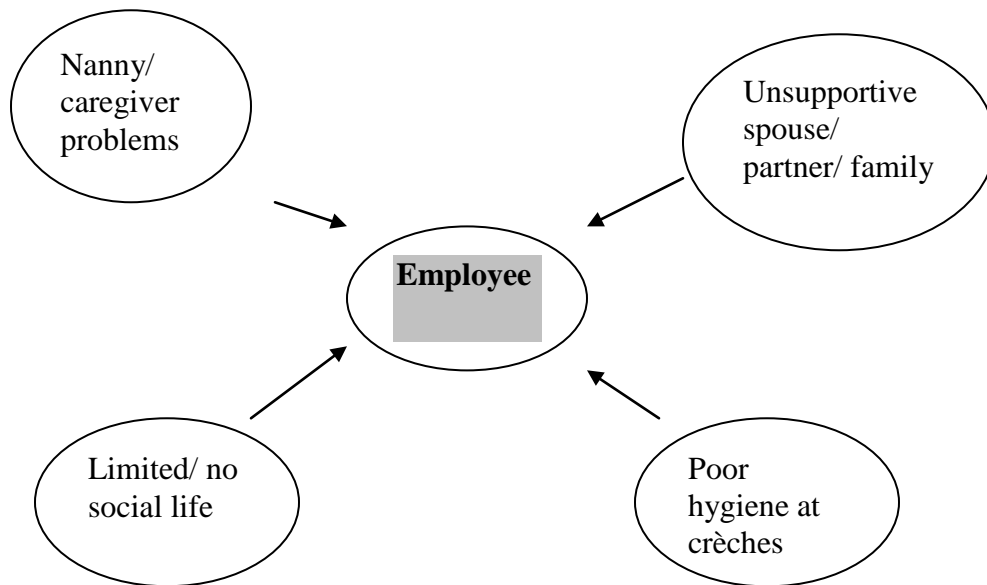


Figure 5.4: Social circumstance related challenges

5.5.3.3 Employee's personal condition/ circumstances

Participants indicated that at times they would be looking forward to breastfeeding their babies once they were born. Much to their disappointment and frustration they would then be confronted with some medical or other problem that would make it difficult or impossible for them to breastfeed their babies. In the words of one such participant she said:

“When I was still pregnant it never crossed my mind that I would not breastfeed...”

A new mom's health status appears to be the main challenge in as far as this category is concerned.

Another challenge is the issue of HIV and AIDS status of the mother. It was expressed in both focus groups and interview discussions that the status of the mom can pose as a challenge with regard to breastfeeding and work. Even among those who are negative, the threat of contracting the virus and infecting the baby through breast milk is enough to make a woman to stop breastfeeding. This occurred several times during discussions. Most health professionals, including dieticians, indicated that because of the threat of contracting HIV and transmitting it to the baby they would not opt to breastfeed for long.

Some participants indicated that they just did not have enough breast milk and they opted to formula feed. In some instances, when the baby feeds directly from the breast there is enough milk. The problem starts to be when they have to express and not enough milk comes out, leaving the mom with no option but to practice mixed feeding.

Breast problems were not uncommon during focus group discussions. This was also reason enough to make a mom opt to feed the baby with formula. Below (Figure 5.5) is a diagrammatic representation of challenges related to the employee's physical condition.

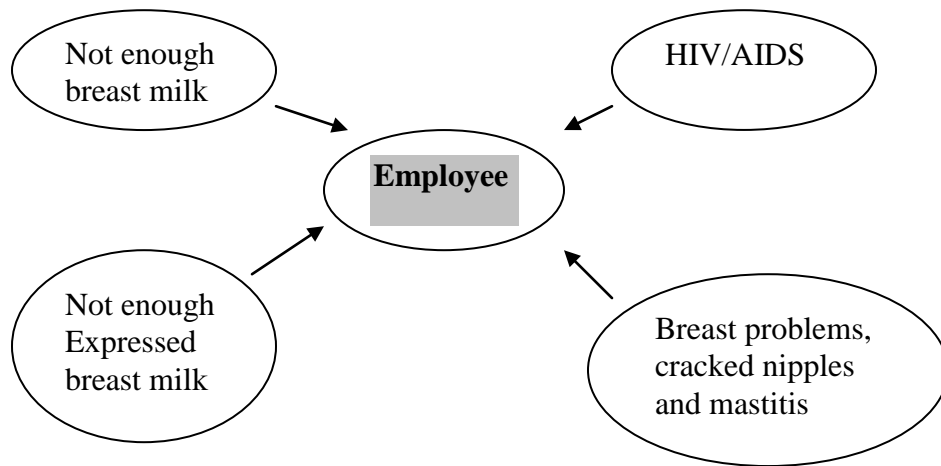


Figure 5.5: Challenges related to employees' condition.

5.5.3.4 Baby related challenges

In some instances the baby would be the one who quits breastfeeding, much to the dismay of the mother who is still eager to breastfeed. This usually occurs on babies who are mixed fed. The baby starts to develop teat confusion and may choose the bottle because it does not need much effort.

As indicated in chapter two (page 5), in order to have adequate flow of breast milk, the breasts need to be emptied on a regular basis. Unfortunately, with most participants this was not the case. A baby would breastfeed in the morning before mom goes to work until late in the evening when they return. The breast milk supply would then dry out and the baby will not want to be breastfed. It is not surprising that all participants who reported that the baby just

stopped breastfeeding also indicated that they were also giving the baby formula to complement breast milk.

Another baby-related challenge was that the baby would refuse to take any milk if it is not directly from the breast. Some focus group participants indicated that this was a major challenge because even if they succeed to express, the baby would not take it. They would then breastfeed before going to work, after work and during day off and/or weekends. Baby related challenges are presented in Figure 5.6 below.

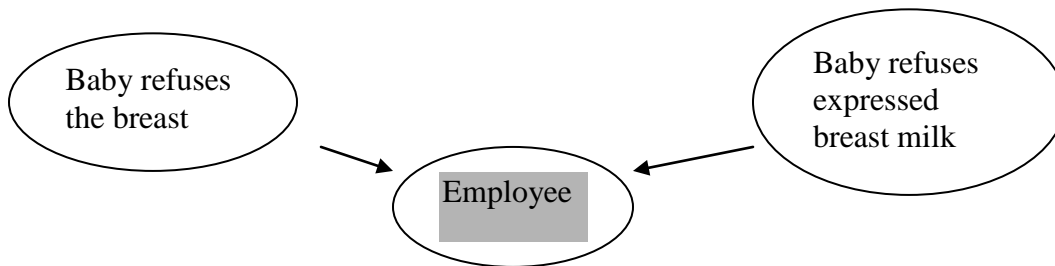


Figure 5.6: Baby-related challenges

5.5. 4 Needs

The last guiding question for both focus groups and in-depth interviews was aimed at identifying what the needs for both employees and employers are. Table 4.11 (page 28) and 4.19 (page 35) outline the employees' needs as reported by employees during focus groups and managers during interviews. Both tables show that most needs are the same with an exception for productivity which was only indicated by managers as the need that employees should provide.

The main cause for concern is that in as much as managers have identified breastfeeding employees' needs, most of them professed that their hands are tied as they do not have the powers and resources to provide for such needs. The unfortunate fact is that from the responses of both employees and managers during the study, communication is a challenge. It appears as though employees are sitting at one corner waiting for the manager to initiate communication whereas the manager is also looking at the employee to initiate communication. The end result then becomes non-communication among employees and their managers.

5.6 Conclusion

The findings of this study indicate that breastfeeding practices of healthcare providers are no different from that of the general population. There is a mix of those who breastfeed their babies, giving them breastmilk only, those who practice mixed feeding and those who formula feed their babies. They are all faced with various challenges irrespective of what method of feeding they opt for.

Both the employees and the employer have needs that are still to be met. In the next chapter we will explore ways in which these needs may be met in an environment of mutual cooperation.

CHAPTER 6 CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The findings of this study reveal several key aspects that can assist in creating a breastfeeding friendly work environment. These are mainly based on the needs as reported by both employees and the managers. These needs are at par with the needs of working mothers as cited in chapter two of this study. In this chapter some conclusions are reached based on the findings of this study. Recommendations are made to the relevant stakeholders in an effort to address gaps identified during the research.

6.2 Conclusions

Through careful scrutiny of the report by both employees and managers against the objectives of this study the following conclusions could be made:

6.2.1 A choice of breastfeeding

More employees continued to breastfeed their babies for some time until they were compelled to quit because of some reason or another. Some of employees in this category found breastfeeding painful for the first baby and it got better with subsequent babies.

6.2.2 Formula feeding

Another group of employees believe that breastfeeding and work too tiresome and as such opt for formula feeding.

6.2.3 No support for breastfeeding employees

The Department of Health and Social Development (DHSD) does not have any support structures put in place to support breastfeeding employees within their employ. There were no policies to address the issue of breastfeeding and work during the time of the study. This resulted in a situation where each manager uses his/her discretion on how to support employees during pregnancy and child birth. This creates disparities in management of institutions within the same district and provincial government department.

6.2.4 Workplace challenges

Workplace challengers have the highest influence on employees' decision whether to breastfeed or not to breastfeed. Among these challengers poor communication and lack of consultation were the main source of pain for employees who participated in this study. The first Bathopele principle is not adhered to in the employment relationship within the DHSD.

6.2. 5 Success factors

The main success factors for breastfeeding healthcare providers are strong family support, counseling and planning prior to the birth and also after the baby's birth.

6. 3 Recommendations

6.3. 1 Improvement in communication

As indicated earlier in this study, both employees and their managers need to take positive steps towards improving the level of communication. The importance of communication cannot be overemphasized. One apparent sign of lack or poor communication is the report by one manager who indicated that they show support to breastfeeding employees by placing them on night duty. On the other hand, employees feel that their managers do not support them because they place them on night duty when their babies are still young (below one year).

Communication in this regard has three factions:

6.3.1.1. Communication between managers and employees

Employees and employer/ management should take necessary steps to initiate and maintain communication. A proper atmosphere based on the values of the department of health and social development should be created to ensure that there is no communication breakdown.

6.3.1.2. Communication among employees

Employees to create platforms for inter-sectional and intra-sectional communication to support and to facilitate processes aimed at creating a breastfeeding friendly environment. This may involve formation of support groups for breastfeeding employees and facilitating training on breastfeeding including proper positioning of the baby on the breast.

6.3.1.3. Communication among managers

Managers could put the issue of breastfeeding support as one of the important subjects on their agenda during management meetings. In such meetings it is easy for managers to assist each other and to guide each other in a way to boost employee morale and to create a nurturing and caring environment for employees. Several managers during interviews confessed that they hardly talk about how breastfeeding or even new mothers should be supported. This status quo needs to be reversed if institutions are as concerned about productivity as they profess.

6.3.2 Infrastructural issues

The fact that all five institutions where the study was conducted are at rural areas or peri-urban areas compounded some of the problems rose. Infrastructure is not an exception either. There is a need for more creativity and if this challenge is to be overcome. Below, a summary of proposed recommendations regarding infrastructural improvement are made.

6.3.2.1. Breastfeeding Room

It is acknowledged that all the five study institutions have serious space problems and may not be able to address some of the needs overnight. One of the institutions has already tried one of the efforts by identifying a room for breastfeeding employees. Although this is not fully utilized due to accessibility issues raised by employees, such efforts need to be done supported by proper protocols and communication regarding how such a room should be used.

Other institutions could go a long way in showing active support of breastfeeding employees by identifying such rooms. In order to ensure proper utilization of the room, any efforts should involve both management and employees. One of the positive aspects regarding breastfeeding room creation is that it is within the local hospital management's powers to identify, it does not require any higher management approval. It can easily fit within the short term plan of the institution.

6.3.2.2. Proper Accommodation

The current accommodation criteria should be reviewed in the light of the above-mentioned inputs by employees. Employees with babies below two years should be given an option to stay at least a two bed roomed house. The current state housing policy (Departmental Circular 50 of 2006) does not recognize breastfeeding employees as priority for consideration in state houses. The need for more houses within institutions cannot be overlooked.

6.3.2.3. Crèche

The provincial government should embark on a situational analysis and feasibility studies in an effort to initiate creation of crèches or day care centers in district hospitals. This may involve doing partnership with the private sector for assistance in case where the hospital does not have enough resources to create such. The private business may built such a crèche within walking distance from the hospital

6.3.3 Breastfeeding Policy

A policy that addresses breastfeeding and work should be developed from the provincial department of health and social development. The DHSD is the custodian of maternal and child health and should therefore take a lead in promoting and supporting breastfeeding, including breastfeeding by its own workers. A legislative framework informed by the code, the Innocenti declaration 2005 and the ILO convention 2000 should be developed. The main focus of this policy should be:

6.3.3.1. Breastfeeding Breaks

In chapter two of this study it was indicated that breastfeeding breaks are a human right (ILO Convention 2000) and as such the department should put systems in place to introduce breastfeeding breaks at institution. The policy is the tool by which managers can be able to regulate the usage of these breaks in a way that they do not interfere with employee productivity. The policy will determine the length of the breaks and how the employees could take them.

6.3.3.2. Breastfeeding and Night Duty

At present, whether or not the employee performs night duty lies in the hands and discretion of the manager. The policy should address the ideal period for commencement of night duty or after hour service by affected professionals. The average recommended age as indicated by employees during focus groups is one year after baby's birth.

6.3.3.3. Breastfeeding and Training/ Workshop Attendance

The policy should give guidance on how managers and supervisors are supposed to deal with breastfeeding employees training and development. This item must look at logistical issues like whether the department will arrange for babysitting facilities at a subsidized rate or at the employee's cost, including transportation.

6.3.4 Areas for Further Research

As indicated in chapter one, this study was exploratory, focused on creating a platform for further study. The following are suggestions for further study:

- The impact of HIV/AIDS in decision making on breastfeeding among healthcare providers.
- The impact of community outreach services on breastfeeding among healthcare providers.
- The rate and length of exclusive breastfeeding among healthcare providers.

- Night duty and child care among nurses, a matter of professional responsibility or a human rights violation?

6.4 Conclusion

This study was investigating breastfeeding practices of healthcare providers in Capricorn district. This was done in light of the fact that healthcare providers are part of the general population whereas they are also custodians and service providers for maternal and child health. The results of this study show that in as far as breastfeeding and work is concerned, they are in the same boat with the rest of the working women globally.

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APPENDIX A
Consent to Participate Form (Focus Group)

You are invited to participate in a research project that will help us gain insight into breastfeeding issues. We are asking you to be a participant in this study because of the role you play as healthcare provider in breastfeeding management. The study is focused on breastfeeding practices of healthcare providers. You will be one of approximately 70 to 150 female healthcare providers participating in small groups of about 7 to 15 people in five level 1 district hospitals at Capricorn district.

In the group, everyone will be describing their feelings, experiences and needs with regard to breastfeeding and work. The group meeting will last about 1 and 1/2 hours. In the group, we will audiotape record and take notes to make accurate record of what is said, including your comments. There is no right or wrong answers to the questions raised in the group; the important thing is for you to share your experiences, feelings and needs.

Our notes and the information you provide us will be kept confidential. Only the people involved in this project will have access to the information and it will be kept in a locked place. No one else will see your responses. We will only report summarised results, so your identity will be unknown. We will not disclose any information that can be identified with you, nor connect your name to any information we present.

Your decision not to participate will not affect your working conditions in any negative way. If you decide to participate, you are free to discontinue participation at any time. There are no perceived risks to you in participating. We want you to feel comfortable while participating, you can let us know if you are uncomfortable and you don't have to answer any question that feels uncomfortable. You can leave the group if you need a break at any time. We think you will probably benefit by participating, because many people find it helps them to talk about their experiences, and because the information you provide may help other people faced with experiences similar to yours.

If you have any questions, please ask me. If you have any questions later, I will be happy to answer them. You can reach me (Maatlape B. Mawela) at 015 527 8073 or 084 504 1225, Botlokwa Hospital.

Your signature indicates that you have read the information provided above and have decided to participate. Your signature also indicates that you have given permission to be audiotape recorded during focus group. You can keep a copy of this form.

Participant Signature: _____

Date: _____

Investigator Signature:

Date:

APPENDIX B

Consent to Participate Form: In-depth Interviews

You are invited to participate in a research project that will help us gain insight into breastfeeding issues. We are asking you to be a participant in this study because of the role you play as healthcare provider in breastfeeding management. The study is focused on breastfeeding practices of healthcare providers. You will be one of approximately 10 managers participating in unstructured in-depth interviews in five level 1 district hospitals at Capricorn district (at least 2 from each hospital).

In the interview, you will be describing your feelings, experiences and needs with regard to breastfeeding and work. The interview meeting will last about 30 minutes to an hour. In the interview, we will audiotape record and take notes to make accurate record of your comments. There is no right or wrong answers to the questions raised in the interview; the important thing is for you to share your experiences and feelings with regard to breastfeeding and work.

Our notes and the information you provide us will be kept confidential. Only the people involved in this project will have access to the information and it will be kept in a locked place. No one else will see your responses. We will only report summarised results, so your identity will be unknown. We will not disclose any information that can be identified with you, nor connect your name to any information we present.

Your decision not to participate will not affect your working conditions or hospital in any negative way. If you decide to participate, you are free to discontinue participation at any time. There are no perceived risks to you in participating. You can let us know if you are uncomfortable and you don't have to answer any question that feels uncomfortable. You can request for a break if you need one at any time.

If you have any questions, please ask me. If you have any questions later, I will be happy to answer them. You can reach me (Maatlape B. Mawela) at 015 527 8073 or 084 504 1225, Botlokwa Hospital.

Your signature indicates that you have read the information provided above and have decided to participate. Your signature also indicates that you have given permission to be audiotape recorded during the interview. You can keep a copy of this form.

Participant Signature: _____

Date: _____

Investigator Signature: _____

Date: _____

(Both consent forms were modified from the University of Columbia, School of Social Work Sample of Consent to Participate Form, 2001)

APPENDIX C

Questions for Focus Groups

1. When you discovered that you are pregnant, what were your feelings with regard to breastfeeding in relation to your work?
2. What factors did you consider in order to reach a decision whether to breastfeed your baby or not to breastfeed?
3. Please share with us your experiences with regard to breastfeeding and returning to work.
4. Please share with us how you attained to balance your responsibilities as a breastfeeding mother and an employee.
5. What are the factors that determined how long you are to breastfeed your baby?
6. In your opinion, how should both the employees and employer work together in order to make the workplace more breastfeeding-friendly?

APPENDIX D

Questions for In-depth Interviews

1. What thoughts dominate your mind when an employee informs you or you discover that one of your employees is pregnant?
2. How can you describe the relationship between breastfeeding and productivity of employees if there is any?
3. Could you please share with me the measures your institution is applying in order to support breastfeeding employees.
4. In your opinion, how should both the employees and employer work together in order to make the workplace more breastfeeding-friendly?

Appendix E

The Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare 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 one half-hour of birth.
5. Show mothers how to breastfeed and maintain lactation, even 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 groups and refer mothers to them on discharge from the hospital or clinic (UNICEF, 2009)