THE LIVED EXPERIENCES OF NURSING STAFF IN TRANSITION TO A
BABY FRIENDLY HEALTH CARE, AT DR GEORGE MUKHARI HOSPITAL

By

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NOVEMBER 2016
DECLARATION

Student number: 201114764

I, Matlou Germinah Mabokane, declare that this study, “The lived experiences of nursing staff in transition to a baby friendly health care, at Dr George Mukhari Hospital” submitted to the University of Sefako Makgatho Health Sciences, for the degree of M Cur Nursing Science is my own work and that all the sources and quotes used in this study are acknowledged by means of complete references and this work has not been submitted before for any degree at any other institution.

Signature: ………………… Date:

Student number: 201114764
DEDICATIONS

I dedicate this study to the following people for the love and support given to me to make this successful: My sons, Thabang and Katlego who sacrificed their time for me.
ACKNOWLEDGEMENTS

I acknowledge and appreciate the presence of the following people in my life; they made me successful in my study:

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- My Co-supervisor, Dr M.LM Sengane, who have been there for me from the beginning until the end of the study, you meant a lot to me. Thank you.
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- My colleagues, Angy and Mary who were always there for me.
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- The Superintendent of the Tertiary Academic Institution in Gauteng Province, for giving me permission to conduct the research in their institution.
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ABSTRACT

Baby Friendly Care is the result of the implementation of the Baby Friendly Hospital Initiative, thus implementing the ten steps of successful Breastfeeding. WHO and UNICEF developed a criterion for accreditation for institutions which proof that Baby Friendly Care are practiced successfully in their environment. South Africa, with all its provinces supports the global strategy of Baby Friendly Care. The process of accreditation uses the implementation of the ten steps of successful breastfeeding as the criteria. However, implementation of the ten steps of successful breastfeeding remains a challenge to some of the health care institutions, like Dr George Mukhari Academic Hospital, which is not accredited in spite of its efforts.

The purpose of the study was to explore the lived experiences of nursing staff at tan academic tertiary hospital in transition to a baby friendly care. The objectives were to explore and describe the lived experiences of nursing staff regarding the implementation of the Ten Steps of Successful breastfeeding for successful baby friendly care. The second objective was to identify strategies for the successful implementation of the Ten Steps of Successful Breastfeeding, for achievement of a successful Baby Friendly Health Care status.

A qualitative, explorative and descriptive study was conducted. Participants were sampled purposively. Data collection was done by means of individual interviews. The sample size of the study was fifteen participants and saturation was reached by seven participants.

The findings revealed that nursing staff have knowledge and understanding about Baby Friendly Care; however nursing staff have a challenge on implementing the ten steps of successful breastfeeding. The need for successful implementation of the ten steps for successful breastfeeding is essential, especially in South Africa where there is a high infant and child morbidity and mortality rates.

Key words: Baby Friendly Hospital Initiative, Baby Friendly Practices, breastfeeding, exclusive breast feeding, mixed feeding.
TABLE OF CONTENTS

DECLARATION i
DEDICATION ii
ACKNOWLEDGEMENTS iii
ABSTRACT iv
LIST OF ABBREVIATIONS ix
LIST OF TABLES x
ANNEXURES xi

CHAPTER 1: BACKGROUND AND RATIONALE OF THE STUDY

1.1 Introduction 01
1.2 Background and rationale 01
1.2.1 Global views on Baby Friendly care (BFC) infant feeding 03
1.2.2 Baby Friendly Care in South Africa 04
1.2.3 Baby Friendly Care at Provincial level 04
1.2.4 Accreditation process 05
1.2.5 Significance of the study 08
1.2.6 Theories 09
1.3 Research Problem 11
1.4 Research Purpose 12
1.5 Research Objectives 12
1.6 Research Questions 13
1.7 Operational Definitions 13
1.7.1 Accreditation Process 13
1.7.2 Baby 13
1.7.3 Baby Friendly 13
1.7.4 Baby Friendly Hospital Initiative 14
1.7.5 Baby Friendly Practices 14
CHAPTER 2 RESEARCH METHODOLOGY

2.1 Introduction 24
2.2 Research design 24
2.2.1 Qualitative research 24
2.2.2 Explorative and descriptive studies 25
2.3 Setting 26
2.4 Population 27
2.5 Sampling 27
2.5.1 Sampling criteria 29
2.6 Testing the interview guide 30
2.7 Data collection 30
2.8 Data analysis 31
2.9 Trustworthiness 32
2.10 Ethical considerations 34
2.11 Conclusion 36

CHAPTER 3 DATA ANALYSIS AND LITERATURE REVIEW

3.1 Introduction 37
3.2 Research questions 37
3.3 Findings and literature review 37
3.4 Description of themes, categories and subcategories 38
3.5 Conclusion 106

CHAPTER 4 DISCUSSION OF FINDINGS

4.1 Introduction 107
4.2 Purpose of the study 107
4.3 Research objectives 107
4.4 Discussion of findings 108
4.5 Conclusion 112

CHAPTER 5 SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction 113
5.2 Purpose of study 113
5.3 Research questions 113
5.4 Research Objectives 113
5.5 Summary 114
5.6 Limitations of the study 116
LIST OF ABBREVIATIONS

AFASS - Affordable, Feasible, Accessible, Safe and Sustainable

BFC - Baby Friendly Care

BFHI - Baby Friendly Hospital Initiative

BFP - Baby Friendly Practice

DoH - Department of Health

DoH &SD - Department of Health and Social Development

HIV - Human Immuno Virus

E/N - Enrolled Nurse

MDG - Millennium Development Goals

N/A - Nursing Auxiliary

N/M - Nursing Manager

NDoH - National Department of Health

PMTCT - Prevention of Mother-To-Child Transmission

R/N/M - Registered Nurse Midwife

SDG - Sustainable Development Goals

WABA - World Alliance for Breastfeeding Action

WHA - World Health Assembly

WHO - World Health Organization

UNICEF - United Nation Children’s Fund
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The Ten Steps of Successful breastfeeding</td>
<td>03</td>
</tr>
<tr>
<td>1.2</td>
<td>Requirements for accreditation</td>
<td>05</td>
</tr>
<tr>
<td>1.3</td>
<td>Maternity patients per month from July to September 2014</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>from labour ward monthly statistics</td>
<td></td>
</tr>
<tr>
<td>1.4 a</td>
<td>Proposed sample N-15</td>
<td>18</td>
</tr>
<tr>
<td>1.4 b</td>
<td>Actual sample N-7</td>
<td>18</td>
</tr>
<tr>
<td>3.1</td>
<td>Themes, categories and subcategories</td>
<td>38</td>
</tr>
</tbody>
</table>
LIST OF ANNEXURES

ANNEXURE 1: Interview Protocol (English version)

ANNEXURE 2: Observation sheet

ANNEXURE 3: Consent form for participation in the research project at the University of Limpopo (English version, Sefako Makgatho Health Sciences University)

ANNEXURE 4: Letter requesting permission to conduct research at Dr George Mukhari Academic Hospital

ANNEXURE 5: Medunsa Research & Ethics Committee Clearance Certificate

ANNEXURE 6: Permission to conduct Research at Dr George Mukhari Academic Hospital

ANNEXURE 7: Co-coder letter
CHAPTER 1

BACKGROUND AND RATIONALE OF THE STUDY

1.1 INTRODUCTION
The World Health Organization (WHO) and United Nation Children's Fund (UNICEF) has instituted principles and guidelines for Baby Friendly Hospital Initiative (BFHI) as the hallmark for successful breastfeeding (WHO & UNICEF, 2009:1). Health care institutions which practices Baby Friendly Care successfully are accredited as 'Baby Friendly hospitals' or 'clinics' and those that do not meet the criteria remain unsuccessful. The institutions which have been accredited Baby Friendly Hospital Initiative status means that they are successfully implementing the ten steps of successful breastfeeding (WHO & UNICEF, 2009:39). The ten steps of successful breastfeeding are the main strategy used to assess and evaluate practice for Baby Friendly. The ten steps of successful breastfeeding were evidenced proven that if successfully implemented, Baby Friendly Hospital Initiative status is met. Baby Friendly practices protect and promote maternal and child health care as proven by WHO and UNICEF (WHO, 2009: 1-102).

1.2 BACKGROUND AND RATIONALE
The background and the rationale to the breast feeding initiatives will be discussed below.

1.2.1 Global views on Baby Friendly Care (BFC) and feeding
The World Health Organization (WHO) and the United Nation Children’s Fund (UNICEF) are the umbrella bodies, responsible for policy development which are planned to guide all the health care institutions, rendering mother and child care services. The global strategies for child care were developed by UNICEF in 1983, which focused on breastfeeding (WHO & UNICEF 2009:39). In 1981, the World Health Assembly (WHA) adopted a 'Code of Marketing Breast milk substitutes' to control the use of artificial feeds, and to promote breastfeeding practices. In 1989, the WHO and UNICEF introduced 'The Ten Steps of Successful Breastfeeding, and integrated and

Since 1991, about 20 000 health care facilities, over a period of 15 years, in 156 countries globally, have been awarded the Baby Friendly Hospital Initiative status, by the World Health Organization and the United Nations Children’s Fund 1998. In 2002, the Global Strategy for Infant and Young Child Feeding was adopted by all the World Health Organization member states, and was revised in 2008 (National Department of Health 2013:54). Baby Friendly Hospital Initiative is still the most important strategy implemented in the health care system which provide maternal and children’s services to promote, protect and support breastfeeding since 1989 to date as revised and expanded in 2009 (WHO & UNICEF, 2009:1).

Since 1991, the World Breastfeeding Week is celebrated from the 1st to 7th of August annually, by the World Alliance for Breastfeeding Action (WABA). The World Alliance Breastfeeding Action, is a worldwide network of individuals and organizations, concerned with protecting, promoting and supporting of breastfeeding worldwide (UNICEF, 2013:26). The year 2012, was the twentieth year celebration of the World Breastfeeding Week, and the tenth year celebration of the WHO and UNICEF on the Global Strategy for Infant and Young Children Feeding. The world Breastfeeding Week is celebrated yearly with different themes to protect, promote and support breastfeeding practices for babies (UNICEF, 2013:26). The principles of the Ten Steps of Successful Breastfeeding remain the main strategy in protecting, promoting and supporting breastfeeding (NDoH, 2013:65).

The Baby Friendly Hospital Initiative was a strategy of Millennium Development Goals (MDG) for 2015; goals 3, 4 and 5, which aimed at reducing child mortality, and improving maternal health and improving health by reducing and controlling HIV and AIDS (United Nation MDG, 2015:1). The Sustainable Development Goal (SDG 3) is to ensure healthy lives and promote well-being of all ages. Child and maternal health
together with HIV and AIDS in some countries the mortality still remains high (Sustainable Development Goals 2030:1)

In South Africa, maternal, perinatal and under-5 mortality still remain high regardless of the efforts that are attempted. The ratios based on the 1998 Demographic and Health survey are as follows: Maternal mortality 300/100 000, under-5 56/1000, Infant mortality 40/1000 and Neonatal mortality 14/100 live births (Department of Health, 2012:7).

The process of accreditation is by evaluation, using an appraisal form, to assess the practices of the Ten Steps of Successful Breastfeeding. Table 1.1 presents the ten steps for successful breastfeeding, as a guide and directive for Baby Friendly Practices (NDoH, 2013:65).

Table 1.1 Ten Steps of Successful Breastfeeding (WHO & UNICEF, 2009:1)

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Guidelines exist on evidence based breastfeeding in a health care facility, Written Breastfeeding Policy</td>
</tr>
<tr>
<td>2.</td>
<td>Training of all the health care workers on evidence based breastfeeding practices</td>
</tr>
<tr>
<td>3.</td>
<td>Education and support of the pregnant and lactating women</td>
</tr>
<tr>
<td>4.</td>
<td>Initiation of breastfeeding immediately within an hour after birth</td>
</tr>
<tr>
<td>5.</td>
<td>Establishing and maintaining breastfeeding through facilitative processes</td>
</tr>
<tr>
<td>6.</td>
<td>Encouraging Exclusive breastfeeding</td>
</tr>
<tr>
<td>7.</td>
<td>Practicing rooming-in</td>
</tr>
<tr>
<td>8.</td>
<td>Unrestricted breastfeeding practices, feeding on demand</td>
</tr>
<tr>
<td>9.</td>
<td>Alternative feeding methods not interfering with breastfeeding, giving no artificial teats and pacifiers</td>
</tr>
</tbody>
</table>
1.2.2 Baby Friendly Practices in South Africa
Extra items have been added to the ‘Ten Steps of Successful Breastfeeding in the South African context, by addressing breastfeeding during illness, concerning the Human Immunodeficiency Virus (HIV) associated illnesses, Code Compliance and Mother friendly care (National Department of Health, 2013:66). The Code Compliance (Act No 54 of 1972:R991) supports the International Code of Marketing Breastmilk Substitutes which was agreed at the World Health Assembly in 1981(Department of Health & Social Development, 2014:19). South Africa supports WHO guidelines of 1989.Breastfeeding is also promoted during illness of the mother or infants, for example, premature infants are fed with expressed breastmilk and in other exceptionally difficult circumstances (NDoH 2013:26)

In the National Breastfeeding Consultative meeting, held on 22nd to 23rd of August 2011, South Africa was declared as a country which is strongly promoted, protected and supported Excusive Breastfeeding, according to the practices of the principles of Baby Friendly Care (NDoH, 2013:58). In 2013, the legislation of “South African Infant and Young Child Feeding Policy 2013” was promulgated which is in line with the global policy (NDoH, 2013:1).

1.2.3 Baby Friendly Practices at Provincial level
In Gauteng Province, presently only 10 institutions have been accredited for Baby Friendly Hospital Initiative to date (Department of Health, 2007:7). The assessment for the Baby Friendly Hospital Initiative by regions in the Gauteng Province is still in progress. The two yearly re-assessment of accredited institutions is done, to determine its sustainability of Baby Friendly Hospital Initiative status. The training of health care workers for the Baby Friendly Hospital Initiative in institutions, who render maternal, infants and child services, is still also being continued (DoH & Social Development, 2014:1).
The Minister of Health and Social Development in South Africa was concerned, about Baby Friendly Hospital Initiative as noted in circular 42 of 2011. In 2011, the Gauteng Health Department developed a Draft Implementation Plan, called the Tshwane Declaration 2011, which strongly supports the implementation of breastfeeding of babies in the health care settings (Tshwane Declaration, 2011:1). The Tshwane Declaration plan was adopted, to replace the National Policy of Infant and Young child feeding of 2007, in order to be aligned with the World Health Organization’s recommendations (National Department of Health, 2013:9).

1.2. Accreditation processes

Accreditation involves the evaluation of the principles of Baby Friendly Practices of breastfeeding practices, within each health institution (WHO & UNICEF, 2009:1). Each institution developed its own self-assessment guidelines from the WHO and UNICEF documents (WHO & UNICEF, 2009:71)

The appraisal tools and checklists are used to assess the current practices of breastfeeding, in terms of the Ten Steps of Successful Breastfeeding (WHO & UNICEF 2009:45).

The evaluation focuses on how the current Baby Friendly Care practices measures against the ten steps of successful breastfeeding (WHO & UNICEF, 2009:39). The first stage of the process is a self-assessment, carried out by the institution, using their own assessment tool. If the institution is successful with the assessment, then the global criteria are followed whereby the district and provincial are involved in the next phase of the assessment (WHO & UNICEF, 2009:71). The global criteria for accreditation that is followed, is outlined on Table 1.2.

Table 1.2 The Global criteria for accreditation for the status of Baby friendly practices. Adapted from WHO and UNICEF, (2009:7).

<table>
<thead>
<tr>
<th>No.</th>
<th>Details</th>
<th>Outcome Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Records</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding policy available and reviewed</td>
<td>• Evidence of 80% of availability of breastfeeding policy which includes compliance to The Code of Marketing Breast-milk Substitutes and compliance to the Prevention of Mother to Child Transmission according to guidelines and supporting and promoting infant feeding options chosen</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>Policy is displayed in relevant areas in the facility in different languages</td>
<td>• 80% evidence of observation indicate that the policy is displayed.</td>
<td></td>
</tr>
<tr>
<td>Knowledge of managers and staff about the policy</td>
<td>• 80% evidence of staff to be aware of the policy and implementation of the policy</td>
<td></td>
</tr>
<tr>
<td>2. Nursing staff trained in Breastfeeding Management for 20 hours. Record of trained health care staff in the institution</td>
<td>• 80% evidence of knowledge, certification of health care staff, available refresher training and the training curriculum which covers all the items included in the Hospital Self-Appraisal Tool</td>
<td></td>
</tr>
<tr>
<td>3. Mothers have knowledge and information during antenatal visits about breastfeeding</td>
<td>• Evidence of a report by 70% of the mother’s report that staff members have given them information about breastfeeding</td>
<td></td>
</tr>
<tr>
<td>4. Initiation of breastfeeding immediately after birth</td>
<td>• Evidence of 80% report of initiation of breastfeeding after birth, immediately, within five minutes of birth, within ten minutes or soon as they were able to respond after delivery</td>
<td></td>
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</tr>
<tr>
<td>5.</td>
<td>Show mothers how to maintain lactation even if they should be separated from their infants.</td>
<td>• Evidence of the report 80% of the mother’s report that they have been shown and given information breastmilk expression by hand.</td>
</tr>
<tr>
<td>6.</td>
<td>Encouraging Exclusive Breastfeeding</td>
<td>• 80% of mothers who report that that their infants were given only breastmilk since they were born, no food</td>
</tr>
<tr>
<td>7.</td>
<td>Practicing rooming-in</td>
<td>• Evidence of a report that 80% of women that roomed-in 24 hours after birth</td>
</tr>
<tr>
<td>8.</td>
<td>Unrestricted breastfeeding practices</td>
<td>• Evidence of a report of 80% of no breastfeeding schedules by mothers</td>
</tr>
<tr>
<td>9.</td>
<td>Give no artificial teats or pacifiers to breastfeeding infants</td>
<td>• Evidence of report that 80% women did not use bottles or dummies</td>
</tr>
<tr>
<td>10.</td>
<td>Support groups</td>
<td>• Evidence of report that 80% of availability and use of support groups in the community</td>
</tr>
<tr>
<td>11.</td>
<td>Global criteria:</td>
<td>• A review breastfeeding policy indicates 80% of compliance to the Code of Marketing Breastmilk Substitutes</td>
</tr>
<tr>
<td></td>
<td>Code compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mother-friendly care</td>
<td>• 70% of mother's report that they have been given information that they could have companion during antenatal visit, labour and birth and also they were encouraged to walk</td>
</tr>
</tbody>
</table>
HIV and infant feeding

- 70% of the mothers reported that they have been given information during antenatal care about HIV, that it can be transmitted to the baby during pregnancy, importance of testing and infant feeding option chosen.

1.2.5 Significance of the study

The academic tertiary hospital in study; has not managed to obtain the status Baby Friendly Initiative in spite of efforts since 1996. The researcher was interested to explore the reasons why the efforts were not successful. The study therefore explored and described the *lived experiences* of nursing staff regarding the implementation of the ten steps of successful breastfeeding and identified the strategies that may be used in order to enhance managing the processes of change for accreditation of the academic tertiary hospital in study to become a Baby Friendly. These two words, Baby Friendly Practices and Baby Friendly Care will be used interchangeably as the meaning is the same in this study.

Research of this nature can be of considerable value, in promoting Baby Friendly Care activities thus enhancing breastfeeding successful in an institution. Infants and young children can derive maximum feeding from their mothers and illnesses related to feeding problems such as malnutrition or gastro-intestinal conditions may be reduced (Pattinson & Rhoda, 2014:9). The study may help to reduce maternal mortality caused by postpartum haemorrhage. Early sucking of the infant stimulates uterine contraction thus promoting involution of the uterus and lessens the risks of postpartum haemorrhage as postpartum haemorrhage is one of the five conditions contributing to maternal deaths in South Africa (Pattinson & Rhoda, 2014:11, National Committee for Confidential Enquiry into Maternal Death, 2012:4).
Gaps in health and nursing practice may be identified and care may be improved. As such, Baby Friendly care will be successfully promoted in the institution and the institution will also be accredited Baby Friendly Initiative as is the strategy that is required by WHO and UNICEF. The study will also help to identify the practices that are contributing to failure of the staff to implement the ten steps for successful breastfeeding and changes may be implemented where possible.

1.2.6 Theories

The theories of change and managing the change processes theories were used to underpin this study for the implementation of Baby Friendly Care, in this context. The research study considers the three stages model of change, as described by Kurt Lewin (Van Vliet, 2014:1). Change is to be considered in health care facility when client’s safety is enhanced and new evidence is available (Porter-O Gray & Malloch, 2010:43).

The three stages of change theory are unfreezing, change and freezing or refreezing, as the strategy for managing change, and for the maintenance of the continuous process. The unfreezing stage is the stage where a person has to be ready to change and to understand that change is necessary. It is the stage to prepare for the desired change. Change is the stage of transition from old practices moving forward towards the expected goal. Stage two is the implementing of the desired change whereby adjustments are made to the preferred change. Freezing or refreezing refers to the permanent change that is established and maintained, thus solidifying the permanent desired change (Van Vliet, 2014:1).

Semenic, Childerhose, Lauziere and Grolean (2012:13) in their study, recommended the following factors to affect for successful change. The inter and intra organizational factors, which entails management, workers and the environment. Other factors that were recommended were maternal factors, such as previous delivery experiences, external factors, such as socio economic status and home feeding practices, such as support from the family. Semenic et al (2012) stated that hospital practices involve the
support given by knowledgeable health care workers about the Baby Friendly Hospital Initiatives to the mothers. The knowledge and attitudes of the nursing staff are very important during this change and the maternal factors involved the mother’s ability to make choices and decisions about infant feeding. Change in home feeding practices also involves the positive influences and support offered by their significant others.

Gerrish and Lacey, (2010:512) stated that special attention is required to the aspects, that may prevent successful implementation of change. The lack of staff information and skill deficit, such as insufficient knowledge regarding the current recommendations and guidelines were identified as factors that required close attention. The psychological factors involved, included the individual’s attitudes, beliefs, values and previous experience of health care workers. The organisational factors, involved the systems in practice and processes, which may create an organisational culture that is not responsible to change. The human and material resources, which are lack of tools and equipment required to facilitate change, was the another factor that was identified.

The triangulation of theories of change was applied in this study. The theoretical triangulation is the use of interpretations of information, by other people or researchers that can be applied to a given area (Burns & Grove, 2009:726). The integration of these theories of change in this study are important to the changes required in implementing the Ten Steps of Successful Breastfeeding practices (Porter-O’Gray & Malloch, 2013:50; Semenic et al, 2012:13; Gerrish& Lacey, 2010:512).

According to Semenic et al (2012:7) the researchers noted that within the hospital management practices, the lack of in-service training and the lack of implementation of guidelines and monitoring progress prevented the successful management of the change process of the Baby Friendly Hospital Initiative. They also recommended that specific objectives of the Baby Friendly Hospital Initiative, such as the breastfeeding strategies and the guidelines must be actively implemented, for successful breastfeeding to be achieved. The Baby Friendly Initiative to be gradually implemented, through a step by step process. There should be also on-going support provided for real
change to occur, by addressing the policies, staffing and training issues as well (Semenic et al, 2012:14).

In this research study, change should occur on breastfeeding practices, through the application and implementation of the ten steps of successful breastfeeding. The evidence based practice approach is supported by evidence variety of sources, for example, those institutions which have been accredited for BFHI since 1991 (WHO & UNICEF, 2009:39)

1.3 RESEARCH PROBLEM

The hospital in this research study in the Gauteng Province, is one of the hospitals without accreditation as a Baby Friendly Hospital, and was also included in the schedule for the institution, to be assessed by the Department of Health in Gauteng region. In view of the issue that there are still many health care facilities that have not been accredited as Baby Friendly Hospital, the researcher assumes that the accreditation of some of the institutions remains a serious challenge in the Gauteng Province.

The hospital in this study is a tertiary and academic health institution. It has not yet acquired the Baby Friendly Hospital status, in spite of its efforts to meet the criteria, since 1996. The maternity department is the first area, whereby any pregnant woman with her unborn baby comes into contact with the nursing staff, and this department has the responsibility to establish successful breastfeeding practices according to the local and global directives (Department of Health, 2013:65; WHO & UNICEF, 2009:9).

The research problem was developed logically from the reviewed literature and the researcher concentrated on a specific problem that was identified (Fouche & Delport, 2011:108). The underlying assumption by the researcher was that the tertiary academic Hospital has been trying to implement the ten steps for successful breastfeeding. However, it appears that certain criteria of the ten steps of breastfeeding are still not fully achieved. The researcher's assumption, is supported by the fact that the hospital in this study, receives correspondences from the Department of Health, as well as from
the Tshwane District Re-Babies Friendly committees. There is evidence that the tertiary academic hospital is actively involved in breastfeeding issues, and has been assessed for accreditation several times with little success.

The researcher was interested, to explore the reasons why the efforts were not successful, and therefore conducted this research study. The researcher’s aim was to provide full description of human experience in real life and discover the meaning of those experiences (Fouche & Delport, 2011:316). This research study, explored the lived experiences of nursing staff on Baby Friendly Practices, in order to assess the processes of change for accreditation, at the tertiary academic hospital, to achieve a Baby Friendly status in this institution.

Research of this nature can be of considerable value, in promoting Baby Friendly activities, that enhances successful breastfeeding in an institution. The result is that Infants and young children can derive the maximum feeding from their mothers, and reduce or prevent illnesses related to feeding problems, such as malnutrition or gastrointestinal conditions (WHO & UNICEF, 2009:34).

1.4 RESEARCH PURPOSE

The purpose of this study is to explore the lived experiences of the nursing staff, regarding the implementation of the ten steps of successful breastfeeding, at a tertiary, academic hospital, in transition to becoming a baby friendly care institution, in the Gauteng province.

1.5 RESEARCH OBJECTIVES

The objectives of the study were to:

- Explore and describe the lived experiences of the nursing staff, regarding the implementation of the Ten Steps of Successful Breastfeeding for a successful Baby Friendly Care, in a tertiary, academic hospital in the Gauteng Province.
- Identify strategies required for the successful implementation of the Ten Steps of Successful Breastfeeding, for the achievement of a successful Baby Friendly Care hospital status.
1.6 RESEARCH QUESTIONS

The following research questions were asked:

- What are the lived experiences of the nursing staff, in a maternity department at Tertiary, Academic Hospital, regarding implementing the Ten Steps of Successful Breastfeeding, for the achievement of a successful Baby Friendly Care hospital status?
- What are the strategies required for the successful implementation of the Ten Steps of Successful Breastfeeding, for the achievement of a successful Baby Friendly Care hospital status?

1.7 OPERATIONAL DEFINITIONS

1.7.1 Accreditation Process

The accreditation process of achieving a baby friendly hospital status is the system that has been developed to assess if the ten steps of successful breastfeeding is implemented according to an established criterion. Any health facility that is interested in becoming accredited as a Baby Friendly Hospital by WHO and UNICEF’s criteria, should first appraise itself (WHO & UNICEF, 2009:1).

The institution in study is rendering maternal, infant and young children’s services and is not yet accredited for Baby Friendly. In this study the researcher assumes that baby friendly accreditation process is still in progress. The institution is has not been accredited for baby friendly in spite of efforts since 1996 in which the first group of nursing staff trained for BFHI and Baby Friendly training and other activities are still continuing.

1.7.2 Baby
A baby refers to a person from birth to 18 months of age (DoH, 2013:69)
In this study it refers to a baby as well as a child from birth to the age of 5 years.
1.7.3 Baby Friendly
Baby Friendly is defined internationally, as can be used by health care facilities that successfully passed the external assessment, according to the Global criteria of WHO/UNICEF of 1992, namely the ten steps of successful breastfeeding (DOH & Social Development, 2014:55).

1.7.4 Baby Friendly Hospital Initiative
A Baby Friendly Hospital Initiative (BFHI), is a strategy which ensures that the maternity health care facilities, become centres for breastfeeding support, by implementing the ten steps of successful breastfeeding; giving benefits to the mothers, babies and health care facilities (WHO & UNICEF, 2009: 39). In this study, it refers to the ability, to provide total quality care through feeding to both the pregnant women, delivered women, infant and young children.

1.7.5 Baby Friendly Practices
Baby Friendly Practices is the rendering of health care services, by implementing the ten steps of successful breastfeeding, by adhering to the principles of the Code compliance and by encouraging adequate feeding, for those babies who are not breastfed (Department of Health & Social Development, 2014:55). These two words, Baby Friendly Practices and Baby Friendly Care, will be used interchangeably, as the meaning is the same in this study. In this study, Baby Friendly Practices refers to the implementation of the strategies of the Baby Friendly Hospital Initiative.

1.7.6 Breastfeeding
Breastfeeding is the natural and normal practice for infants and young children’s’ feeding, on the milk from the mother’s human mammary gland, the breast (WHO & UNICEF, 2009:39). In this study, in order to be a Baby Friendly Hospital, the breastfeeding of new-born babies has to be commenced immediately after the infant is born, if the both the mother and baby’s conditions are satisfactory.
1.7.7 Maternity units
Maternity units refer to hospital wards that are rendering health care services to pregnant women, delivering women and their babies, and also delivered women and their babies (Farlex.Incl, 2012:1).
In this institution, the maternity units in this study are the antenatal care clinic, antenatal care unit, labour unit and the postnatal units.

1.7.8 Mixed feeding
Mixed feeding refers to feeding with breastmilk as well as other milks like formula, other liquids and solid foods (DoH, 2013:70).
In the study Mixed Feeding refers to feeding with breast milk, as well as with other substitutes, such as milk, namely commercial formula, other liquids, such as water and also solid foods such as cereals to the infants and children.

1.7.9 Nursing staff
Nursing staff are the health care personnel, who have scientific knowledge and skills, who provide health care services in terms of Nursing Act, 33 of 2005. There are three categories of nursing staff available, namely, professional nurse and midwife, enrolled nurse and auxiliary nurse (R786,2005 Section 31(1)(a) (c) (d)).
In this study, the nursing staff involved is the three categories, professional nurse midwives, enrolled nurses and auxiliary nurses.

1.8 RESEARCH METHODOLOGY
The researcher selected the research method that appeared to yield the intended results. The research design, population and the sampling will be described below. This study used qualitative research which is explorative and descriptive in nature. There are four fundamental elements which are taken into consideration when utilizing qualitative research, namely, the logic and reasoning involved, the type of methodology or design which is chosen, the entry and access of the researcher to the research setting and the practical considerations of the researcher when planning the study in which she or he should consider the availability of resources needed, for example, funding. These
1.8.1 Research design

The research design is the end result of a series of decisions, made by the researcher concerning the implementation of the study. The series of decisions assisted the researcher, to answer the research questions and to follow through with the research process. The research design, guides the researcher in planning and implementing the study, to achieve its intended goals (Burns & Grove, 2009:218).

This study used a qualitative research approach, with a paradigm that was explorative and descriptive in nature. Qualitative research is defined by Burns and Grove (2009:22), as a systematic, interactive and subjective approach, in which the focus is to describe life experiences of participants towards breastfeeding, and to give meaning to these expressions. The research methodology is discussed in detail, in Chapter two of the study.

1.8.1.1 Setting

The tertiary academic hospital, in this research study is located in the Gauteng Province, to the North West of Pretoria, and it is the second largest hospital in South Africa. This hospital, is a public, referral, tertiary, academic institution. It is a referral hospital for the midwifery and obstetric units, for the local clinics and for the level one and level two hospitals within the geographical area. It comprises of thirteen departments. The department involved in this study is the Maternity units. The following units were included from the maternity corridor, namely, the antenatal care clinic, one antenatal unit, labour ward and two postnatal units. The hospital in this research study, offers health care services twenty-four hours a day, seven days a week. There is a total of 132 nursing staff during the day, and 58 during the night managing these maternity units.
The total number of beds in the maternity wards are 137. The statistics over a 3-month period from July to September 2014 in labour unit comprises of 2548 patients admitted and 2310 deliveries.

Below, is a table of the maternity patients, who have attended this hospital in the study from the period from July to September of 2014.

Table 1.3 The monthly labour ward statistics of the maternity patients per month from July- September 2014.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients</th>
<th>Number of deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>825</td>
<td>772</td>
</tr>
<tr>
<td>August</td>
<td>882</td>
<td>762</td>
</tr>
<tr>
<td>September</td>
<td>841</td>
<td>776</td>
</tr>
<tr>
<td>Total</td>
<td>2548</td>
<td>2310</td>
</tr>
</tbody>
</table>

1.8.2.2 Population

The total population of the nurses were 192 in number. The population in this study were the nursing staff worked in the maternity department, namely the nurse managers, the registered nurse-midwives', and the enrolled nurses and the nursing auxiliaries. The target population were the nursing staff, who worked in the maternity department from June 2013 to June 2014.

1.8.2.3 Sampling

Sampling is defined as a procedure of selecting the participants of the target population. In this study, the participants will compose of the elements, which contain the most characteristics and attributes of the whole sample (Strydom, 2011:231). Burns and Grove (2009:35) stated that sampling is a process of selecting participants to represent the entire population.

Purposive sampling was used on all the categories of nursing staff worked in the maternity department. Purposive sampling involves a conscious selection, by the
researcher of certain participants (Burns & Grove, 2009:716). In this study, the nursing staff of the maternity department was selected. The participants were categorised according to the pre-selected criteria of registered nurse midwives (RN/M), enrolled nurses (E/N), nurse auxiliaries (N/A) and nurse managers (N/M) (R786, 2005 Section 31(1) (a) (c) (d)).

A sample size of fifteen (15) participants was selected as follows: thirteen (13) participants were from different categories of the nursing staff and two were from the nurse manager category. If data saturation was not reached, the intention of the researcher was to increase the sample size. Saturation refers to the situation, where no new additional information has been provided by the participants (Burns & Grove, 2009:721). Saturation was reached by seven participants from the above mentioned categories of the nursing staff.

Table 1.4(a) The proposed sample of the nursing staff N = 15

<table>
<thead>
<tr>
<th>Units</th>
<th>R/N/M</th>
<th>E/N</th>
<th>N/A</th>
<th>N/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC Clinic &amp; Unit</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Labour Unit</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Postnatal Units</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Manager Office</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 1.4 (b) The actual sample of the nursing staff N = 07

<table>
<thead>
<tr>
<th>Units</th>
<th>R/N/M</th>
<th>E/N</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC Clinic and unit</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Labour unit</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Postnatal units</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

1.8.2.4 Sampling criteria
Sampling criteria is defined by Burns and Grove (2009:721), as the required characteristics of the participants, in the target population. The sampling criteria consist of the inclusion and exclusion criteria.

1.8.2.4.1 Inclusion criteria
The inclusion criteria for the nursing staff were as follows: Those who volunteered to participate in the study gave written consent. All the permanent nursing staff, who was working in the maternity department from June 2013 to July 2014, was included. A selection criterion was conducted through the inspection of roster books.

1.8.2.4.2 Exclusion criteria
The participants who were not able to meet the requirement of the study were not included in this research study.

The following additional pre-selection inclusion criteria data was collected, to determine the knowledge and understanding about the phenomenon in study.

- Work experience in maternity department, as it assisted to determine the previous practices of breastfeeding versus current practices.
- Whether trained in a Baby Friendly Hospital Initiative, as it is a requirement for the nursing staff to work in the maternity units.
- Personal breastfeeding experience was of importance, as it assisted in understanding the nurse’s breastfeeding experience, from their own point of view versus the current practices.
- Category of the nursing staff participating in the study.

1.9 Testing the interview guide
Testing of the interview guide was conducted on two participants. The participants were selected from the same population, but did not participate in the main study. The
questions were similar to the interview guide and the duration for the interview was 40 minutes. Testing the interview guide was conducted, to provide a trial run before embarking on the actual study. Changes on the guide were to be done where necessary, and there were no changes that were needed to be made (Creswell & Clark, 2011:187).

1.10 DATA COLLECTION

Semi-structured, face to face, one-to-one interview were done, English language was used for data collection. Refer to Annexure 1 for the interview guide. The data collection will be discussed in Chapter 2.

Polit and Beck (2008:384) stated that researchers using qualitative methods of data collection enter the field or setting knowing the sources of data, that is, participants are purposively chosen who can provide more information, about the phenomenon in the study.

Qualitative data was collected using semi-structured questions through the face-to-face voice recorded interviews so that the information was accurately captured. The audio recorded interviews were listened to, and checked for completeness, after each interview. The audio recorded tapes were labelled using unique code numbers, and were kept safely. Questions were asked within the frame of the ten steps of successful breastfeeding, and the change theories of Lewin (Van Vliet, 2014:1, Porter-O’Gray Malloc 2013:4).

Field notes were used to collect notes on the observations made during the interviews and was also done during the visitation by the researcher in the units after the interviews. Field notes provided the researcher with raw data (De Vos, Strydom, Fouche & Delport, 2011:406). The interviews were conducted by asking questions, to meet the research objectives. Paraphrasing; reflection and the use of silence were used during the interviews, in order to gather meaningful data.
The data was collected for a period of six months, from September 2013 to March 2014 (Greeff, 2011:343; Holloway & Wheeler, 2010:96, Polit & Beck, 2008:519). There were problems encountered during data collection and prolonged to this period of six months. After three months of data collection, the researcher observed that use of roster book as discussed in Chapter 2 on 2.7 Sampling did not materialising due to activities in the units which were to be done by participants strictly, then the researcher requested nursing staff who have volunteered to participate, present in the units and not strictly occupied on the day of data collection to be interviewed.

The interviews were scheduled for three days a week, and there was approximately forty minutes allocated for each participant. Only two nursing staff was interviewed per day, because verbatim transcription of the voice recoded data was done after collection, as well as member checking thereafter. The interviews were done in a special room within the maternity units, in a room that was not used frequently, with the sign “No DISTURBANCE” on the door.

1.11 DATA ANALYSIS

Verbatim transcriptions of the audio-taped interviews were done. The raw data, the audio tapes of the qualitative interviews were collected, and were converted and saved on to the computer into separate files, that is, the hand written data from the researcher was typed word by word, and also the transcriptions from the tapes was filed accordingly. The transcriptions were then discussed with the members, to make sure that they agreed on what they meant to say. This occurred for several times until the data was considered correct. The data collected was then analysed.

Data analysis, in this study was done concurrently with data collection. The transcripts from the interviews were transcribed verbatim, and analysed according to themes, categories and subcategories, using Tesch’s techniques (Creswell, 2009:125). Data analysis will be discussed in detail in Chapter 2.

1.12 TRUSTWORTHINESS
As this study was qualitative in nature, trustworthiness was the quality measure that was applied. The quality enhancement strategies used were, credibility, dependability and authenticity (Polit & Beck, 2008:239) more details are described in chapter 2. The trustworthiness of the data was determined in this study to ensure that the data was accurately collected and analysed (Holloway & Wheeler, 2010:96). Trustworthiness is discussed in more detail in Chapter 2.

1.13 BIAS

Creswell (2007:157) states that to prevent bias to occur, researchers should refrain from judgement and preconceptions about the nature of the experience in the study. The researcher was the interviewer, who went in without any knowledge about the phenomenon in study. The language used to collect data was English. Bias, is defined by Burns & Grove (2009:689) as any influence which can interfere with the findings of the study, which can change the direction of the study.

There are two unavoidable biases in this study, namely, the volunteered participants and the method of instrumentation, that is, the observation. The researcher has tried to minimize the biases, by adhering to the aims and objectives consistently throughout the study. The other strategies to minimize bias will be discussed in the research methodology in Chapter 2.

1.14 ETHICAL CONSIDERATIONS

In order, that the study complied with ethical standards, the research proposal was reviewed and approved by the Medunsa Research Committee (MREC) of the University of Limpopo (Medunsa campus), which is now Sefako Makgatho Health Sciences University, permission was requested and granted by the Chief Executive Officer of Academic Tertiary Hospital in study (Annexures 4, 5 & 6).

The researcher has adhered to the professional code of conduct, and was guided by the principles of ethics, which considered the right of the participants, as self-determination, privacy, protection from harm and discomfort, anonymity, confidentiality and informed
consent. The ethical considerations were adhered to by the researcher throughout the study. The above-named ethical considerations were described in detail in Chapter 2.

1.15 LAYOUT OF THE CHAPTERS

Chapter One: Background and rationale of the study  
Chapter Two: Research Methodology  
Chapter Three: Data analysis and Literature control  
Chapter Four: Discussion of the findings  
Chapter Five: Summary, recommendations and conclusion

1.16 CONCLUSION

In Chapter 1, the introduction, and the background, the purpose, the objectives, and the research questions were discussed. The framework of the study, data collection, data analysis with trustworthiness, and the ethical considerations were also described in Chapter 2 which focused on the research methodology.
CHAPTER 2

RESEARCH METHODOLOGY

2.1 Introduction

The study used a qualitative research approach, which was explorative and descriptive in nature. The researcher used the focus for understanding qualitative research approach, as it is concerned with the understanding the meaning of the social interaction of individuals and their environment (Polit & Beck 2008:15).

2.2 The objectives of this study were to:

- Explore and describe the lived experiences of nursing staff regarding implementation of the ten steps of successful breastfeeding
- Identify strategies required for successful implementation of the Ten Steps of Successful Breastfeeding, for the achievement of a successful bBy Friendly are hospital status

2.3 Research design

Research design is the end result of a series of decisions, made by the researcher as and to how to implement the research study. The research design assists the researcher to answer the research question in this study and also guides the researcher in planning and implementing the study, to achieve the intended goals (Burns & Grove, 2009:218).

2.3.1 Qualitative research
Qualitative research is described by Burns and Grove (2009:23) as a systematic and interactive approach, which is used to describe the lived experiences of a specific phenomenon. The focus is broad, holistic and subjective. It is holistic and has the intention to give meaning to the whole, and is determined by the experiences expressed by the participants to the phenomenon being studied.

The researcher wished to explore describe the lived experiences of the nursing staff regarding implementation of the Ten Steps of successful Breastfeeding and to identify strategies required for the successful implementation of the Ten steps for Successful Breastfeeding, for achievement of a successful Baby Friendly Care hospital status.

2.2.3 Explorative and Descriptive studies

➢ Explorative study

According to Polit and Beck (2008:20) an exploratory design is an investigation of a phenomenon and the factors related to it. An explorative study answers the question what. It is used to investigate a phenomenon in-depth to gain more insight into the phenomenon, being studied. The aim of the exploration is to be more conversant with the basic facts and to create a general picture of the phenomenon being studied (Polit & Beck 2008:20).

In this study, an exploratory approach enabled the researcher to gain more insight into the lived experiences of the nursing staff, regarding the implementation of the Ten Steps of Successful Breastfeeding for successful Baby Friendly Care. In exploring the researcher is looking closely into the phenomenon to try to discover the real meaning of it. The researcher used interviews to gather information.

An exploratory design is undertaken when little information is known about the phenomenon at hand. Exploratory studies help to increase the knowledge in the field of study (Burns & Grove, 2009:359).

➢ Descriptive study
Creswell (2007:157) states that in a descriptive study, the aim is to describe the human experience, as is experienced by the participants and to allow the phenomenon to emerge fully. According to Burns and Grove (2009:25) descriptive studies helps the researcher to describe what exists and to discover new meanings.

Descriptive design is design that seeks to accurately portray peoples’ circumstances or characteristics in real life situations (Burns & Grove, 2009:697, Polit & Beck, 2012:725). In this study, the descriptive design was used to describe the participants’ lived experiences regarding the implementation of the Ten Steps of Successful Breastfeeding for successful Baby Friendly Care. The researcher’s interest was to provide a description of human experiences on what was seen heard and expressed (De Vos, Strydom, Fouche & Delport 2011:406). Hence, the use of non-verbal communication was also considered. The aim was to know more about the nursing staff’s lived experiences and meanings that they attribute to their experiences of breastfeeding in the maternity units.

2.3 Setting

Polit and Beck (2008:766) described the setting as a physical location and environment in which the data collection takes place.

The setting in this study is a tertiary, academic hospital located in Gauteng; North West of Pretoria, in South Africa. It is the second largest hospital in South Africa. This tertiary, academic hospital is a referral and academic institution. It is a referral hospital which receives patients from the midwife obstetric units, local clinics and level one and two hospitals in Gauteng. The majority of the patients served in the hospital are Black patients from the semi-rural to rural communities. The hospital comprises of six departments; namely: surgery, orthopaedic, paediatric, maternity, medical and psychiatry. The department where the data was collected in this research study was the Maternity department which included; the Antenatal care clinic, one Antenatal, labour and two postnatal units. The Labour unit monthly statistics cases and deliveries for a period of three months outlined in Table 2.1.
Table 2.1 The Maternity patients per month from July- September 2014 from labour ward monthly statistics.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients</th>
<th>Number of deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>825</td>
<td>772</td>
</tr>
<tr>
<td>August</td>
<td>882</td>
<td>762</td>
</tr>
<tr>
<td>September</td>
<td>841</td>
<td>776</td>
</tr>
<tr>
<td>Total</td>
<td>2548</td>
<td>2310</td>
</tr>
</tbody>
</table>

The Ante natal care and post-natal units have forty beds, and the labour unit has eighteen delivery beds, and renders twenty-four hour services for seven days a week. The Ante natal care clinic renders service for about 80 to 180 clients per day, from seven in the morning to four in the afternoon, from Monday to Friday.

2.4. Population

The population is defined as the elements or individuals who meet the inclusion criteria and are representative of the sample (Burns & Grove, 2009:714). The population of concern in this study are all the nursing staff who are working in the maternity department, namely, the nurse managers, the registered nurse-midwives’, and the enrolled nurses and the nursing auxiliaries.

Holloway and Wheeler (2010:137) described the accessible population as the target population who have the particular experience and knowledge required about the phenomenon that is being explored. Burns and Grove (2009:687) defined the accessible population as a part of the target population which has the ability to be part of the sample. In this study, the target population was of the nursing staff who work permanently in the maternity department and who had rich information about the phenomenon being studied.

2.5. Sampling
Sampling is defined by Burns and Grove (2009:721) as a process to select a representative number of people for the study. Strydom (2011:231) refers to sampling as a procedure to select a part of the population in a study, which composed of the most characteristics and attributes of the whole sample. The sample in this study was members who were selected from the maternity units nursing staff, who was working permanently and who had agreed to participate in this study. The researcher used the roster or the off duty books for the sampling.

The researcher selected the sampling method that would yield the intended results. In this study, the researcher used purposive sampling. Purposive sampling is defined by Burns and Grove (2009:716) as a judgemental or selective sampling. It is judgemental as the sample relies on the researcher’s judgement (Strydom, 2011:232). The judgement involves a conscious selection of the participants by the researcher.

The participants were categorized according to the pre-selected criteria by including three registered nurse midwives, two enrolled nurses and two nursing auxiliaries. At the time of recruiting the participants, the right of self-determination, confidentiality, anonymity and prevention from harm and discomfort were emphasized as discussed in Section 2.8.

In this study, the nurses from the categories of permanent nursing staff, namely, three registered nurse midwives, two enrolled nurses and two nursing auxiliaries, working at each unit of the maternity department from June 2013 to July 2014 were selected. A selection criterion was done through the use roster or duty books, as follows:

- Every first Registered Nurse Midwife (RNM) who was on duty on the selected day.
- Every first Enrolled Nurse (EN) who was on duty on the selected day.
- Every first Nursing Auxiliary (NA) who was on duty on the selected day.
- One of the Nursing Manager (NM) who was on duty on the selected day.

The sample size was also determined by the purpose of the study (Burns & Grove, 2009:361; Strydom, 2011:223). The intended sample size was 15 members of the nursing staff. Data saturation was reached by the end of the seventh participant, hence data collection was stopped. The saturation of data is defined by Burns and Grove
(2009:361), as when no new additional information is received from the participants. When saturation has been reached, then data collection was discontinued. Table 2.2 below illustrate the sample size.

Table 2.2 The Sample size of N = 7

<table>
<thead>
<tr>
<th>Units</th>
<th>R/N/M</th>
<th>E/N</th>
<th>N/A</th>
<th>N/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC Clinic &amp; Unit</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Labour Unit</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Postnatal Unit</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Manager’s Office</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>2</strong></td>
<td><strong>2</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

2.5.2 Sampling criteria

Sampling criteria is defined by Burns and Grove (2009:344) as the required characteristics of the target population. Sampling criteria includes the inclusion and exclusion criteria which are developed from the requirements of the sample and the research study (Burns & Grove, 2009:344).

- **Inclusion criteria**

Inclusion criteria include those members who portray most of the characteristics required in the study (Burns & Grove, 2009:345). The following were the inclusion criteria, all the nursing staff had to have been working in maternity department from June 2013 to June 2014. Participants had to be permanent nursing staff of the nursing manager, registered nurse midwife, and enrolled nurse and enrolled nursing auxiliary and who gave consent to participate in the study.

- **Exclusion criteria**

The exclusion criteria refer to the participants who will not fulfil the criteria and therefore will be excluded from the research study (Burns & Grove, 2009:345). All the part time nursing staff, nursing staff employed after June 2014, the different categories of nurses who were on training, for example, the post basic nursing students and those who did not volunteer to participate will be excluded from the study, if they fitted any of the above criteria.
2.6 Testing the interview guide

Testing the interview guide before the data collection process, determines the accuracy of the methods and procedures that will be utilized before the main investigation (Delport & Roestenburg, 2011:195). The same instrument utilized in the interview guide was the one used to gather data in the study. Two participants were selected to be part of testing the interview guide; one participant was from the ante natal care unit and the other one from postnatal care unit.

The participants and the unit selected for the pre-testing were not included in the main study. The results recorded showed that no changes were needed to be made on the interview protocol.

2.7 Data collection

The researcher used the triangulation of data collection methods to collect data from multiple sources. The researcher used face to face individual interviews, which were semi-structured and conducted with the participants in each unit, comprising of a Nursing Manager, Registered Midwives, Enrolled Nurses and Nursing Auxiliaries.

The interviews with the participants were voice recorded; so that the information could be captured accurately. The interviews were done using the interview guide. An interview guide was prepared as a guide to engage participants during the interview (Greeff, 2011:296).

Interviews were conducted by asking probing questions to meet the research objectives. Paraphrasing; reflection and use of silence were applied. The interviews that were voice recorded were transcribed verbatim by the researcher. Transcribing is the verbatim writing of data from the listened voice recorder soon after collection (Holloway & Wheeler, 2010:283).

The data was collected for a period of six months. Collection of data was prolonged as the use of roster book as planned changed after three months due to specific unit’s activities that was to be done by participants for that day, for example, first registered nurse midwife on the selected day attending urgent meeting
Interviews

The interviews were carried out by the researcher, who is a registered nurse and midwife with a post-basic qualification in advanced midwifery, and who was working in the antenatal care clinic at the tertiary academic hospital, at the time of the study. The researcher bracketed her own biases, views and experiences to enhance credibility.

The types of questions asked explored and described the experiences of the participants. Seven participants were individually interviewed privately in a quiet room. Each interview lasted for about 40 minutes.

2.8 DATA ANALYSIS

THEME: Failure of the institution to be accredited for Baby Friendly Hospital Initiative in spite of the efforts that are taken. Data was collected on seven participants

Data analysis is a process conducted to reduce, organize and give meaning to data through coding (Burns & Grove, 2009:733). Polit and Beck (2008:751) defines data analysis as the systemic organization and synthesis of research data. In data analysis, verbatim transcriptions of the audio-taped interviews were done using Tesch’s eight steps of analysing data (Creswell, 2009:125). Tesch’s eight steps of analysing data have helped the researcher to meet research objective number two (Creswell, 2009:125). The following illustrates the Tesch’s eight steps for data analysis:

- Reading through the data to obtain general sense of information and reflect on its overall meaning, checking all general ideas, and impression of the overall depth and credibility of information verbalized by participants.
- Picking one document at a time and going through it; and writing thoughts as they emerge. Identifying categories as they emerged from the data in order to answer the research question. Sentences and paragraphs were highlighted and coded according to the meaning displayed.
- Topics were clustered together and organized according into major and smaller meaningful topics.
A coding scheme was created utilizing the themes and categories that has been identified. Qualitative data analysis was used. Specific sections in all transcripts that represented themes, categories and subcategories were highlighted in different colours and coded.

Finding the most suitable descriptive wording for the clustered topics and transforming them into themes.

Assembling data material belonging to each category in one place and performing a preliminary analysis.

Quotes were selected that best illustrates the meaning of each category and subcategory.

Making the final decision on the coded data (Creswell, 2009:125 & 186).

2.9. Trustworthiness.

The researcher used the effective strategies to measure the quality of trustworthiness. These strategies are discussed by Polit and Beck (2008:539-540) as credibility, dependability, conformability, transferability and authenticity. The strategies were applied throughout the study to avoid bias. The strategies were appropriate and sufficient.

Credibility

Polit and Beck (2008:539) describes credibility as the confidence of the truth and the interpretation of the data. The researcher used triangulation, by using multiple sources of data. The field notes were written in a note book immediately and during data collection. The recorded interviews were played and replayed immediately after the interview and transcribed. The researcher went back to the participants to verify and check if the researcher had documented the actual expressions of the participants by member checking. The researcher bracketed her own biases, views, beliefs, opinions and experiences about the phenomenon in study as she worked in the same environment.

Bracketing is holding back what the researcher knows and her experiences with the phenomenon in study, whilst conducting the interviews (Polit & Beck, 2008:228). The
researcher bracketed own bias. Leading and interrogative questions were not asked. The researcher purposively selected the participants that were familiar with the phenomenon. Prolonged involvement and engagement of the researcher in the field for six months, with persistent observations enhanced credibility (Annexure 2). Prolonged period of data collection also provided the study’s credibility.

- **Dependability**

  Polit and Beck (2008:539) stated that dependability refers to the stability of the data overtime. Dependability is used to check if the findings of the study would be similar, if the study was to be replicated with similar participants, in a similar setting (Polit & Beck, 2012:585). An audit trail, on how the data was collected and how the categories and decisions were done was recorded. The researcher involved the supervisors with research findings to ensure dependability of the study. Both the supervisors have doctoral degrees, and one supervisor is an advanced midwife. The independent coder was also involved in data analysis, which ensured that an audit trail of documents was used during the data coding process.

- **Confirmability**

  Confirmability refers to the congruence between two or more people about the accuracy of the data, as well as for relevancy of meanings (Polit & Beck, 2008:359). The researcher used the coding of the data to improve confirmability. The research proposal, the field notes and the transcripts were given to an independent coder for data analysis, to reach consensus of the data analysis. The independent coder and the researcher discussed the coded data to achieve consensus (Annexure 7). The supervisors were also involved in the data analysis process to confirm the themes, the categories and the subcategories that were formulated.

- **Transferability**

  Transferability refers to the extent to which the findings can be applied in other settings or groups (Polit & Beck, 2008:359). Transferability was enhanced by
collecting data to provide a thick description of rich data, and by examining the methodology clearly. The purposive sampling method ensured that all the nurses complied with the inclusion criteria, and were allowed to participate in the study and gave a dense description of their experiences regarding the implementation of the breastfeeding to enable the reader to apply the findings in other settings.

The description of the data has been provided in the research report for evaluation and applicability in other situations with a similar setting.

- **Authenticity**
  
  Authenticity refers to the extent to which the researcher fairly and faithfully shows the range of different realities (Polit & Beck, 2008:340). The researcher listened to the voice recorded information several times, read the verbatim transcription of interviews and re-read to gain and to familiarise herself with the data. Field notes were written during the analysis of data (Holloway & Wheeler, 2010:337).

2.10 Ethical consideration

The researcher has adhered to the professional code of conduct and was guided always by the principles of ethics. The following ethical considerations such as permission to conduct the study, confidentiality, protection from harm and discomfort, anonymity, consent and privacy were adhered to throughout the study. Discussion of the ethical considerations was as follows:

- **Permission to conduct the study**
  
  The researcher has received approval from University of Limpopo, now Sefako Makgatho Health Sciences University to conduct the study (Annexure 5). Permission was also being granted from the Superintendent of the tertiary academic Hospital (Annexure 6) to collect data in the setting.

- **Confidentiality**
  
  Confidentiality is defined by Burns and Grove (2009:693) as the management of the data of participants by keeping it anonymously, so that no links can be made. The private information is not shared with other people without permission by the
participant. The personal data of the participant received remained between the researcher, the participants and the supervisors. All the data from the transcribed interview, the recorded interview, and the field notes of the participants were kept confidentially and safely.

- **Protection from harm and discomfort**
  The participants were protected from harm and only the interviews were only conducted with the participants by the researcher. No insulting words or vulgar words were used. Informed written consent was obtained from all the participants (Annexure 4).

- **Anonymity**
  Anonymity was considered for the assurance and comfort of participants. De Vos et al (2011:120) describe anonymity as the inability to identify any participants after the study, who had divulged specific information. The target group was informed that no names, no addresses nor contact numbers were to be written in the study. (Burns & Grove, 2009:218). The written consent was kept safe in a secure cupboard.

- **Consent**
  Written informed consent was obtained from all the participants in the study (Annexure 4). The consent form was signed by all the participants and witnessed by the researcher. The information sheet was written and discussed in English in simple terms. (Strydom, 2011:117). The participants were informed that their participation was voluntarily, and that they could withdraw from the study at any time they wish to do so.

- **Privacy**
  Privacy is defined by Burns and Grove (2009:715) as the ethical principle of freedom within a private environment whereby private information cannot be shared with others, except the assigned persons only. The environment where the conversation is taking place is protected from accessibility by other people. A quiet room in the same unit where the participants were working was selected, with the assistance of the unit
manager for the interviews. The door of the interview room remained closed until the end of the interview. A notice was placed on the door with a sign of “NO DISTURBANCE”.

2.11 Conclusion

In this chapter the researcher discussed the steps of methodology and the research processes involved in conducting this research study. The sampling and the sampling criteria were described. The data collection, data analysis, trustworthiness and ethical issues involved in this study were explained. The data analysis and the literature control will be discussed in the next chapter.

CHAPTER 3

FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION.

This chapter will focus on the findings of the analysed data with supported literature. Data was collected through face to face interviews with semi structured questions and the interviews were voice recorded. Field notes were also written. Data analysis was done through coding. Data was interpreted by sorting; organizing and breaking into
smaller manageable pieces (Schurink, Fouche & De Vos, 2011:399). The purpose of the study, research objectives and questions were considered.

3.2 RESEARCH QUESTIONS

The following research questions were asked:

- What are the lived experiences of the nursing staff in a maternity department, at a tertiary academic institution in Gauteng, on implementing the ten steps of successful Baby Friendly Care Practices?
- What are the required strategies for managing the change processes, for the successful implementation of the ten steps of successful breastfeeding, in a tertiary academic institution in Gauteng?

3.3 FINDINGS AND LITERATURE CONTROL

Data was analysed through coding. Coding is the breaking of data into smaller units which discriminate changes in meaning given by the participants (Gerrish and Lacey, 2010:185). Creswell (2009:186) defines coding as a process of organising the material into chunks or segments of text before bringing meaning to information. The researcher and the independent co-coder independently coded the transcripts using Tesch’s descriptive method (Creswell, 2009:186) by identifying themes, categories and subcategories and reached consensus.

3.4 DESCRIPTION OF THEMES, CATEGORIES AND SUBCATEGORIES

Table 3.4 represents a tabulated form of the themes, the categories and the subcategories, which emerged during the data analysis and the coding processes. The description of the analysed data is associated with the participants’ quotes, and is supported with relevant literature. Below is a description of the analysed data.

**TABLE 3.4 Description of the themes, categories and sub-categories**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUBCATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1</td>
<td>3.4.1</td>
<td>Establishment and maintenance of Baby Friendly Practices by nursing staff</td>
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<tr>
<td>---------</td>
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<tr>
<td></td>
<td>3.4.1.1</td>
<td>Initiation of breastfeeding</td>
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<td></td>
<td>3.4.1.1.2</td>
<td>Skin to skin to promote bonding</td>
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<td></td>
<td>3.4.1.1.3</td>
<td>Demand feeding of babies</td>
</tr>
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<td></td>
<td>3.4.1.1.4</td>
<td>Rooming-in to enhance breastfeeding</td>
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<td></td>
<td>3.4.1.1.5</td>
<td>Exclusive Breastfeeding</td>
</tr>
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<td></td>
<td>3.4.1.1.6</td>
<td>Options of Infant feeding method.</td>
</tr>
<tr>
<td></td>
<td>3.4.1.1.7</td>
<td>Mixed feeding and use of pacifiers by mothers on their babies</td>
</tr>
<tr>
<td></td>
<td>3.4.1.1.8</td>
<td>AFASS criteria</td>
</tr>
<tr>
<td></td>
<td>3.4.1.1.9</td>
<td>Expressed breast-milk</td>
</tr>
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<td>3.4.1.1.10</td>
<td>PMTCT and Breastfeeding</td>
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<tr>
<td></td>
<td>3.4.1.1.11</td>
<td>Latching and attachment</td>
</tr>
<tr>
<td></td>
<td>3.4.1.1.12</td>
<td></td>
</tr>
<tr>
<td>Theme 2</td>
<td>3.4.2</td>
<td>The provision of education on Baby Friendly Health Care</td>
</tr>
<tr>
<td>---------</td>
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<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>3.4.2.1</td>
<td>Health education on Baby Friendly Care is given to nursing staff</td>
</tr>
<tr>
<td></td>
<td>3.4.2.2</td>
<td>Delivered and pregnant women are given health education</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.4.2.2.1</td>
<td>Community communication</td>
</tr>
<tr>
<td></td>
<td>3.4.2.2.2</td>
<td>Breastfeeding awareness</td>
</tr>
<tr>
<td>Theme 3</td>
<td>3.4.3</td>
<td>The role of management in Baby Friendly Health Care</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>--------------------------------------------------</td>
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<tr>
<td></td>
<td>3.4.3.1</td>
<td>Support and promotion of Baby Friendly Practices by Management</td>
</tr>
<tr>
<td></td>
<td>3.4.3.2</td>
<td>Ensure availability of Breastfeeding Policy</td>
</tr>
<tr>
<td></td>
<td>3.4.3.1.1</td>
<td>Facilitates Breastfeeding Training</td>
</tr>
<tr>
<td></td>
<td>3.4.3.1.2</td>
<td>Provision of transport for staff</td>
</tr>
<tr>
<td></td>
<td>3.4.3.1.3</td>
<td>Baby Friendly activities</td>
</tr>
<tr>
<td></td>
<td>3.4.3.1.4</td>
<td>Communicate available invitations</td>
</tr>
<tr>
<td></td>
<td>3.4.3.2.1</td>
<td>Breastfeeding Policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 4</th>
<th>3.4.4</th>
<th>Factors hindering successful Baby Friendly Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.4.4.1</td>
<td>Poor attendance of Baby Friendly Training</td>
</tr>
<tr>
<td></td>
<td>3.4.4.1.1</td>
<td>Failure to train all Heath Care Workers.</td>
</tr>
<tr>
<td></td>
<td>3.4.4.1.2</td>
<td>Less number of trained nursing staff</td>
</tr>
<tr>
<td></td>
<td>3.4.4.1.3</td>
<td>No in-house training for Baby Friendly</td>
</tr>
<tr>
<td>3.4.4.2</td>
<td>Lack of knowledge and understanding</td>
<td></td>
</tr>
<tr>
<td>3.4.4.3</td>
<td>Ignorance and negligence</td>
<td></td>
</tr>
<tr>
<td>3.4.4.4</td>
<td>Causes of Lack of Baby Friendly skills</td>
<td></td>
</tr>
<tr>
<td>3.4.4.5</td>
<td>Worry and concern about Baby Friendly Practices</td>
<td></td>
</tr>
</tbody>
</table>

| 3.4.4.2.1 | Nursing staff’s concern |
| 3.5.4.2.2 | Breastfeeding Policy not visible |
| 3.4.4.3.1 | Other Health care workers not trained |
| 3.4.4.4.1 | Insufficient knowledge on Breastfeeding and HIV/AIDS |
| 3.4.4.4.2 | Difficulty in implementing new Baby Friendly practices |
| 3.4.4.4.3 | Delay initiation of babies after caesarean section |
| 3.4.4.5.1 | Post-operative pain after by caesarean section mothers |
| 3.4.4.5.2 | Nursing staff’s concern about mothers on discharge |
### 3.4.4.6

Challenges experienced in Baby Friendly Practices

- Mothers are fearful to breastfeeding
  - 3.4.4.6.1
- Overcrowding of mothers in maternity units
  - 3.4.4.6.2
- Shortage of nursing staff
  - 3.4.4.6.3
- Lack of involvement by Health Care Workers.
  - 3.4.4.6.4
- Poor communication by management.
  - 3.4.4.6.5
- Difficulty of the institution to achieve Baby Friendly accreditation
  - 3.4.4.6.6
- Failure of all Health care workers to attend Baby Friendly training
  - 3.4.4.6.7

<p>| Theme 5 | 3.4.5.1 | 3.4.5.1.1 |</p>
<table>
<thead>
<tr>
<th>3.4.5 Factors that may facilitate Baby Friendly Practices</th>
<th>Formulation of support groups</th>
<th>Members of the breastfeeding support group.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.5.2 Use of knowledgeable people for in-service education</td>
<td>3.4.5.1.2 Involvement of the available support group</td>
<td></td>
</tr>
<tr>
<td>3.4.5.3 Active participation and Involvement by all Health care workers</td>
<td>3.5.5.2.1 Available Breastfeeding champions</td>
<td></td>
</tr>
<tr>
<td>3.4.5.4 Formulation of an active Breastfeeding Committee</td>
<td>3.4.5.3.1 Involvement by management and all health care workers</td>
<td></td>
</tr>
<tr>
<td>3.4.5.5 All Health Care Workers be well informed about Baby Friendly issues</td>
<td>3.4.5.4.1 Trained Health Care Workers in Baby Friendly Care</td>
<td></td>
</tr>
<tr>
<td>3.4.5.6.1</td>
<td>3.4.5.5.1 All Health Care Workers to attend Baby Friendly activities</td>
<td></td>
</tr>
</tbody>
</table>
The following is a discussion of Table 3.4 and the literature control.

A total of seven participants were interviewed in this study, and the participants are represented by the letter P and a unique code number.

### 3.4.1 Theme: Establishment and maintenance of baby friendly practices by nursing staff

The first theme that emerged from the data analysis was the establishment and maintenance of Baby Friendly Practices. Baby Friendly practices are the implementation of the principles of the ten steps of successful breastfeeding, leading towards the accreditation of an institution's status as being a Baby Friendly Hospital (WHO & UNICEF, 2009: 37).

For the successful accreditation of Baby Friendly Practices and receiving the status of a Baby Friendly Hospital, hospitals and health care workers should implement the Principles of the ten steps for successful Breastfeeding as specified on Table 1.1, to receive the above-mentioned status (NDOH, 2013:65).

#### 3.4.1.1 Implementation of skills for Baby Friendly Practices in maternity units

This category refers to the ability of the nursing staff in the maternity units, to demonstrate their capabilities and competencies in applying the Baby Friendly Hospital Initiative strategy, in their units.

In South Africa, in 2011 breastfeeding is supported and protected by the policies of the Tshwane Declaration (NDoH, 2013:57). The South African Infant and Young Child Feeding Policy also promote, protect and support breastfeeding (NDoH, 2013:1).
3.4.1.1.1 Initiation of breastfeeding

The initiation of breastfeeding is the fourth principle of the ten steps of successful breastfeeding.

The participants stated the following:

“I think in Baby Friendly; you introduce the baby to breastfeeding after birth…usually it starts labour ward by putting the baby immediately on the breast after birth” (P1).

“Another principle is the initiation of breastfeeding thirty minutes after birth…Initiation of breastfeeding is encouraging the mother to put the baby on the breast to suck immediately after delivery thus encouraging milk production” (P3).

The participants agreed with the initiation of breastfeeding guidelines, that breastfeeding had to start after birth, and that the initiation of breastfeeding should start at least thirty minutes after the birth of the baby.

During the initiation of breastfeeding, the new-born baby is placed on the breast of the mother, immediately after birth to assist and stimulate the production of breast-milk, Step 4, Table 1.1(NDoH, 2013:65). This step is presently interpreted as skin to skin contact, for at least one hour after the birth of the baby in the revised WHO & UNICEF directives of 2009. The significance of the skin to skin between the baby and the mother, is to encourage the mothers to recognize the readiness of their babies to breastfeed and to offering assistance to the baby if the baby does not make good contact with the mother’s breasts (WHO & UNICEF,2009:11).

3.4.1.1.2 Skin to skin to promote bonding
This subcategory refers to placing the new-born babies being positioned in direct contact on their mother’s chest, without the baby having clothes on, immediately after birth of the baby.

The participants expressed the following: “I think that in Baby Friendly, you introduce the baby to breastfeeding immediately after birth in labour ward to promote bonding. Breastfeeding usually start in labour ward usually it starts in labour ward by putting the baby immediately on the breast after birth” (P1).

“The skill of practicing skin to skin, this skill of skin to skin which is done in labour ward” (P2)

“I, myself, immediately after the baby is born promote skin to skin by giving the baby to the mother, thus promoting bonding…I give the baby to the mother if the condition warrants and she will put the baby on the breast. After fifteen minutes, the other nurse takes the baby to nursery for baby care and thereafter the baby is brought back immediately to the mother to breastfeed” (P3)

“We are promoting skin to skin” (P4)

“During delivery, immediately after the baby is born, the baby is put on the mother’s abdomen to promote skin to skin, bonding and also so that the mother should be able to start breastfeeding… “Normal delivered mothers; we encourage breastfeeding immediately and skin to skin…” (P5).

All the participants described the ways of initiating breastfeeding. Skin to skin starts in labour ward immediately after the baby is born, and bonding is promoted between the mother and baby, as the baby is placed on the mother’s chest.
Skin to skin contact is Step number 4 of the ten steps of successful breastfeeding (NDoH, 2013:65).

3.4.1.1.3 Demand feeding of babies

This subcategory refers to the unrestricted schedules for feeding babies. Babies are fed at any time when they are hungry. Step 7 of the 10 steps of successful breastfeeding on Table 1.1 which is rooming-in, needs to be practised for demand feeding to be successful (NDoH, 2013:65).

One participant stated:

“Also feeding on demand is encouraged as it promotes milk production” (P4).

The participant indicated that demand feeding was encouraged in the maternity units.

Feeding on demand is the 8th step of the ten steps of successful breastfeeding. There is no schedule for feeding the baby. The baby is fed anytime he or she needs a feed. It is step 8 on Table 1.1(WHO & UNICEF, 2009:15).

3.4.1.1.4 Rooming-in to enhance breastfeeding

Rooming-in is the 7th step of the 10 steps of successful breastfeeding.

The participants stated:

“That is what we are trying to do now, to promote bonding. Not to separate the baby from the mother” (P3).

“Rooming-in is practised in labour ward and extends to postnatal wards” (P4).

“Normal delivered mothers, we encourage breastfeeding immediately… babies re not separated from their mothers, remain with their mothers always, I mean that most of the time” (P5).
“We encourage the mothers rooming-in with their babies immediately after delivery” (P7).

The participants explained that they encouraged rooming-in to promote bonding and assist the mothers to breastfeed their babies.

This is maintained by allowing the mothers to remain with their babies for 24 hours. Step 7 on Table 1.1 (NDoH, 2013:65). Rooming-in has many benefits for the mother and baby. It builds the mother's confidence in caring for the baby, and the baby is fed in response to her cues (WHO & UNICEF, 2009: 15).

### 3.4.1.1.5 Exclusive breastfeeding (EBF)

This subcategory refers implies feeding the baby with only breast-milk. The participants stated the following:

“Exclusive Breastfeeding is encouraged; it means the baby does not have to drink water or eat anything except breast-milk, mixed feeding is discouraged” (P2 and P4).

“We encourage Exclusive Breastfeeding, that is, mothers to breastfeed exclusively for six months. We teach the mothers to give nothing, no water nor any food except breast-milk …We are succeeding in implementing Exclusive Breastfeeding while the mothers are still in hospital” (P2 and P4).

“In Exclusive Breastfeeding, from birth, the mother gives the baby only breast-milk, nothing should be given, only breast-milk until the baby is weaned or until the time the baby cannot be breastfed anymore” (P6).

“The principles of Exclusive Breastfeeding in which the mother is to breastfed only for six months, that is, to give breast-milk only…some come for check up with their babies. I specifically interviewed them on the feeding method they have chosen and Exclusive Breastfeeding…We encourage Exclusive Breastfeeding by teaching the mothers on the benefits that breastfeeding has on the baby and mother, we discourage mixed feeding. The mother should Exclusive Breastfeeding for six months” (P7).
The participants encouraged the mothers to practice exclusive Breastfeeding, and also provided them with information on the benefits of breastfeeding. In 2002, the World Fit for Children Policy was endorsed, to decrease the problem of under nutrition and to support exclusive Breastfeeding, safely and to use complementary feeding from the age of two years and more (More, Gauld & Williams, 2007:6).

In 2012, the World Health Assembly endorsed the 6 global targets for nutrition, which includes exclusive Breastfeeding (WHA, 2012:1). Pre-lacteal feeds should be avoided, free samples of infant feeding packs should be avoided and also supplementary feeds should be avoided to reach the exclusive breastfeeding target (WHO & UNICEF, 2009:37). In South Africa, free formula was given to mothers who were HIV positive and who have opted for formula feeding previously, has been phased out from 1 April 2012, in support and promotion of breastfeeding (NDoH, 2013:62, R991, of 2012:1).

3.4.1.1.6 Options of Infant feeding method

This subcategory refers to the available methods of feeding, in which the mother has preference to use to feed her baby.

Mothers have the right to choose the infant feeding method which they feel confident and comfortable to use. A plan for the feeding option chosen by the mother, whether breast or formula should be accompanied by a feeding plan (NDoH, 2015:38).

The participants stated the following:

“I educate the mothers on the option of infant feeding. As the mothers are still pregnant, but they need to know about infant feeding so that after delivery they should not have problems on feeding the baby. We start by teaching them to choose the option of feeding, either breastmilk or formula. But we encourage them to choose breastfeeding as it is very important” (P4).
“Those who choose formula, we teach them the following: care of the utensils used, preparation of the formula found out from them about the ability to buy the formula, that is, affordability, assess their ability to ensure cleanliness, for example, boiling water and the ability to sterilise equipment used” (P5).

“As you know that patients have rights, they have the rights to choose what they think is right for them or not, if they choose formula, I teach them to use formula in the correct manner, which is Exclusive Formula Feeding….The formula is for those mothers who choose not to breastfeed as it is their right, those mothers who breastfeeding is contraindicated and those mothers who are very ill” (P7).

The participants advised the mothers about their preferences and choices of infant feeding.

The option for infant feeding is breastfeeding or formula feeding, although the mothers are encouraged on breastfeeding (WHO & UNICEF, 2009:34). The rights of the mothers as human beings are considered, as well as their rights of informed individual choices and decision-making (Gerrish & Lacey, 2010:28).

3.4.1.1.7 Mixed feeding and use of pacifiers by the mothers on their babies

This subcategory refers to the feeding of the babies with both breast-milk, as well as formula feeds. In between the breastfeeds, the babies are also given water and other preferred food substitutes, according to a food plan.

The participants verbalised the following:

“Midwives, other staff and student nurses should discourage mixed feeding and artificial feeds which make babies sick” (P3).

“We do not encourage mothers to bottle-feed. In Neonatal Intensive Care Unit, feeding cups are used” (P5).
“I teach them about the importance of not mixed feed and also not using other breast-milk substitutes” (P6).

“In mixed feeding you will find that the mother is giving the baby both the breast-milk and the formula as they have a tendency of saying that the baby is not getting enough milk from the breast” (P7).

The participants explained that they advised the midwives, other nursing staff and student nurses to discourage mixed feeding.

Step number 6 and 9 of the 10 steps of successful breastfeeding, is supported on Table 1.1(WHO & UNICEF, 2009:16). It indicates that the use of artificial teats, soothing agents, dummies and pacifiers are discouraged, as they will confuse the baby’s’ feeds. The World Health Assembly endorsed the six targets for nutrition in 2012, which emphasized exclusive breastfeeding (More, Gauld & Williams, 2007:24).

Infant feeding has been discovered through research that is the cause of child mortality from birth to the age of five years (NDoH, 2013:35). In the year 2015, seventeen Sustainable Development Goals were agreed upon by the United Nations in which the SDG 3 is to ensure healthy lives and promote well-being of all at all ages by 2030. In this goal child health is taken into consideration as the mortality rate in some countries still remains high, for example, Sub-Sahara, and Southern Asia(Sustainable Development Goals 2030:1). However, some of the reasons being that, early introduction of other foods and fluids contributed to high morbidity rates. Feeding the babies water contributed to high morbidity, causing diarrhoea and vomiting, leading to dehydration and even death (WHO & UNCEF, 2009, NDoH, 2013:16).

3.4.1.1.8 Affordable, Feasible, Accessible, Safe and Sustainable (AFASS) criteria for a choice of infant feeding

Affordable refers to the ability of the mother to buy formula feeds to feed the baby all the times. Feasible refers to the mothers ‘understanding of the information in her individual
situation. Sustainable refers to building the mothers’ confidence in her ability to feed safely and to carry out her feeding decision with confidence (UNICEF, 2007:6-7).

The participants stated:

“Okay, I look at the Affordable, Feasible, Accessible, Safe and Sustainable criteria and I do not educate the mother in public teach about the criteria. According to the criteria, the mother should be able to afford to buy the formula, the fire should be available for boiling water to prepare the formula and also water should be clean. All things for preparing formula should be available. Everything that is to be used must be affordable and accessible” (P4).

“The mothers who choose formula, I teach them about AFASS criteria and Exclusive Formula Feeding. As we know that patients have rights and choices, we allow them to make own choices as long as you give them full information” (P6).

The participants indicated that they taught the mothers individually about the AFASS criteria and exclusive feeding.

An AFASS criterion is a measure used for the women when they choose the option of formula feeding. It is an acronym s for Affordable, Feasible, Accessible, Safe and Sustainable (NDoH, 2013:7). The mothers who have Infants, who cannot consume breast milk due to galactocemia and other medical conditions, should be advised on the types of special formula to meet the AFASS criteria (Department of Health and Social Development, 2014:40).

3.4.1.1.9 Expressed breast-milk

This subcategory refers to the ability of the mothers to express breast milk for future use for their babies. The need arises, when they are separated from their babies, or the mother has to go back to work, or when the mother has added responsibilities away from home.
Breast-milk is expressed by the mothers by hand, by squeezing the breasts gently by the mothers manually. Mothers are taught by demonstration, by the nursing staff, how to hand express breast-milk, and how to store the expressed breast-milk for future use, Step 5 on Table 1.1 (WHO & UNICEF, 2009: 12, Department of Health and Social Development, 2014:41). There is a need for the nursing staff to build the mother’s confidence and to give support to them, when they are expressing and preserving their expressed breast to create a breast milk bank.

The participants reported the following:

“We encourage the mother to express breast-milk into a cup so that they baby can breastfeed. We feed them with a cup or feeding glass. Sometimes when the mother is in High Care Area and the baby in ward 24 (neonatal unit) the nurse from ward 24 come with a feeding glass and give it to the mother to hand express breast-milk …We teach the women and indicate to them to continue breastfeeding even if they are returning back to work soon. Women should be given a chance to breastfeed even if they are returning to work. They should have a small cooler bag with ice pack to keep the expressed breast-milk safe” (P3).

“Expressed breast-milk can be kept safe in a refrigerator for a period of a year as frozen” (P4).

“For babies who are sick and transferred to neonatal intensive care unit, we advise mothers to hand express breast-milk…mothers who have delivered by Caesarean section are in pain, we as midwives assist them to put the babies on the breast and hand express breast-milk…If the baby is admitted in Neonatal Intensive Care Unit, we assist and encourage breast-milk expression” (P5).

“I have enjoyed Exclusive Breastfeeding on my second born as I was expressing breast-milk have done it for three months only as I have at school, sometimes separated for some days from the baby” (P6).
The participants described the different ways that they advised the mothers to express breast--milk, and the methods adhere to exclusive breastfeeding.

Step number 5 of the ten steps of successful breastfeeding, is to inform and demonstrate to the mothers, how to maintain lactation, even if they were separated from their babies. The mothers may be separated from their infants if they are working (NDoH, 2013:41). The Department of Health and Social Development (2014:40) provides information on how to hand express breast-milk, how to feed expressed breast-milk and how to preserve the breast-milk safely at all times.

3.4.1.1.10 Prevention of Mother-To-Child Transmission of HIV and Breastfeeding

This subcategory refers to the management of the HIV positive, pregnant mothers on preventing their babies from contracting the disease. The baby has to be protected during pregnancy, labour and the puerperium period. Prophylactic treatment needs to be prescribed for both the mother and the new-born baby, and exclusive breastfeeding has to be implemented for the baby for one year

NDoH (2015:139) states that all mothers must be counselled on breastfeeding during the antenatal care and on discharge to minimise the risk of HIV transmission to their infants. About 30-40% of children born to HIV positive mothers may become infected with HIV, if protective and promotive measures of breastfeeding are not implemented appropriately (NDoH, 2008:39-40).

“PMTCT stands for Prevention of Mother to Child Transmission by women who are HIV positive...I educate the mothers on the option of infant feeding. As the mothers are still pregnant, but they need to know about infant feeding so that after delivery they should not have problems on feeding the baby” (P4).

“We start by teaching them to choose an option of feeding, either breast-milk or formula. But we encourage them to choose breastfeeding as it is very important just want to clarify the issue of choosing an option, we don’t give all mothers option, mothers who are HIV positive, we encourage Exclusive
Breastfeeding…The mothers who are HIV positive understand and practice what we encouraged them while they are still with us” (P4).

“HIV positive mothers, we educate and encourage the mothers on breastfeeding. Those who choose formula feeding we teach them the following: care of the utensils used, preparation of the formula, find out from them about the ability to buy, that is, affordability, assess their ability to ensure cleanliness, for example, boiling water and the ability to sterilise equipment’s used” (P5).

“In our Antenatal care clinic, HIV Testing and Counselling is done by expert. The staff members are trained on Prevention of Mother–To-Child Transmission. Mothers are taught infant feeding and options that are available. Breastfeeding is reinforced” (P7).

The participants stated that they taught the mothers about infant feeding during the antenatal period, in addition the mothers were counselled by an expert, after the delivery of the baby, as well.

PMTCT is the acronym for the Prevention of Mother to Child Transmission (NDoH, 2015:10). The Human Immuno Virus (HIV) has the ability to cross the placenta to the unborn child. The World Health Organization, the United Nations Children’s Fund and government and non-government bodies have endorsed the guidelines and policies for implementation, to prevent the transmission of the Human Immuno Virus to the unborn child (NDoH, 2015:42, NDoH, 2011:24, WHO & UNICEF, 2009:53). The Human Immuno Virus is also transmitted through breast feeding. In the Prevention- of -Mother – To - Child -Transmission (PMTCT), exclusive breastfeeding is encouraged, as it is one of the strategies that has shown to be the best infant feeding method used (WHO & UNICEF, 2009:34, NDoH, 2011:41).

3.4.1.1.11 Latching and attachment of the baby to the mothers’ breast
This subcategory refers to the positioning of the baby on the breast, and how the baby suckles from the breast.

The participants described the positioning and attachment as follows:

“Latching is how you take off the baby from the breast and attachment is how you put the baby on the breast properly, it entails positioning of both the mother and baby” (P6).

“Yes, it is possible. Usually in the morning I like to make my own little survey and observing how the mothers position the babies on the breast, how they put them on the breast and I also ask them questions about breastfeeding” (P7).

“We assist by positioning them comfortably, putting the pillow on the lap, not on the abdomen” (P5).

The participants stated that they assisted the pregnant and the mothers who had already delivered their babies, with the positioning of the baby for feeding, and that they also monitored the progress of the mothers and their babies.

Mothers are expected to be shown and demonstrated on latching and attachment of the baby to the breast. Step 4 and 5 of successful breastfeeding must be promoted and supported, as illustrated on Table 1.1 (WHO & UNICEF, 2009:11; NDoH, 2013:65). The proper positioning of the baby, good attachment and effective suckling of the baby, are of importance for successful breastfeeding (Department of Health and Social Development, 2014:26).

3.4.1.1.12 Assessment tool for accreditation of a baby friendly hospital

This subcategory refers to the use of an appraisal tool, to determine whether the institution that is rendering maternal and child services, is able to implement and practice baby friendly care.
Institutions develop their own appraisal tools, developed from the universal tool of the World Health Organization and United Nation Children’s’ Fund (WHO & UNICEF, 2009:71). For the institution to be successful and receive an accredited status, a performance of 70 to 80% and above, should be attained, in all the principles of the 10 steps of successful breastfeeding according to Table 1.2 (WHO & UNICEF, 2009: 78).

The participants stated the following:

“There is an assessment tool made by the Breastfeeding Committee and also we have evaluation reports for our performance. The assessment is not for the ward but is for the whole maternity department other principles are only practiced in specific wards, like, skin to skin which start in labour ward. As such, poor performance of one ward affects the whole department” (P4).

“Assessment is done. We usually get the report from the Breastfeeding Committee They inform us about performance in different wards, for example, in labour ward about skin to skin, postnatal ward about rooming-in. Evaluation is done by the Breastfeeding Committee and our dieticians are steering in this” (P7).

The participants stated that they had an assessment tool developed by the institutions breastfeeding committee, and that they also have appraisal reports on exclusive breastfeeding practices. However even the institution is still not accredited as a Baby Friendly hospital

The World Health Organization and the United Nations Children’s Fund stated that every institution rendering maternal and new-born services, should be accredited to obtain the status of a Baby Friendly Hospital Initiative (WHO & UNICEF, 2009:40). The Department of Health and Social Development in South Africa (2014:58) outlined the steps to follow for the assessment of achieving the Baby Friendly Hospital Initiative. From the information gathered, the participants indicated that the nursing staff have tried their best to implement Baby Friendly Practices, however the hospital is still not yet accredited.
3.4.2 THEME 2: THE PROVISION OF EDUCATION ON BABY FRIENDLY HEALTH CARE

The second theme that emerged was the provision of education on baby friendly health. This theme refers to the sharing of information, about the 10 steps of successful breastfeeding, within HIV and AIDS, Code compliance and Mother-Friendly practices.

One of the principles of the 10 steps for successful breastfeeding is the education and support of pregnant and lactating women, which is step number 3. The women are to be informed about the benefits and the management of breastfeeding, as per Table1.1 step 3 (WHO & UNICEF, 2009: 11, NDoH, 2013:65).

In this research study, health education that needs to be given is on Baby Friendly Health Care, includes topics on the benefits of breastfeeding for the mother and baby, the breastfeeding technique and the physical examination of the breasts with nipple preparation of the mother.

3.4.2.1 Health education on Baby Friendly Care is given to nursing staff

This category refers to the sharing of information, by knowledgeable persons on the baby friendly practices, to empower the nursing staff.

Step number two of the principles of successful breastfeeding, is to train all the health care workers on the skills needed to implement the Baby Friendly practices, as described in chapter 1, Table 1, step 2 (WHO & UNICEF, 2009:9).

3.4.2.1.1 In-service education, workshops and symposia
This subcategory refers to the ability of the staff to attend updating sessions, on baby friendly care for the growth and development of the baby and to improve the mother and child services.

The participants stated that:

“Management provides in-service education for us, we are taught even if others are unable to attend, those who are working night duty. Nursing staff working during the day are able to attend. The management also allows us to attend training” (P1).

“By that time it was not easy because we were not given opportunity to attend workshops like the one I attended in Kalafong three years ago. We are given information about breastfeeding continuously and we are more skilled on breastfeeding. They help us with in-service education and Breastfeeding Management Course Training” (P2).

“…I am just from training in Kalafong not long ago…I do not remember any Baby Friendly in-service, but what I remember is that there were Baby Friendly Training sessions…I wish everybody should attend Baby Friendly Training and have knowledge on all issues pertaining to breastfeeding and its importance” (P3).

“I am not sure but what I know is that nursing staff have been trained in our department…Baby Friendly activities are workshops, symposia and in-service education (P4).

“I think we are about ten who have attended training…Everybody in the hospital should attend Baby Friendly Hospital Initiative workshops and seminars. Regularly, it is important” (P5).
“Oh! Yes, I always attend the annual Breastfeeding symposia which is held in Gauteng, breastfeeding meetings and other workshops held in other institutions” (P7).

The participants implied that the number of trained nursing staff in maternity units, is few as compared to the number of nursing staff working there.

The staff on night duty is unable to attend these in-service sessions, as there are no sessions of in-service training, during the night. The participants suggested that all the staff members in maternity, should be able to have a chance to attend an in-service session.

WHO & UNICEF (2009:15) stated that a strong policy should be available in a facility, which is supported by the management on in-service training. According to the researcher’s assumption in the maternity units, in this research study, the Baby Friendly Hospital Initiative training is still continuing, to educate and inform the healthcare workers of updated information.

Opportunities have been available for Baby Friendly Hospital Initiative training since 1991 globally. In 2009 the Baby Friendly Hospital Initiative 20-hour course for maternity staff was updated and revised from an 18-hour course, as indicated on section 3 (WHO & UNICEF, 2009:53, Department of Health and Social Development, 2014:1). These course sessions outline the guidelines for facilitators. In South Africa, the Baby Friendly Hospital Initiative training started in 1996, and since then 247 nursing staff have been trained (UNICEF, 2007:2).

3.4.2.1.2 Health talks are given by knowledgeable nursing staff

This subcategory refers to that education information that was given to nursing staff, to have more knowledge about the baby friendly practices.

The participants said:
“We have breastfeeding charts on the wall which we read and earn from them. Mothers are encouraged to read them...We also get health education from our seniors” (P1).

“Now we have knowledge and depend on the individual to implement Baby Friendly...We have knowledge on the importance of breastfeeding... “Yes we have knowledge on the importance of breastfeeding, breastfeeding was not compulsory for six months, now is compulsory and Exclusive Breastfeeding is encouraged” ...You know, the training has opened our eyes. We did not know the dangers of mixed feeding, now we know them” (P2).

“We are teaching midwives about breastfeeding” (P3).

The participants reported that they gave information to the other staff on the knowledge about Baby Friendly Practices, using charts during training sessions. Full information is to be given to mothers on the physiology and mechanisms of breastfeeding.)

Breastfeeding techniques are to be taught, Step 3 on Table 1.1 (Department of Health and Social Development, 2014:26; WHO & UNICEF, 2009:9, NDoH, 2013:65). WHO and UNICEF (2009:30) outline the course sessions of the facilitators, who are knowledgeable on breastfeeding. The facilitators should be trained on Baby Friendly Hospital Initiative, and have to undergo a facilitator’s training course for 5 days (WHO & UNICEF, 2009:30).

3.4.2.1.3 Delivered and pregnant women are given health education

This category refers to the information, which is given to the pregnant and delivered women on baby friendly care.

The participants stated:

“We give heath education on the importance of breastfeeding” ... “We have breastfeeding charts on the walls which we read and learn and also the mothers
are encouraged to read and learn from them.” She repeated and said: “Utilization of the breastfeeding charts that I have mentioned earlier” (P1).

“I have taught the mothers about breastfeeding…:” I also give health education on breastfeeding. Educate the mothers about the advantages and importance of breastfeeding… and involving everybody” (P2).

“I educate the mothers on the options of infant feeding while the mothers are still pregnant, they need to know about infant feeding, so that after delivery they should not have problems on feeding the baby start by teaching them to choose an option, either breast-milk or formula, but we encourage them to choose breastfeeding as it is very important …I teach about a certain standard called Affordable, Feasible criteria” (P4).

“…and also educating the mothers about breastfeeding and involving everybody…This is done through giving health talks at churches and where there are functions in the community, thus collaboration” (P3).

“By teaching mothers and nursing staff, inform them that breastfeeding is the best, good and safe, it is not expensive like formula” (P4).

“Yes, we teach the mothers about Exclusive Breastfeeding where they should give breast-milk only…If they choose formula teach them to use the formula I the correct manner, which is Exclusive formula feeding usually teaches them on the use of formula with regard to Exclusive formula feeding for six months, care of bottles and teats and about the risks that are encountered and also about the allergies that exist also refer them to the dieticians for more information and demonstration of preparation of feeds…”(P7).
“I like to observe how the mothers positioned their babies on the breasts, how they put the bar babies off the breasts and I also ask them some questions about breastfeeding” (P7).

“We also give health education on breastfeeding educate the mothers about the advantages and importance of breastfeeding” (P2).

The participants indicated that the information of breastfeeding is shared with the mothers, through different ways of teaching and communication. However the hospital remains unsuccessful to be as a Baby Friendly institution.

The third step of the 10 steps of successful breastfeeding is to inform all the pregnant women, about the benefits and management of breastfeeding (WHO & UNICEF, 2009:10 and 17, NDoH, 2013:11). There are different topics that can be discussed with the woman during pregnancy on breastfeeding and the importance of rooming-in, as indicated in the document of Minimum content (Department of Health and Social Development, 2014:16). Daniels and Jackson (2011:37) in their study described the need for knowledge and information by all relevant staff members about Baby Friendly practices, as it encouraged good team performance, cohesion and knowledge integration.

3.4.2.2.1 Community communication

This subcategory refers to a way of giving information to all the hospital staff, clients who are visiting the hospital, as well as to the public. Thus, communication assists as a way of giving information, listening and building an individual’s confidence.

Support should be provided to mothers on how to breastfeed, initiate and discuss their choice of infant feeding method (NDoH, 2008:8).

The participants shared the information as follows:
“We teach other Health Care Workers during Breastfeeding Week, by presenting different topics on Baby Friendly Practices at the hospital radio station; people are allowed to ask questions (P4).

The 10th step of successful breastfeeding is to promote the establishment of breastfeeding support groups, and to refer the mothers to these groups if available, on discharge from the hospital or clinic (WHO & UNICEF, 2009:17, NDoH, 2013:59). Community interventions are communicated for the continuity of support, protection and to promote breastfeeding. Breastfeeding support was encouraged and promoted by World Alliance for Breastfeeding Action in 2013, through the theme of “Breastfeeding Support: Close to Mothers” (World Alliance for Breastfeeding Action, 2013 1). The support of the mothers is needed from the community health centres, close to their residence, when they are discharged from the hospital.

Continuing support through communication can be sustained by the family, health care workers, champions and close community members, such as friends or from other mothers (Daniels & Jackson, 2011:38). Support is given also by other primary level facilities, such as the community health centres where routine care of the well and a healthy infant is provided.

3.4.2.2. Breastfeeding awareness

This subcategory refers to the ability to encourage people to be aware about breastfeeding and to help them to recognize the importance and changes that are occurring with breastfeeding.

Step number 3 of the 10steps of successful breastfeeding, is to inform all the pregnant women about the benefits of breastfeeding (WHO & UNICEF, 2009:10). For this step to be successful, step number 10is to be implemented.

The participants stated the following:
“Yes, they are trying to support us. During the Breastfeeding month, we give mothers’ health education and campaign for Breastfeeding awareness. They help us arranging and preparing for campaigns and celebrations” (P2).

“During Breastfeeding Week, every morning we sing holding Breastfeeding flag, making people aware of the International Breastfeeding Week, majority of the people you find are mothers…we formulate questionnaires for them in languages that they understand and give positive answers. Even during competitions, there is a questionnaire, one who answers best get a present, for example, baby pack with baby clothes which usually are donation… We also celebrate World Breastfeeding Week which is held from 1st to the 7th of August every year” (P4).

“Different media is used to make awareness, like dramas which are performed during open days. People are also given pamphlets with information about breastfeeding. The mothers take part in competitions that are held during Breastfeeding Week, every morning we sing holding a Breastfeeding flag, making people aware of the International Breastfeeding Week…We formulate questionnaires for them in the language they understand and they give positive answers…one who answers best get a present, for an example, baby pack with baby clothes which we usually donate” (P4).

Community support is a type of social support. It includes the mother to mother support or community peer counsellor support (Daniels & Jackson, 2011:4). Community support can be provided, through the use of innovative and different strategies, such as breastfeeding classes. The health facility needs to foster the establishment of support groups to provide information and guidance to the mothers on breastfeeding (WHO & UNICEF, 2009:17).
The World Breastfeeding Week was initiated by World Alliance for Breastfeeding Action in 1991 and is held yearly, from the 1st to the 7th of August (UNICEF, 2013:26). The aim is to promote and support breastfeeding practices. The themes for the years are deduced from the 10 steps of successful breastfeeding, in an effort to encourage the health facilities to sustain the ten steps of successful breastfeeding.

3.4.3 THEME 3: THE ROLE OF MANAGEMENT IN BABY FRIENDLY HEALTH CARE PRACTICES

Theme 3 refers to the assistance that is given by the managers of the hospital towards the implementation of Baby Friendly Care.

For a successful Baby Friendly initiative, the management has to be involved as they represent leadership of the institution (Semenic et al, 2012:9). Management plans, organizes and control how the institution operates and functions. The Millennium Developmental goals had indicated that one of the strategies was that all the health care services, which renders maternal, new-born and child care services should have a Baby Friendly Hospital Initiative, by the year 2015.

3.4.3.1 Support and promotion of Baby Friendly Practices by Management

The first category refers to how managers assist and encourage the health care workers, with regard to Baby Friendly Care.

The revised Baby Friendly Hospital Initiative package by UNICEF of 2007, section 3 states that for promotion and support of Baby Friendly Hospital Initiative, all the staff of the maternity units, should attend a 24-hour course on the Baby Friendly Hospital Initiative, as well as studying the guidelines for course facilitators, planning and preparation of assessors (UNICEF, 2007:6). This is the responsibility of the management, to encourage the success of the Baby Friendly Hospital Initiative, through their continuous support and encouragement.

Subcategories were generated and discussed as follows:

3.4.3.1.1 Facilitates Breastfeeding Training
The first subcategory revealed the training of the health care workers was performed on the implementation of the 10 steps of successful breastfeeding.

The participants said:

“The management also allows us to attend lactation management training course” (P1).

“I attended Breastfeeding Management Training Course.:” I am not sure about the number but they (nursing staff) are many who have been trained” (P2).

“I am a Breastfeeding Committee member and trained in breastfeeding…They arrange and allow nursing staff to attend Breastfeeding course…We are ten nursing staff in ANC and only two have not attended training” (P7).

“I think we are about ten who has been trained…” (P5).

“I know only about the nursing staff who has attended Breastfeeding Training” (P6).

The participants indicated that some of them attended the breastfeeding training courses.

Health care workers in Gauteng Province are also trained for Baby Friendly Initiative, as it is a global strategy (Department of Health and Social Development, 2014:4). The training of the health care workers is available, whereby priority is given to maternity staff, as they are the first health care contact persons who meet with the mothers (WHO & UNICEF, 2009:30). Non-clinical staff attend 8-hour course in the district where training is scheduled.

3.4.3.1.2 Provision of transport for staff

The second category refers to the provision of transport by the institution management, for the staff to attend the breastfeeding activities and events, which are held outside the hospital.
The participants communicated the following:

“The management provide in-service education for us” (P1).

“They help us with in-service education” (P2).

“...they arrange transport for us and inform us about the invitations that in-service educations are available” (P3).

“The nursing does attend workshops that are held outside the hospital” (P5).

“By that time it was not easy because we were not given opportunities to attend workshops like the one I attended at Kalafong Hospital three years ago; now it easy because we are given information and knowledge about breastfeeding unlike previously. They also arrange in-service education for us” (P2).

“Usually, in-service education and symposia that are held outside the institution do attend even if I am off duty. We also attend Breastfeeding Symposium which is arranged every year by the Gauteng Breastfeeding Forum...GBF also arranges Baby Friendly quarterly meetings which we do attend as the institution” (P4).

“The operational managers and management inform us about available workshops and seminars through circulars and invitations, and also encourage everyone to attend, also cleaners and clerks” (P5).

According to the participants, the transport was provided, but some staff was not able to attend, because of their inconvenient work schedules.WHO and UNICEF (2009:15) recommended that there should be a strong policy in a facility, which is supported by senior staff or management together within-service education. The management of maternity department and other senior staff need to agree seriously, to implement and enforce practices that support breastfeeding.

3.4.3.1.3 Baby Friendly Practice activities
The third category refers to all the available skills, demonstrations, techniques and information about the 10 steps of successful breastfeeding, and the three related items of breastfeeding.

The participants said:

“During International Breastfeeding week…We campaign starting from June to August. We also have open day whereby dramas are performed, aiming and teaching mothers on how to breastfeed. Health talks are given daily on different topics on breastfeeding” (P7).

“We reach other Health care workers during Breastfeeding week by presenting different topics on Baby Friendly practices at the hospital radio station; people are allowed to ask questions. Different media is used to make awareness, like dramas which are performed during open days” (P4).

The participants stated that they observed the International breastfeeding week and scheduled a programme for the whole week.

The World Alliance for Breastfeeding Action has declared the 1st to the 7th August as the International Breastfeeding Week. The mission of World Alliance for Breastfeeding Action is to protect, promote and support breastfeeding worldwide, within the framework of Innocenti Declaration of 1990. In 2005, it was expanded to the Global strategy for Infant and young child feeding. The goal is to foster a strong and cohesive breastfeeding movement (More, Gauld & Williams, 2007:17).

3.4.3.1.4 Communicate available invitations

The fourth subcategory refers to give information about the communication that are available on the Baby Friendly practices.

One of the participants said:
“Communication is through the operational managers and management”. They inform us about available workshops and seminars through circulars and invitations (P5).

The participant indicated that communication was through the management staff.

For the successful implementation of the Baby Friendly Care practices, the management should offer support to subordinates in their facilities (Daniels & Jackson, 2011:38). Support is demonstrated through the communication of the available information about the current Baby Friendly activities. The researchers requested support for improvement as it is needed, through offering more training and workshops. Also, Assistance from the district nutrition staff is to be established, to improve the feeding practices.

3.4.3.2 Ensure availability of Breastfeeding Policy

The second category, refers to the ability of the institution to have their own guidelines on breastfeeding, as adopted from the WHO and UNICEF.

The Breastfeeding Policy of a facility should include the aims and objectives, the national and international guidelines, the local and national data of breastfeeding rates and the World Health Assembly resolutions, as the minimum recommendations as well considering the ten steps of successful breastfeeding, and the Code of marketing of the breast-milk substitutes (WHO & UNICEF, 2009:39; NDoH, 2013:1).

WHO & UNICEF (2009:1) stated that one of the principles of the ten steps for successful breastfeeding was described as a Written Breastfeeding Policy that should be in a strategic place in the maternity unit and should be accessible to all the maternity staff. The Breastfeeding Policy is important, as it gives direction on how to implement the Ten Steps of Successful Breastfeeding.
The subcategory of the breastfeeding policy refers to the guidelines of breastfeeding which were developed to safeguard and protect breastfeeding. The Breastfeeding Policy is and the first Step of the Ten Steps of Successful Breastfeeding are guidelines for breastfeeding practice (NDoH, 2013:65).

The participants stated:

“Yes, there is a breastfeeding file, where we put everything pertaining to breastfeeding. Each ward has its own file” (P4).

“The Breastfeeding Policy is kept in a file in the duty room and also placed on the wall in the unit where everybody can be able to read” (P6).

“The Breastfeeding Policy says that skin to skin should be promoted immediately after birth, the baby should be put on the mommy’s tummy thus promoting bonding and initiation” (P7).

The participants indicated that the Breastfeeding Policy is available in the institution, and that the skin to skin contact was also included in the policy.

A written Breastfeeding Policy should be known and implemented by all the Health care workers (WHO & UNCEF, 2009:1). Every health care facility which renders maternal, new-borns and child health care services must possess Breastfeeding Policy according to World Health Organization. Semenic et al (2012:9) describes that the availability of a formal, written and visible policy is essential to support breastfeeding practices. In support and promotion of breastfeeding in South Africa, the Infant and the Young Child Feeding Policies were promulgated (NDoH, 2013:2).

3.4.4 THEME: FACTORS HINDERING BABY FRIENDLY PRACTICES (BFP) IN MATERNITY UNITS

Theme 4, refers to the barriers that prevent the success of Baby Friendly Practices in the ante natal care clinic and the ante natal unit, labour unit and the post-natal units.
The factors hindering the Baby Friendly Practices are the problems that the nursing staff is faced with when they try to meet their goals to achieve a Baby friendly hospital status. There are several studies, which have been done, which reflects the factors that are contributing to the unsuccessful Baby Friendly Practices (Semenic et al, 2012:1; WHO & UNICEF, 2009:1).

Factors that help in the successful implementation of new practices or change include the sharing of information to the staff and efficiency of skill acquisition, psychological experiences (beliefs, values and culture), organisational factors and the availability of resources (Gerrish & Lacey, 2010:512). If the abovementioned factors are not taken into consideration, the implementation of the new practices would not be possible.

Semenic et al (2012:4) in their study mentioned that the factors that prevent the success of the Baby Friendly Hospital Initiative are organizational factors; strength and style of leadership, the shortage of staff, maternal factors, perception and attitudes, external factors, home feeding practices and the support of significant others, in supporting breastfeeding (Semenic et al, 2012:5).

Daniels and Jackson (2011:37) in their study noted that one of the factors that prevented the success of the Baby Friendly Hospital Initiative, was the “hospital practices”, mainly the lack of information and skills of the health care workers. According to the above researchers, the delay of the initiation of breastfeeding by mothers may be caused by the nursing staff, which lacks the knowledge and skills in teaching and assisting the breastfeeding woman to hold and position the baby on her breast. It is difficult for a member of the nursing staff to communicate information that they may not know.

There is also the inhibition of demand feeding, due to routine practices based on feeding time, due to resistant to change to new feeding practices. There is also the lack of support by the health care workers due to a lack of interest, reluctance to assist or other negative factors. Also, separation of mothers and their new-born infants through the use of nurseries and baby cots, or a very short stay of the mother post-delivery or in the post-natal units (Semenic et al, 2012:9).
3.4.1 Poor attendance of Baby Friendly training

The first category of Theme 4, refers to the inability of all the health care workers to attend the Baby Friendly Initiative training.

One of the participants said:

“We are taught even others are unable to attend in-service education, those who are working night duty. The nursing staffs that are working during the day are able to attend in-service education” (P1).

The participants implied that only the nursing staff attended the Baby Friendly training, and the other healthcare workers were not able to attend. This is one of the elements which can affect the accreditation for Baby Friendly Hospital Initiative.

Semenic et al (2012:9) described the lack of Baby Friendly Initiative training, and that the Baby Friendly education is not mandatory by management, leads to a lack of information and knowledge on the Baby Friendly issues. If the healthcare workers are not trained in the Baby Friendly Hospital Initiative, they would not be able to offer the mothers effective guidance and provide skilled counselling to them (NDOH, 2013:65).

3.4.1.1 Failure to train all healthcare workers

This subcategory refers to the other members of the multidisciplinary healthcare team, not being trained in the Baby Friendly Initiative.

Step number 2 of the 10 steps of successful breastfeeding is to “train all the health care staff or providers with skills needed to implement the breastfeeding policy”; step 1 on Table 1 (NDoH, 2013:65).

The participants said:

“It should be hands on deck…I mean everybody should be involved mean even the managers (” P2).
“Yes, I wish that everybody should attend Baby Friendly training and have knowledge on all issues pertaining to breastfeeding and its importance” (P3).

“There is a list of trained staff in Baby Friendly Hospital Initiative, who is only nurses” (P4).

“The other health care workers have this mentally that breastfeeding is only for nurses” (P7).

The participants implied that the other health care workers do not attend Baby Friendly Initiative training, as they feel it is for nursing staff only.

NDoH (2013:68) describes all the health care workers or providers, in terms of the laws pertaining to the type of service offered. Health care workers comprise of the administrators, managers, nursing staff, doctors, pharmacists, dieticians, clerks, cleaners, securities and gardeners.

Semenic et al (2012:4) stated that, if management is not committed in the Baby Friendly Hospital Initiative training, the attendance is likely to be poor, as the health care workers will attend the training on voluntarily basis. For a facility to be accredited for the Baby Friendly Hospital Initiative, all the health care workers should be trained in the ten steps of successful breastfeeding, so that it is fully implemented (Table 1.2).

3.4.4.1.2 Less number of trained nursing staff

This subcategory 2 refers to the small number of nursing staff; who have attended the Baby Friendly Initiative (BFI) training in the maternity units. Table 1.2 illustrates that for an institution to be accredited to be a Baby Friendly Initiative, 80% of nursing staff who work in the maternity units should have been trained on Baby Friendly Initiative practices.

The participants communicated the following:
“I am not sure, but what I know is that some of the nursing staff have been trained in our department and I am not sure of the staff that has been trained” (P4).

“People, namely, nursing staff want to go for Baby Friendly Hospital Initiative training, but they cannot go in large numbers because of shortage of staff…Yes, this is due to shortage of staff and it pertain to nursing staff only I don’t know about other health care workers…There is also less nursing staff trained in Baby Friendly in our unit” (P5).

“Most of the time primigravidae are not attended to and they need supervision” (P6).

The participants indicated that the number of nursing staff that have attended the training are less than 80% in their maternity units.

There is no policy in place enforcing training. However, nursing staff attend the training voluntarily and others are not happy towards the Baby Friendly Initiative. This has led to the poor attendance for the Baby Friendly Hospital Initiative training (Semenic et al, 2012:4).

3.4.4.1.3 No in-house training for Baby Friendly

Subcategory 1 refers to the inability of the institution to train their health care workers on the Baby Friendly Initiative.

One participant said:

“I think if the institution can be able to train its own staff” (P7).

The participant indicated that there was no available Baby Friendly Initiative training programme, in the institution in this research study.
The institution has not the authority to train Baby Friendly Initiative programme, which has led to many health care workers being untrained. The trainings are done in other facilities (DoH &SD, 2014:5; WHO & UNICEF, 2009:15). Daniels and Jackson (2011:38 study findings revealed that there was a dire need for in-house training.

3.4.4.2 Lack of knowledge and understanding

The second category refers to the inability of nursing staff to have sufficient information, about Baby Friendly practices.

The participants said:

“That is why I usually attend even when I am also off duty so that I should not be behind with the latest changes available and information” (P4).

“I wish that everybody should attend Baby Friendly Hospital Initiative training and have knowledge on all the issues pertaining to breastfeeding. It is important have learned a lot from that training, even the information I did not know” (P3).

“Yes, but not all. Everybody working in the ward should be trained, including cleaners” (P5).

Health education was described as follows by participants:

“We give health education on the importance of breastfeeding, but because of the issue of coding for HIV, most of the women have more questions especially those who are coded. They are concerned about safety in breastfeeding and want to know more about this issue and some of us we do not have information” (P1).

“…but our mothers (breastfeeding women) are not trustworthy, as you teach them, others don't listen and some do listen and understand” (P2).
“The other challenge is in educating women; other women will tell you that they are going back to work” (P3).

The participants summarized the issues of the breastfeeding initiative training, health education, trust of mothers and the challenges in educating the women. Sharing information about HIV/AIDS was also stated as confusing concerning the information about HIV/AIDS and breastfeeding practices.

Semenic et al (2012:7) stated that the lack of knowledge disables the health care workers from offering the relevant information because of misunderstanding of the Baby Friendly issues. The correct information is acquired by attending the Mother and Baby Friendly Training, in-service education and health education given by the experts (WHO & UNICEF, 2009:58). Insufficient knowledge and a lack of understanding by nursing staff affect the correct information that is shared with the mothers (Gerrish & Lacey, 2010:512).

Conflicting ideas and negative attitudes by the health care workers are due to lack of knowledge (Semenic et al, 2012:4). The nursing staff who is working in the maternity units are the first persons who meet the pregnant and the mothers who have delivered babies, and there is a need for them to have the best knowledge about the Baby Friendly practices (WHO & UNICEF, 2009:39).

3.4.4.2.1 Nursing staff’s concern

This subcategory refers to the concerns of health care workers, who provide the health care services in terms of Nursing Act,2005 (Act 33 of 2005) (NDoH,2013:68).

The participants said:

“Hmm! But for me, these women are not trustworthy to take the referral letters for themselves back to the clinics” (P2).

“There is a problem of monitoring. We teach the mothers even if others are not trustworthy. “Others do not listen”. “Oh! Do we trust these women; will they take the referral letters to the community health nurse monitoring them when they have gone home. They come back here with sick babies” (P2).
The participant showed signs of worry and despair, about the mothers who return to the health care service institution with sick babies which leads to the nursing staff querying the mothers understanding and knowledge of the information taught and the way the mother is implementing it, when she is discharged from the hospital.

The study done in Brazil showed that high exclusive breastfeeding rates for the first six months of babies were higher on babies that were hospitalised. The rates of Exclusive Breastfeeding dropped down ten days after discharge from hospital (KimaniMunage, Kyobutung, Wekesah, Wanjoji, Muriuki, Musoke, Norris, Griffiths, & Madise, 2013:10).

Semenic et al (2012:9) described that lack of adequate preparation during the ante natal care visits, the inconsistent and inadequate information received from the staff who teach the Baby Friendly practices and the lack of appropriate teaching tools, leading to the mothers having insufficient information, causing poor motivation and early weaning practices.

3.4.4.2.2 Breastfeeding Policy not visible

The subcategory refers to that dissatisfaction of the Breastfeeding Policy being placed, in an area where it is not easily accessible and visible.

A written Breastfeeding Policy should be known and implemented by all the Health care workers (WHO & UNCEF, 2009:1). The policy should be effective and discussed, to education and inform all the members (NDoH, 2013:65).

The participants reported that information was given as follows:

“I don’t know, but I think we should inform other midwives about the policy, (seems not sure with wide opened eyes) I don’t know” (P3).

“Everyone should know the Breastfeeding Policy by heart and practising the contents of the Policy. On daily basis, in the mornings or any other time, we give health talk to clients on it, you will find out that when some people are not
present, health education is not given because of the attitudes that others have on Baby Friendly. That is the problem we are encountering as far as the Breastfeeding Policy is concerned... Yes. They know it (Breastfeeding Policy) but they don't know the contents of the Policy” (P6).

“Skin to skin also become difficult which lead to the issue of the institution contradicting the Breastfeeding Policy” (P7).

The participants indicated that the Breastfeeding Policy is available, but all the nursing staff do not know about the contents of the policy. Some nursing staff was unsure of whether the Breastfeeding Policy was available in the institution, and its importance was not known.

The Breastfeeding Policy should be available, visible, and consistent and recognized by all the health care workers. It should be a clear policy which supports Baby Friendly practice, and also be available to the high risk Neonatal Intensive Care Units. It should be communicated at all levels in the institution as a legal practising protocol (Semenic et al, 2012:9).

3.4.4.3 Ignorance and negligence

This category 3 refers, that there is available information, but nursing staff have little or no knowledge about the information, showing their disinterest.

One of the participants said:

“They know that Breastfeeding Policy is there, but they don’t know the contents of the Policy think they are ignorant and negligent as everybody has been trained for Baby Friendly Hospital Initiative, so people should just have positive attitudes” (P6).
According to the participant, the nursing staff has attended the training on Baby Friendly practices, but some nursing staff has negative attitudes and views about the Baby Friendly Initiative.

Semenic et al (2012:4) described the impact of the hospital infrastructure routine, which inhibits demand feeding and leads to giving pre-lacteal feeds by the health care workers, which affect the success of the Baby Friendly Initiative. These, health care workers were identified as persons who were not interested in BFI. The researchers also identified that some health care workers portray the attributes of reluctance, negative attitudes and discomfort about the Baby Friendly Initiative.

3.4.4.3.1 Other Health care workers not trained

The subcategory refers to the health care professionals namely, the doctors and ancillary workers like the cleaners, who have not attended the training for Baby Friendly Initiative.

WHO and UNICEF (2009:15), describes all the health care workers as health care providers, such as the administrators, managers, nursing staff and the doctors. NDoH (2013:68) describes the other health care workers, as clerks, cleaners, securities, counsellors and gardeners. The non- clinical staff are expected to attend an 8-hour training programme (WHO & UNICEF, 2009:15).

The participants said:

“I do not know but I think we should inform other midwives about the Breastfeeding Policy (repeated), I don’t know” (P3).

“It should be hands on deck…I mean everybody should be involved mean even the managers” (P2).

“Yes, I wish that everybody should attend Baby Friendly training and have knowledge on all issues pertaining to breastfeeding and its importance” (P3).
“There is a list of trained staff in Baby Friendly Hospital Initiative, who is only nurses” (P4).

“The other health care workers have this mentality that breastfeeding is only for nurses” (P7).

The implication by the participants is that the staff who have attended training were only nurses, but according to the available documentation and Baby Friendly Initiative, training is for all the health care workers.

Principle number two of the 10steps, is to “train all the health care staff in skills necessary to implement the breastfeeding policy” in chapter 1, Table 1, step 1 (NDoH, 2013:65). The health care worker’s information and the skill deficit contribute to the failure to implement the new practices needed (Gerrish & Lacey, 2010:512).

3.4.4.4 Causes of lack of Baby Friendly skills

The category refers to the factors that affect the nursing staff, due to their lack knowledge on implementing the Baby Friendly Initiative.

More, Gauld and Williams study (2007:16) New Zealand found that there were barriers that prevented the successful implementation of the Baby Friendly Care practices. The Breastfeeding Policy of an institution is an important element for promoting the Baby Friendly Hospital Initiative. The difficulty towards implementation arises if the policy is not known or understood.

The following elements were identified as the causes leading to unsuccessful implementation of Baby Friendly Hospital Initiative at the Maternity Department in the institution in this research study.

3.4.4.4.1 Insufficient knowledge on Breastfeeding and HIV/AIDS
The first subcategory refers to the inadequate information that the nursing staff have, regarding the breastfeeding of Mothers who have tested HIV positive, and those mothers who have already been diagnosed with AIDS.

The participants provided the following information:

“Yes, especially for coded women, others say boil breast-milk, some say don’t boil. They say Exclusive Breastfeeding only and others say choose method of infant feeding, I am also confused…it also makes me confused because Exclusive Breastfeeding is encouraged. They say other mothers should express and feed the baby with a cup” (P1).

“Baby Friendly is simple, even if sometimes we encounter problems because of the issue of Prevention of Mother –To- Child Transmission (PMTCT). Some mothers are not empowered with knowledge about the phenomenon. some of us (nursing staff) do not teach mothers properly on Prevention of Mother –To –Child Transmission, some nurses discourage mothers not to breastfeed and there are no risks in breastfeeding when you are HIV positive. There is nothing wrong with breastfeeding and Prevention of Mother –To- Child Transmission” (P4).

They say Exclusive Breastfeeding only and others say choose method of infant feeding, I am also confused…it also makes me confused because Exclusive Breastfeeding is encouraged. They say other mothers should express and feed the baby with a cup” (P1).

“Baby Friendly is simple, even if sometimes we encounter problems because of the issue of Prevention of Mother to Child Transmission (PMTCT). Some mothers are not empowered with knowledge regarding PMTCT, some of us (nursing staff) do not teach mothers properly on PMTCT, some nurses discourage mothers not to breastfeed and there is no risk in breastfeeding when you are HIV positive. There is nothing wrong with breastfeeding and PMTCT” (P4).
The participants remarked on the uncertainty about the breastfeeding practices of the HIV positive mothers, as well as the conflicting information that was given to the mothers. There are conflicting ideas and misunderstanding that are expressed by nursing staff on issues of exclusive breastfeeding and HIV.

According to the global criteria on HIV and Infant feeding, the curriculum requires that the training records should reflect that training is provided by the relevant staff with sufficient information about HIV and how the risks of HIV is consistently prevented. Eighty percent of the staff should be able to describe how to prevent HIV transmission, during the first six months of infant feeding (WHO & UNICEF, 2009:23). NDoH (2015:87) states that all pregnant women should receive at least four sessions of HIV counselling, during their ante natal care visits.


3.4.4.4.2 Difficulty in implementing new Baby Friendly Care practices

The second subcategory refers to the nursing staff that has problems in implementing the ten steps of breastfeeding, as prescribed.

The participants said:

“They do give feedback even if others are unable to give as expected. You can make out from their presentations that a person who is presenting does not understand. Some of them admit that they also did not understand some of the discussions during the in-service education especially with regard to PMTCT and infant feeding” (P1).
“I have realized that it is not all of us who are implementing Baby Friendly principles” (P3).

“…not to be successful in Baby Friendly, is due to lack of interest of nursing staff on breastfeeding and Baby Friendly practices as many have trained …some nurses from other wards would not participate whether they are asked or delegated, most of the nursing staff remain spectators, even mothers are better of…lack of interest and reluctant of nursing staff to implement what they been taught… I don’t know because it is not easy because even if you invite them they don’t come, really I don’t know what can be done to motivate nurses. . There is a list of trained staff in Baby Friendly Hospital Initiative, who is only nurses” (P4).

The participants indicated that staff were not interested and lacked the motivation to persist in continuing with the Baby Friendly issues. Also, they did not implement the 10 steps of successful breastfeeding as required, as there was a lack of involvement and active participation by some of the nursing staff.

Semenic et al (2012:4) in their study identified the barriers, which prevented the success of the Baby Friendly Initiative. The barriers were related to management, health care workers, health care user’s individual clients and significant others.

More, Gauld and Williams (2007:18) identified that exclusive breastfeeding was difficult when mothers and their babies were discharged from hospital. Other authors identified psychological barriers such as attitudes, beliefs, values and previous experience of breastfeeding as problems to the mothers. The organizational culture of the health staff, which is reluctant to respond to change also, worsens the problem (Gerrish and Lacy, 2010:512).

3.4.4.3 Delay initiation of babies after Caesarean section

This subcategory refers to the delay in not initiating breastfeeding immediately after the baby is born or during the first hour of birth on mothers, who have delivered by caesarean section.
The participants said:

“Caesarean section mothers are unable to start breastfeeding immediately as the mothers are kept first in recovery room in theatre, thereafter they are transferred to Post Natal Care ward. The two-hour protocol is not adhered to” (P5).

The participant implied that there are protocols in the institution on the initiation of breastfeeding, on the mothers who have delivered by caesarean section, but this protocol appears not to be always adhered to.

Semenic et al (2012: 3) outlined the issue of mothers who may have problems on the initiation of breastfeeding or delay of the babies first feed, especially of babies who have been delivered by caesarean section. More, Gauld and Similarly, Williams’s (2007:16) study also identified difficulties in implementing the initiation of skin to skin contact of mothers towards the babies, who were delivered by caesarean section.

The participant stated that:

“Yes, we are succeeding in implementing Exclusive Breastfeeding while the mothers are still in hospital but the problem is that; we don’t make follow up on the mothers when discharged home” (P4).

The participant implied that women are taught about exclusive breastfeeding in hospitals and clinics, but when the women have been discharged from hospital, this may not be practiced.

The researchers identified that there is lack of family support, as the significant family members are not engaged, during the information giving sessions at the ante natal, post-natal and primary care period, as some family members resort to pre-lacteal feeds, if they encounter breastfeeding problems (Semenic et al, 2012:9).
Health care workers have to make follow up on mothers on discharge to determine that information is implemented at home. Social support groups are also important (NDoH, 2013:12).

3.4.4.1 Post-operative pain after Caesarean section

The sub category refers to the pain that is experienced by the mothers, who have delivered by surgical intervention, caesarean section.

The participants provided the following information:

“Yes, the caesarean section mothers are unable to put their babies immediately on the breast after birth as they are in pain and because of anaesthesia” (P1).

“Mothers who have delivered by caesarean section are in pain” (P5).

The participants indicated that the initiation of breastfeeding on the mothers delivered by caesarean section is delayed, due to the pain that is experienced by the mothers and the effects of anaesthesia that was administered, during the operation.

Semenic et al (2012:14) outlined the factors that may prevent the successful breastfeeding and the birthing experience by caesarean section. The mothers who has delivered by caesarean section encounter problems on breastfeeding. This is due to the pain that they experience and the effect of anaesthesia which was given during the operation (More, Gauld & Williams, 2007:16). Initiation and skin to skin contact which promote bonding are also delayed (Department of Health and Social Development, 2014:23).

3.4.4.5 Worry and concern about Baby Friendly Practices

This category refers to the worry and concern that the participants have about Baby Friendly Practices.
The following information was provided by the participant:

“But why are we not accredited? “…we are really trying our best to implement Baby Friendly practices. According to the Millennium Development Goals, the hospital should be Baby Friendly by the year 2015” (P2).

The participant showed concern and worry about the institution which is not accredited, even though they were trying very hard to implement the 10 steps of breastfeeding practices.

Gerrish and Lacey (2010:512) explained that the person’s psychological status played an important role in adapting to change. The hospital is not yet accredited for Baby Friendly Hospital Initiative which is now called Mother-Baby Friendly Initiative, regardless of efforts made.

3.4.4.5.1 Nursing staff concern about other nursing staff

This subcategory refers to the concern which the other nursing staff have on their colleagues concerning the Baby Friendly Initiative.

The participants expressed themselves as follows:

“I think what makes Baby Friendly practices difficult in the institution is lack of interest by nursing staff on breastfeeding and Baby Friendly issues as many have been trained. You will find when there are Baby Friendly activities like meetings, symposia, and workshops, nurses do not attend, most of the time, only members belonging to the Breastfeeding Committee are the one attending. That is why usually I do attend even when I am off duty so that I should not be behind with the latest changes and information…even if you invite them to breastfeeding meetings, they don’t come…some nursing staff from the wards would not participate, whether they are asked or delegated…” (P4).

“Usually we do have an open day during that week of awareness, most of the nursing staff in our department, don’t participate, they become spectators. Really
I don’t know what we can do to motivate nursing staff. There is lack of interest and reluctant of nursing staff” (P4).

“Others have some attitudes; you will find that there are very few who are able to do what are expected of them, to implement the Policy. They know the Policy but they do not know the contents because they are ignorant and negligent as almost everybody has been trained for by Friendly, so people should have positive attitudes” (P6).

The participants implied that some nursing staff has negative attitudes towards the Baby Friendly Initiative. According to the participants, some nursing staff are demotivated, ignorant, negligent, reluctant and not actively involved in BFI.

The second step of the Ten Steps of Successful Breastfeeding is to train all the health care workers in all the skills needed to implement the Breastfeeding Policy (NDoH, 2013:65). If the perception of the health care workers on the Breastfeeding Policy is poor, the implementation also becomes delayed. The psychological status of the healthcare workers is important for the implementation of changes required in BFI in an institution (Gerrish and Lacey 2010:512). In one unit, it was mentioned that all staff members have been trained for Baby Friendly and in other units the nursing staff were not trained at all.

Semenic et al (2012:15) outlined the attitudes that create barriers, as conflicting ideas by institution staff and the views and resistance to change by the health care workers. The dogmatic and inflexible attitudes were identified by the researchers. The other barriers that were mentioned, was the reluctance of management to allocate time for breastfeeding support.

3.4.4.5.2 Nursing staff's concern about mothers on discharge about breastfeeding
This subcategory refers to the concern which the nursing staff have on the mothers, when they have been discharged to go home with their babies.

One of the participants said:

“Regarding health education that is given in postnatal wards, we can teach but there is a problem of monitoring them (women) when they have gone home. They come back with ill babies…Hymn! But for me these women are not trustworthy to take referrals for themselves back to the clinics…There is a problem of monitoring them, we teach them even others are not trustworthy” (P2).

The participant implied that the mothers are not trustworthy. They are taught and practice what they have been taught when they were in hospital with their babies; but when they home it seems as if they are not supported at home, and therefore may default in correct feeding practices. Often, the mothers return to hospital with their babies being sick.

Semenic, Childerhose, Lauziere and Grolean (2012:14) stated that lack of knowledge by the mother’s post child birth and the advice or lack of support from their families, lead to demotivation and early weaning practices. Inadequate preparation during the antenatal care period or having no opportunities for ante natal care are the other contributing factors, to feeding difficulties.

3.4.4.6 Challenges experienced on Baby Friendly in maternity units

This category refers to the problems experienced on implementing Baby Friendly practices.

Semenic et al (2012:9) describe the barriers for implementing the Baby Friendly practices, as related to challenges within the organization, the health care worker, the healthcare user and with their significant others.

3.4.4.6.1 Mothers are fearful to breastfeeding
This subcategory refers to the situation whereby pregnant and delivered mothers have fear of breastfeeding their babies when they are HIV positive due to insufficient information that they receive.

The participant stated:

“But, because of the issue of Coded for HIV, most women have more questions, especially those who are coded and are on HIV treatments, as they are concerned about the safety (of their babies) in breastfeeding, want to know more about HIV and breastfeeding…They say Exclusive Breastfeeding only but others say choose method of infant feeding…Yes, for women who are coded, others say boil milk, some say do not boil milk…They say other mothers should express their breasts and feed with a cup. Others say boil breast-milk; some say do not” (P1).

The participant indicated that there are conflicting information given to mothers who are HIV positive on infant feeding, by the health care workers.

NDoH (2013:16-17) states that full information should be given to pregnant and delivered mothers at ante natal care, during labour, postnatal care and in the communities. Information is given to alleviate fears that may arise (NDoH, 2014:20-21, 71). There is lack of knowledge provided by the health care workers, the use of outdated practices and misconceptions, leading to the mothers being fearful about breastfeeding (Semenic, Childerhose, Lauziere & Grolean, 2012:9).

3.4.4.6.2 Overcrowding of mothers in maternity units

This subcategory refers to the large number of mothers, who are attended to in the maternity department, in relation to the environment and the nursing staff.

The participants said:
“Yes, very few mothers are being helped as I have said earlier, due to overcrowding” (P5).

“Overcrowding is a problem. In each cubicle in our unit there are supposed to be two midwives, most of the time is only one midwife. Immediately after delivery is completed, the mother is transferred to the stretcher to create bed for the next mother; there is no enough time for assisting the mother in breastfeeding. Mothers are not helped as supposed due to shortage of staff and overcrowding” (P5).

“According to me, there is overcrowding, the hospital is overpopulated. One of the evidenced based practices is to encourage doula which becomes difficult for us because of overcrowding, we cannot allow accompaniment by relatives” (P7).

The participants indicated that there are more mothers than the nursing staff can cope with. Therefore, the nursing staff is unable to render the best quality care which they are expected to provide.

Management is responsible to control the overflowing of mothers in the facility and to promote quality care. The overflow in the hospitals is rendering the practising of the Baby Friendly Initiative, as ineffective (Gerrish & Lacey, 2010: 512). Semenic, Childerhose, Lauziere and Grolean (2011:36) identified that there is frustration on the nursing staff, due to the increased workload and of having few nurses, resulting in a disproportion between the nursing staff and the mothers.

3.4.4.6.3 Shortage of nursing staff

This subcategory refers to the insufficient number of nurses available to render best practices in breastfeeding practices.

The participants described the shortage of staff as follows:

“For now, we do not as we are short staff” (P2).
“Hey! I do not know as shortage of staff is a long standing problem in our institution think we are about four who have trained, (sigh and repetition), I have told you that we are having a problem of staff shortage” (P3).

“It is not done because of shortage of staff but we trying...Nursing staff want to go for Baby Friendly training, but they can’t go at large numbers because of shortage of staff. Training also is after 2-3 months’ period, if we were having enough nursing staff, I think many may attend. Yes, this is due to shortage of staff and it pertain to nursing staff only don’t know about other HCW’s” (P5).

“Staff shortage, this makes supervision by nurses on mothers difficult. Most of the mothers are primigravidae and need help” (P6).

The participants implied that the shortage of nursing staff contributed to the poor service that is rendered on the Baby Friendly Initiative.

The Baby Friendly principles are not implemented sometimes, due to the shortage of staff (Gerrish & Lacey, 2010:512). Semenic, Childerhose, Lauziere & Grolean (2011:36) reported that one of the factors that prevent the success of the Baby Friendly Hospital Initiative was the hospital practices. The increased workload and the low staffing levels were identified as barriers in implementing the Baby Friendly Initiative.

Semenic et al (2012:9) in their study identified that the organizational factor, including the shortage of staff and the high staff turnover, contributed to the failure to implement the Baby Friendly Practices. Gerrish & Lacey (2010:512) also concurred with the above, that Baby Friendly principles were not implemented sometimes due to the shortage of staff.

3.4.4.6.4 Lack of involvement by other Heath Care Workers

The sub category referred to the poor participation by other health care personnel, excluding the nursing staff.

Baby Friendly Practices needs the active participation by everybody in an institution. By everybody, it means management and all the healthcare workers. Step number two of
the 10 steps of successful breastfeeding was to “train all the health care staff in skills necessary to implement the breastfeeding policy (NDOH, 2013:65). This means that everybody who is working in the institution should be trained in practising the Baby Friendly practices, thus influencing others.

The participants described the lack of involvement by the participants as follows:

“It should be hands on deck…I mean everybody should be involved mean even the managers” (P2).

“Yes, I wish that everybody should attend Baby Friendly training and have knowledge on all issues pertaining to breastfeeding and its importance” (P3).

“Yes, we do encounter problems and I think what makes Baby Friendly Practices in the institution difficult is lack of interest by nursing staff on breastfeeding and BF issues…even if we invite them to breastfeeding meetings, they do not come…Doctors? I have not seen doctors involved in breastfeeding…Yes, there is lack of interest and reluctant of nursing staff to implement what they have been taught lack of involvement by Health care workers, management also, is not actively involved…” (P4).

The participants indicated that there was a lack of interest and reluctance on promoting and protecting breastfeeding.

Porter O’Grady & Malloch (2013:36) stated that there was a need to change the attitudes and perceptions of the health care workers, which created barriers for successful Baby Friendly Hospital Initiative training. Those barriers assumed that the health care workers know enough about breastfeeding, the belief that there is no important difference between breastfeeding and bottle-feeding, and that the management staff are not actively involved in supporting the health care workers in breastfeeding issues, due also to lack of knowledge.

3.4.4.6.5 Poor communication by management
This subcategory referred to the failure of managers to provide information required by the subordinates.

The participants said:

“I am not sure, but what I know is that some of the nursing staff have been trained in our department…the management also arranges transport for us to train outside the hospital; and also inform us about the invitations that are available even if most of the time they inform us late” (P4).

“We are taught even others are unable to attend in-service education, those who are working night duty. The nursing staffs that are working during the day are able to attend in-service education” (P1).

The participants implied that invitations from the management on Baby Friendly issues are received late by the nursing staff, while planning for the units has already been done and may not be possible for the staff to attend. This causes inconveniences and leads to voluntary training and rejection to attend an important training event.

Semenic et al (2012:9) stated that the organizational culture lacks the focus on the 10steps of successful breastfeeding checklist. Lack of designated leaders for the Baby Friendly initiative, accompanied by the lack of support from the organisation contributes to the unsuccessful implementation of the programme.

3.4.4.6.6 Difficulty of the institution to achieve Baby Friendly accreditation

The sub category refers to the failure of the institution in this research study, to achieve Baby Friendly Hospital Initiative status.

The participants said:
“But why are we not accredited because we are really trying our best to implement Baby Friendly practices? I have worked in lying-in wards long ago, and Baby Friendly was not implemented during that time…now we have knowledge…according to the Millennium Development Goals, the hospital should be Baby Friendly by the year 2015” (P2).

“Yes, during the breastfeeding training I heard about that, all the ten steps of successful breastfeeding should be implemented for an institution to be accredited” (P3).

The participants implied that they are not yet in a position that they can be accredited, as they are still trying to implement Baby Friendly Practices.

All principles of the 10 steps of successful breastfeeding should be implemented fully, for successful accreditation to be achieved (WHO & UNICEF, 2009:33). Daniels and Jackson (2011:36) stated that to be accredited successfully for the Baby Friendly Initiative, the main role of the health care workers is the implementation of the ten steps of successful breastfeeding. Accreditation is the evaluation that is done on implementation of the principles of Baby Friendly practice, namely the ten steps of successful breastfeeding.

It is done through the use of a formulated appraisal tool (WHO & UNICEF, 2009:59). Accreditation indicates that the quality of best practices for the new-born babies care is practiced in an institution. There are guidelines available from the World Health Organization and United Nations Children’s Fund for accreditation. The Institutions also develop their own guidelines from the international mother bodies, such as the policies of the World Health Organization and United Nations Children’s Fund

3.4.4.6.7 Failure of all Health Care Workers to attend training

The subcategory refers to the health care personnel, who do not attend the Baby Friendly Initiative training.
The institution’s stakeholders are expected to encourage all the HealthCare Workers, to be knowledgeable about the Baby Friendly Practices and to support all the managements in the institution, for an example, nursing management, personnel management and others.

One participant said:

“There is a list of trained staff in Baby Friendly Hospital Initiative, who is only nurses” (P4).

The participant implied that the health care workers, who attend the Baby Friendly Initiative training, are only the nursing staff.

Research has been done in which new implementation for success is discovered and staff should read up about them. Step two of the ten steps of successful breastfeeding, is that all health care workers should be trained in Baby Friendly Initiative (NDoH, 2013:65).

3.4.5 THEME: FACTORS THAT MAY FACILITATE BABY FRIENDLY PRACTICE TO BE SUCCESSFUL

Theme 5 refers to the elements that should be taken into consideration to implement the Baby Friendly Practices successfully.

Porter O’Grady & Malloch (2013:36) stated that there is a need to change attitudes and perceptions of health care workers, which create barriers for successful Baby Friendly Hospital Initiative training.

Semenic, Childerhose, Lauziere & Grolean (2011:38) in their study, recommended that for Baby Friendly Hospital Initiative to be successful, specific objectives of Baby Friendly Hospital Initiatives, strategies and the Breastfeeding Guidelines and Policies, needs to be actively implemented. This will assist in transforming the institutions to be more mother and baby friendly. Included in the Breastfeeding Guidelines is the “Ten Steps of Successful Breastfeeding” in chapter 1, Table 1, which is the hallmark for successful
Baby Friendly Care practices, which lead to successful accreditation of the institution for Baby Friendly Hospital Initiative (WHO & UNICEF, 2009:1; NDoH, 2013:65).

3.4.5.1 Formulation of support groups

This category refers to the ability of building groups, in which the members help each other on breastfeeding issues.

Principle number 10 of the ten steps of successful breastfeeding is to promote the establishment of support groups and to refer the mothers, to them on discharge from the hospital or clinics. The theme for 2013 International Breastfeeding Week was “Breastfeeding Support: Close to Mothers”. The aim of this theme was to encourage and identify in key individuals, who are supposed to provide support to the breastfeeding mothers (World Alliance for Breastfeeding Action, 2013:1).

The following information was given by the participant:

“I think involving the support groups…They will take over where we have left as the will continue with what we have been doing as hey will be outside the hospital and also as they are as writing referral letters to local clinics” (P2)

Implication by the participant is that there should be continuity of care service even if the mothers and babies are discharged from their hospital, to the support groups, as there should be collaboration with the community clinics.

Daniels and Jackson (2011:38) stated that for the successful implementation of Baby Friendly Initiative, there is a need for support for improvement of breastfeeding practices. This support can be provided in different ways; such as, the utilization of breastfeeding champions from the district nutrition staff during in-service education and workshops. Five circles of support were identified, namely, the women, who are the centre, surrounded by the following: the family and the social network, the health care
systems, the workplace and the employment, government/legislation and the response to crises and emergencies (World Alliance for Breastfeeding Action, 2013:1).

3.4.5.1.1 Members of the breastfeeding support group

This subcategory refers to the people who may belong to the breastfeeding support group.

Support groups are formed by health care workers, at different levels (hospitals and clinics), pregnant and delivered women, community and significant others, that is, families /relatives, colleagues and other service providers.

The participants said:

“Mothers who have been discharged should be allowed to return and give report of what they are doing [s] support groups” (P5).

“We encourage mothers to form support groups at local clinics” (P7)

The participants implied that mothers are to be encouraged to belong to support groups, and they should also be allowed to come back to the hospital to report on their progress.

Step number ten of the 10steps of successful breastfeeding, encourages the establishment of Breastfeeding support groups (NDoH, 2013:66). On-going support should be given by the health care workers on discharge at the home or at the Primary health care level (NDoH, 2013:20). Facilitators are supposed to be skilled, getting all staff to be on board and implementation of baby friendly care should be an on-going process (Wieczorek, Schmied, Dorner & Dur,2015:7).
3.4.5.1.2 Involvement of the available support group

This subcategory refers to that breastfeeding support groups that are available and should be invited to participate and motivate other mothers about the Baby Friendly Initiative in the institution.

The participant said:

“I think of involving support groups” (P2).

The participant implied that all the health care workers should be educated, and should be able to be involved and participate, including the managers, gardeners and other labourers, so as to be able to give the support that is needed, by the breastfeeding or formula feeding mother.

On-going support is implemented by involving the community health nurses at the local, clinics by writing referral letters as they will take over, where the hospital’s nursing staff has ended its care and practices of breastfeeding initiatives (NDoH, 2013:20).

3.5.5.2 Use of knowledgeable people for in-service education

This category refers to the use of knowledgeable persons to teach the health care workers, about the Baby Friendly Initiative.

The Baby Friendly Hospital Initiative is part of the global strategy for infants’ and young children’ feeding requirements to reduce morbidity and mortality. Knowledge is an important element in supporting and strengthening the Baby Friendly Practices (WHO & UNICEF, 2009: 30). Semenic et al’s study (2012:13) recommended that for an institution to be successful in implementing the Baby Friendly Initiative, the organization should seek out people who are motivated about the Baby Friendly Initiative to teach and facilitate its implementation. The organization should also select leaders and champions who have knowledge and competence in understanding Baby Friendly Practices.
3.4.5.2.1 Available Breastfeeding champions

This subcategory refers to the breastfeeding champions, as persons who have more knowledge on breastfeeding, Baby Friendly Hospital Initiative and PMTCT (HIV positive and breastfeeding), according to the participants understanding.

The participant said:

“I think if somebody with more knowledge from the Department of Health can come and give us in-service training” (P1).

The participant implied that in-service education should be given by people who know more about the topic, who are experts and for the nursing staff to attend to gain beneficial information and be knowledgeable.

Support for the improvement of the knowledge on Baby Friendly Care, is that champions in the Baby Friendly Initiative should also support the district nutrition staff (Daniels & Jackson, 2011:38). Ahmed, Diana and Richardson (2011:76) in an abstract on “Current Breastfeeding Knowledge”, suggestion that for the successful implementation of the 10steps of breastfeeding, knowledge on breastfeeding should be improved, by using school and university books to emphasize breastfeeding and maximise their knowledge on breastfeeding.

3.4.5.3 Active participation and involvement by all HealthCare workers

This category refers to the active participation and involvement of all health care workers in Baby Friendly practices.

The participant shared the following information:

“Okay, according to Millennium Development Goals, the hospital should be Baby Friendly the year 2015. It should be hands on deck. I mean that everybody should be involved, even the managers” (P2).
The implication of the participant was that to be able to meet the Millennium Development Goals 2015, all the health care workers in the institution should have been actively involved in the Baby Friendly Initiative.

The WHO recommends the training of all the health care workers, to provide and support them with more knowledge and better skills. There should be an attitude change to increase and enhance their motivation towards baby friendly hospitals (NDoH, 2013:65). Semenic et al (2012:9) stated that leadership can play a major role in facilitation, participation and involvement of a strong administrative and managerial staff support, by co-ordinating and decentralizing the Baby Friendly approach to the staff members.

3.4.5.3.1 Involvement by management and all health care workers

This subcategory refers to the involvement of all the managers and all personnel working in the health care institution in the Baby Friendly Initiative.

One of the Millennium Development Goals for 2015 was that all the institutions offering maternal and child care services should be Baby Friendly accredited (Millennium Development Goals, 2015:1). This means that for an institution to be accredited for Baby Friendly all health care workers should be involved; this process is still a work in progress project.

The information was shared by participants:

“I think the management to be actively involved, matrons should work with us together, provide available education. Top management’s role is very important” (P5).

“I think all the staff can be trained, even the general assistants…I think if the management can involve all health care workers, by encouraging all departments to send at least one person to attend breastfeeding in-services that are available in the institution, just like what is done in HIV and AIDS. Every health care worker should be well informed about breastfeeding” (P7).
The participants implied that the top managers, as well as the other health care members should be involved in the Baby Friendly Practices initiatives.

The institution has to have a strategic plan developed, should have an interdisciplinary core task team, Baby Friendly Initiative co-ordinators and strong leaders to proceed with this programme. The Baby Friendly Initiative should be included in the hospital accreditation criteria and should involve the quality assurance and quality management team (Semenic et al, 2012:13).

3.4.5.4 Formulation of active Breastfeeding Committee

This category refers to the formulation of an active breastfeeding committee.

Task teams should be formed with staff from the other facilities, as collaboration raises awareness outside the institution.

One participant said:

“All those who have attended breastfeeding training should be members of the breastfeeding committee (P3).

The participants implied that the continuity of support groups can be sustained, if the formulated Breastfeeding committee is visible and active by encouraging other health care workers in the Baby Friendly Initiative.

Semenic et al (2012:13) recommended that for the successful implementation of the Baby Friendly Initiative, the institution should develop an organizational culture, by identifying motivated persons and leaders who have knowledge and competence in taking the Baby Friendly Initiative forward.

3.4.5.4.1 Trained health care workers in Baby Friendly Care
This subcategory refers to the utilisation of the health care personnel, who have been successfully trained in Baby Friendly care.

The participants said:

“Again, Breastfeeding Committee should be established…The Breastfeeding Committee should be available…I think if Breastfeeding Committee can be established and do its function, people will be motivated and encouraged …All those who have attended Breastfeeding Training should be members of the Breastfeeding Committee” (P3).

“I am a member of the Breastfeeding Committee in D G Academic Hospital which affiliates with Gauteng Breastfeeding Forum…as Breastfeeding Committee, our work is to liaison with Gauteng Breastfeeding Forum about Baby Friendly practices and implement new practices that are available” (P4).

“I think if the Breastfeeding Committee can involve all health care workers by writing a list of those who have trained and delegate them to teach others. It should be a continuous process; those who have been taught should teach others” (P6).

“I think if it can be said that those who have attended training in different departments to teach those who has not trained, it would be better” (P7).

The participant indicated that the staff that has been trained as Baby Friendly Health Care Workers should form the Breastfeeding Committee, as they have more knowledge about Baby Friendly.

The Breastfeeding committee should be formed by the health care workers, who have been trained in a 20-hour course, as they will have more information on the Baby Friendly Care Initiatives (WHO & UNICEF, 2009:30).
3.4.5.5 All HealthCare Workers be well informed about Baby Friendly issues

This category refers to that all the health care workers, who are working in the hospital and who should have knowledge and information about the Baby Friendly Initiative.

The participant stated:

“Yes, I wish that all health care workers should attend Baby Friendly training and have knowledge on all issues pertaining to breastfeeding and its importance. I have learned a lot from that training” (P5).

The participant wished for all the health workers to have some form of training in BFI.

Step number two of the 10steps of successful breastfeeding, is that all the health care workers should attend BFHI training, in chapter 1, Table 1, step 2 (NDoH, 2013:65). All the health care workers should have access to formal and informal breastfeeding education and skills training (Semenic et al 2012:7).

3.4.5.5.1 All Health care workers to attend Baby Friendly activities

This subcategory refers to the involvement of all the persons, who are working in the institution to support and promote Baby Friendly activities.

The participants said:

“Yes, wish everybody should attend Baby Friendly training and have knowledge on all issues pertaining to breastfeeding and its importance learned a lot from that training, even the information I did not know before…Midwives, other staff and also student nurses should discourage mixed feeding and artificial feeds which make babies sick” (P3).

“I think training for Baby Friendly may assist” (P6).
“I think if management can involve all health care workers by encouraging all departments to take at least one-person to attend breastfeeding in-services that are available” (P7).

“Everybody in the hospital is to attend Baby Friendly workshops and seminars regularly, attendance is important” (P5).

The participant implied that all the Health Care Workers should attend scheduled activities on Baby Friendly Care. The managers, nursing staff, clerks, security officers, cleaners, labourers and doctors should all attend the Baby Friendly Hospital Initiative training, to be knowledgeable and updated about breastfeeding improvements and updates.

For the success of the Baby Friendly practice, all the health care workers should be trained in BFI. The clinical staff needs to be trained on a 20-hour course and the non-clinical staff is to be trained in an 8-hour course (WHO& UNICEF, 2009:1).

3.4.5.6 To develop outreach programmes

This category refers to the ability to develop Baby Friendly programmes that should be disseminated through outreach programmes.

The participant stated that the Information should be shared as follows:

“People are also given pamphlets with information about breastfeeding think we can also make outreach programmes through invitations whereby mothers are allowed to come along with their partners and families” (P4).

The implication of the participant was that the mothers and members of the families can be reached through different methods of communication, and should be part of the outreach programmes and awareness campaigns.
Collaboration is a way to communicate with other members in the community, to enhance the continued support to the mothers (WHO & UNICEF, 2009:82). Baby Friendly Initiatives can be sustained by continuing support with health care workers, families and significant others in the community. Semenic et al (2012:9) described the engagement and education of the community, through the creation of public campaigns to highlight the benefits of the Baby Friendly Initiatives.

3.4.5.6.1 Invites mothers, partners, families and community at large

This subcategory refers to involving the mothers with their partners, families and the community, by inviting them to attend and participate in Bay Friendly activities, in the institution and in the community.

The participants said:

“…Teaching the midwives about breastfeeding and also educating the mothers about breastfeeding and involving everybody…This is done through giving health talks at churches and where there are functions in the community, thus collaboration” (P3).

“I think we can also make outreach programmes through invitations whereby mothers are allowed to come along with their partners and families” (P4).

The participants suggested ways of teaching professionals and non-professionals and about Baby Friendly Initiative, by using outreach programmes effectively.

In the circles of support, the family, social networks and other structures or people in the community, were identified as important individuals by the World Alliance for Breastfeeding Action to promote the Baby Friendly Initiative (WABA, 2013:1).

3.5 CONCLUSION

The data analysis, findings and literature control were described in this Chapter. Five themes with categories and subcategories emerged from the data, on the experiences in the implementation of the ten steps of successful breastfeeding in the maternity units.
CHAPTER 4

DISCUSSION OF THE FINDINGS

4.1 INTRODUCTION

In this chapter, the focus is on the discussion of the findings that nursing staff described as their everyday life experiences, concerning the implementation of the principles of the ten steps of successful breastfeeding. According to their experiences, the nursing staff tried to implement the ten steps of successful breastfeeding in the maternity wards, but encountered many challenges. However, through the findings of this study, recommendation may be provided to assist to solve these problems as reflected by the participants.

Data was analysed using Tesch's eight steps of open coding by identifying themes, categories and subcategories (Creswell, 2009:186) as was discussed in detail in Chapter 2. In this chapter the findings of the study together with literature control are discussed.
4.2 PURPOSE OF STUDY
The purpose of the study was to determine the lived experiences of the nursing staff, regarding the implementation of the ten steps of successful breastfeeding at a tertiary, academic hospital in transition to becoming Baby Friendly Care institution, in the Gauteng province.

4.3 RESEARCH OBJECTIVES
The objectives of the study were to:

- Explore and describe the lived experiences of the nursing staff, regarding the implementation of the ten steps of successful breastfeeding
- Identify strategies required for the successful implementation of the Ten Steps of Successful Breastfeeding, for the achievement of a successful Baby Friendly Care hospital status.

4.4 DISCUSSION OF FINDINGS
In this study, five themes were identified. The discussion below will be based on these themes and the literature control.

4.4.1 Establishment and maintenance of Baby Friendly Practices by nursing staff
The participants gave the information that in the maternity units in the hospital, the skills of the ten steps of successful breastfeeding were known and implemented. The implementation of the ten steps of successful breastfeeding is the strategy recognized by WHO and UNICEF for the success of infants and young children’s’ survival (WHO & UNICEF, 2009:2; NDoH, 2013:16).

The lived experiences of the participants were that the following skills were implemented in maternity units, namely the initiation, promotion of bonding, skin to skin contact, demand feeding, rooming - in, exclusive breastfeeding, expressed breastmilk, choosing infant feeding methods, Affordable, Feasible, Accessible and Safe criteria, latching of the baby, attachment of the breast, breastfeeding and HIV care. The
following practices were discouraged by the institution in study, namely mixed feeding, formula feeding and the use of pacifiers. Health talks were given on the importance of breastfeeding, using the available learning material on different topics and in different sessions. These are some of the ten steps of successful breastfeeding that are included in Chapter 1, Table 1.1.

The researcher identified that the participants' had theoretical knowledge about Baby Friendly Practices, but the implementation of some of the ten steps for successful breastfeeding was not done or was poorly done. For an institution to be Baby Friendly, the ten steps of successful breastfeeding should be adhered to as illustrated in Chapter 1, Table1.2. Some of the skills of the Baby Friendly Initiative were not fully implemented, as instructed by the WHO and UNICEF, due to organizational problems as discussed in Theme 3, category 3.1.4. Management plays a key role for promoting the implementation of the 10 steps of successful breastfeeding, through the support that they offer to the nursing staff in the maternity units. Accreditation of an institution to be a Baby Friendly Hospital dictates that the quality and best practices for the care of newborns and their mothers, should be practiced at a high standard in the maternity wards in that institution.

4.4.2 The provision of education on Baby Friendly Care.

The findings reported on health education were that health education was given in different ways to the nursing staff, the management, the other health care workers and the mothers, but not all the health educators were fully knowledgeable of the Baby Friendly Hospital Initiative. Some of the nursing staff and the mothers had some knowledge about the Baby Friendly care, which posed a problem for practicing the Baby Friendly fully in the institution (Semenic et al, 2012:7). In the study by Daniels and Jackson (2011:37), the findings revealed that the lack of knowledge and understanding of the Baby Friendly Initiative by nursing staff was a barrier. Health education is one of the important principles of the ten steps of successful breastfeeding as illustrated in Chapter 1, Table 1.1, and Step 3). It was identified that the health education was given to both nursing staff and mothers, but was minimal and with limitations.
4.4.3 The role of management in Baby Friendly Care

The participants described that the management of the maternity wards in the hospital supported and promoted the Baby Friendly Practices. A Breastfeeding policy was available in the maternity ward and was recognized by some of the nursing staff.

The findings were that the management team should offer opportunities for Baby Friendly in-service education, training for Baby Friendly Hospital Initiative and attendance of Baby Friendly activities, such as symposia and workshops. The participants also attended workshops which are scheduled in other institutions. From the information given, only some of nursing staff attended the Baby Friendly Training and the other Baby Friendly activities. The other nursing staff and the health care workers were not involved in the Baby Friendly activities. Baby Friendly Hospital Initiative training, in-service education and workshops are compromised because of the problems that are encountered due to time and staffing problems. Semenic et al (2012:4) identified the organizational factor as one of the challenges for implementation of Baby Friendly Care. It becomes difficult for the maternity department to achieve 80% or more during Baby Friendly assessments, due to the low number of nursing staff that attend the Baby Friendly training in maternity units. For accreditation to be achieved, 80% of nursing staff in maternity department should have been attended Baby Friendly Imitative training as illustrated Table 1.2, Step number 2 (WHO & UNICEF,2009:9).

4.4.4 Factors hindering Baby Friendly Practices to be successful

The participants described the factors that affected the Baby Friendly Practices that were not successful. The factors that affected the lack of success of the Baby Friendly Practices were identified, and were related to the nursing staff, the pregnant and delivered women, the management team, the other health care workers and the institution as whole. If the identified factors are not taken into consideration for Baby Friendly care, as related by the participants, the institution will not be successful in implementing and achieving the Baby Friendly hospital status.

There are several studies, which have reported the underlying factors that have contributed to the lack of success of being accredited as Baby Friendly hospitals.
Daniels and Jackson in their study identified the following factors in the implementation of the Baby Friendly Initiative, such as the shortage of staff, the increase and heavy workloads, the lack of understanding and knowledge. Resistance and reluctance to change was also revealed (Daniel & Jackson, 2011:37). Semenic et al (2012:13) identified the factors as organizational related to inadequate staffing, leadership issues, Breastfeeding Policy and training; health care providers related to lack of knowledge and understanding, attitudes and reluctance to change. The factors related to the health care users revealed that there was a lack of knowledge and understanding, a lack of family support and previous experiences in giving birth.

The researcher identified the following problems that are causing the lack of success in the implementation of Baby Friendly care, namely the shortage of nursing staff, overcrowding of mothers, the lack of involvement by the other health care workers, poor communication by management, no training of all for some health care workers for Baby Friendly care, fearful mothers and also the failure of the hospital to be accredited despite the efforts made. The nursing staff lacked the knowledge and skill to demonstrate to the women, how to hold and breastfeed their babies. There was a lack of interest, resistance and a lack of motivation by the other nursing staff concerning the implementation of the Baby Friendly Practices.

The Breastfeeding Policy was available, visible and but not recognized by all the health care workers. Step 1 on Table 1.1 is that the institution is to “have a written breastfeeding policy that is communicated routinely to all health care staff” (WHO & UNICEF, 2009:7). Pregnant and breastfeeding mothers were given insufficient and conflicting information about breastfeeding practices. Many nursing staff did not trust the breastfeeding approaches of the mothers after they had been discharged, and also the use of the referrals letters that should be taken to the local clinics.

4.4.5 Factors that may facilitate Baby Friendly Practices

The participants offered many suggestions that may facilitate the success for the Baby Friendly Practices. Semenic, Childerhose, Lauziere and Grolean (2012:13) in their study recommended that the following factors should be considered for a Baby Friendly
Initiative to be successful, namely; inter and intra organizational factors, individual factors related to knowledge, practices and attitudes of health care users and providers as well as external factors related to family and community. These factors should be considered by a facility for change to be successful.

The following were suggestions for improvement on the Baby Friendly Practices, suggested by the participants. They included that the old or previous practices of breastfeeding should be withheld. The ways for initiating change and implementation should be identified for the successful practice of Baby Friendly practices. Semenic et al (2012:9) states that there is a need to change attitudes of the health workers and consumers which creates barriers for successful Baby Friendly Practices.

Staff information and skill efficiency are factors that may help in the successful implementation of new practices or changes. Practices, attitudes, and knowledge of health care providers, organisational culture and philosophy which is related to leadership, human and financial resources are of importance in managing change (Semenic et al., 2012:9).

Gerrish and Lacey (2010:15) described that staff information and efficient skills are factors that may help in the successful implementation of the new practices or changes. Psychological experiences related to culture, values and beliefs; organizational factors, for example, hospital practices and the availability of resources are important factors to be considered. If the abovementioned factors are not taken into consideration, the implementation of new practices would not be easy to be successful. The change should be communicated and introduced step by step to all the Health Care workers, in order for the success of being a Baby Friendly Hospital.

4.5 CONCLUSION

The lived experiences of the nursing staff in the transition to a baby friendly health care were explored at the tertiary, academic hospital in this study. The practices and the challenges encountered were described; suggestions for improvement were recommended, and were to be managed through the change process for the successful
CHAPTER 5

SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

In the study, everyday life experiences on implementation of the principles of the ten steps of successful breastfeeding were explored. According to the information given, the nursing staff informed that they were trying their best to implement the ten steps of successful breastfeeding but there were some problems encountered. However, the nursing staff has opinions that could be done for improvement. The summary, implications of the study and recommendations are discussed in this chapter.

5.2 PURPOSE OF STUDY

The purpose was to determine lived experiences of nursing staff, at an academic tertiary hospital to a transition to a Baby Friendly Care.

5.3 RESEARCH QUESTIONS

The research questions for the study were:

- What are the lived experiences of nursing staff at an academic tertiary hospital on implementing the ten steps of successful breastfeeding?
What are the strategies required for the successful implementation of the Ten Steps of Successful Breastfeeding, for the achievement of a successful Baby Friendly Care hospital status?

5.4 RESEARCH OBJECTIVES.

The research objectives for the study were to:

- Explore and describe the lived experiences of nursing staff regarding the implementation of the ten steps of successful breastfeeding.
- Identify strategies required for the successful implementation of the Ten Steps of Successful Breastfeeding, for the achievement of a successful Baby Friendly Care hospital status.

The chapter provides the summary of the study, the recommendations and the conclusions.

5.5 SUMMARY

Five themes were generated from the analysed data, and literature was used to justify the findings of this research study.

The ten steps of successful breastfeeding were identified as being implemented by some of the participants, but was not fully implemented in the maternity units from the information given from the participants. The participants were knowledgeable about the ten steps of successful breastfeeding, however the researcher identified that some of the ten steps of successful breastfeeding were compromised. The reasons for the problem of the success of breastfeeding being compromised were that the breastfeeding policy was available but was not spontaneously used by all the nursing staff, there was a lack of training on baby friendly practices by some of nursing staff in the maternity department, and also there were no support groups available within the maternity department.

The research objective of exploring and describing the lived experiences of nursing staff in maternity units on implementing the ten steps of successful breastfeeding for successful Baby Friendly Care in the institution in study was met. The implementation of
the ten steps of successful breastfeeding is the strategy recognized by WHO and UNICEF (2009:1), and should be fully implemented for the success of maternal, infant and young children’s’ survival.

5.5.1 Experiences of nursing staff on implementing of the ten steps of breastfeeding

In this study the participants; the nursing staff described their everyday experiences of implementing the ten steps of successful breastfeeding. The research question: “What are the lived experiences of nursing staff at this academic tertiary hospital on implementing the ten steps for successful breastfeeding” was answered. The nursing staff provided information on the different methods that were used to provide Baby Friendly knowledge. They explained that they tried their level best to implement the Baby Friendly Care, but they regularly encountered problems that hampered their success with the ten steps of breastfeeding. Health education was offered by the participants to the pregnant and delivered women, and the community and the other Health Care Workers also encouraged breastfeeding by using different methods, such as one to one counselling as well as visiting the mothers.

The researcher identified that not all the health care workers and the nursing staff have the knowledge and the understanding about Baby Friendly Practices, as it was mentioned that some of the nursing staff was unable to give feedback on the in-service training or workshops that they had attended. Health education cannot be compromised for both the nursing staff and the mothers.

The factors which hindered the Baby Friendly practices were identified by the researcher, from the transcripts of the participants, and were related to the nursing staff, pregnant and delivered women, management, other Health care workers and the institution as whole, in terms of the ten steps of breastfeeding.

5.5.2 Strategies for managing change for successful implementation of the ten steps
The second objective of identifying the strategies for managing change was achieved through the suggestions made by the participants and the second research question, “What are the required strategies to manage change for successful implementation of the ten steps” was answered. They stated that there were ways that may facilitate and improve the implementation of the ten steps of breastfeeding.

In managing the identified problems, the theories of change should be applied together with the processes of managing change. Porter-O’Grady and Malloch (2013:51) stated that to improve and facilitate change, evidenced based practice should be used. The following elements should be taken into consideration: personal knowledge, change and innovation, collaboration, embracing vulnerability and managing risks.

Protocols, guidelines, policies and other researchers on breastfeeding should be revisited and gaps in practice identified. Ways for managing change should be determined and applied in practice for successful implementation. According to the studies done, it means that if the identified factors are not taken into consideration for Baby Friendly care, the institution will have difficulties in the success for Baby Friendly care. Change should be communicated and introduced step by step to all the Health Care Workers. Evaluation of the process of change should be done to improve practice.

5.6 LIMITATIONS OF THE STUDY
The study was concerned on the implementation of the ten steps for successful breastfeeding in transition to a Baby Friendly institution only by nursing staff; other health care workers were not included. The knowledge and understanding of the nursing staff about the phenomenon was also not included in the study. The institution in the study was the only academic one in the location and the findings cannot be generalised.

5.7 RECOMMENDATIONS

The researcher developed recommendations regarding the education for the health care workers in the unit, reviewing of the existing Breastfeeding Policy, support breastfeeding mothers and to encourage further research on the ten steps of
breastfeeding. The recommendations were made based on the conclusions drawn from the findings.

5.7.1 Education to unit Health care workers

It is the responsibility of the hospital management to train all the Health Care workers to apply the Baby Friendly practice in the maternity wards. Baby Friendly Training should be compulsory and offered to all the Health care workers. The Mother and Baby Training should be available to the health care workers who are working in the maternity department, within six months of them being appointed. Baby Friendly Practices should be included in the orientation programme of the newly appointed nursing staff in the institution and in the maternity units. The nursing staff in the maternity units should also be encouraged to facilitate and stimulate the mothers about breastfeeding, as they are the first people whom the pregnant and delivered women come into contact with, in the hospital. A follow up system needs to be in place to assess and monitor the progress of the nursing staff in the maternity department, who have been exposed and trained in the Baby Friendly practices.

There should be a continuous orientation and on-going mentoring of the maternity unit staff, about the ten steps of successful breastfeeding. The management should inform the nursing staff timeously, about the essential and relevant forthcoming events on Baby Friendly issues. The use of an effective communication medium should be established and regularly applied in practice to enhance the ten steps of breastfeeding. The health education programmes should be initiated as recommended for the health institutions that are rendering maternal care of the new-born and child services. Relevant health education topics on breastfeeding should be planned and offered to the mothers, according to the trimester that they are in during pregnancy, individually or in groups.

Strategies for the implementation of the ten steps of breastfeeding should be put into practice as part of the change process. The nursing staff should be encouraged to comply with the national guidelines of Baby Friendly care, and to be understood, applied
and supported by the nursing management. An active and visible task team for the Baby Friendly Initiative should be formulated to facilitate the process.

5.7.2 Reviewing of existing Baby Friendly protocol

The institution should have a Breastfeeding Policy that is well recognized by all the Health Care Workers who work there. Strategies for implementing the ten steps of successful breastfeeding should be put into practice, as also suggested by the participants. This could be met by implementing the strategies for managing change. There is a need to understand that change has to occur, to try and resolve the problems that exist which prevented the success of the accreditation process in the Baby Friendly Hospital Initiative, at the Tertiary Academic Hospital in this study. Also for management, to overcome those problems which are encountered through managing the processes of change, such as a positive attitude.

The breastfeeding policy has to be formulated, so that it is aligned with the international one; taking into consideration the institution in this research study. A system needs to be planned to determine that all the nursing staff understand and are knowledgeable of the contents of the Breastfeeding Policy. An Action plan should be designed.

5.7.3 Support breastfeeding mothers

For Baby Friendly practices to be successful, the pregnant and delivered women need support from the health care workers on the ten steps of breastfeeding. The health care workers should provide the mothers with accurate information about breastfeeding to increase their knowledge. The questions from the mothers are to be answered genuinely with understanding from the health care workers, and should be at the level of the individual mothers. Support is to be continued by the nursing staff when the mothers are discharged from hospital and referral letters should be written to the local clinics. The mothers should be given contacts by the nursing staff and the other health workers of the available support groups in their area, to be able to get help on baby care and breastfeeding. The support group should be formed and initiated by the health care
workers who have knowledge about Baby Friendly care, so that they are able to assist the mothers.

5.7.4 Further research

Further research is recommended to explore the ways of how the institution can be assisted to train all the health care workers, including the nursing staff on night shift, managers and the doctors. Breastfeeding education is minimal as described in the journal of Human Lactation of 2011, whereby the study revealed that the information in the paediatric and the nursing textbooks as well as obstetrics about breastfeeding and Baby Friendly Initiative was minimal and insufficient (Azza, Diana & Richardson, 2011:72). During this study also, it was difficult for the researcher to find school textbooks with information on the Baby Friendly Hospital Initiative or Baby Friendly Practices. The information was found mainly on the department of health, WHO and UNICEF Policies, guidelines, protocols, journals, research studies of other people and internet document. As such, research is needed on breastfeeding education, to improve the knowledge of nursing staff and medical practitioners on Baby Friendly care.

5.8 CONCLUSION

For the successful implementation of the ten steps of successful breastfeeding, change management strategies are very important. Baby Friendly practice is compromised at the tertiary, academic Hospital in this research study due to problems that were encountered. This study focused on the living experiences of the nursing staff on the implementation of the ten steps of successful Breastfeeding. The nursing staff in the maternity department expressed that there were challenges in implementing the Baby Friendly Practices, and suggestions for improvements were suggested to facilitate change.

Baby Friendly Practices is one of the global strategies recognized for successful feeding practices. For the successful implementation of the ten steps of successful breastfeeding, strategies for managing the process of change should be planned in
practice. Overcrowding and the shortage of staff were identified as the major factors, contributing to the scoring of lower than 80% on the Baby Friendly assessments.

REFERENCES


ANNEXURE 1

INTERVIEW GUIDE

INTERVIEW GUIDE

Topic
The lived experiences of nursing staff in transition to a baby friendly health care, at Dr George Mukhari Hospital

1 Introduction and greetings
Good morning madam...
How are you?
Let us start with our interview
Approximate time will be 40 minutes

2 Questions
2.1 Central question
How is it for you to implement the Baby Friendly principles in the ward?
2.2 Probing questions

What measures have been taken by management for you to be able to promote and support current breastfeeding practices?

I heard you said… may you please elaborate how are you engaged in Baby Friendly Care?

What written protocols are available to guide BFHC practices?

How do you assess your goal achievement in the ward on breastfeeding principles?

Is the any partnership involved in supporting and promoting BFC? (Doctors) If any, how...

What are the hampering factors according to your view in implementing the ten steps of successful breastfeeding?

What suggestions can you make to implement BFC successfully in GMH?

How is progress to BFH status monitored?

3. Conclusion

From what I hear you said…
Is there anything you want to add?
Thank you for participating in this interview.
# Annexure 2
## Observation Sheet

### Observation Sheet

<table>
<thead>
<tr>
<th>Observation sheet</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pregnant delivered women with their new-borns in the units are informed about benefits and management of breastfeeding?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do units have records where they indicate that breastfeeding was discussed?</td>
<td></td>
<td></td>
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<tr>
<td>3 Are mothers helped by nursing staff to initiate breastfeeding?</td>
<td></td>
<td></td>
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<tr>
<td>4 Is rooming- in practiced except where hospital procedures or separation due to medical situation is indicated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Is breastfeeding on demand practiced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Do nursing staff teach and observe latching?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 When is caesarean section mothers given their babies to hold, after 30 minutes, 1 or 2 hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Is the hospital having a written breastfeeding policy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Is the breastfeeding policy available and visible in the unit for all nursing staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Do the hospital arranged for special training in lactation management?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Do you have the list for trained staff in the unit?</td>
<td></td>
<td></td>
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<tr>
<td>12 Are the ten steps of successful breastfeeding displayed in the unit? Is there a mechanism for evaluating effectiveness of the policy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Is there anywhere in the records breastfeeding is reflected?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14 Is progress to BFH status monitored? 

15 Is there a gap analysis? 

16 Is there a catch up plan? 

17 Is there a list of the community support system? 

ANNEXURE 3

SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY

(ENGLISH CONSENT FORM)

ENGLISH CONSENT FORM

SEFAKO MAKGATHO SCIENCES UNIVERSITY [ENGLISH CONSENT FORM]

Statement concerning participation

Name of Study

THE LIVED EXPERIENCES OF NURSING STAFF IN TRANSITION TO A BABY FRIENDLY HEALTH CARE, DR GEORGE MUKHARI ACADEMIC HOSPITAL

I have read the information on the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.
I know that sound recordings will be used. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name and hospital number are not revealed. Regarding images of the face, I understand that it may not be possible to disguise my identity, and I consent to the use of the sound recordings.

I understand that participation in this Study is completely voluntary and that I may withdraw from it at any time and without supplying reasons.

I know that this Study has been approved by the Medunsa Research Ethics Committee (MREC), University of Limpopo (Medunsa Campus) now called Sefako Makgatho Health Sciences University and Dr George Mukhari Academic Hospital. I am fully aware that the results of this result of this Study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Study.

Name of volunteer Signature of volunteer

Place. Date. Witness

Statement by the Researcher

I provided verbal and written information regarding this Study

I agree to answer any future questions concerning the Study as best as I am able.

I will adhere to the approved protocol.
ANNEXURE 4

LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH STUDY AT
DR GEORGE MUKHARI ACADEMIC HOSPITAL

Department of Nursing Science
University of Limpopo
Box 142
Medunsa
TEL NO : (012) 521-4664
FAX NO : (012) 521-3820

The Chief Executive Officer
Dr George Mukhari Hospital
Private bag X422
PRETORIA
I, Matlou Germinah Mabokane, request permission to conduct study at the hospital.

The proposed research study is “The Lived Experiences of nursing staff in transition to a Baby Friendly Health Care at Dr George Mukhari Academic Hospital”.

The wards of choice for the study are: ante natal care clinic, ante natal ward, labour ward and the two postnatal wards.

The objectives of this study are to explore and describe the lived experiences of nursing staff, regarding the implementing the Ten Steps of Successful Breastfeeding for a successful Baby Friendly Care in a tertiary, academic institution in Gauteng Province, and to identify strategies for the successful implementation of breastfeeding for the achievement of a successful Baby Friendly Care hospital status.

The research proposal has been sent to the Medunsa Research Committee for approval.

Thank you in advance

Yours sincerely

M. G Mabokane (2011147640)
MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 07/2012
PROJECT NUMBER: MREC/4210/2012: PG

PROJECT:

Title: The lived experiences of nursing staff in transition to a baby friendly
health care, at Dr. George Mukhari Hospital

Researcher: Ms MG Mabokane
Supervisor: Dr. JM Dippnerar
Co-supervisor: Dr. ML Serojane
Hospital Superintendent: PMT Matsanola (DGMH)
Other Involved HOD: MM Dimatit (DGMH)
Department: Nursing Science
School: Health Care Sciences
Degree: MCur

DECISION OF THE COMMITTEE:

MREC approved the project.

DATE: 12 September 2012

PROF. GA OGBUNANJO
CHAIRPERSON MREC

The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (5C000004319), as an Institutional Review Board (IRB000005122), and functions under a Federal Wide Assurance (FWA00009419).

Expiry date: 11 October 2016

Note:

i) Should any departure be contemplated from the research procedure as
approved, the researcher(s) must re-submit the protocol to the committee.

ii) The budget for the research will be considered separately from the protocol.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.
ANNEXURE 6

PERMISSION TO CONDUCT RESEARCH AT DOCTOR GEORGE MUKHARI HOSPITAL

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DR GEORGE MUKHARI HOSPITAL

To: Ms. Geminah Matsha Matshane
Department of Nursing Science
University of Limpopo
MEDUNSA
0204

Date: 23rd November 2012

RE: PERMISSION TO CONDUCT RESEARCH.

The Dr. George Mukhari Academic Hospital hereby grants you permission to conduct research on “The lived experiences of nursing staff in transition to a baby friendly health care at the Dr. George Mukhari Academic Hospital”.

We note that you have already obtained ethical Clearance from the Human Research Ethics Committee.

This permission is granted subject to the following conditions:
☐ That the Hospital incurs no cost in the course of your research;
☐ That access to the staff and patients at the Dr. George Mukhari Academic Hospital will not interrupt the daily provision of services;
☐ That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.

Yours sincerely

[Signature]

DR. PMT. MA буку
DIRECTOR: CLINICAL SERVICES
ANNEXURE 7

CO-CODER LETTER

Dr Annatjie van der Wath (M Cur, Ph D) annaydw@mweb.co.za

Qualitative Data Analysis

This serves to confirm that Annatjie van der Wath has co-coded the following qualitative data: 7 interviews for the study:

THE LIVED EXPERIENCES OF NURSING STAFF IN TRANSITION TO A BABY FRIENDLY HEALTH CARE, AT DR GEORGE MUKHARI HOSPITAL

I declare that the candidate and I have reached consensus on the major themes and sub/categories as reflected in the findings during a consensus discussion.

Annatjie van der Wath (M Cur, Ph D) annaydw@mweb.co.za