

**THE INFLUENCE OF THE WORKPLACE ENVIRONMENT ON BREASTFEEDING
PRACTICES OF WORKING MOTHERS RETURNING TO WORK: A CASE STUDY OF
TWO COMPANIES IN KWA ZULU NATAL**

By

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TWO COMPANIES IN KWA ZULU NATAL.**

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**A thesis submitted in full compliance with the requirements for a Master's Degree
in Technology: Nursing, Department of Community Health Studies at the Durban
University of Technology.**

**I, Penelope Reimers, do hereby declare that this dissertation is representative of
my own work**



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Abstract

Purpose

Breastfeeding is a key child survival strategy important for the long-term health of both the mother and child. The number of women in paid employment has increased exponentially, yet very few of these women continue breastfeeding as recommended by the World Health Organisation. The purpose of this qualitative study was to identify the factors affecting breastfeeding practices in the workplace.

Objectives of the study are to:

- 1: Describe managers' attitudes to and knowledge about providing breastfeeding support.
- 2: Identify mothers' attitudes towards breastfeeding and the workplace environment.
- 3: Describe the practices of the breastfeeding mothers in the workplace.
- 4: Identify factors that influence breastfeeding practices within the workplace environment

Method

The theoretical frameworks adopted were the Situation- Specific Theory of Breastfeeding and the BASNEF model. The frameworks together with the literature review provided the background which informed this study.

The research was a case study of two multi -national companies in Durban, KwaZulu Natal; participants were mothers and managers in the companies. Purposive sampling

was used for selecting eight women who participated in the focus groups, two follow up interviews were conducted and five managers were interviewed. Data collection techniques also included a reflexive journal and field observation. After a thorough review of the data, the main themes which emerged were used to guide the discussion and answer the objectives of the study.

Results

The two companies reflected a scenario of pressures in the workplace environment affecting women's choices regarding combining work and breastfeeding; societal pressures were dictating acceptable behaviour. Breastfeeding was not a priority for employers, no breastfeeding policy existed. Breastfeeding mothers were isolated and employers and employees were not engaging on the issue.

Conclusions and Recommendations

Simple enabling factors within the workplace would allow mothers, their infants and employers to enjoy the benefits of supporting breastfeeding in the workplace; this would be a win-win situation. Government, non-governmental organisations and society have a responsibility to overtly protect, support and promote breastfeeding in society and in the workplace.

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Abbreviations

AIDS- Acquired Immunodeficiency Virus

BASNEF- Beliefs, Attitudes, Enabling Factors and Subjective Norms

BFHI- Baby- Friendly Hospitals Initiative

B/F-Breastfeeding

COSATU- Confederation of Trade Unions

DOH- Department of Health

EBF-Exclusive Breastfeeding

HIV- Human Immunodeficiency Virus

IBFAN- International Baby Food Action Network

ILO- International Labour Organisation

IMCI- Integrated Management of Childhood Illnesses

IMR- Infant Mortality Rate

LLL- La Leche League

MDG- Millennium Development Goals

STB- Situation-Specific Model of Breastfeeding

WHO- World Health Organisation

UNICEF- United Nations Children's Fund

Chapter One - Introduction and Overview

1.1 Introduction to the study

“Health at the beginning of life is the foundation for health throughout life” (NHS Plan 2000).

Breastfeeding is a key child survival strategy, and is also important for long- term health for both mother and child. Yet, millions of children die needlessly every year as a result of not being breastfed, they lack the protective properties found in breast milk (Jones, et al. 2003). In recognition of this missed opportunity, global policies have been adopted to protect support and promote breastfeeding (See Figure 1, pg. 3). The World Health Organisation (WHO) recommends exclusive breastfeeding for the first six months and then advocates continuing for up to two years and beyond, with the introduction of complementary solids. Due to the public outcry about the marketing of infant formulas and the negative effect it had on breastfeeding, the International Code of Marketing of Breast Milk Substitutes (WHO, 1981) was instituted to control the aggressive marketing of infant formula. The Innocenti Declaration (UNICEF, 1990) set targets to protect, promote and support breastfeeding. Then the Baby-friendly Hospital Initiative or BFHI (UNICEF, 1991) built on the achievements of the preceding policies and provides for the protection and support of breastfeeding in maternity hospitals. This was later followed by the Global Strategy for Infant & Young Child Feeding (WHO, 2003) which recommends an integrated approach for governments and organizations to help them meet appropriate and optimal feeding targets for infants and young children. Now, in the twenty first century, there is a global commitment to support breastfeeding practices

and provide infants with the best possible nutrition in order to ensure their health and wellbeing for the future. The purpose of the study is to identify the factors affecting breastfeeding practices in the workplace both from the mothers' and the employers' perspective.

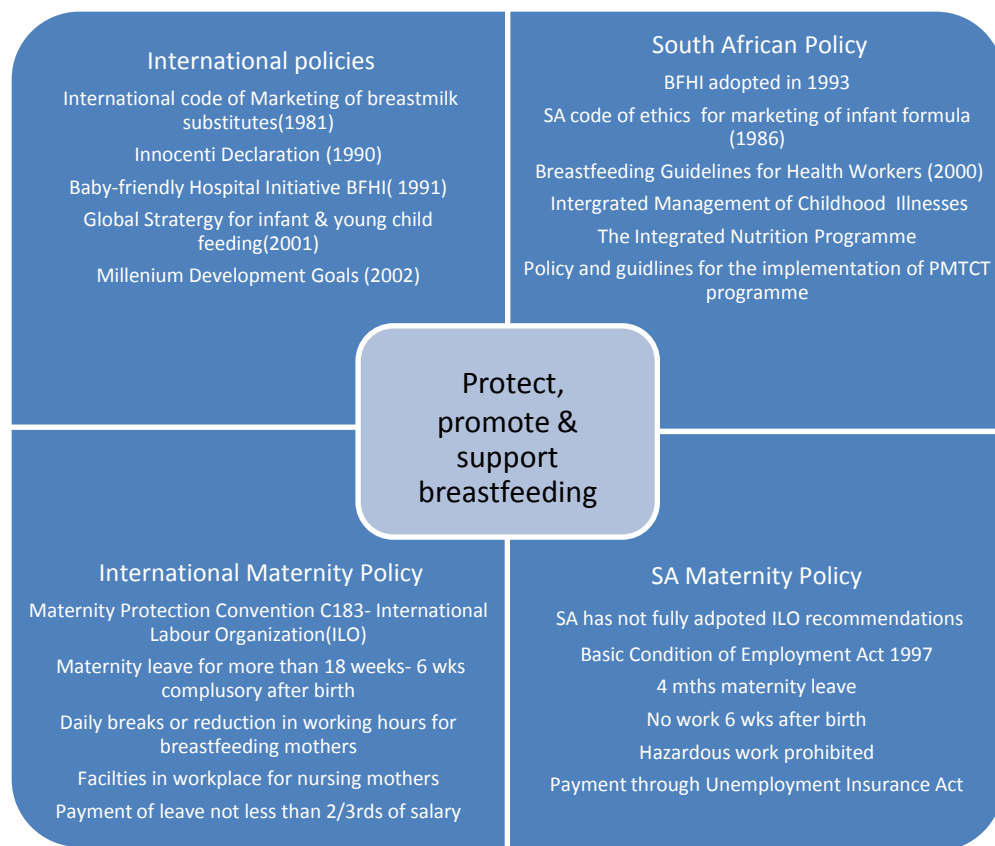


Figure 1. Policies protecting breastfeeding - International and National

1.2 Understanding the Health Care System in South Africa

In order to better understand the breastfeeding milieu in South Africa one has to look at the Health Care system within the country and how it operates. Exclusive and prolonged

breastfeeding were the norm in most African cultures. However the widespread use of human milk substitutes by Westerners undermined breastfeeding and led to bottle feeding amongst many African women, who considered this to be the more sophisticated way to feed a baby (Clement, 1978). In Africa the greatest declines in breastfeeding have been in the countries where there has been extensive distribution of food (King and Ashworth, 1987). This occurred in South Africa as a result of the HIV pandemic and the distribution of formula to prevent the transmission from mother-to-child of the virus through breastfeeding. The distribution of artificial formulas and food provided temporary relief in areas where poverty was a problem but inadvertently this undermined breastfeeding and the traditional foods used for weaning. As a result it created a demand for artificial formulas which most people could not afford. Additionally, the increasing participation of women in the labour force contributed to this decline. In the 1980's the Human Immunodeficiency Virus (HIV) pandemic further eroded breastfeeding as HIV- infected women were advised to formula feed because of the risk of transmission of the HIV through breast milk. This had a spillover effect on breastfeeding even in mothers who were not HIV positive (South Africa. Department of Health. Infant and Young Child Feeding Policy, 2008).

The Public Health Care system provides care for 80% of the population. District-based Primary Health Care Clinics have made health care more accessible to many people and in particular health care is free for children under six and for pregnant and breastfeeding women. Public facilities are under-resourced (Health Care in South

Africa, 2008). As a result health care providers work under tight time-constraints because of the shortage of staff and large volume of patients that need to be seen. They have little time to offer advice and support when it comes to breastfeeding. This is true of both the private and public sectors throughout sub-Saharan Africa (Chopra, et al. 2005. Leshabari, et al. 2007).

There is nevertheless an increasing trend towards public-private partnerships. For example, the South African Milk Bank Reserve (SABR, 2008) has established a partnership where private hospitals pass on their excess donated breast milk to public hospitals to feed vulnerable and preterm babies. This particular programme has raised awareness of the importance of breastfeeding and breast milk not only for the survival of preterm and ill babies but for all babies. Within the health system and the Department of Health (DOH) there is also an integrated nutrition programme which aims to increase the proportion of mothers who breastfeed their babies exclusively until they are six months of age and who then continue to breast feed for at least 12 months with the addition of appropriate complimentary foods. The standards for this are set out in: The S.A. Breast Feeding Guidelines for Health Workers (South Africa. Parliamentary Monitoring Group, 2000), the Integrated Management of Childhood Illnesses (IMCI), (WHO, 1999). The Integrated Nutrition Programme for S.A. (South Africa. Department of Health, 1998) and Policy and Guidelines for the implementation of the Preventing of Mother-to-Child-Transmission (PMTCT) programme (South Africa. Department of Health, 2008). (See Figure 1, pg.3).

Despite government's efforts to promote, protect and support breastfeeding, rates remain low in South Africa (The S.A. Demographic Health Survey, 2003). Women are taught the importance of breastfeeding but may lack adequate support from the government and wider society to enable them to continue to breastfeed back in the workplace. For example Sayed (2006) found that initiation rates of breastfeeding among women employed at the University of KwaZulu-Natal were at 59%. However, when these women returned to paid employment, the rates dropped to 4%. This seems to suggest that sustaining breastfeeding in the workplace is fraught with difficulties. In fact, the Department of Health has acknowledged that attitudinal changes, including in the workplace, are necessary to establish a true breastfeeding culture (South Africa. Parliamentary Monitoring Group. Breastfeeding Guidelines, 2000). Provisions have been made within the legal framework to support breastfeeding – the Basic Conditions of Employment Act No. 75 of 1997 provides guidelines in the Code of Good Practice for employers and employees in section 26(1). It states that arrangements should be made for two paid breastfeeding breaks of 30 minutes per day (in addition to lunch and tea breaks) each for employed mothers with infants less than six months of age. Apparently however, few companies or breastfeeding women seem to be aware of these guidelines.

Both private and public health services, health professionals, companies and society all have important roles to play in supporting, protecting and promoting breastfeeding.

1.3 Infant mortality rates

South Africa has adopted but not ratified most of the international policies intended to promote and protect breastfeeding and yet there is a steady increase in the under-five mortality rate, partly due to the HIV/Acquired Immunodeficiency Virus (HIV/AIDS) pandemic (Ijumba & Padarath, 2006). Forty per cent of deaths in the under-fives category are believed to be due to HIV and the remaining 60% (considered preventable) occur mostly in babies under a year old. In these situations, poverty and socio-economic factors play a role in maternal and child health. These mothers and babies are at increased risk of malnutrition and illness. Research shows that one third of the children who died in S.A last year were severely malnourished and over 60% were underweight for their age (Bradshaw, et al. 2008). Breastfeeding all children would provide the optimal nutrition needed and help to counter some of these issues.

The 2006 Infant Mortality Rate (IMR) (an indicator of a nation's social and economic progress and an indicator of adherence to the United Nations Convention of the Rights of the Child, Article 24) in SA was 56/1000 (UNICEF,2003). Based on current trends, it seems unlikely that South Africa will reach the Millennium Development Goals (set by the United Nations in 2000) of reducing the mortality rate of children under five by two-thirds by 2015. However, there is hope. Interventions which have been proven to reduce infant mortality can be implemented. One such intervention is breastfeeding, which has

the potential to reduce the 10.8 million needless deaths of children every year worldwide by 13% (Jones, et al. 2003).

1.4 Importance of breastfeeding

Breastfeeding provides the best possible nutrition for babies. Breast milk is easily digested, economical and convenient. The many factors and nutrients in breast milk have never been duplicated. Many of these benefits have long-term effects even into adulthood, and so provide a stable foundation for a healthy life. Listed below in Table 1 are some of the other nutritional benefits and protective effects of breastfeeding:

Table 1. Health benefits of breastfeeding

Health benefits of breastfeeding

- The brain doubles in size by six months and needs very specific nutrients in order to do this (Lawrence, 1998).
- Immune properties (anti-inflammatory and anti-microbial) in breast milk help protect the baby's immature system against infections including, diarrhoea, respiratory and ear infections, meningitis and urinary tract infections (INFACT, 2002).
- Breastfeeding contributes to a decreased risk of allergies, asthma, childhood cancer, diabetes and inflammatory bowel disease (INFACT, 2002).
- Breastfeeding promotes better cognitive development Studies have shown breastfed babies have higher IQs (Horwood & Fergusson, 1998).
- Babies have lower rates of cholesterol and less risk of cardiovascular disease later in life (Singhal, et al. 2004).
- Women who breastfeed have less post-partum bleeding, less risk of pre-menopausal breast cancer, less ovarian cancer, less osteoporosis and improved mental health (Enger, et al. 1998, Tryggvadottir, et al. 2001).

Table 2. Costs of NOT breastfeeding

Costs of NOT breastfeeding

- Death and illness from bacteria contaminated powdered infant formulas (U.S. Food and Drug Administration, 2002).
- Melamine contamination of infant formulas (WHO, 2008).
- Cavities, braces, malocclusion (Palmer, 1998).
- 550 million formula cans which amount to 86,000 tons of metal and 800,000 pounds of paper waste are added each year to U.S. landfill sites each year (U. S. Breastfeeding Committee, 2002).

1.5 Global breastfeeding practices

Until the 1940's most women breastfed their babies but many wealthy women used the services of wet nurses (Baumslag & Michels, 1995). However, in industrialized nations after World War 2, women's infant feeding practices began to change. The marketing of infant formulas led to a rapid decrease in breastfeeding rates. This "scientific" way of feeding babies was promoted and supported by many in the medical profession (Apple, 1994). Formula was fed to babies in hospitals in the United Kingdom (UK) and the United States of America (USA) and mothers were routinely given drugs to prevent lactation (Baumslag and Michels, 1995). These practices led to an alarming increase in infant mortality because babies were no longer protected by the immune properties in breast milk and they became victims to illnesses like diarrhoea and pneumonia. Infant feeding choices were seen as a matter of convenience and lifestyle,

as both breast and artificial feeding were seen as equally advantageous. As research revealed the important health and psychological advantages of breastfeeding, opinions began to change (Hamosh, 2001, Picciano, 2001). Breastfeeding rates then began to rise again in the late 1970's in Western nations, but continued to decline in developing countries. Many women had lost confidence in their ability to breastfeed successfully and society has lost much of its ingrained knowledge of breastfeeding which was passed down through the generations.

Donor Milk Banking is another recently revived practice which has reinforced the value and benefits of breast milk. These milk banks were introduced to provide breast milk for preterm or ill babies whose mothers were unable to do so (Wright, 2001). Healthy lactating mothers, who are pre-screened, expressed extra milk which they donated. This milk is then pasteurized, which kills any undiagnosed illness (such as HIV) yet retains most of the beneficial properties of the breast milk (Tully, Jones and Tully, 2001). It is then fed to the babies who need it.

1.6 HIV and breastfeeding

In the South African context, exclusive breastfeeding is particularly important in light of the high rate of Human Immunodeficiency Virus (HIV) infection. The risk of transmission of the HIV through breastfeeding would normally result in a policy which recommends formula feeding for all HIV positive mothers. However, formula feeding in resource-poor settings carries with it risks of morbidity and mortality from diarrhoea and pneumonia. In

S.A. this risk of dying from pneumonia and diarrhoea is estimated to be about 6% - or to put it another way, artificial feeding carries a greater risk than the risk of HIV transmission through exclusive breastfeeding. Significantly, exclusive breastfeeding has been shown to substantially reduce the incidence of transmission of HIV infection to the baby and offers the protective effects of breast milk so vital for child survival. So where replacement feeding (formula feeding) is not affordable, feasible, accessible, sustainable and safe, exclusive breastfeeding for six months is recommended by WHO (2006). Where the above are not issues, formula feeding is the method of choice as it reduces the risk of transmission.

The same cannot be said of mixed feeding (where the infant receives breast milk from the mother and some formula milk). It doubles the risk of transmission of HIV to the baby (Coovadia, et al. 2007). This is because formula causes damage to the infant's gut lining and so greatly increases the risk of the virus entering the infant's system.

Thus, if an HIV positive mother has chosen to exclusively breastfeed her baby, it is particularly important that she has available workplace facilities which encourage her to sustain lactation. Unfortunately, there is a great deal of misinformation amongst health professionals and mothers about HIV and breastfeeding (personal experience). One way to tackle this is through corporate lactation programmes which focus on educating their employees. For example, research has shown that HIV positive mothers can express their milk and heat treat it by flash-heating (bringing the milk to a high

temperature for a short period of time - 72° C for 15 seconds). Flash heating protects the anti-infective properties in breast milk but destroys HIV (Israel-Ballard, et al. 2006).

HIV and breastfeeding is an important issue in South Africa, but it is not the primary focus of this study. It has been included as it is an important part of the context within the current S.A. health milieu and should the findings of this study ultimately inform health care policies around breastfeeding and the workplace, they will no doubt also be considered in the light of the HIV /AIDS context. However for the purposes of this study, greater focus will be placed on breastfeeding within the workplace in general.

1.7 Factors which affect breastfeeding

There are many factors which affect breastfeeding and its duration. These are outlined here in broad terms. The decision to breastfeed is influenced by numerous personal, emotional, social and cultural issues. For example, the advice and support of health care professionals and close family and friends encourage women to continue breastfeeding (Britton, et al. 2006). On the other hand, a lack of confidence and skill, initial problems with latching and sustaining breastfeeding, a lack of facilities in public places and the return to paid employment are some of the reasons why women stop breastfeeding (Nelson, 2006(a)). Additionally, breastfeeding rates across the world have decreased as artificial substitutes became available. Exposure to advertising of human milk substitutes prenatally increases early cessation of breastfeeding and shortens its duration (Howard, et al. 2000). The marketing of these formulas has undermined

breastfeeding and led to a culture of formula feeding (Baby Milk Action, 2007). However for many women, possibly the majority, returning to work is a financial imperative. Working class and middle class households depend on this income; and, in the case of single mothers, especially those who receive no maintenance and where child support grants are minimal, their wages are absolutely essential. Single mothers are the sole breadwinners and face the additional stress of providing for their family. Ironically, it is often even more imperative for them to continue breastfeeding due to the financial constraints they face.

Women today often face the disapproval of society when they choose to stay at home to care for their babies. Thus, many women choose to return to work. Additionally, the added attractions of a stimulating work environment, the opportunity to maintain a sense of identity, and financial independence are further reasons why many women return to their paid roles (Vincent, et al. 2004.).

In the Innocenti Declaration (UNICEF1990& 2005), it is indicated that over the past ten years the number of women in paid employment has increased exponentially by 200 million women. Yet there is little support offered by governments or by society to help them balance their roles as mothers and employees (UNICEF1990 & 2005). These dual roles can lead to conflict, stress and divided loyalties. This is particularly true of infant feeding decisions. Women may be torn between wanting to continue breastfeeding, and yet not having the facilities and support in the workplace to do this.

1.8 What are the choices?

Breastfeeding mothers know about the benefits of breastfeeding but few are choosing to breastfeed their babies for the period recommended by WHO. The WHO Global Data Bank documents findings from 94 countries and reveals that only 35% of infants between ages of naught-four months are exclusively breastfed (Nelson, 2006(b)).

Several factors influence a woman's choice to breastfeed, such as whether she has the support of her family and friends, and how much experience and information she has about breastfeeding. Many women lack confidence in their ability to provide adequate nourishment for their babies and are unaware that there are risks attached to formula feeding (personal experience).

1.9 Can places of employment play a role?

Employees are a key resource for companies. Moreover, this is reflected in the wide variety of resources and provisions made available to them in the work place. For example, a work canteen or on site cafe would typically offer vegetarian and halaal options for those who require them. In a similar vein, companies are well positioned to accommodate the needs of women by providing maternity leave and child care facilities. This could include providing breastfeeding information antenatally to expectant mothers, and offering advice about returning to work and combining breastfeeding and work. Provision of facilities for breastfeeding mothers at work would include something as

simple as a room with a plug point and fridge and allowing mothers the opportunity to express milk during the working day.

There are many issues responsible employers could consider when women return to work such as: what sort of supportive environment do women who are still breastfeeding require? Do women returning to work have special needs and what policies are in place to support them? Many executives have never even considered the impact of accommodating breastfeeding women in the workplace and are unaware of the benefits to the company. This became clear in the results of a pilot questionnaire which was sent out to three business executives known to me.

Whose responsibility is breastfeeding once a women returns to work? Does the state have the responsibility to legislate paid maternity leave, breastfeeding breaks and facilities? Should companies be proactive in having a policy and facilities to support breastfeeding mothers? Or does the woman have to shoulder the responsibility to request time and space to express milk for her baby during her work day? Labbok (2006) suggests that if breastfeeding is regarded as an issue of women's rights then the responsibility to support breastfeeding becomes a combined one for the family, society and workplace.

1.10 Need for support

When women return to work after maternity leave they may feel the pressure to conform and fit back into the work environment. The pressure they face balancing the new roles of mother and employee can cause stress and divided loyalties (Vincent, et al. 2004). Women may want to continue breastfeeding or expressing milk in order to maintain lactation but they may not be prepared to ask for the necessary facilities at work for fear of being frowned upon or even jeopardising their jobs. Often women do not feel they have the privilege or right of choice, as the workplace is not a mother- or baby-friendly environment. So in order to maintain their image in the workplace, a woman may forfeit breastfeeding. In the pilot focus group (June, 2007), it was clear that women in senior management positions may find it especially difficult to combine breastfeeding and work when they report to an uninformed superior, who is unaware of the benefits of sustaining breastfeeding.

1.11 Rationale for study

Maternal and child health are priorities globally. Furthermore, breastfeeding is an important factor in promoting child and maternal health and also in reducing infant mortality. The benefits of breastfeeding are extensive and include nutritional, immunological and psychological advantages as well as economic benefits for the family (Kosmala-Anderson, & Wallace 2006). The Lancet Child Survival Series states that exclusive breastfeeding for the first six months of life and continued feeding for the first twelve months is by far most effective preventive measure in reducing child

mortality. It has the potential to save millions of lives annually (Jones et al, 2003). Breastfeeding is also vital at national and economic levels in terms of savings to the health care system and gains from increased productivity. Additionally, breastfeeding is environmentally friendly as it saves water, energy, and reduces packaging and pollution. In sum, continued breastfeeding once women return to work has important short and long term health benefits for both mother and baby and society at large (Hanson, 1999; Davies, 2001; Singhal,et al. 2001).

1.12 The study context

This study examines the workplace environment and its influence on breastfeeding practices of working mothers. It was conducted as a case study of two companies (A and B) in KwaZulu Natal. These companies were chosen because they operate internationally and follow global trends with regards to human resource management. It was thought that they were most likely to be at the cutting edge of providing employee benefits and were likely to employ large numbers of working mothers. The companies were chosen because of convenience (the researcher had access to them through personal contacts) and their willingness to participate. A detailed description of the companies can be found in Chapter 3.3.3 and 3.3.4, pg. 76 & 77).

1.13 Policies unique to South African corporate environments

The introduction of Employment Equity and Black Economic Empowerment Acts to redress the wrongs of apartheid also seek to provide fair treatment for both sexes.

Since the Act's inception, an increasing number of women have been appointed to positions within companies, and in fact six out of ten new labour force entrants in S.A. are women (Harrison, Bhana & Ntuli, 2007). Additionally, 77% of companies employ women as senior managers (Grant Thornton Survey, 2007).

Notwithstanding these facts, many women in SA remain marginalized as gender discrimination remains a problem (Bentley, 2004). Casual and contract labour and outsourcing have contributed to this issue. For contract labourers, pregnancy complicates an already difficult situation as there is no obligation for companies to pay them during their maternity leave or give them time off for antenatal visits. However, companies are obliged to reserve their jobs for them (Basic Conditions of Employment Act, 1997). Once they return to work there is also a legal obligation for companies to provide two breastfeeding breaks (not tea and lunch) during the working day until the baby is six months old. Despite this legal provision, few women or companies make use of this, as they are seemingly unaware of the legislation. Hence, women returning to work after childbirth face challenges and difficulties. They seek to provide the best nutrition for their babies, but the work environment and long hours of separation from their babies are not conducive to sustaining breastfeeding.

1.14 Social responsibility in corporate environments

The Socially Responsible Investment (SRI) Index was launched in 2004 on the Johannesburg Stock Exchange to put SA in line with global trends (Finlay, 2004). In

order to qualify to be listed, companies have to meet certain criteria including the provision of services and the implementation of certain policies in the workplace. Peer pressure from listed companies and the brand image of being an SRI listed company encourages many organisations to enlist. Both companies A and B in this study are SRI listed and very involved in sponsoring projects in the community. Supporting breastfeeding mothers in the workplace could be one way companies could be rated as being socially responsible, given the benefits for both mother and child. It would also demonstrate support for working mothers and their families and the day- to- day challenges they face.

1.15 Definition of terms:

Breastfeeding- Is the suckling of the infant or young child on the mother's breast and the activity of the mother nursing her baby.

Exclusive Breastfeeding- (WHO, 1991) is when the infant receives only breast milk (including expressed breast milk). It allows the infant to receive drops, syrups (vitamins, minerals, medicines) but does not allow the infant to receive anything else. It specifically excludes water.

Breast milk- Is human milk which an infant or young child obtains from suckling at the breast or from expression of milk from the breast.

Complementary Feeding- This refers to the giving of other foods from six months onwards to a breastfed baby to complement his breast milk intake. If foods are given

before six months this would be referred to as replacement feeding; and giving non-human milks after six months to a breastfed baby is also referred to as replacement feeding

1.16 Significance of the study

Sayed (2006) found that the lack of facilities was a major barrier to sustaining breastfeeding in the workplace. Thus, many women who returned to paid employment stopped breastfeeding and introduced artificial substitutes. My study explores this issue at two given sites.

The potential value of this study is that it provides information and raises awareness of the following:

- The experiences of employed breastfeeding mothers
- The work environment and attitudes towards breastfeeding
- The importance and benefits of supporting breastfeeding in the workplace
- Practical requirements for an environment conducive to breastfeeding in the Workplace

This knowledge and awareness could enable health professionals and senior managers to be more supportive toward working mothers and equip them with the educational information they need to drive change. Furthermore, recognising the importance of this as yet untapped opportunity, health professionals such as occupational health nurses

could become more involved in instituting corporate lactation programmes in the workplace.

1.17 Framework

The main framework adopted for this study is Nelson's 2006(a) Situation-Specific theory of breastfeeding (See Chapter 2.15.3, pg.59). This model looks at various factors which contribute to either conflict in the breastfeeding experience or congruity (positive reinforcement) of breastfeeding. In the workplace, breastfeeding women need certain enabling factors to help decrease conflict in their breastfeeding experience and help them sustain breastfeeding. The model however is incomplete as it does not fully address issues around identity of the mother and the enabling factors which would contribute to a positive breastfeeding experience for women in the workplace. The Beliefs, Attitudes, Subjective Norms and Enabling Factors (BASNEF) model complements and provides missing aspects, namely the enabling factors, which play a role in changing health behaviour (Hubley,1993).

1.18 Position of researcher

I am a registered Nurse, Midwife and International Board Certified Lactation Consultant with a special interest in human milk banking and breastfeeding. Additionally, I am the coordinator of a Breast Milk Bank which is situated in Durban, South Africa. The Breast Milk Bank is attached to Ithemba Lethu, a transition home which cares for babies who have been abandoned or orphaned due to HIV/AIDS - until they are placed in adoptive

families. Many of these babies arrive at the home malnourished and suffering from tuberculosis, respiratory distress, eczema and dehydration and often infected with HIV. These babies are given all the medical attention and love that they need but one ingredient in particular has been key to their recovery and subsequent quality of life: breast milk. These immune-compromised babies are fed with donated pasteurised breast milk. Their progress has been well documented (case studies done by researcher) and the radical transformation seen in many of them has again reinforced the importance of breast milk. Having witnessed the cessation of breastfeeding of many of the donor mothers when they returned to work at 4 months, the decision to explore in greater depth the reasons behind this early cessation of breastfeeding was taken. Internationally and nationally, breastfeeding is promoted. Yet despite the many policies that support it, South Africa has one of the lowest rates of exclusive breastfeeding in Sub-Saharan Africa i.e. 11.9% between naught and three months and 1.5 % between four and six months (The SA Demographic Health Survey, 2003). As the number of women in the labour market continues to grow, these dual roles of motherhood and career require women to make important choices which are further influenced by their personal, family, health matters and social factors (Harrison, Bhana & Ntuli, 2007).

1.19 Aim of the study:

The aim of the study is to identify the factors affecting breastfeeding practices in the workplace in the specific context of two multi-national companies in Durban, South Africa.

1.20 The research questions in this study are:

With specific reference to two multi-national companies, what factors influence breastfeeding practice in the work place?

Sub Questions:

- What are the attitudes of managers to providing facilities for employed breastfeeding mothers?
- What are the attitudes of breastfeeding mothers about sustaining breastfeeding while employed?
- What is the current situation regarding facilities and processes re: breastfeeding mothers?

1.21 Objectives of this study are to:

- 1: Describe managers' attitudes to and knowledge about providing breastfeeding support.
- 2: Identify mothers' attitudes towards breastfeeding and the workplace environment.
- 3: Describe the practices of the breastfeeding mothers in the workplace.
- 4: Identify factors that influence breastfeeding practices within the workplace environment

1.22 Overview of the writing style and structure of the study

1.22.1 Writing style

This study has been written mainly in a traditional formal academic format using the third person passive tense. However the research design followed a qualitative approach as the focus was on the experiences of the breastfeeding mothers and their employers. Therefore I have however chosen to indicate my subjective involvement through the use of the personal pronoun “I”.

1.22.2 Structure

The Chapters of this dissertation are organised as follows:

Chapter Two – Literature Review: the theoretical framework used for the study

Chapter Three - Methodology describes the methods used for the study

Chapter Four - The data, findings, analysis and discussion of the data.

Chapter Five- Recommendations and Conclusion

1.23 Conclusion

This chapter provides an overview of the important components of the study, describing the background and the context in which the research was undertaken. It identifies the main concept, breastfeeding - which is a key child survival strategy, and is also important for longer term health of both mother and child. It acknowledges the consequences of inadequate attention paid to child survival strategies and policy implementation in terms of noting the millions of children who die needlessly every year.

The chapter highlights specific interventions, such as breastfeeding, that have been proven to reduce infant mortality. It recognises the South African adoption of most of the international policies intended to promote and protect breastfeeding and yet describes the steady increase in the under-five mortality rate. Government's efforts to promote, protect and support breastfeeding are noted, but then so are the concomitant low rates of breastfeeding (The SA Demographic Health Survey, 2003). Other interventions such as the teaching of the importance of breastfeeding are noted, but so is the lack of adequate support from the government and wider society to enable women to continue to breastfeed back in the workplace. What is not known is to what extent companies are supporting mothers in South Africa.

In addition this chapter provides the aim, objectives and rationale for the study as well as the research questions. The limitations, assumptions and definitions of terms used are listed and the chapter concludes with an overview of the remaining chapters.

Chapter Two- Literature Review and Theoretical Framework

2.1 Introduction

This chapter will look at the literature on breastfeeding and employment which will inform this study. The focus will be on new mothers and the challenges they face in returning to work. The main framework for the study looks the factors which either contribute to or cause conflict in the breastfeeding experience (Nelson, 2006(a)).

2.2 Women in employment

Increasingly new mothers are returning to full time employment shortly after childbirth and find themselves facing a dilemma: trying to sustain breastfeeding while employed (Dunn, et al. 2004). Statistics SA (2006) show the employment rate amongst adult women in South Africa is 42.5% (See Table 3) and six out of ten new labour force entrants in S.A. are women. Global trends show that the number of employed women is steadily increasing.

Table 3. Percentage of employed women in various countries

Country	Percentage of working women	Reference
United States of America	51% (children under one year) 60.7% in 2003	Libbus, 2002 Biagioli, 2003
United Kingdom	58% (children under five)	Day Care Trust, 2001
South Africa	31% (children under six) 42.5% in 2008	SADHS, 1998 Piliso, 2008

Despite the fact that women are encouraged to exclusively breastfeed for six months and to sustain breastfeeding for two years and beyond, there is no support in the workplace for this and the social norm appears to be to encourage feeding with artificial substitutes once the mother returns to work. So women are faced with contradictions of the current recommendations about breastfeeding and a situation in the workplace which neither supports nor recognises its importance. Significantly, returning to work is one of the major reasons for stopping breastfeeding (Hamlyn, et al, 2002, Schwartz, et al. 2002). It is also associated with a shorter duration of breastfeeding (Dennis, 2002, Chatterji & Frick, 2005). So although breastfeeding would ensure the highest attainable standard of health for children, women are denied the opportunity of providing this because of the workplace environment.

The perception that work and breastfeeding are mutually exclusive remains pervasive (Valdes, et al. 2000). There are many reasons for this. Women who return to work are expected to fit back into a male-dominated workplace environment. Those women who want to continue breastfeeding are faced with numerous challenges:

- Lack of company policy about breastfeeding or awareness of any policy

In a 2007 study by Gatrell in the United Kingdom, none of the 20 mothers interviewed were aware of any company policy supporting breastfeeding. This was confirmed by Kosmala- Anderson and Wallace (2006) in their study when they discovered that only 8.7% of respondents were aware of any workplace policy regarding breastfeeding.

- Lack of facilities to express breast milk or feed the baby

Employers generally fail to facilitate sustained breastfeeding because they possibly are unaware of the benefits of continued breastfeeding and of the need for breastfeeding facilities (Witters-Green, 2003). Many women who choose to continue breastfeeding are forced to express milk in toilets at the workplace (Witters-Green, 2003). Other women, who would like to continue, stop breastfeeding because of the lack of facilities.

"I had a terrible few weeks trying to prepare myself. I had four months maternity leave and...when you have this little person and you're breastfeeding exclusively, it's a wonderful sort of bonding thing, it's very intimate and I didn't want to leave him. And you want to do what's best for your child nutritionally. So coming back full- time was heart-breaking. I was very, very upset...and it took me months to adjust and stop feeling resentful against them because they had made me give up breastfeeding."(Gatrell 2007: 398).

- Lack of support from colleagues

This lack of support is often a result of women being afraid to admit that they are breastfeeding, but even in instances where colleagues know, they are often not supportive (Gatrell, 2005).

- Negative attitudes/taboo about breastfeeding in the workplace

Hausman (2004) argues that the workplace is a male-dominated environment where pregnancy is tolerated, but once women return to work this 'accommodation' ends and her lactating body does not fit into the entrenched 'male norm' in the workplace. This leads to women hiding the fact that they are still breastfeeding, and expressing breast milk in secret during the working day, often in the toilet (Gatrell, 2005). A quote from a teacher in Gatrell's study (2007:398) illustrates this well.

"Breastfeeding? In School? Putting breast milk in the staff fridge? You're joking. You can smell the testosterone when you walk in the door and you have to fit in, which obviously you can't do if you're breastfeeding. I hated giving up and (baby) cried because she wanted me, but I had to get back to work and the Head was not best pleased with me anyway, being off on maternity leave. So I needed to work at fitting back in, so breastfeeding was out of the question."

- Social norm is to bottle feed

The fact that most companies do not consider providing facilities for women returning to work after childbirth indicates that the expectation is that these women will formula feed their children. Women in Kosmala-Anderson and Wallace's study (2006:189) commented, *"As the rooms offered to me to express milk were not private or were not suitable, this meant that I stopped breastfeeding/offering expressed breast milk on my return to work. The lack of facilities to express milk was the only reason that I moved to formula milk for my daughter."*

- Stress of handling the dual role of mother and employee

Women feel overwhelmed and tired trying to balance these dual roles and this has a direct effect on milk production and often leads to them stopping breastfeeding (Rojjanasrirat, 2004).

2.3 Global perspective

Figure 1 (pg.3) outlines the general policies in place to support breastfeeding and to provide protection for employed nursing women. These are briefly discussed here.

Recent events have emphasised once again the importance of breastfeeding and the risks attached to feeding artificial substitutes to infants. In China in September 2008, over 47,000 infants were admitted to hospital with urinary problems associated with the consumption of formula contaminated with melamine, a chemical compound. Many of these babies died (WHO, 2008). Breastfeeding was universal in China until the 1970's when economic circumstances improved and the use formulas became wide spread due to aggressive marketing by formula manufacturers. Breastfeeding rates dropped from 80 % in the early 1950's to as low as 13.6% in Beijing today. The structure of Chinese families has also changed and many grandmothers care for babies while the mothers return to employment. This scenario is typical of what has happened in many developing countries around the world (Pomfret, 2008).

- The International Code of Marketing of Breast Milk Substitutes was adopted by the World Health Assembly in 1981. By controlling the inappropriate marketing of artificial formula, the Code seeks to protect breastfeeding. The Code bans all promotion of bottle feeding and sets out requirements for labelling and information on infant feeding. Over 60 countries have adopted the Code and passed the necessary legislation to support it. Studies have shown that the Code is systematically violated, formula is distributed by health facilities and health care workers are giving gifts (Taylor, 1998, Aguayo, et al. 2003). These actions undermine breastfeeding. Countries like Brazil which based their national legislation on the Code and have enforced it have seen dramatic increases in their breastfeeding rates (Rea, 1990). Countries like Kenya, Mexico and Bolivia who did not enforce the Code have lower breastfeeding rates (International Breastfeeding Action Network (IBFAN, 2003). Enforcing the Code requires the dissemination of adequate information to health care professionals and the public about the Code. Many health professionals in South Africa are unaware of the Code (personal experience) but are in a position to play a very important role in protecting breastfeeding.
- The Innocenti Declaration was adopted by WHO/UNICEF in 1990 and called for governments to develop national breastfeeding policies and set targets for breastfeeding. The Declaration acknowledged that improved breastfeeding practices helped children achieve the best standards of health. Governments were asked to appoint breastfeeding coordinators, implement the Baby-Friendly Hospital Initiative, and remove obstacles to breastfeeding within the health care system, community and

workplace. The declaration urged that '*imaginative legislation*' be passed to support the rights of working women who wished to continue to breastfeed. In particular, the Baby-Friendly Hospital Initiative (BFHI) was set up to ensure that maternity facilities adopt practices to support, protect and promote breastfeeding. In order to qualify, hospitals have to meet certain criteria to be accredited as Baby-Friendly. The use of the UNICEF 18 hour breastfeeding course to train health care workers in the BFHI has proven to be effective in Belarus and has led to higher breastfeeding rates (Kramer, et al. 2001). One of the most important aspects of the Ten Steps (See Table 4) is to foster the development of community based breastfeeding groups and refer mothers to them on discharge. Table 4 sets out the Ten Steps in the BFHI.

Table 4. Ten steps to successful breastfeeding in BFHI

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

- The Maternity Protection Convention (No. C183) of the International Labour Organization (ILO) made recommendations about maternity benefits. These include:
 - Maternity leave of longer than 18 weeks, with a minimum of six weeks compulsory leave after delivery
 - Daily breaks or reduction in working hours for nursing mothers
 - Provision of facilities for nursing mothers
 - Payment of maternity benefits not less than two-thirds of the salary

- The Global Strategy for Infant and Young Child Feeding (2003) was another joint effort between WHO and UNICEF to revitalise global commitment to supporting the appropriate feeding of infants and young children. This was in response to statistics that demonstrated malnutrition as a factor in 60% of the 10.9 million deaths in children under- five globally and only 35% of infants globally were exclusively breastfed in the first four months. Allowing poor feeding practices to continue directly impacts the health of infants and poses major threats to the social and economic development of nations. The strategy outlines proven interventions such as providing skilled practical support for mothers and families to enable them to successfully breastfeed. It also outlines government's responsibility to implement comprehensive policies on infant feeding. Again, the strategy calls for governments to take action to not only pass legislation to protect the breastfeeding rights of working women but also to find ways to enforce the legislation, in line with international labour standards. The strategy recommends exclusive breastfeeding (EBF) for the first six months and thereafter continued

breastfeeding for up to two years and beyond, alongside the introduction of complementary foods.

- The United Nations Convention on the Rights of the Child (1990, Article 24) is another such policy. This states that each child has the right to the highest attainable standard of health and that governments need to ensure environments that will empower women to breastfeed.
- The breastfeeding focus will help with at least six of the Millennium Development Goals (MDG). They are: poverty alleviation, gender issues/empowerment, reducing child mortality, improving maternal health, combating HIV, malaria and other diseases and sustainable/environmental protection (United Nations Millennium Development Goals, 2000). Breastfeeding empowers women to provide optimum nutrition of their babies so reducing the need to depend on partner for funds for purchasing formula.

Yet despite these policies, little is being done internationally or locally *in practice* within the workplace to provide for women who want to continue breastfeeding. Ultimately, women are not being empowered to breastfeed their babies once they return to work (Gatrell, 2007).

2.4 The South African perspective

- South Africa adopted and implemented BFHI in 1994. There were 178 accredited Baby Friendly health facilities in South Africa at the end of 2005. This is equivalent to 37% of the total available facilities (Ijumba & Padarath, 2006).
- The Innocenti Declaration was also adopted by South Africa, and Breastfeeding Guidelines for Health Workers were drawn up in 2000. However, the policy does not go as far as passing “imaginative legislation” to support the rights of working women who wish to continue to breastfeed.
- South Africa is a signatory to the United Nations Convention on the Rights of the Child (1990, Article 24) and the Millennium Development Goals (MDG) adopted by the UN in 2000. (Chapter 2.3, pg. 34).
- South Africa’s Basic Conditions of Employment Act 75 (1997) has not fully adopted the Maternity Protection Convention. The current Act:
 - Provides four months of unpaid maternity leave
 - Provides six weeks leave after delivery
 - Prohibits work which is hazardous to the mother
 - Ensures maternity benefits paid by Unemployment Insurance (Act 32 of 2003) - up to a maximum of 60% of salary for four months.

It does not include daily breaks for breastfeeding after baby reaches six months of age. Neither does it allow for a reduction in working hours or the provision of facilities for nursing mothers. Payment of maternity benefits are not compulsory.

- The Integrated Management of Childhood Illness (IMCI) was launched by WHO in 1995 as a means of reducing mortality and morbidity in developing countries by providing a framework for health care workers in the management of common childhood illnesses (WHO, 1999). This too has been adopted by South Africa, and breastfeeding forms an important part of the management. Seventy-six per cent of Primary Health Care Clinics in South Africa have implemented the IMCI programme (Ijumba & Padarath, 2006).
- New Partnership for Africa's Development (NEPAD) is another South African initiative. It is seen as the vehicle that will help deliver the MDG goals and the Africa Fit for Children Plan of Action, which is part of the UN World Fit for Children declaration (Ijumba & Padarath, 2006).
- The Global Strategy for Infant and Young Child Feeding has been adopted by South Africa and policies on infant feeding have been passed. However, as yet, no legislation enforcing the rights of breastfeeding women exists.
- The WHO International Code of Marketing of Breast Milk Substitutes was adopted by SA in 1986 (WHO, 1981). The protection of breastfeeding includes legislation on

maternity leave, and the establishment of day-care centres near places of work. Compliance with the Code has been voluntary until now, but Draft Regulations Relating to Foodstuffs for Infants, Young Children and Children, No. R1130 of 8 June 1984, are due to be finalised by late-2008 (South Africa, 2007). The regulations will ensure there is no commercial pressure with regards to infant feeding, that information given to parents will be informative and scientific and importantly, breastfeeding mothers will be supported.

2.5 Infants at risk in South Africa

- In South Africa, the under-five mortality rate is 69 per 1,000 live births, which amounts to 75,000 deaths annually. These rates have been on the rise since 1990. Brazil, Mexico and Egypt who had similar under-five mortality rates in 1990, have now halved their rates to meet the MGD goals. Significantly, South Africa needs to reduce its rate by 14% a year in order to meet the fourth MDG by 2015 (Bradshaw, et al. 2008). The major causes for these deaths are HIV/AIDS, neonatal causes and infections such as pneumonia and diarrhoea. Breastfeeding could play an important role in reducing these deaths. For example, Brazil halved their infant mortality rates in 10 years by promoting, protecting and supporting breastfeeding (Arnold, 2006). The lack of progress in reducing mortality rates in S.A. is not due to a lack of policy, but rather problems within the social and economic environment in the country (Ijumba & Padarath, 2006).

One such environmental factor was the attempt to reduce the transmission of HIV from mother-to-child through breastfeeding, by resorting to formula feeding - which in turn led to an increase in mortality rates. In actual fact, breastfeeding provides protection for these infants against the morbidity and mortality caused by infections (See Chapter 1.6). The risk of transmission of HIV to infants solely fed on breast milk from six weeks to six months is 4% (Coovadia, et al. 2007). The decision for HIV-positive mothers to breastfeed should be an informed one, made on the balance of risks for the situation. *“Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.”*(WHO, 2006).

2.6 The Infant feeding decision-making period

Women do not make the decision to breastfeed in isolation. Their attitudes towards breastfeeding, previous experiences, family member attitudes and their work environment all play a role. In fact, the decision to breastfeed is influenced by multiple emotional, sexual, social and cultural connotations (Marshall, Godfrey & Refrew, 2007). Although breastfeeding is promoted as the best way to feed a baby, very little breastfeeding is seen in society and overall breastfeeding rates are low in South Africa (The SA Demographic Health Survey, 2003). Some of the identified barriers to breastfeeding include: conflicting advice given by health professionals, limited access to breastfeeding education, and the unwarranted use of infant formula in maternity units (Cantrill, Creedy & Cooke, 2003, Apgar, Serlin & Kaufman, 2005).

Dykes (2005) suggests that women may have lost confidence in their body's ability to breastfeed successfully. This could be partly due to the emancipation of women, freeing them up to work outside the home and to take on responsibilities other than that of mother/caregiver. The concerted marketing of infant formula could also have contributed to this, as women have opted to feed their babies with artificial substitutes and so the culture of breastfeeding has largely been lost. The changing role of women in the labour market and the conflict between their roles as mothers and career women means they face challenges in nurturing their babies and pursuing their careers. Admittedly, there are gaps in the understanding of these socio-cultural factors that influence employed women's breastfeeding behaviour and these need to be researched further (Gatrell, 2007). Having a good understanding of these factors would help to positively influence breastfeeding and provide the kind of support women might find helpful if they wanted to breastfeed.

Some research has already been done to shed light on these issues. This includes Kearney and Cronenwett's findings (1991) that prenatal and postpartum education and support contributes to successful breastfeeding. As women make the decision to breastfeed either prior to their pregnancy or within the first trimester, (Arora, et al. 2000), breastfeeding issues need to be raised early on in the pregnancy. Informed mothers are more likely to make adequate preparations and consider continuing breastfeeding when they return to work. Additionally, fathers also play an important role in the decision to breastfeed. According to Cohen (2002) in a summary of eleven studies, 75% of mothers

saw the father as being an important factor in their decision to breastfeed. One of the major factors for women who formula fed their babies was their perception of their partner's attitudes (Arora, et al. 2000). Women need continual support to breastfeed and their partners are the ones who most often give that support. Thus, prenatal education of breastfeeding should include the partners. One means of providing this education prenatally and postnatally is through on-site occupational health nurses.

2.7 Maternal readiness/capacity

In this context 'readiness' is defined as the willingness and eagerness to breastfeed and the possession of the necessary skills to do so. Here readiness will be considered in the context of mothers' returning to full-time employment.

Research demonstrates that the length of maternity leave affects the mother's ability to successfully establish breastfeeding (Bar Yam, 1997). The current duration recommended for maternity leave is fourteen weeks, according to The Maternity Protection Convention of 2000 (International Labour Organisation, 2000). However, a lengthier time frame may be required. In SA, the Basic Conditions of Employment Act of 1977 entitles women to maternity leave of no less than 4 months, which is to start from 4 weeks prior to due date of birth, and end no less than 6 weeks after birth of the child. Maternity leave is classified as unpaid leave, unless otherwise agreed by the parties. There are also strict provisions around the nature of work that pregnant or nursing employees are permitted to perform i.e. nothing hazardous to either her health or that of

the child. The fact that maternity leave is unpaid results in many women returning to work early out of financial necessity, especially those employed as contract workers.

A study by McKinley & Hyde (2004) found that mothers who returned to full-time employment when their babies were four months old breastfed for roughly eight weeks less than mothers who were not employed when their babies were four months old. Many other studies have also associated early cessation of breastfeeding with returning to paid employment (Scott, et al. 2006, Chatterij & Frick, 2005). Tables 5a and 5b (adapted from Kosmala-Anderson & Wallace, 2006) explore the relationship between return to employment and the rate of breastfeeding.

Table 5a. Maternal employment and breastfeeding rates

Country	Age of baby	Full-time employee	Part-time employee	Not employed	Reference
Australia	6 months	39% still breastfeeding	44% still breastfeeding	56% still breastfeeding	Cooklin, Donath & Amir, 2008
United States of America	6 months	22.8% breastfeeding	33.4% breastfeeding	35.4% breastfeeding	Biagioli, 2003

Table 5b. Percentage of women who stopped breastfeeding when they returned to work.

Country	Percentage of women who stopped breastfeeding(b/f) when they returned to work	Reference
England	19% stopped b/f at 4-6 months	Hamlyn, et al. 2002.
Scotland	28% stopped b/f at 4 months	Support for breastfeeding at work, 2004.
Spain	32% stopped b/f because of return to work	Escriba, et al. 1994.

While the association between these two factors is clear, there are some who argue that intention to return to work affects initiation of breastfeeding at birth (Brown, Poag & Kasprzycki, 2001, Dennis, 2002, Hill 2000). This is confirmed by a recent cohort study (Hawkins, et al. 2007) which found that women employed full time were less likely to initiate breastfeeding and those women that returned to work within four months postpartum were less likely to start breastfeeding than those who returned at five or six months.

Furthermore, the management of the breastfeeding, in terms of maintaining supply, breast discomfort, engorgement, leakage and fatigue becomes easier as the infant ages (Riordan, 2005). Many mothers felt that the bonding and closeness they experienced during breastfeeding helped them cope with the subsequent absences and long hours away from their babies; and thus enhanced their commitment to continue breastfeeding (Stevens and Janke, 2003).

In reality, leaving a new baby to return to work is a traumatic experience for many women. Having to stop breastfeeding may make an already traumatic experience even worse. Yet these women return to work and are expected to immediately conform to the workplace, to contribute and make up for the time they were away with little or no understanding of the huge transition and emotional state of mind they find themselves in (Pilot focus group, June 2006). In the workplace, women are seen as employees and

not mothers as the environment largely does not recognise their hidden family roles (Gatrell, 2007).

2.8 Role conflict and women's identity

Societal expectations of women have changed. No longer are they expected to be merely full-time mothers and primary caregivers; now they are also able to pursue successful careers while caring for their children. Women have to a large extent driven this change. This has resulted in conflict in their roles and identities. There is pressure to balance their time and energy between the logistical, emotional and psychological demands of being a good mother and responsible employee (Bar Yam, 2001). Society places a great deal of value on a woman's career, yet does not place as much value on the role of a stay-at-home mother. This can cause conflict within the mother as her desire is to nurture and care for her baby and yet society's goal is for her to achieve success at work. Van Esterik (1995) believes that mothers should never be forced to choose between caring for their babies and productive work but instead, they should be valued for both.

While it is acknowledged that personal factors such as financial situations may require some women to return to work early, such decisions are driven by social factors too. Kahu and Morgan (2007) found that women cited their loss of identity and drive for a sense of personal success and well-being as the main factors for returning to work. Many women did not want to waste their education and skills. Moreover, they felt

pressure to contribute to the family income and not become dependent on their partners. Women also choose to return to work because it provides a sense of self identity and relationships outside the home. However, despite it being a personal choice, coping with the demands of work and the baby bring about inevitable challenges and frustrations. Fitting back into the workplace after having a baby came with considerable cost, pressure, stress and readjustment issues. McMahon states, '*the political, organisational and ideological contradiction between those spheres (caring at home and paid work) are reduced to the private problem of organising and scheduling, a private problem of balancing*' (McMahon, 1995, p. 206). Society as a whole and the workplace specifically, does not value the mother's unique role and ability to provide the best possible nutrition for her baby by breastfeeding, even once she returns to work. Once women are back in the workplace the pressure for them to integrate back into the male environment is great. They are expected to underplay their feminine sides - a source of conflict for breastfeeding women. Essentially, they are expected to look and conduct themselves precisely as they did prior to maternity leave (Gatrell, 2007).

2.9 Women's rights

The Constitution (South Africa, 1996) grants all South African women formal recognition as equal citizens to men. Consequently, women may not be discriminated against on the grounds of gender or pregnancy. Taking this a little further, it is interesting to consider whether breastfeeding could be regarded as a woman's right, as first suggested by Labbok (2006). If a mother's choice to breastfeed were considered her

right, then simply returning to employment should not deny her that right. Nor should it deny her child – who under separate Acts is entitled to the right to the highest attainable standard of health (UNICEF, 1989).

Pamela Morrison (2008) has developed an argument about a woman's right to choose to breastfeed as opposed to an infant's right to be breastfed. The WHO Global Strategy (2003) interprets Children's Rights and says that they have the right to adequate nutrition. The same document says that women have the right to decide how to feed their children and to full information so that they can execute the decisions they make. Morrison (2008) points out that "adequate nutrition" is not "optimal nutrition" and infants are not yet children yet they are particularly vulnerable and their rights have not been mentioned. So whose right takes precedence - the mother's right to decide how to feed her infant or the infant's right to be breastfed? Morrison asks if the fact that the baby's right to be breastfed imposes a duty on the mother to breastfeed. Is this another "inconvenient truth"? Is it ethical for a mother to decide not to feed her baby when doing so places the baby at risk of disease and possibly death? If the health implications of not breastfeeding are ignored could that be regarded as 'sanctioned negligence'? One of the prime reasons for health professionals' reluctance to strongly advocate breastfeeding is a fear of instilling guilt in the mother if she chooses not to breastfeed. Interestingly, as Morrison points out, guilt is used by health workers to change other behaviours like smoking, alcohol consumption or dietary habits - but not breastfeeding. In the words of another researcher in this field, "*It is politics which determines whose truth is heard*" (Van Esterik, 1995:163).

If breastfeeding is indeed an issue of women's rights, then structures would have to be put in place to support breastfeeding both in society and in the workplace. Even if it is not a matter of human rights, there is sufficient evidence to suggest that workplace structures to support breastfeeding women would be beneficial in promoting the health of both the mother and her baby.

Paradoxically, this question of gender rights and insisting that women should be regarded as equal in the workplace may be a crucial factor in the reluctance of senior women, or women active in trade unions or other employee organisations, to negotiate for "allowances" for breastfeeding. Breastfeeding once again makes women different from men, a fact that many women have wanted to play down. The right to breastfeed, or to express breast milk, would be a women's right only.

2.10 Infant readiness/capacity

The age of the baby and a successful initial breastfeeding experience are additional positive determinants of continued breastfeeding. The older the baby, the more able the mother is to extend time between feeds and leave sufficient expressed breast milk for the baby while she is away at work (Riordan, 2005). Additionally, the ability to return to work on a part-time basis, or with reduced working hours helps many women to continue breastfeeding for a longer period of time (Cardenas and Major, 2005). Offering this kind of alternative to women returning to work could help solve the problem of

sustaining lactation but it may also encourage women who do not want to return to fulltime employment to return to work.

2.11 Institutional and workplace network

Institutional and workplace networks which provide support and/or education for new mothers may be additional factors in ensuring that employed mothers continue to breastfeed (Bai, Peng & Fly, 2008)

2.11.1 Policies

The ILO recommends one or more daily breaks to enable mothers to feed their babies, or express their breast milk, or as an alternative, a daily reduction of working hours (counted as working time) (International Labour Organisation, 2000). Further recommendations are the establishment of facilities for nursing at the workplace and the payment of maternity benefits of not less than two-thirds of the salary. This convention has not been fully adopted in South Africa and the S.A. Health Review (Ijumba & Padarath 2006) recommends that these provisions *are* adopted in future to support working mothers who need to breastfeed. Many European countries enact these recommendations and give mothers time off during the day to breastfeed (See Table 6, IBFAN, 2006). As already noted in Chapter 1.2 (pg.6) the S.A. guidelines recommend two breaks of 30 minutes each.

Table 6. Paid breaks allowed for employed breastfeeding women

European Union Countries	Paid breastfeeding breaks allowed per day or reduction in working time
Luxembourg	90 minutes
Austria	90 minutes
Spain	60 minutes
Norway	2 hours
Portugal	2 hours
Italy	2 hours
United Kingdom	Entitled to reasonable work time breaks
South Africa	2x 30 minutes up to 6 months

When policies favour breastfeeding as they do for example, in Norway, the rates of sustained breastfeeding are higher: 99% of women start breastfeeding and 85% are still breastfeeding at four months (Lande et al., 2003). In Canada, job protection for women on maternity leave was extended from six months to a year in 2001. This increased the amount of time women stayed at home post-delivery and also led to an increase in the duration of exclusive breastfeeding at six months by 39% (Baker & Milligan, 2008).

According to Galtry (2002, 2003) there is a substantial lack of discussion on child health care and the costs and benefits of breastfeeding in policy formulation, especially given the increasing numbers of employed mothers and the recommendation to exclusively breastfeed for six months. Her view is that in order to match high female employment rates with increased rates of breastfeeding, supportive labour market policies are

essential. Internationally, laws supportive of breastfeeding emphasize its importance as a public health concern. They also contribute to an increase in the resources allocated to breastfeeding. In the U.S.A, as the number of companies running corporate lactation programmes has continued to grow, they have noted the benefits in terms of reduced absenteeism, reduced health care costs and an enhanced image of the company. A summary is provided in Table 7 (Bonaan, 2000).

There is a return on investment when companies do support breastfeeding. One-day absences from work to care for sick infants was more than twice as common for mothers who formula fed their infants(Cohen, Mrtek and Mrtek, 1995). Reduced health care costs for these infants resulted in lower insurance claims for businesses, CIGNA, an insurance company in the U.S.A. found that over a two year period of the 343 employees who participated in the lactation programme the annual savings were \$240,000 in addition to 62% fewer prescriptions and \$60,000 savings in reduced absenteeism (Dickson et al, 2000). This can have a positive impact on the bottom line of the company, apart from the health care and absenteeism savings there is also greater loyalty to the company and the spinoff of increased productivity. A study of several companies in the U.S.A. offering lactation programmes revealed a retention rate of 94.2 % as opposed to the national average of 59% (Ortiz, Mc Gilligan & Kelly, 2004).

Table 7. A summary of Corporate Lactation Programmes in the U.S.A.

Company	Facilities Provided	Breastfeeding Education	Benefits experienced	Research- in company
Proctor & Gamble	Mothers' room Hospital grade pumps Refrigerator	Prenatal program run by Lactation Consultant(LC)	Reduced absenteeism Greater productivity	Breastfed babies had less Dr's visits so fewer absent days for mother.
Cigna Corporation	Mother friendly room Hospital grade pump Refrigerator	Counselling by LC pre and post delivery for 6 months. Support groups for mothers	More than 1000 women enrolled in program. More than 40% of mothers feed beyond 6 months (above national average)	
Home Depot	Hospital grade pump Mother's room Refrigerator	Lunch time seminars at worksite Education prenatally for woman and spouse Access to LC post partum until she stops feeding	Breastfeeding duration increased to 8.7 months on average	Reduced absenteeism & increased productivity. Average absenteeism from work for new mothers in first year was 9 days. The program reported only 3 days absence due to babies' illnesses
Aetna	Mothers room Hospital grade pumps Refrigerator	Extensive program and LC is available throughout pregnancy and afterwards	36% of mothers feed for 6 months or longer. Positive feedback from mothers, reduced stress, support network	Reduced stress in mothers Return on investment US\$2.18 to every US\$1 spent.

In Table 8 the effectiveness of the Corporate Lactation programmes (C.L.P.) is illustrated. The percentage of women who initiated breastfeeding, and then continued to breastfeed at six and twelve months, was significantly higher in mothers who were part of the C.L.P. interestingly, their success rate was even higher than those of women who worked part time (Business Backs Breastfeeding, 2003).

Table 8. Effectiveness of Corporate Lactation Programmes in U.S.A. on breastfeeding rates.

Mothers	Initiated breastfeeding(b/f)	Breastfeeding at 6 months	Breastfeeding at 12 months
Mothers in CLP	97.5%	57.8%	21%
Not in CLP but employed full time	69%	27.1%	12.6%
Not in CLP but employed part time	72.7%	36.8%	20.8%

2.11.2 Attitudes

According to the Australian Breastfeeding Association, some employed mothers face conflicts when they return to work because their employers are not supportive of their intention to breastfeed. This was due to a lack of suitable facilities for expressing and storing milk, a lack of time and privacy to do so, or a lack of flexible work options. Women have expressed a need for supportive attitudes in the workplace (Rojjanasrirat, 2004). This may be due to a gap between employer and employee perceptions of the need for on-site breastfeeding support (Dunn, et al 2004). Many employers see little value in supporting breastfeeding in the workplace (Libbus and Bullock, 2002) and often employers lack knowledge of the benefits of breastfeeding (Ong, et al. 2005). In a study by Netshandama in 2002, South African women said they felt isolated as they had no support in the workplace, and they hid the fact that they were expressing breast milk at work from their colleagues. Other studies confirm that many mothers conceal the fact they are breastfeeding from their colleagues and management (Gatrell, 2007).

2.11.3 Facilities

Zinn's research (2000) in the USA demonstrates the success of Corporate Lactation Programmes in the workplace. The provision of prenatal education on breastfeeding, the services of a lactation consultant and a private room in the workplace with equipment for pumping milk were effective in encouraging 75% of employed mothers to continue breastfeeding for at least six months. Thus, there is evidence to suggest that employer-sponsored lactation programmes do help to overcome obstacles and conflicts faced by employed mothers.

2.12 Professional and formal network

The enabling factors determined by Bar Yam (1997) for continued successful breastfeeding in the workplace are:

- Time - expressing milk or breastfeeding takes time. Women need about 20 minutes to express milk and in an eight hour day they will need to express two or three times, depending on the age of their baby.
- Support - Women need support from their line managers, colleagues and from other breastfeeding mothers.
- Space - Women need private space (with a plug point for electric breast pumps), a hand basin, and a fridge to store the milk and most importantly, the room should have a key so that it can be locked for privacy.

- Gatekeepers - It is important to have someone who ensures that women have the time and space to express milk; this would usually be a human resource person or a secretary.

In their review of combining employment and breastfeeding Cardenas and Major (2005) identified specific time-based, stress-based and behaviour-based conflicts that women face when combining breastfeeding and employment. The greater the conflict experienced by women, the more difficult it is for them to balance work with successful breastfeeding.

In the workplace environment, time is consumed by work and so finding time to express milk is difficult. Strain, tension and anxiety are caused by the role conflict women face being mothers and employees and they face incompatible expectations at home and at work. Unsupportive work environments add to this stress. Women also face a perceived lack of control over their circumstances at work. This extreme stress has a direct effect on a women's ability to lactate and produce milk for her baby. This scenario is described by Umporn (Yimyam, Morrow & Srisuphan, 1999: 961).

"I planned to continue breastfeeding after returning to work because I knew that breast milk was best for my baby. You know, it's just so hard to maintain supply. During my busy times at work, I didn't have enough time to express. Also, it's painful and unpleasant to express so I seldom did. This may have caused a decrease in my supply. I felt that I didn't have enough milk for my baby. She would always cry when I breastfed

her, and I had to give her a bottle after that. Eventually, my baby refused to be breastfed any more. So, she was fully weaned just three weeks after I returned to work.”

Combining breastfeeding and working means that the woman has to perform part of her role of breastfeeding at work. Women find this embarrassing and awkward. A lack of private facilities to express and store milk, are major problems and these conflicts often lead to an early cessation of breastfeeding. A supportive supervisor, who ensures that the facilities and a flexible time schedule are available and allows women to express, makes for a much easier adjustment back to workplace. This also decreases the conflict and stress of job security (Cardenas and Major, 2005). While these research findings are useful and informative, there is a need for more randomised controlled trials to establish the benefits of workplace interventions to support and promote breastfeeding amongst mothers who are employed full time (Abdulwardud and Snow, 2007).

Hubley (1993) describes the necessity of having enabling factors in place in order for behavioural change to occur in health practices. The behavioural change in health practices mentioned by Hubley(1993) can be adapted to workplaces too.

As mentioned, mothers need support and accurate information about breastfeeding both during pregnancy and in the postpartum period, including support from the health care providers and occupational health nurses (Kearney and Cronenwett, 1991). This information about breastfeeding should also be given to the mother's partner and to grandmothers as well as employers and co-workers, whose support is essential for

initiating and sustaining breastfeeding (Arora, et al. 2000). These individuals play an important role in promoting breastfeeding as a norm, and in educating and disseminating the right information to women. Problematically, bottle feeding has become the cultural norm amongst working mothers, as Sayed's brief survey indicated (2006).

2.13 Informal psychosocial network

A study in the United States found that without support most women stopped breastfeeding within a month of returning to work (Cardenas and Major, 2005). When they received support, they were able to continue to breastfeed for longer and some even exceeded their breastfeeding goals (Cardenas and Major, 2005). Hence, women need support from the time they start breastfeeding *and* on an ongoing basis. This support can come from trained peer counsellors. In Bangladesh 70% of mothers who received support from peer counsellors were still breastfeeding at five months, whereas only 6% of those who received no support were still breastfeeding at five months (Haider, et al. 2000). Social support could also come from partners, families, and health care providers. This support has also been shown to prolong breastfeeding (Britton, et al. 2007). Additional support might be in the form of mother-to-mother support networks - allowing women to share experiences and seek emotional support from other mothers. Role models of women who have successfully worked and continued to breastfeed have also been found to be helpful (Canada, Department of Labour, 2008).

2.14 Economic benefits of providing support

Providing support for breastfeeding mothers in the workplace has been shown to reduce employee absences (related to infant illnesses) and result in less time lost to the company. A study by Cohen, Mrtek & Mrtek (1995) found that 75% of illnesses in infants of working mothers occurred in the formula-fed group. Of the 28% of infants who had no illnesses, 86% were breastfed.

Increasingly, new mothers are returning to work shortly after the birth of their babies and this may have an impact on the long-term health of both mother and child. Increasing breastfeeding duration in these women by enabling them to continue breastfeeding once they return to work will have a positive impact on the health and economy of nations (Weimer, 2001). In fact, an analysis done by the Los Angeles Department of Water and Power (Cohen, Mrtek & Mrtek, 1995) claimed a saving of three dollars for every one dollar spent on its lactation programme - because mothers missed less work and returned to work earlier. Business savings for companies who support breastfeeding are substantial. The Insurance Company CIGNA in the U.S.A., found that after a two year period of studying 343 employees who belonged to a Corporate Lactation programme, the annual savings were US\$ 240,000 in health care expenses. In addition to this, there were 62% fewer prescriptions and an estimated US\$ 60,000 in savings because of reduced absenteeism (Dickson, et al. 2000). Weimar (2001) has shown that US\$ 3.6 billion could be saved in the USA if breastfeeding rates were increased from 64 to 75 % (a saving calculated on the basis of cost savings from the treatment of three childhood illnesses). Although further studies are needed, the

available evidence points to substantial return on investment when breastfeeding is promoted and supported, and this support should be extended to the workplace.

2.15 Theoretical framework

The Theoretical Frameworks adopted for this study are the Situation-Specific theory of breastfeeding (S.T.B, Nelson, 2006(a)) and the Beliefs, Attitudes, Subjective Norms and Enabling Factors (BASNEF) model (Hubley, 1993). The model used most often in breastfeeding research has been the Theory of Planned Behaviour (TPB) derived by Ajzen and Madden in 1986. This model has been used to predict breastfeeding norms and attitudes and the outcomes of breastfeeding. While this is a useful model, it fails to consider the impact of social support on sustaining breastfeeding. Nelson developed the S.T.B in order to provide a holistic approach to examining all the factors which come into play and influence a woman's breastfeeding experience. The Model will be explained in the light of additional current literature.

2.15.1 Background

In the development of this theory, Nelson looked at the literature available on breastfeeding from a medical, psychological and sociological perspective. She then examined reviews of data to provide a meta-synthesis.

2.15.2 Historical context of breastfeeding

The decline in breastfeeding (See Chapter 1.5 pg. 9) coincided with the marketing of formulas. By 1905 Nestle was selling baby formula around the world. When companies turned to

the developing world to sell their products, the combination of formula and contaminated water proved to be a lethal cocktail and killed thousands upon thousands of infants in third world countries - and still does (Baumslag and Michels, 1995). Aggressive marketing of infant formulas also contributed to a culture of formula feeding to such an extent that there was a real threat of it replacing breastfeeding as the method of feeding Infants (Doolan, 2008). Moreover, breastfeeding in public was frowned upon because women's breasts became a "commodity" which appeared in all forms of media to sell a wide variety of things from ice creams to motor cars (Doolan, 2008).

However, after many years, a public outcry against large corporations undermining breastfeeding led to the International Code of Marketing of Breast Milk Substitutes (1981), (See Chapter 2.3, pg 30) as mentioned earlier. Later, the Innocenti Declaration, the Baby-Friendly Hospital Initiative and the Global Strategy for Infant and Young Child feeding were adopted by the WHO/UNICEF and governments were asked to adopt national breastfeeding policies and targets for breastfeeding to reinforce a "breastfeeding culture" (See Chapter 2.3, pg 31).

Despite all the above policies, Nelson found that in practice women were not receiving the kind of support and information they should be able to expect from health professionals. Furthermore, the interventions used to help breastfeeding mothers were often inconsistent and insensitive to their individual situations. Thus, the S.T.B. framework was developed to investigate and address these concerns.

The S.T.B. is represented visually in Figure 2. Each section of the model will be briefly discussed (Nelson, 2006(a):17).

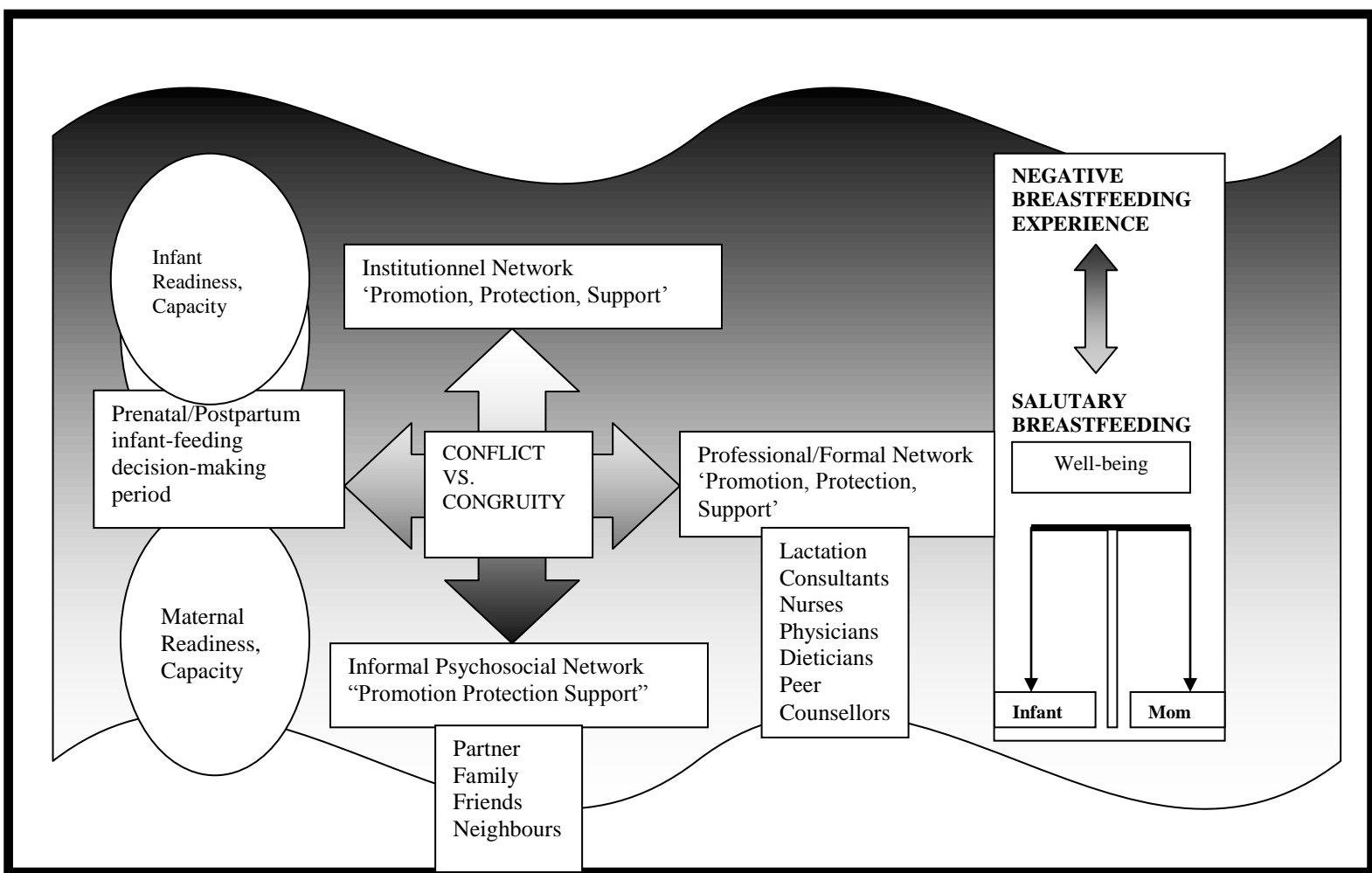


Figure 2. A situation-specific theory of breastfeeding

2.15.3 The situation-specific theory of breastfeeding (Nelson, 2006(a))

The Situation-Specific theory provides a framework for examining the various levels of conflict versus consistency that exist for breastfeeding mothers, between the mother

and her infant and the mother and her support networks. All of these various experiences will either help facilitate and encourage the mother's breastfeeding or will discourage and hinder it and this can be applied to working mothers.

The Situation-Specific (S.T.B.) model of breastfeeding explores the infant and maternal readiness capacity, the institutional/workplace network, the informal psychosocial network and the professional/formal network. All these relationships will influence the level of conflict or congruity that the breastfeeding mother will face and whether or not she will have a beneficial breastfeeding experience in the workplace (See Appendix 1 for permission to use framework).

2.15.4 The BASNEF model

Normally, one model would be considered sufficient to frame the research process. However, the STB model does not address specific issues related to breastfeeding in the workplace (i.e. facilities, space, time, privacy, managerial and collegial support). The BASNEF model broadly addresses these deficiencies because it introduces the additional enabling factors which will play a role in behaviour change. BASNEF adds another perspective to the STB model and provides additional insight into the situation. Hubley (1993) uses this model to describe how individuals change their health behaviours. Beliefs, attitudes, enabling factors, and subjective norms (namely, beliefs about what behaviour other influential people would wish the person to perform) all play a role. In Figure 3 one can see all the factors which influence a change in health

behaviour as described in the BASNEF Model. In addition, the BASNEF model provides a greater depth and richness in understanding people's beliefs, emotions and attitudes and their importance in forming the values which lead to health-related behaviours. While the S.T.B. model generally addresses external influences, values tend to be personal and internal. Hence, the importance of adding the perspective which the BASNEF model introduces. Below in Figure 3 is a model of how individuals change their behaviour (Adapted from the International Water and Sanitation Centre, 2003).

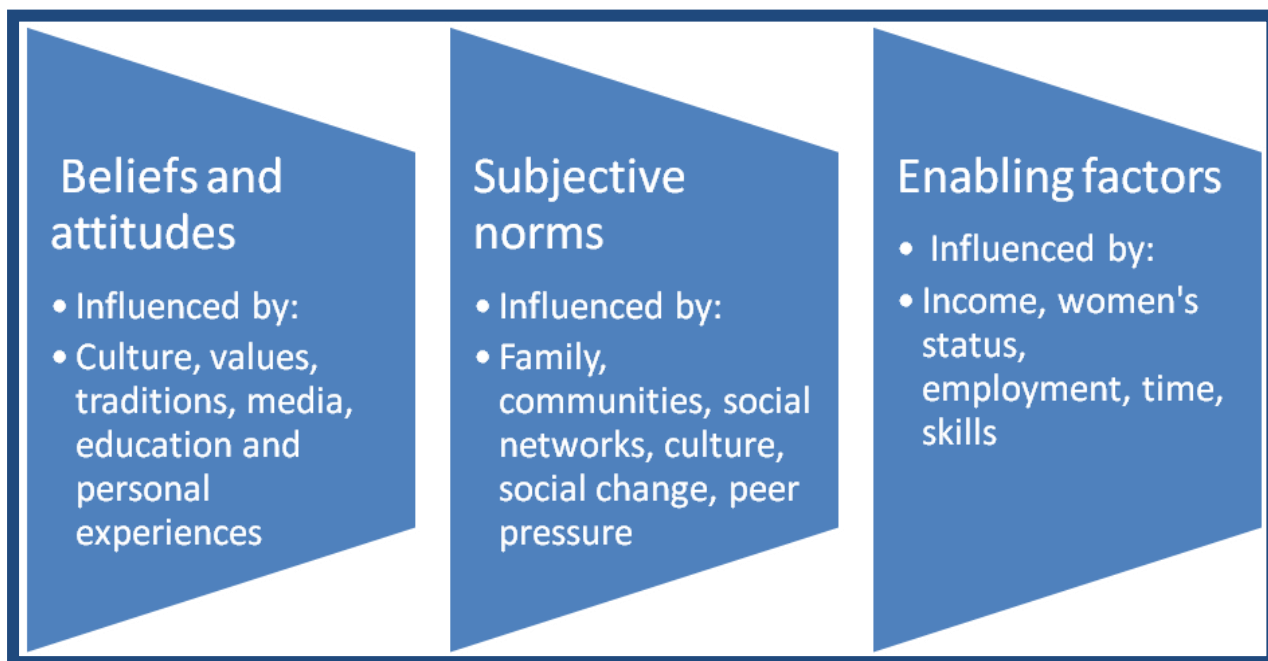


Figure 3. BASNEF model- How individuals change health

In order for a motivated person to change his/her behaviour, the enabling factors, materials and/or facilities must be in place. For example, a woman motivated to breastfeed on returning to full-time employment needs certain enabling factors in place

in order to be successful. For the purposes of this study, the focus is on these enabling factors.

Previously, theories predicting breastfeeding outcomes have used the theory of planned behaviour (T.P.B.). The S.T.B. model provides new insight into ideal breastfeeding outcomes and methods of support for mothers through various networks. Additionally, this theory includes new ideas such as the very personal nature of the breastfeeding experience, and the vulnerability of the mother/infant dyad which depends upon support from many networks. It points out that conflict can easily undermine professional help and the mother's own efforts. It also stresses the need for consensus amongst health professionals and the provision of coordinated support. Becoming aware of conflict will enable individuals to address and reduce it; this would in turn increase the consistency of the networks that support both the mother and her infant in their breastfeeding experience.

This model could also be applied to the exclusive breastfeeding recommended by W.H.O. As discussed earlier, exclusive breastfeeding in the South African context could be life saving. Health Professionals need to positively enable mothers to make informed decisions and then support them in those decisions, remembering that the theory recognises that each mother's situation is unique, as are the interactions from her networks.

There are several other theories in the research which could have been used to support this study; however, for reasons of simplicity and parsimony, only the two mentioned above were selected. The other theories that could justifiably apply are described below.

The Systems Model of Breastfeeding Working, based on the General Systems Theory (Wood, 1992), considers the breastfeeding working mother as an open system. The supports from home and work are the inputs into this system, and as long as these are balanced, a steady state is maintained. Problems are seen to arise from background factors which are connected to home or work. Whereas success, or a steady state, is a result of feedback mechanisms within the open system. Successfully combining work and breastfeeding is the goal of this model (Wood, 1992). The S.T.B. model was chosen however as it explores in more detail the various factors and networks associated with a successful breastfeeding experience.

Another conceptual framework that was considered was that of the three phases of delay. This framework explains the reasons for maternal and perinatal deaths, and interventions which prevent treatment delays (Thaddeus and Maine, 1994). The three phases are:

Phase One: A delay in seeking care by the individual or her family.

Phase Two: A delay in reaching an adequate Health Care facility.

Phase Three: A delay in receiving adequate care at the facility.

This framework could have been adapted to suit the study, however the research examined thus far appears to suggest that the issues mothers face with breastfeeding in the workplace go beyond delays in seeking help or facilities, and have their foundations in perspectives, attitudes, influences, culture and perceptions.

Thus, the S.T.B. framework and the BASNEF Model were adopted for this study. They provided direction for the methodology and for the data analysis conducted. Additionally, together they have provided a precise framework within which the study can be described. Finally, they are simple and yet contain the required, relevant concepts (Talbot, 1995).

The frameworks will be discussed using the same headings used for reviewing the literature but the perspective will be breastfeeding initiation and contribute to a positive breastfeeding experience.

2.15.5 Prenatal/Postpartum infant-feeding decision-making period

Many studies have looked at the dynamics that affect this important decision making period. Appropriate information is necessary for women to make an informed decision about breastfeeding. One study found that 78% of women made the decision about infant feeding before pregnancy or in the first trimester (Arora, et al. 2000). This was confirmed by another study which found that women who decided to breastfeed before pregnancy were three times more likely to breastfeed than those who decided during or after the pregnancy (Chezem, Friesen & Boettcher, 2003). This then is a critical time for

women to be informed about the possibilities of combining work and breastfeeding and to be given information regarding how to best prepare. Presently in South Africa, information about breastfeeding is given in prenatal classes towards the end of the pregnancy (personal experience). Women are informed about the benefits of breastfeeding but not about the risks attached to formula feeding. Decision making is also influenced by the immediate family and their feelings and knowledge of breastfeeding (Bar-Yam, 1997).

2.15.6 Infant readiness and capacity

Many factors influence the infant's readiness to breastfeed. These include keeping the mother and infant together immediately after birth, and in the early postpartum period. This has been directly related to successful breastfeeding (Nakao, et al. 2008). Edmond, et al. (2006) found that in Ghana a 24 hour delay in initiating breastfeeding meant that babies were 2.5 times more likely to die than if they started breastfeeding within the first hour. The baby and mother are "primed" for breastfeeding to happen immediately after birth. Skin-to-skin contact between the mother and her baby plays an important role here. A baby left skin-to-skin on the mother's abdomen has been shown to find its own way to the breast and can self attach to the breast (Widstrom, et al. 1987). Exposing the baby to the mother's harmless bacteria colonises the baby's skin and gut. These bacteria will then protect the baby from other harmful bacteria in the environment (Hanson, 2004).

The infant's ability to latch well and suckle will also affect the mother's milk production and the frequency and the duration of feeds. Premature and ill infants may require specialised help and support (Spatz, 2004). Epidurals, general anaesthetics and pain medication given in labour may also affect the ability of the infant to root and attach to the breast immediately after delivery. One study found epidurals did not affect the neurobehavioral status of breastfeeding 8-12 hours post delivery (Chang & Heaman, 2005) while another (Baumgarder, et al. 2003) found that it did have a negative impact on breastfeeding in the first 24 hours. Hale states that there are insufficient good studies which have looked at outcomes after epidurals related to breastfeeding (Hale, 2008). However lactation consultants complain that infants delivered to medicated mothers are generally less alert, have poorer muscle tone and feed poorly (Hale, 2008).

2.15.7 Maternal readiness and capacity

A woman's capacity to breastfeed successfully will be directly impacted by her preparedness, her personal goals and ability, her interaction with her infant and other individuals in her immediate environment. Her education and past experiences of breastfeeding (or lack of them) play a role here, as does her knowledge about breastfeeding (Kronburg & Veath, 2004). A woman's intention to return to work will also affect her breastfeeding goals and intentions. Many women returning to work will feed for shorter periods or may not even initiate breastfeeding at all (Chatterji & Flick, 2005).

2.15.8 Informal psychosocial network

The amount of protection, promotion and support breastfeeding receives within a woman's social network will vary considerably depending on her age, culture, social

class. Positive role models within this group also provide support and encouragement to new mothers as they often lack confidence in their ability to breastfeed (Raisler, 2000). Numerous studies have shown that women place great importance on the advice and attitudes of close family and friends (Tarrant, et al. 2004). The duration of their breastfeeding is often influenced by this social group.

The mother's education, her infant feeding intentions, self confidence and earlier breastfeeding experience can be used as early predictors of breastfeeding outcomes. Interventions to support these women should aim at improving their confidence and resources and focusing on practical knowledge. The first five weeks is the time when they require the most support as this is when most women stop breastfeeding (Kronburg & Vaeth, 2004).

2.15.9 Professional/ formal network

Health Care providers often have limited knowledge about managing breastfeeding problems once they arise. Thus, new mothers are given conflicting advice (Cantrill, Creedy & Cooke, 2003). Women are extremely vulnerable shortly after birth and rely on advice of the professionals. Too often, formula is used to manage a breastfeeding problem without professionals being aware of the dangers this poses to establishing breastfeeding (Personal experience). There is also insufficient support given to sustain breastfeeding in the early weeks post-partum (Apgar, Serlin & Kaufman 2005). Improving the quality of care during this crucial pre- and post-natal period will improve outcomes of breastfeeding.

2.15.10 Institutional network

Many health professionals have inadequate knowledge about breastfeeding. A survey conducted in England revealed that 50% of the 549 respondents, who were mainly midwives and health visitors, had a poor knowledge of evidence-based practice and had no breastfeeding policy (Wallace and Kosmala-Anderson, 2007). Breastfeeding policies in institutions are important to ensure evidence-based procedures are followed. All staff dealing with breastfeeding women should be trained and updated regularly on new research findings.

2.16 Databases used for literature review

The concepts of all the issues surrounding breastfeeding and employment were searched using the following databases: Sabinet, SAE Publications, Proquest, Science Direct, Pubmed, SpringerLink, Epubnet, and the Cochrane Database.

The search included all English language literature published in the following fields:

Health Sciences, Social Sciences and Humanities, Education, Psychology, Business, Academic Research Libraries, Dissertations and Theses, Nursing and Allied Health, Evidence Based Resources from the Joanna Briggs Institute.

2.17 Conclusion

This literature review has shown that breastfeeding duration is reduced in mothers who return to paid employment, and that the duration is influenced by various factors which include readiness, support, attitudes, facilities and policies. Women face a dilemma:

they hear some positive messages that promote breastfeeding from health professionals and yet when they return to paid employment there are often no structures in place to help them sustain breastfeeding. On the whole society does not actively support breastfeeding or even regard it as the norm. On a macro level, both labour market policy and socio-cultural support are important factors which need attention if breastfeeding rates amongst employed women are to be increased (Galtry, 2003).

Chapter Three- Methodology

3.1 Research Design

3.1.1 Introduction

Yin (1994) describes a research design as a means of defining a set of questions to which one seeks to find an answer or conclusion. The design is the logic which then links the data to be collected to the questions of the study. Each aspect of the design is interrelated and possesses both flexibility and constraints (Maxwell, 2004). He further describes a good research design as being similar to the good design of a ship, which enables it to safely and effectively reach its destination.

This chapter lays out the research design decisions made for this study, giving an overview of the methodology and methods. The data collection methods used to gather information regarding the factors affecting breastfeeding practices will be discussed. The data will be used to answer the research questions.

This is a qualitative study, the aim being to understand the phenomena from the participants' view rather than from an objective point of view (Green and Thorogood, 2004). A qualitative approach was chosen as it focuses on the rich experiences of employers and the employed breastfeeding mothers and listens to hear the meanings attributed to these experiences. Qualitative research also seeks to be holistic so strives to understand the whole picture (Polit and Beck, 2004). It is important to look at the

whole picture and understand what the factors are which affect breastfeeding practices in the workplace.

The focus is on experiences and perceptions which form a base for knowledge unlike a positivist paradigm (Polit and Beck, 2004). One of the most important tasks in qualitative research, according to Hitchcock and Hughes (1995), when analysing the data is to manage it and to make sense of it. This involves delving to find the hidden meanings and researched based insights and understanding the factors which affect breastfeeding in the workplace. Previous research on the subject has been examined critically and referred to during the data analysis.

This research is a case study of two multi-national companies. A case study is the ideal method when an in-depth holistic investigation is needed (Feagin, Orum & Sjoburg, 1991). It is a way of investigating an empirical topic by following specific procedures where knowledge is derived from observation and experience rather than from theories. (Yin, 1994)

The study will include an observational aspect. Data were collected by observing the behaviours of the participants, their interactions, non-verbal behaviour and the atmosphere. The physical setting of the company and the environment and the facilities were also observed. These data were diligently recorded in field notes and in a research diary (Mouton, 2001.) The data analysis, ethics and validity issues will also be discussed.

3.2 Methodology

3.2.1 Interactive model of research design

Maxwell (1996) proposes that a qualitative research design has five components which are characterized by the issues they address: These five components will be discussed in relation to this study. They are the purposes, conceptual context, research questions, methods and validity of the study. A brief overview is provided here but they will be discussed in more detail under the relevant section. The overview is intended to indicate the continuous interaction between all the elements which are part of a qualitative design. The design is a reflexive process which is in action throughout each phase of the study (Maxwell, 1996). So focusing on the research question, examining ethics issues and validity, collecting the data and analyzing them are all happening continuously and moving from one component of the design to the other, each interacting with the other.

- Purposes: The goal of the study is to gain a better understanding of the issues which face breastfeeding mothers in the workplace and thereby encourage companies to provide policies emanating from the evidence which would support breastfeeding mothers in the workplace. Sustaining breastfeeding has significant health benefits for mothers and babies and the economic benefits for companies and the nation. The purpose of the study is informed by current research and knowledge.

- **Conceptual Context:** The literature review and theoretical framework provide the background which has informed this study. The frameworks which have been used also guide the questions and approach. The physical context is the workplace environment of working mothers and their employers. The conceptual context focuses on the influences, on what they do, think and feel with regards to sustaining breastfeeding in the workplace. The context also includes societal attitudes and support or lack of it for breastfeeding. It involves looking at their real-life experiences and so acquiring first-hand knowledge about breastfeeding practice in the workplace. The context is also defined by my own experiences and background knowledge as a Lactation Consultant which I have drawn upon constantly and also considered it to ensure it does not influence the data collection and interpretation.

- **Research Questions:** These have been discussed in Chapter 1.20 (pg.23). The study is seeking to understand the multiple factors which influence breastfeeding practice in the workplace. Are these practices influenced by the attitudes of mothers? What are management's attitudes to providing for these mothers? What is not known is to what extent companies are supporting breastfeeding mothers in South Africa. The aim of the study is to identify factors affecting breastfeeding in the workplace in the specific context of two multinational companies. The objectives of the study are to:
 - Describe employers' attitudes to and knowledge about providing breastfeeding support.
 - Identify mothers' attitudes towards breastfeeding and the workplace environment.
 - Describe the practices of the breastfeeding mothers in the workplace.

- Identify factors that influence breastfeeding practices within the workplace environment.
- Methods: A qualitative approach was chosen to look at the holistic yet in-depth experiences of mothers and employers. A case study of two multi-national companies was undertaken using focus groups and in-depth semi-structured interviews and observation. Content analysis was used. Whilst this was guided by the research objectives and theoretical frameworks, it also allowed for new and emerging themes.
- Validity: Peers (breastfeeding experts) reviewed findings, different data collection methods were used, an audit trail was provided, a thorough literature review was undertaken, and member checking of transcripts was done.

3.3 Study setting

The setting for this study was two multi-national companies in the Durban area in KwaZulu-Natal (KZN). Durban is the largest city in KZN with a population of approximately 3.5 million people. Durban accounts for half of the province's employment and income (Wikipedia, 2008).

3.3.1 Choice of research sites

The research sites are two multi-national companies based in the Durban area. One is in the petro-chemical industry and the other in the manufacturing sector. These companies were chosen because as multinational companies they were thought to be

at the cutting edge of providing employee benefits and are most likely to have large numbers of working mothers. The reason for choosing private companies over public service organisations is based on the following assumption: companies are profit driven and the private sector constitutes a significant portion of SA industry. If policies catering for working breastfeeding women can work in an environment where profit is the objective, then it would be much easier to roll out these policies in other organisations. Choosing two companies broadened the perspective that is gained of the relationship of the workplace environment to the breastfeeding practices of mothers. The companies were chosen based on convenience (the researcher had a contact) and their willingness to participate - which made gaining access easier. The companies are different in that Company A has shift and office workers and Company B has only office workers who are at head office as the factory sites are scattered across the country. Shift and office workers face different challenges when it comes to maintaining breastfeeding in the workplace. The petro-chemical industry faces legal restrictions; young children and pregnant women are not allowed access to chemical or potentially dangerous work sites (South Africa. Basic Conditions of Employment Act 75, 1997).

The Companies included in the study are referred to as Company A and B in order to protect their identities (See Chapter 3.10, pg 97).

3.3.2 Permission and access to research sites

Verbal permission was obtained from the companies and participants to conduct the research after fully informing them of the process involved. (See Appendix 4 for letter of information) Access to the companies was at mutually determined convenient times.

Focus groups were run with verbal permission from management in the workplace over lunch-time, in an assigned meeting place. Semi-structured interviews were held in an assigned place within the company at a time convenient to each interviewee.

A brief background of each company is provided.

3.3.3 Company A

Company A is a large petro-chemical company which has a refinery and operates on a shift system 24 hours of the day. Because of the nature of the business there is a very strong smell of emissions on site, which is not conducive to the health of pregnant or breastfeeding women. The company employs 600 culturally diverse fulltime staff and 2000 contract workers. Fourteen per cent of staff (85) are women and the aim is to increase this to 25% by 2010 (Communications Manager, Company A). It has a Black Economic Empowerment Policy and recognises the need to redress the historically disadvantaged. The vision of the company is to deliver value and earn the confidence and respect of all the people they interact with. The company believes their areas of responsibility are; their employees, customers, shareholders and society. Health and safety is of utmost importance. The objectives are to ensure a better quality of life for the communities closest to the operational area and to demonstrate responsibility towards the environment. The company seeks to ensure a safe workplace but also to make a valued contribution to society. The Social Involvement Policy supports initiatives in the community that promote self-sustainability; education is the key focus here. The employees are seen as a valuable asset, particularly as the country faces a shortage of

skills as a result of many people seeking employment abroad. In 2006 the Employee Assistance Programme was launched where 24 hour counselling with legal and financial advice is available to employees (Company Website, 2007).¹

3.3.4 Company B

Company B is a large fast-moving consumer goods company with head offices in Durban. The company is one of the largest food and personal care companies in the world and operates in 100 countries and employs 179,000 people worldwide. Large scale restructuring from 1994 has led to outsourcing of non-essential services; in fact since 2004, 13% of the workforce have been retrenched. This inevitably leads to job insecurity for those employees who remain. Internationally, women account for 33% of management (Summary Company Monitor, 2003)². Repeated requests for the breakdown of the number of employees from the local company were not successful. The head office for the South African company is in Durban and employees all work in an open plan modern office block. . The manufacturing plants are set in many cities around the country.

Company B's mission is to add vitality to life. The employees are regarded as critically important to the business and so the company ensures that they achieve professional fulfilment, work/life balance and an ability to contribute to the business. In 2006 the People Vitality Programme was launched to improve the well-being and efficiency of

¹ Reference not listed because of confidentiality

² Reference not listed because of confidentiality

employees at work. Employees' well-being is said to be at the heart of company culture (Mission Statement, Company B website).³

In 2007 a charter of health and well-being benefits that will be offered to all employees by 2010 was drawn up. It will involve training in exercise, nutrition and mental resilience, and include regular follow-ups. The company has also introduced new video conferencing facilities at four of their regional headquarters to cut down on travel and improve the employees' work-life balance (Sustainable Development, 2007).⁴

Their corporate purpose is to be successful and in order to achieve this they need "*the highest standards of corporate behaviour towards everyone we work with, the communities we touch, and the environment on which we have an impact.*"(Company website, Purpose and Principle, 2008)⁵.

The company is committed to addressing social and environmental challenges and to contribute to sustainable development. Through local actions they aim to address global and environmental concerns, together with governments (Sustainable Development, 2007: An Overview). The company is committed to making a contribution to the Millennium Development Goals (MDG) which address poverty and hunger alleviation, health and environmental sustainability (Sustainable Development 2007: An Overview). Because nutrition lies at the heart of the business they have an impact on

³ Not listed due to confidentiality

⁴ Not listed due to confidentiality

⁵ Not listed due to confidentiality

the diets of millions of people. The company in fact participates in global initiatives to improve nutrition through food fortification. They are a member of the Global Alliance for Improved Nutrition and also currently a member of the World Food Programme, which help to improve the health and nutrition of children through school feeding programmes. The company is developing a school education programme on nutrition, health and hygiene (Sustainable Development 2007: An Overview). It seems as if enabling women who return to work to continue breastfeeding their babies would naturally fit into the core values of the company. Allowing women time and space to express breast milk for their babies in the work place has been shown to reduce absenteeism and engender loyalty to the company (Cohen, Mrtek & Mrtek, 1995).

3.4 The study population

The population included people employed by the two companies who met certain criteria (See Chapter 3.5.1, pg 82).

As an outsider I had to access the companies through contacts at management level. The managers were able to assist with both entry and the selection process, guided by the criteria.

3.5 Sampling strategy

Research participants who met the eligibility criteria below were selected from the companies. A sample of four to six in each organisation was chosen for the focus groups.

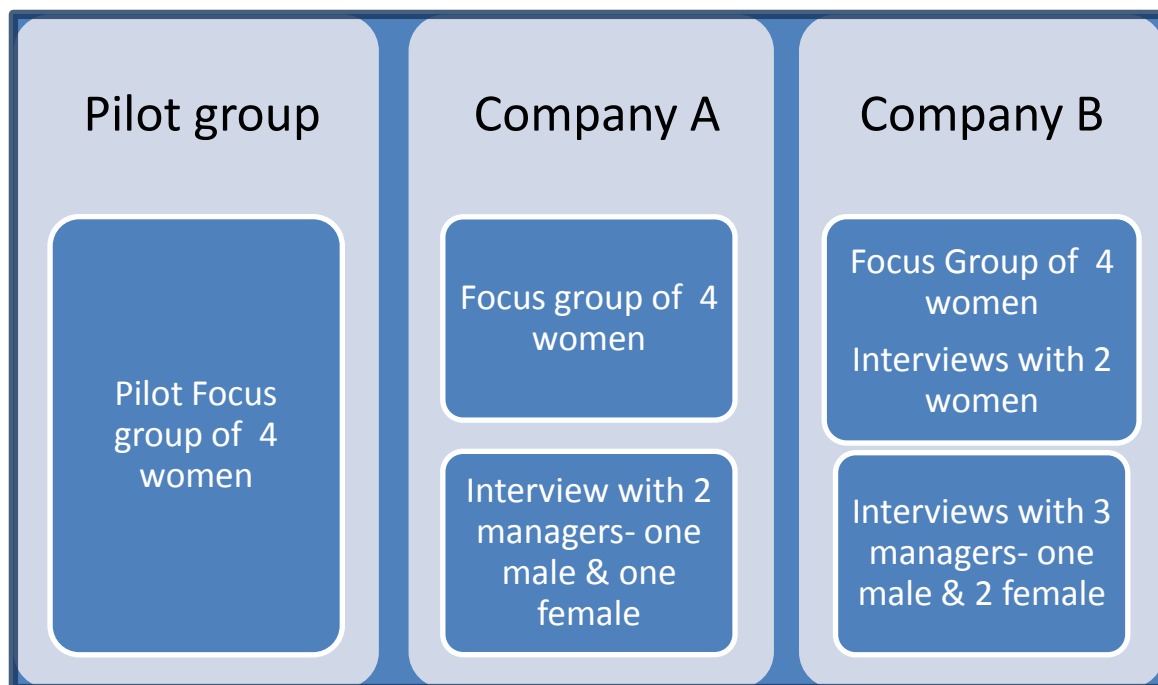
Sampling involves deciding which people to observe or interview. In qualitative research we are dealing with such small numbers that it is important that samples are purposive rather than random (Miles and Huberman, 1994). A case is also described as a unit of analysis by Miles and Huberman (1994). The unit forms the heart of what is to be studied and the boundary will be the context in which it is studied. When sampling in qualitative research, it is important that boundaries are created to define which aspects of the cases can be examined within the time available and which relate to the research questions. Second, a sampling frame needs to be created to help to uncover, confirm or qualify the basic processes or constructs of the study (Miles and Huberman, 1994). “*Within case sampling*” (Miles and Huberman, 1994:29) has been chosen. Even within a single case many decisions have to be taken regarding which aspects of the case will be sampled, for instance which “*roles, activities and processes*” (Miles and Huberman 1994:29).

Purposive sampling was used for selecting the focus group participants and the managers. This allowed for the deliberate selection of people who would be able to provide the information required for the study. It also allowed for heterogeneity to ensure that a wide range of views are collected (Miles and Hubermann, 1994). The sample (four to six) in each organisation were selected from line management. There are no critical rules for sample size in qualitative research; of much more importance is the quality of the participants and their ability to communicate their experiences (Polit and Beck, 2004). The intended number of manager and follow up interviews were not conducted due to difficulty in accessing participants. The study did not seek to make

broad generalisations of all companies or even of companies in Durban but rather to raise questions to be taken forward into the broader arena. The emphasis was on examining the experiences of the women and managers in the two companies.

Four mothers took part in the focus group discussion and two managers were interviewed from Company A.

Four mothers took part in the focus group discussion and follow-up interviews were



conducted on two mothers and three managers were interviewed from Company B.

Figure 4. Sample of respondents selected from each company

3.5.1 Eligibility criteria for mothers

- Employed full time (as part-time working mothers do not face the same difficulties)
- Willing to participate
- This is a South African context where cultural diversity is a major descriptor of the population so representation from all cultural groups within the companies was sought.
- All work levels (this study looked at breastfeeding in general, and was not peculiar to blue or white collar workers).
- Had children below the age of 3 years, so their breastfeeding experience is recent and relevant.
- Must have breastfed their children to enable them to answer related questions

3.5.2 Eligibility criteria for managers

- Willing to participate
- Both sexes, to get views from both perspectives.
- Should be in Human Resources or Line Managers, as they deal directly with policy regarding employed mothers and women report to them.

3.6 Research study sequencing





Figure 5. Research time sequencing

3.7 Pilot study

Frankland and Bloor (1999) make a case for pilot studies to present a qualitative researcher with an obvious clarity of the focus of the study.

A pilot focus group was conducted with four breastfeeding mothers who were all academics and had returned to work. The women were selected from the list of mothers from the Donor Milk Bank programme. This sampling was purposive. The purpose was to pre-test the scenarios from the press which were to be used as probes to stimulate discussion in the focus groups. The probes worked well and no adjustment was made to them.

3.7.1 Data highlighted in the pilot study

Data from the pilot study was rich and raised issues and alerted the researcher to their importance. This helped shape the study. The main themes which were raised were the general lack of breastfeeding information and support experienced by the women, the lack of facilities in the workplace for expressing breast milk and the stress involved with combining breastfeeding and work. The other notable feature was the mention of how few of their friends were breastfeeding. Cara mentioned that out of ten friends who had children, only two of them were breastfeeding. The decision was made to mention the data from the pilot studies in the data analysis. Van Teijlingen and Hundley (2001) feel that contamination of data from using pilot studies is less of a concern in qualitative research, where researchers often use some or all of their pilot data as part of the main study. The data were mentioned in the analysis but not included in the selection of the main themes

neither did they influence the conclusions. What was evident from the responses from both the questionnaires and the focus group was that the idea of providing facilities in the workplace for breastfeeding mothers to express milk for their babies is a totally foreign concept to managers. One manager felt that it was not an employee wellness issue and so not the responsibility of the company. One chief executive officer of a large company felt breastfeeding should be supported, but was concerned about the cost of providing this support. He felt the cost should be borne by government. Should supporting breastfeeding women be the sole responsibility of the state?

3.8 Data collection

The data collection techniques included focus groups (Cohen, et al. 2001) semi-structured interviews (Yin, 1994) and my reflexive journal (Green and Thorogood, 2004), which also included the systematic field observation of the environment (Mouton, 1996).

3.8.1 Data collection tools

All the qualitative methods used to generate data are discussed below.

3.8.1.2 Focus group discussions

Focus groups provide an opportunity for an exchange of opinions, discussion and the possibility of eliciting some divergent views (Cohen et al., 2001). They also enable participants to reflect on others' opinions and have the opportunity to react to them. The sharing of their experiences can be valuable.

The focus group (one in each company) comprised four mothers within each company. In these groups the attitudes and behaviour within the workplace were explored, both towards breastfeeding women and of breastfeeding women. Scenarios were taken from the various newspaper reports from around the world (See Appendix 3) and were presented as a catalyst to introduce debate. This encouraged a more spontaneous response to a situation from the participants rather than relying on a more contrived situation in which they might provide what they thought was required of them. See Table 9 (pg. 90) for the development of an instrument for data collection according to the objectives and theoretical framework.

The focus groups lasted between 20-30 minutes and were held in private meeting rooms in the respective companies. After each focus group observations of the environment, interactions and body language of participants and thoughts were recorded. Focus group discussions were transcribed and these transcriptions were checked with the respondents. Member checking helps establish credibility (Polit and Beck, 2004).

Table 9. Development of instrument for data collection according to the objectives & theoretical framework

Objectives	Theoretical	Tools	Related Questions/Probes based on
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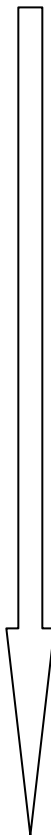
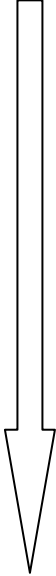
	Framework		the literature [sources cross-referenced in -- literature review]
<p>To describe employers' attitudes and knowledge about providing breastfeeding support</p> <p>To identify mothers' attitudes towards breastfeeding and the workplace environment</p>	<p>Situation-Specific Theory of breastfeeding (Nelson, 2006). See 2.15.3</p> <p>BASNEF Model-Beliefs and Attitudes (Hubley, 1993). See 2.15.4</p> 	<p>In-depth semi-structured interview</p> <p>Focus group Discussions</p>	<p>What are management's attitudes to providing facilities for employed breastfeeding mothers? (Libbus & Bullock, 2002). See 2.11.2.</p> <p>What are the perceptions of responsibilities of the company to breastfeeding mothers? (Dunn et al. 2004). See 2.11.2</p> <p>What are attitudes to breastfeeding in the workplace? (Ong et al. 2005). See 2.11.2.</p> <p>What are the perception of the benefits/liabilities of breastfeeding in the workplace to the Company? (Libbus & Bullock, 2002).See 2.11.2</p> <p>What are breastfeeding mothers' attitudes about sustaining breastfeeding while employed? (Bar Yam, 2002. See 2.8). (Cardenas and Major, 2005. See 2.12). (Kronburg, 2004. See 2.15.5).</p> <p>Newsweek- November 2006 (See Appendix 3) Mother kicked off plane in USA for breastfeeding her child. Texas Restaurant refused to serve a breastfeeding mother. Many US state laws state that breastfeeding in public is obscene. What do you think the law should say about breastfeeding in public? What do you think would make it easier for mothers to breastfeed their babies when out of away from home?</p> <p>United Press International-May 2006 Rome- An Italian member of parliament member, Dontello Paretti won a court case and installation of a nursery allowing her to safely breastfeed her 3 month old baby while at work. She had threatened to breastfeed her daughter in front of her colleagues unless a place was found. Do you think that mothers could be more vocal about their rights to breastfeed at work? Does lack of facilities mean lack of support?</p>

Table 9 (Cont.) Development of instrument for data collection according to the objectives and theoretical framework.

Objectives	Theoretical	Tools	Related Questions/Probes based on
------------	-------------	-------	-----------------------------------

Objectives	Theoretical framework	Tools	Related Questions/Probes based on the literature [sources cross-referenced in -- literature review]
<p>To describe the practices of the breastfeeding mothers in the workplace</p> <p>To identify factors that influence breastfeeding practices within the workplace environment</p>	<p>Situation- Specific Theory of breastfeeding (Nelson, 2006(a). See 2.15.3</p> <p>BASNEF Model- Beliefs and Attitudes (Hubley, 1993). See 2.15.4</p> 	<p>Focus groups and In-depth follow up interviews</p> <p>Focus groups and in-depth follow- up interviews</p>	<p>What is the current situation regarding facilities and processes re: breastfeeding mothers? (Galtry, 2002 & 2003. See 2.11.1). Zinn, 2000. See 2.11.3).</p> <p>Maternity Leave (available/ duration), (Bar Yam, 1997. See 2.7).</p> <p>Reasons for stopping breastfeeding (Scott et al, 2005. See 2.7).</p> <p>Expression of breast milk (option/ duration) (Witters Green, 2003. See 2.2) (Gatrell, 2005. See 2.2).</p> <p>What factors influence breastfeeding practice in the workplace? (Cardenas and Mayor, 2005. See 2.12), (Britton et al. 2007. See 2.13).</p> <p>Workplace environment facilities, supports and barriers (International Labour Organization, 2000. See 2.3).</p> <p>(Rojjanasrirat, 2004. See 2.11.2).</p> <p>Professional Support (availability and manner), (Wallace and Kosmala Anderson, 2007. See 2.15.8).</p> <p>Psychosocial support (who and how) (Raisler, 2000. See 2.15.6).</p>

3.8.1.3 Semi-structured in-depth interviews

The advantage of this tool is that it allowed some structure yet also flexibility. So although there is a topic guide, this can be adjusted to probe issues relevant to the topic which may be raised by the interviewee (Ritchie and Lewis, 2003). This is also an ideal way of probing perceptions and opinions of individuals (Parahoo, 1997). Yin (1994) considers interviews to be an important tool in case studies because of their open-ended nature and ability to generate opinions and facts. By using in-depth semi-structured interviews, both in follow-up interviews with mothers from the focus group and with managers, I was able to clarify the participants' response, probe issues more deeply and collect data rich in detail (Talbot, 1995). Interviews do have the danger of being biased and subjective (Cohen and Manion, 1994) and this was noted to guard against it happening. (See Table 9)

Five Managers from the companies participated in semi-structured interviews.

The interviews were used to address the objectives:

- (a) Explore attitudes and behaviour within the workplace towards breastfeeding women.
- b) Attitudes and knowledge about breastfeeding practice and what would influence practices within the workplace relating to a mother-friendly environment.

Semi-structured follow-up interviews were conducted on two mothers at Company B. I was unable to gain access to women for follow-up interviews in Company A due to a

lack of response from both the women who were approached and the contact person in the company who was approached on several occasions.

The semi-structured interviews followed on after the focus group discussion, but were held on separate days. The question probes were based on the objectives and literature review and issues which had been raised in the focus group discussion (See Appendix 2). This allowed for mothers to provide their ideas and feelings individually and provide insights into their situations.

All focus groups and interviews were recorded on a tape recorder with permission from the interviewees (See Appendix 5). All these were then transcribed and the transcriptions were checked by the interviewees for accuracy. They were also given the opportunity to add any further comments; however nobody did.

3.8.1.4 Reflexive journal

Deliberation from my reflexive journal (kept for the two years over which the research ran) helped to identify potential problem areas within the research. This was to help detect personal bias due to my own beliefs and values, role conflict, lack of neutrality, all of which may have affected the focus group discussions, interviews or the interpretation of the results. The reflection also covered issues on access and relationships. It was important for me, as the researcher, to bracket my agenda, experience and evidence-based research for the purpose of this study. Self reflexivity is the continuous process of

examining how the researchers' own values and perceptions and behaviour or presence could affect the data collected (Parahoo, 1997).

It was in fact this process of reflection which helped me to recognize how one of the questions I asked in the focus group discussion in Company B had been very leading. Fortunately, as it turns out the women in the group did not agree with my question/statement so it provided opportunity for them to further clarify their feelings about the issue. Additionally, the journal also comprises field notes documenting my observations of the facilities with respect to mothers' breastfeeding needs. The various data gathering techniques (focus groups, semi-structured interviews and field observation) allowed for triangulation (Polit and Beck, 2004).

In the interest of the examiners the raw data containing the journal and transcripts of the focus groups and interviews are attached in a CD Rom.

3.9 Data analysis

"No delusion is greater than the notion that methodcan make up for a lack of mother-wit, either in science or in practical life."

Thomas Henry Huxley (1825-1895).

The qualitative data were gathered to answer the research questions and find the themes emerging from the data and the meanings attached to those themes. A process

was followed (Miles and Huberman, 1994) when undertaking this analysis but common sense and insight and good judgment are an important part of the process (O'Leary, 2004). Logical thought processes were used, while inductive and deductive reasoning played a role in grasping and organizing the data and in generating possible alternate explanations (Polit and Beck, 2004).

Initially, NVivo qualitative software package was used to store and analyse the data and categories of nodes were created. I found this to be very time consuming and reverted to thematic analysis initially structured by the theoretical framework and objectives. Data analysis began concurrently with the collection of the data (Speziale and Carpenter, 2007). The process began with data reduction which involved reading all the transcripts, research diary, memos and observations over many times, selecting, focusing on and transforming the data. All the data were reviewed for content and coding was used to categorise the data; this provided a baseline for further themes and arguments. Themes which emerged were also identified through continual engagement with the literature (O'Leary, 2004). Data were then organized into tables, charts and matrices to help with the interpretation and identification of emerging themes. As recurring themes and patterns and interconnections emerged, possible explanations and propositions were initiated yet these were not finalized until the very end, as findings were continually interrogated. Divergent views and ideas were also searched for. All this was recorded in the reflexive and thoughts relating to emerging data recorded.

Thick description was used to give a thorough description of the context. Extracts from interviews or focus groups were used directly in the analysis, keeping as close to the text as possible, so that the analysis accurately reflects the concerns of participants (Polit and Beck, 2004). Evaluation occurred throughout the study.

Conclusions flowed from the analysis and answered the research objectives and questions and were made considering current literature and two frameworks, namely the Situation-Specific Theory of Breastfeeding (Nelson (a), 2006) and the BASNEF Model (Hubley1993). Their significance was carefully considered (O'Leary, 2004).

3.10 Ethical considerations

Confidentiality was maintained so no statement in the findings is able to be linked to a particular person.

Maintaining anonymity in qualitative research is not possible because the researcher interacts with the participants and the companies. However, identities of the companies will be protected as far as possible through the use of the terms "Company A" or "Company B" and the way in which the issues are presented. Normally the researcher would give a description of where the companies are based for credibility reasons. This has not been done in this study, to protect the company's identity. Pseudonyms were used in focus group discussions. Permission was obtained for all visits, focus groups and interviews with the company and participants concerned. Informed consent was

signed by all respondents they were assured of their right to withdraw at any time without prejudice. An information sheet/consent form was provided (See Appendix 5). Only I, as the researcher, and the supervisors and some peers had access to the data and they have been stored safely away from the company staff.

Ethics approval was obtained from the Institutional Research Ethics Committee (See Appendix 6).

3.11 Rigour/ validity

Whittmore, et al. (2001) believe that validity and reliability are fitting in qualitative studies as do Meadows and Morse (2001). However there is some debate as to the importance of data that establish the truth and rigour of the experiences of the respondents as opposed to data that also allow space for creativity (Polit and Beck, 2004). Lincoln and Guba (1985) refer to various criteria important for establishing the trustworthiness of the data. They are credibility, dependability, confirmability and transferability.

Denzin (1989) sees validity more as something that improves understanding of the phenomena rather than their correctness. He describes it as having differing views in a kaleidoscope, all views adding to the richness.

The following checks were undertaken to ensure the trustworthiness of the data.

- Peer debriefing was be used where peers, researcher and breastfeeding advisor will review the findings (Polit and Beck, 2004)

- Critical peers were used in focus groups and their observation and reports are included in the data analysis for the focus groups.
- Confidence in the data and their interpretations has been established by triangulation, using many sources (the literature, reflexive diary, critical peers, data from same sources over different times, data across the sources) for collecting data to validate the conclusions (Lincoln and Guba, 1985).
- Dependability has been ensured by providing an audit trail .See Figure 4 to follow my decisions and choices (Parahoo, 1997)
- Reflexivity has been demonstrated as mentioned earlier.
- Credibility - member checking was done with participants as data were collected (Polit and Beck, 2004). See 3.12
- Transferability- a detailed data base of thick description was kept in order for others to understand my conclusions (Talbot, 1995).
- Integrity- there were on-going checks on the above to ensure validity (Polit and Beck, 2004).
- Verification- this has been ensured through a thorough literature review, bracketing and data saturation (Polit and Beck, 2004)
- External experts in the field were used to assess whether the project is trustworthy and valid.

3.12 Peer review

Critical review by recognised experts in the lactation field was used as it would offer objective advice on study. The reviewers had no conflicts of interest, and had a good understanding of the subject matter and research methodologies and outcomes. They were asked to look at the following issues (University of Aberdeen, 2007).

- Evidence of adequate literature review
- Clear stated objectives
- A clear and strong methodology
- If the data analysis was appropriate and described
- If the conclusions and outcomes of the study are appropriate

Additional insight into the data by a peer reviewer was valuable and has been added in red (See Chapter 4.6.2.4)

3.13 Limitations

Focus group members were chosen by the contact person in the company who had been given the eligibility criteria. The sample of women from Company B did not reflect the demographics of the company, some women chosen did not meet all the criteria set e.g. one woman had not breastfed at all. So although she contributed to the group, women who met all the criteria would have had more personal experience to share. That said, it was interesting that her perspective was much the same as the other women. There is the possibility that the focus group effect may have prevented some women from expressing their opinions.

Due to work pressure and time constraints on the part of management, repeated attempts to set up interviews with more managers were not successful. Similarly no follow up interviews were conducted in Company A due to lack of interest/time on the part of those women who were approached personally on numerous occasions.

As an outsider, I was very aware that my presence and involvement in the focus groups and interviews could have influenced the outcome. Although an expert in my field, I was not conversant with company politics and this may also have had untoward effect on the results gathered. Nonetheless, listening to those involved and seeking to explore the meanings of what was said helped me to identify the factors that affect breastfeeding practices in the workplace.

In the interpretation of the data the limitations of the small number of participants in the study is acknowledged. Most of the sample of women were middle class and in skilled jobs.

Chapter Four - Data Analysis

4.1 Introduction

Analysing data cannot be done just by using a set of tools. The analysis has to position the study within a broader context (Green and Thorogood, 2004). In this study I have moved between the data and the broader social structure, and have been guided by both the study's objectives and theoretical background. My theoretical background and experience as a Lactation Consultant has helped me to better understand the meaning of the data and gain insights into the meanings.

After a thorough review of the data, a list of important themes was made. The themes and sub topics were grouped within six main headings in the theoretical framework used for this study (Situation-Specific Theory of Breastfeeding and the Beliefs, Attitudes, Subjective Norms and Enabling Factors Model).

The six main headings are:

- Infant readiness and capacity

- Prenatal/Postpartum infant-feeding decision making period

- Maternal readiness and capacity

- Institutional Network

- Informal Psychosocial Network

- Professional/Formal Network

Although the framework was used for initially examining the data, it was just the starting point. Categories generated were derived from the framework but they also emerged from the data and were used to interrogate and extend the conceptual framework (Chapter 5, Figure 11, pg 154). Miles and Huberman (1984) see the conceptual framework giving the boundary, but at the same time providing flexibility for it to develop and grow. Lesham and Trafford (2007:99) see the conceptual framework as “*a device which makes sense of the data.*”

Each section included a category “other”, to provide for any issues which were not yet accounted for by the frameworks. The raw data were then applied to the framework (Richards and Richards, 1994). Each theme was indexed in the raw data. The data were then displayed in matrix format. Each main theme had sub topics which were displayed in separate columns and each respondent was allocated a separate row. Some data appeared in multiple places. This immersion in the data and familiarisation with it helped raise issues that needed investigation and helped develop insights and interpretation (Ritchie and Lewis, 2003).

Data were generated from the various data collecting methods; pilot studies, focus groups, interviews, observations during the various focus groups and interviews and the reflexive journal. The data were seen a “whole” from which the themes emerged that went beyond the initial structured containment of the questionnaires.

The data has been discussed according to the main themes which emerged from these matrices in order to answer the objectives of the study.

4.2 Demographics of participants

Pseudonyms have been given to the participants.

Table 10. Participant demographics Company A

Date of interview/focus group	Name	Personal Detail	Maternity leave and age of child and length of breastfeeding	Focus group or Interview
21 June 2007	Win	African- Female 31 Yr Married	3mths leave Twins 8 yrs Unsuccessfully tried to breastfeed	Focus group
21 June 2007	Pam	African- Female 20-25 yr Married	4 mths leave 5 mth old baby Breastfed 2 weeks	Focus group
21 June 2007	Cindy	White- Female 20-25 yr Married	3 mths maternity leave +1 mths leave 15 mth old baby Breastfed for 51/2 mths	Focus group
21 June 2007	Dee	Asian- Female 26-30yr Married	4 mths leave Breastfed for 2 weeks 16 mth baby	Focus group
10 December 2007	Helen (Manager)	White- Female 40 + yr Married	6 mths leave Breastfed 8-9 mths Teenage Children	Interview
10 December 2007	Luke (Manager)	White- Male 50 +yr Married	N/A	Interview

Table 10 gives a breakdown of the demographics of the participants at Company A. At a glance one can see that most women had a relatively short maternity leave which would possibly have affected their ability to maintain breastfeeding.

Table 11. Participant demographics Company B

Date of interview/focus group	Name	Personal Detail	Maternity leave and age of child and length of breastfeeding	Focus group or Interview
4 December 2007	Kay	White- Female 26-30 Yr Married	6mths leave 3 yr old Unsuccessful with breastfeeding	Focus group
4 December 2007	Lee	White-Female 31 yr+ Married	6 mths leave Children 2 1/2 yr and 9 mths Breastfed for 8 and 6 mths respectively	Focus Group
4 December 2007	Karen	White- Female 31 yr+ Single	6 mths leave Breastfed both children for 7 + 4 mths respectively	Focus Group
4 December 2007	Carol	White- Female 26-30 yr Married	6 mths leave Children Breastfed 4 + 3 mths respectively	Focus Group
6 December 2007	Lee Same as above, she was in the focus group and follow-up interview	White- Female 31 yr+ Married	6 mths leave Children 2/1 yr and 9 mths Breastfed for 8 and 6 mths respectively	Interview
11 December 2007	Kim	White- Female 31yr+ Divorced	6 mths leave Children Breastfed for 3-4 mths	Interview
6 December 2007	Eric (Manager)	White- Male 50yr+ Married	N/A	Interview
26 January 2007	Jane (Manager)	White- Female 50yr + Married	N/A	Interview
13 October 2007	Pria (HR Manager)	Asian- Female 20-25 Yr Married	N/A	Interview

4.2.1 Duration of breastfeeding

Table 11 above lists the participants' demographics from Company B. Interesting to note that with the company policy of giving six months maternity leave, most women breastfed for a much longer period than those in Company A. It is however worth noting

that three of the women breastfed their second babies for less time than they did their first babies. This runs counter to the trend found in research that mothers breastfeed subsequent babies for longer periods than their first babies (Nagy, Orvos, Pal, Kovacs and Loveland, 2001). The reasons for this shorter duration were followed up subsequent to the focus groups and are as follows:

Karen,” My milk wasn't all that good the second time and I put it down to me rushing around too much. In that time, I tried to start a small business which did not work out (baby was only 6 weeks at the time of me starting the business). I had also been retrenched from Company B (when I was 7 months pregnant) and was preoccupied with the concern about being unemployed, which we really could not afford.”(Karen, 13 November 2008). Karen was later reemployed by Company B.

Similarly Carol said, *“To be honest, my milk was not good with either of my pregnancies....so I think I just persevered more with my first. I was also obsessed with losing the baby weight - embarrassed to say - and my doc told me that I couldn't think of losing weight until I had stopped breastfeeding ”(Carol,13 November 2008).*⁶ Lee's reason for stopping breastfeeding was because she returned to work and had had such a bad experience trying to express with her first baby that she did not even try with her second.

⁶ Carol is pregnant again and has decided, following our focus group discussion, to seek support to successfully breastfeed this baby.

So the reasons for stopping breastfeeding earlier in these three cases can be attributed both to the stress of work and prevailing societal norms. None of the mothers in the study breastfed for the two years recommended by the WHO (WHO, 2003).

Closer examination of breastfeeding duration for Company A revealed that Helen and Cindy were the ones who managed to breastfeed for the longest. Helen took six months maternity leave with her first child and managed to continue feeding for three months after she returned to work. She had the same length of maternity leave with her second child, but she was unable to maintain her supply. She felt this was due to the fact that she was so busy. Cindy only had 3 months maternity leave and added her annual leave to this, but only managed two weeks of breastfeeding once she returned to work. She faced enormous pressure as a contract worker who worked shifts and long hours.

Table 12 below provides a comparison between Company A and B. The information in the table was accessed from the description of the companies (See Chapter 3.3.3 and 3.3.4, pg 76) and from the interviews of the managers. The main differences between the companies are the type of business they were involved with and as a result their differing vision and mission statement. The length of maternity leave offered varied as did the different challenges they faced in supporting breastfeeding.

Table 12. Comparison of two companies

Company & vision/ mission statement	Environment	B/f policy	Mater- nity	Managements' attitudes to b/f &
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			leave	priorities (based on interviews)
Company A To be a safe, world-class petroleum refiner which delivers excellence to customers & shareholders is respected & has confidence of their people. For their behaviour to align with their values and business principles.	Petro-chemical production	No policy	4 mths	Understanding but practicalities of running a production line problematic. Skills retention key Gender equality 24 hour production
Company B Their mission is to add vitality to life & meet everyday needs for nutrition, hygiene & personal care with brands that help people to look good feel good and get more out of life.	Office block- Manufacturing off site	No policy	6 mths	Open to idea but no requests from mothers Gender equality Best Company to work for survey

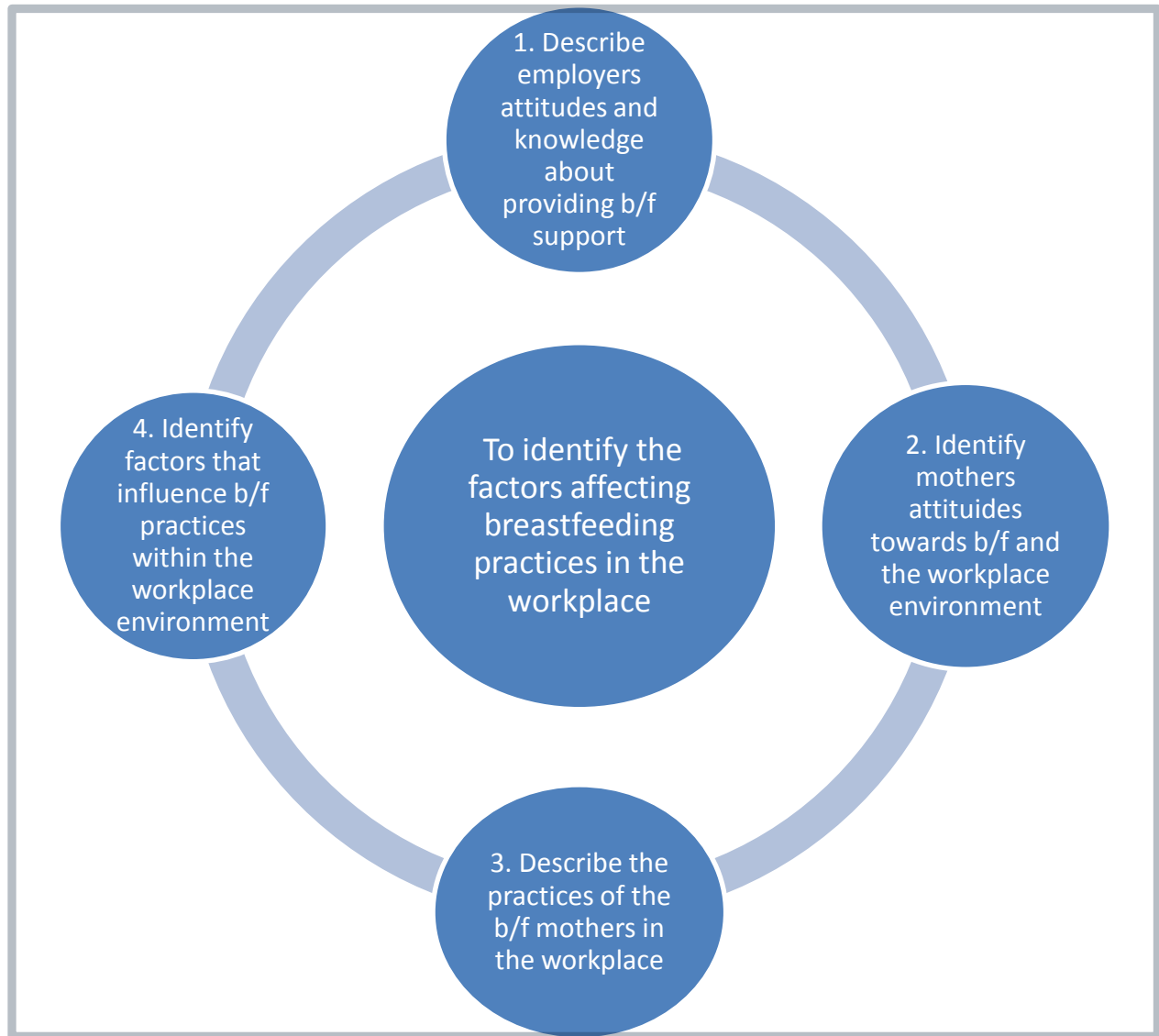


Figure 6. Aim and objectives of the study

The above figure shows the aim of the study and the objectives which will be used in the data analysis to achieve that aim.

Framework

Objectives

Themes from Data

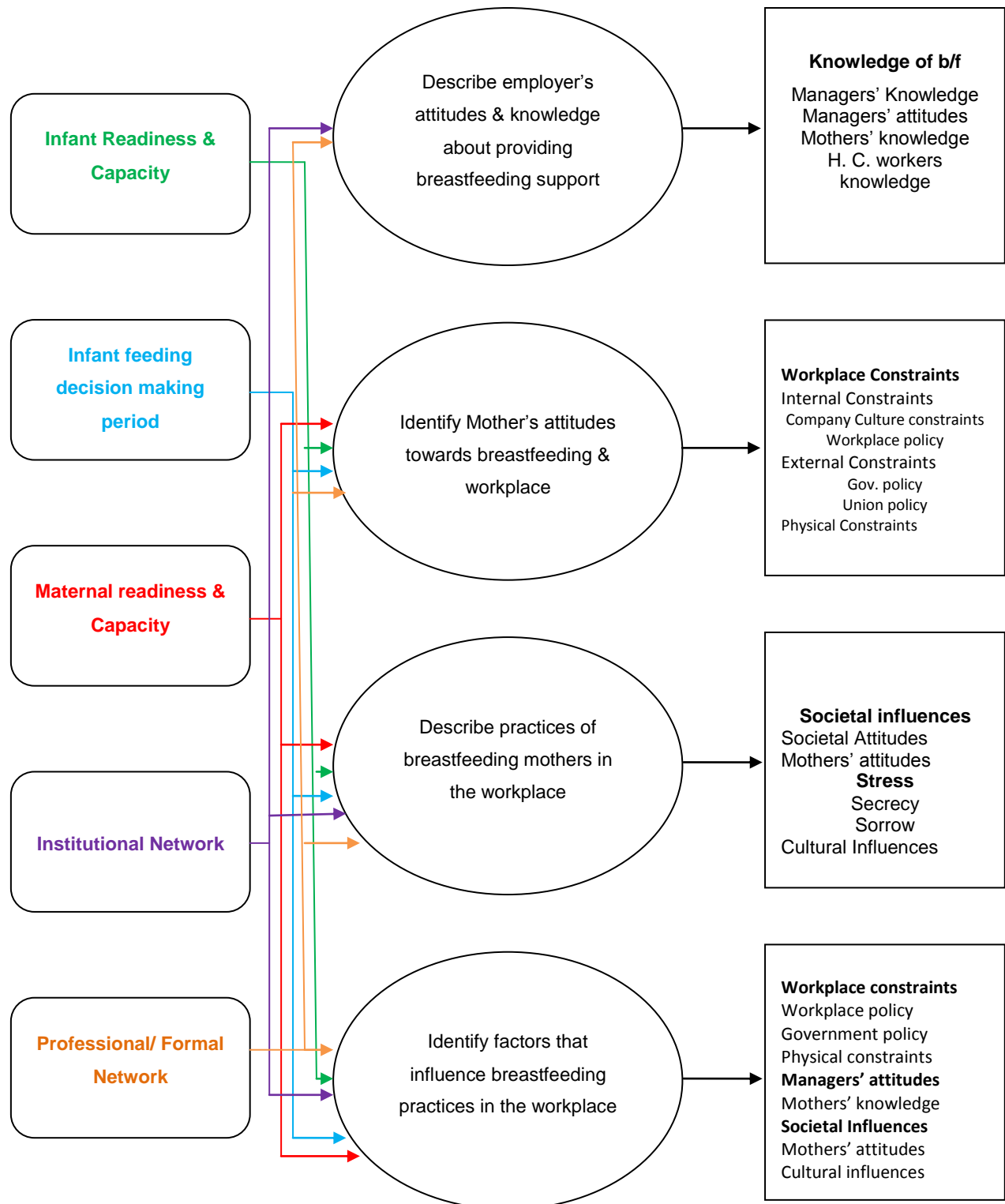


Figure 7. Conceptual map summarizing framework, objectives and themes

Figure 7 above demonstrates how the SST framework (Nelson, 2006(a)) is linked to the objectives and the emerging themes from the data. Below is the discussion of these emerging themes.

4.3 Main themes emerging from the data

The main themes emerging from the data which will be discussed are:

- Knowledge of Breastfeeding
- Workplace Constraints
- Societal Influences

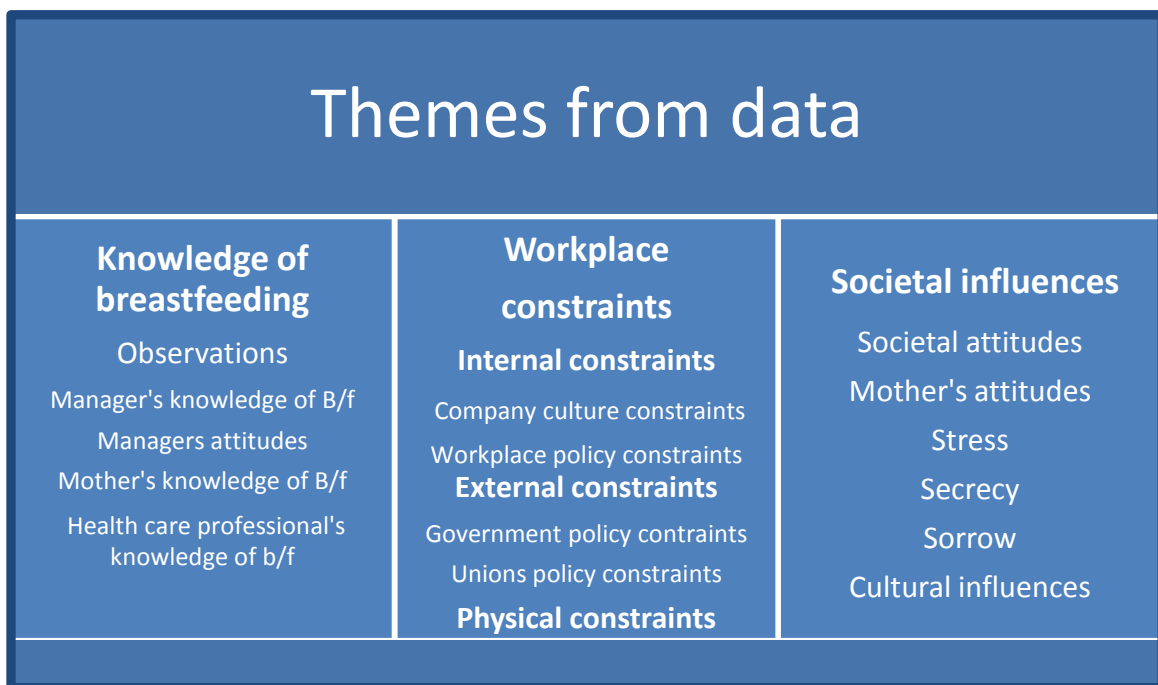


Figure 8. Main themes emerging from the data

In this figure the breakdown of the main themes discussed is displayed.

4.4 Knowledge of breastfeeding

4.4.1 Observations

Managers were uncertain at the commencement of the interviews. The non-verbal cues detected were those of discomfort about being questioned on a topic that was new territory to them, and one they may not know anything about. Managers made a concerted effort to give details of the employee assistance programmes that were in place in the companies.

The environments were so business orientated that it was difficult to imagine a breastfeeding mother being accommodated.

4.4.2 Manager's knowledge of breastfeeding

For three of the managers who were interviewed, the issue of providing breastfeeding support in the workplace was new and something that they had not considered before. There was a lack of understanding about what providing support would entail, but once it was explained, they were open to the idea and felt it would be easy to implement. Most felt that breastfeeding was beneficial but were not really aware of how long women should breastfeed for. There was some incredulity from a manager about the length of time someone breastfed for; breastfeeding for extended periods seemed to elicit a negative response.

"I mean I have heard of a women who has breastfed her kid until about three years old....what is the ideal?" (Jane, Interview, Company B, 26 January 2007).

Another's comments indicated wholehearted support for breastfeeding despite his lack of knowledge about breastfeeding and what facilities were available. Recent exposure to breastfeeding with the birth of a grandchild could possibly have sensitised him to breastfeeding.

"I don't know all the scientific stories...but I think that it is absolutely appropriate. I don't even know if we've got that facility within this company." (Eric, Interview Company B, 6 December 2007). The lack of discussion and emphasis on breastfeeding in the media, which is a vital public health concern, means that the average educated "man in the street" remains uniformed about a fundamental yet critical health issue (Research Journal, 15 December 2007).

A female manager, who had herself breastfed was unsure if the company would benefit but felt that the provision of facilities would generate good will amongst employees, reduce stress levels and help with retention of skills but emphasised the practical realities of implementation would be very, very difficult (Helen, Interview Company A, 10 December 2007).

4.4.3 Managers' attitudes

Companies talked about how valued their employees were, and yet there was a reluctance to set up a culture of entitlement. So there was a degree of caution here about what implications this would have for the company long term, how much this would cost them and eat into profits. There was also the unspoken fear of setting

precedents which could continue to be claimed. It was evident that there was also a sense of discomfort/embarrassment discussing breastfeeding. This was confirmed in discussions with the previous international director for Company A who said the company would provide the necessary facilities for women in the workplace because in the current environment it was the right thing to do. However management would not want to be seen making a public announcement to this effect (Peter, 2007). It was interesting that breastfeeding rights were seen in the light of being “politically correct” something expedient and probably short-lived and faddish rather than a long-term health benefit, which was an employee’s right.

Another retired Human Resource Manager from Company B gave a very candid opinion. He felt if there was sufficient demand the company would provide facilities. He added that women would not use the facility though even if it were available. He felt they would rather go to the toilet to express so they were not seen to still be breastfeeding (Simon, 2008).

Truss et al. (1997) found there was a contradiction between the rhetoric of Human Resource Management (HRM) of employees being valuable assets and the reality within the day-to-day operations of companies. Soft HRM (developmental humanism) focused on integrating policies and business objectives, but at the same time treating employees as valuable assets due to their commitment and skills. The hard model was utilitarian HRM and this integrated policy with business strategy. Employees were viewed as skills to be used, and as a necessary cost rather than a competitive benefit.

So even if a company embraced their employees as valued assets, the reality was that in most companies bottom line performance took priority over the interests of employees (Truss, et al.1997).

A couple of the managers felt that work breaks to express breast milk were a far healthier option than the current smoking breaks allowed employees.

“And it certainly would probably take less time out of a worker’s life than the smokers when they go out to smoke. So going to express at work wouldn’t be an issue” (Jane, Interview, Company B, 26 January 2007).

“Ja, I think that would be absolutely appropriate for the company to do that (breaks for Moms to express) because I think we’ve got a non-smoking policy in this business, for example. And so people go out doors to smoke, in any case to smoke...so it could be up to 20 minutes whatever. So I think this is a far healthier option and more affordable thing to do.” (Eric, Interview, Company B, 6 December 2007).

These two respondents raised an important issue. The first comment was positive and interactive, the second a bit more ambivalent, which revealed that breastfeeding facilities had not been thought through previously. South Africa had policies to protect people from the dangers of smoking. It would not seem inappropriate therefore, for the government to develop policies, particularly for mothers in the workplace, to help protect their babies from disease and sometimes even death, and at the same time improve the

health of their mothers. Government championed this legislation, business and society had to adjust their policies accordingly. The campaign raised awareness about the dangers of smoking and media covered the issues widely. Those people who smoked were excluded, they had to leave the workplace or restaurant, and this meant smoking was unacceptable in public places. It changed societal thinking and behaviour. If government championed breastfeeding in the same way, it would become the natural acceptable way to feed an infant.

A female manager who had breastfed her children and returned to work while still breastfeeding understood the importance of breastfeeding and the pressures women faced. When discussing shift workers and their difficulties in finding time to express she said, “*That’s regrettable because that almost forces the mother to almost wean her baby.*” (Helen, Interview Company A, 10 December 2007). There was a sense here of acceptance of the inevitable facts and status quo. Breastfeeding was the victim of the circumstances in the workplace. There was no sense of trying to change the status quo.

It appeared there was a general lack of knowledge about breastfeeding and women’s needs on returning to work. Having knowledge in itself would not necessarily change behaviour. Knowledge needs to be combined with an awareness and understanding about breastfeeding. This general lack of awareness has resulted in a lack of emphasis of breastfeeding in society and the expectation that most women will have stopped breastfeeding when they return to work. Only one and a half percent of children between four and six months are exclusively breastfed in South Africa (The South

African Health and Demographic Health Survey, 2003). Health professionals and government have not prioritized promoting, protecting and supporting breastfeeding and educating mothers and the public. The fact that the majority of women used artificial substitutes to feed their babies indicated that the general perception was that formula was as good as breastfeeding. This in turn possibly contributed to managers' attitudes towards breastfeeding. They were unaware about the importance of breastfeeding-even more so if they were young and did not have families of their own; it was not something they have even considered.

4.4.4 Mother's knowledge of breastfeeding

Many women in this study had little or no knowledge of breastfeeding practices and even less about expressing and how to combine breastfeeding and work outside the home. Most felt there was insufficient educational support and some women tried to learn how to breastfeed from a book once they got home from hospital. It was clear that women were "at sea" when it came to breastfeeding, and were left to their own resources to cope.

"We leave hospital before our milk has even come in, and then you suckle at home trying to read from a book." (Sandy, Pilot Focus Group, 4 June 2007).

..."They don't talk about the challenges with regards to breastfeeding, sometimes it's difficult. Sometimes it's painful...you feel so guilty that you can't do this thing that you

are meant to do as a mother. .not enough information is out there.” (Pam, Focus Group A, 21 June 2007).

“There is a huge amount of ignorance and non-awareness of breastfeeding...and the needs from the general community...literally once you have your baby and they say you must breastfeed, and that’s the beginning of your education regarding breastfeeding.” (Liz, Pilot Focus Group, 4 June 2007).

Some women stopped breastfeeding early as they were unsure about sufficient supply (Dee, Focus Group A, 21 June 2007 and Karen, Focus Group B, 4 December, 2007).

A lack of confidence in their breastfeeding ability often led women to wean early, because of a perceived insufficiency of supply (Dennis, 2002). Others had very bad experiences trying to express and so decided to stop breastfeeding. The women who had six months maternity leave seemed happier about stopping breastfeeding, three out of the four stopped before they returned to work. But two mothers said it had gone so well, they would have liked to continue although the workplace environment did not lend itself to that.

4.4.3 Health care workers knowledge of breastfeeding

Women needed the help and support of Health Care professionals and this was especially true when they combined breastfeeding and work (See Chapter 2.15.9, pg 67). In order to successfully sustain lactation, women needed information to enable

them to plan ahead; how many times during the day they needed to express to maintain their supply, how to best store the milk in the workplace, how to handle the stress that comes with combining the roles of employee and nurturer.

...“They never educated me..my antenatal class, my gynae and the clinic that I visit every month. I’m finding out the stuff as it happens, not with any pre-knowledge...”
(Lee, Focus Group B. 4 December 2007).

Pam (Focus Group A, 21 June 2007) agreed,” *I think not enough education or information is out there for mothers because...obviously you get it in baby magazines that you read while you are pregnant but you know there are so many perceptions about whether to breastfeed or not to breastfeed.”*

There are no pamphlets in the workplace on combining work and breastfeeding and very little is available in antenatal classes.

Interestingly, two articles which appeared in a popular parenting magazine (Grinker, 2006 and Van Vuuren, 2007) on the subject of “Working Mom” never even raised the subject of breastfeeding. This lack of discussion and information seems to indicate that combining breastfeeding and work were not considered the norm and this in turn could influence employers’ perceptions of women’s needs.

It seems that Health Care providers all operated independently of each other so that the Antenatal Care provider, the Obstetrician and the Child Health Care Professional Nurse were not coordinating breastfeeding advice given to mothers. Nobody really took

responsibility for breastfeeding and it “fell between the cracks” so mothers received inadequate information to equip and prepare them for breastfeeding. One way of supporting breastfeeding amongst health care professionals and raising its profile, would be for medical aids to take breastfeeding up as a preventive health issue. Some medical aids encourage exercise, fitness and stress reduction and provide incentives by offering discounts for gym membership, travel and relaxation. There is enough research to support the implementation of similar membership discounts for women who initiate and sustain breastfeeding.

Bester (2006) found that the lack of knowledge, experience and support for breastfeeding was a barrier to women breastfeeding. Mothers depended on Health Care providers for information about breastfeeding in order to make informed decisions. In fact women encouraged by health care providers were four times more likely to initiate breastfeeding (Miracle and Fredland, 2007). Women make their decision during the antenatal period (See Chapter 2.15.5, pg 64) but are so focused during this period on labour and delivery that they do not think too much about breastfeeding until the baby arrives. The long-term future and back-to-work needs are not even discussed. The hospital stay post-delivery is one or two days and women are discharged before breastfeeding is established with nobody to help and support them (personal experience).

Health Care Professionals have an ethical responsibility to provide scientific information to these women on the benefits of breastfeeding and the risks of artificial formulas

(Miracle and Fredland, 2007). They have also been identified as the source of much conflicting advice about breastfeeding which results in supplementation with formula and subsequently the cessation of breastfeeding (Tarrant et al, 2004).

The Occupational Nurse in the workplace was ideally placed to offer information to pregnant women. It seems however that the women in the companies in this study had little or no contact with her; some even commented that they did not even know that she existed. There was also an apparent lack of interest and response on the part of the Occupational Health Nurses Society in South Africa when I contacted them about the matter. The apparent lack of concern about breastfeeding as a health issue in the workplace revealed a lack of insight and understanding about its importance in the health and welfare of both the mother and her infant. The emphasis of health and safety in the workplace is focused on prevention of accidents, medicals, treating minor ailments and chronic disease (personal experience as an Occupational Health Nurse). Little time is left for preventative health education.

4.5 Workplace constraints

4.5.1 Internal constraints

4.5.1.1 Company culture constraints

Employers expected women who returned to work after maternity leave to be productive and fully engaged with their job immediately. This was the experience of most women.

The women felt the attitude of the employers was that they had had six months maternity leave, *“Now get back to work and carry on where you were before you left.”* (Lee, Focus Group B, 4 December 2007). This she found impacted on her stress levels which in turn affected her milk supply. Stress affects oxytocin, the hormone responsible for the “let-down” reflex in breastfeeding (Lawrence and Lawrence, 1999).

“ The boss doesn’t exactly come to you and say; welcome back from maternity leave....he’s like, where have you been for the past four months, please catch up.” (Sandy, Pilot Focus Group, 4 December 2007).

Women found there was no accommodation for how they felt when they returned to work and this made things difficult for them, *“So I think even beyond breastfeeding there is no real support system when you get back and I think it’s very traumatic, especially with your first child.”* (Kara, Focus Group B, 4 December 2007).

“In particular many of these companies don’t support breastfeeding at work, not necessarily by them saying it, but just by the environment and the way it is structured.” (Pam, Focus Group A, 21 June 2008).

The apparent lack of support and understanding in the workplace discouraged many women who were trying to continue breastfeeding. The lack of policy regarding breastfeeding appeared to equate with a lack of support for breast feeding.

There is the added expectation that all breastfeeding should happen behind closed doors and that in the male-dominated work environment women needed to preserve a professional image (Lee, Focus Group B. 4 December, 2007). In fact pregnancy and breastfeeding threatened that professional identity (Bailey, 2000). Are women in fact striving to be as men or striving to be valued for their differences? Is a mind shift is required in the corporate environment and society as a whole, if women are to be valued for their unique ability to provide optimum nutrition for their babies (Reflexive Journal, 28 January, 2008).

Companies are faced with pressures to perform and are profit driven. Many studies have shown that there is a substantial return on investment for companies who support breastfeeding employees (See Chapter 2.11.1, pg. 47 & Chapter 2.14, pg. 56) Absenteeism is reduced in mothers of breastfed infants as they are healthier, there are reduced health care costs again because infants are healthier, there are higher retention rates after childbirth and greater loyalty from these women, productivity is increased (Cohen, Mrtek & Mrtek, 1995, Dickson, et al. 2000). So it would seem that this could be a win-win situation for the breastfeeding employees, the companies and the baby.

An increasing number of women are being trained as operators in Company A in order to balance the gender profile (Helen, Interview, Company A, 10 December, 2007). This presents challenges when they are pregnant or return to work and are breastfeeding - they cannot be absorbed into other jobs, neither is there anyone to cover for them if

they take breaks. Has the push for gender equality in some instances been a disservice to women, as their jobs preclude them from breastfeeding? Van Esterik (1989) suggests that breastfeeding empowers women and in so doing contributes to gender equality and is a human right issue.

Office workers have more flexibility than workers on a production line and are more likely to continue breastfeeding (Chen, et al. 2006).

Breastfeeding was not high on management's agenda though. As one woman commented, "*Those kinds of issues are not top of the list for management. They've got operational issues to deal with and really women here are the minority.*" (Pam, Focus Group A, 21 June 2007).

Another Manager (Jane, Company B, 26 January 2008) admitted that they have a business to run and deadlines have to be met, so everyone has to work and carry their load. There is also the problem that peers have to pick up the extra load of work if a woman is allowed the flexibility to take breaks or go home early. One manager indicated that the companies no longer have extra people to fill roles of a skilled operator on a shift so "*The company might have the desire to be accommodating, it's actually extremely difficult in a practical level.*" (Helen, Interview, Company A, 10 December 2007). Management had apparently not reflected on how they manage with lunch, tea and smoke breaks in these cases or considered whether they may be able to use the same system for women who need breastfeeding breaks. These scheduled breaks

could be extended to accommodate the 20 minutes twice a day that a women needs to express milk for her baby. In reality this would cost the company very little in terms of time lost. The current guidelines (Basic Conditions of Employment Act 75 of 1997) though do point out that the breastfeeding breaks should be over and above lunch and tea breaks.

4.5.1.2 Workplace policies

There are no breastfeeding policies in either Company A or B. There was almost an apprehension that a policy was “too formal” and so the matter was shifted to each individual line manager. Management were not averse to providing support but were wary of creating a precedent; they wanted to provide support but not concede a right.

A manager commented, “...*It’s a tricky one because the moment you put it in black and white...it immediately becomes a right..I think there should be guidelines rather than making it law and policy.*” (Eric, Interview Company B, 6 December 2007)

A female manager acknowledged that not having a policy was not necessarily a good thing as from personal experience, “*You assume you can’t do that (express breast milk) because no one does it, or no one says anything about it.*” (Helen, Interview Company A 10 December 2007).

Women who attempted to expressed milk during the working day felt very isolated (Cindy, Focus Group A, 21 June, 2007). The numbers of breastfeeding women at any one time within a company would be limited, so conceding a right to them to have a private place and time does not seem unreasonable. It also means that the fear of women taking advantage of this right is unfounded. The total number of women breastfeeding at a given time would be low, so the time period that they would need support and facilities in the workplace would be limited.

Women were very unsure as to what to expect when they returned to work. With staff turnover and internal transfers often their immediate boss had moved when they returned from maternity leave. The understanding or support for breastfeeding depended upon how informed or supportive the immediate line manager was about breastfeeding. The Human Resources manager confirmed that the matter that concerned women most when they returned from maternity leave was what job they would be allocated (Pria, Interview, Company B, 13 November 2008).

Lee said, *"First time I came back to work I had a male director and he was very supportive..he had his own family..he said take time, as long as you need to settle in...be flexible.. But this time around I've got a new boss, he's also new to the industry...it was a new job for me, so it was proving myself to the new boss, proving myself in the new job. The new boss...you know..even though he said I could take as much leave as I need, there was a degree of expectation that hangs over the pressure of the job itself."* (Interview, Company B, 6 December 2007).

The absence of any policy and the fact that breastfeeding was regarded as a private matter made women reluctant to raise the issue with management. As one person commented, *“ I don’t think anybody has the courage to stand up and say look I think things need to change around here because the issues with a mother are very private.”* (Pam, Focus Group A, 21 June 2007).

The Human Resources Manager from Company B (Interview, 13 October, 2008) said that they had a very open forum for discussions so there were many opportunities for women to raise these issues. The fact was that they were not raising them.

From the findings it was clear that there were no policies in place and so women found it extremely difficult to continue breastfeeding as they lacked information, support and facilities. They were also faced with the stress of balancing work and mothering. Therefore this anomaly exists where international breastfeeding guidelines, to which the S.A. government is a signatory, recommends exclusive breastfeeding for six months. This should be followed by the introduction of complementary foods at six months and continued breastfeeding for 2 years and beyond (WHO, 2003). However no supportive policies were in place within the workplace to ensure that employed women could actually do this.

4.5.2 External constraints

Companies made it clear that they were complying with the law with regards to maternity provisions and breastfeeding (Occupational Health Nurse, Company A, 21 June, 2007 and Helen, Interview, Company A, 10 December, 2007). Lee (Interview Company B, 6 December, 2007) felt that having a policy in place would make it easier for mothers who were breastfeeding. Dee (Focus Group A, 21 June, 2007) was unaware of her rights about breastfeeding in the workplace and this was echoed by the majority of women in the focus groups. Helen, (Interview Company A, 10 December, 2007) admitted that despite the liberal constitution in place in South Africa, not enough was being done to recognize women's roles in families and provide them with support, this included support relating to infant feeding. Eric, (Interview Company B, 6 December, 2007) felt that South Africa was lagging behind Western Europe when it came to policies around family responsibilities and more needed to be done. This issue was also discussed repeatedly in my reflexive journal. Supportive policies need to be legislated by government (The Innocenti Declaration, 2000).

4.5.2.1 Government policies

Government policy to promote gender equality in the workplace comes without putting in place gender sensitive policies which acknowledge a women's role in caring for children (Benjamin, 2008). The Convention on the Elimination of all forms of Discrimination against Women (CEDAW), to which SA is a signatory, expresses these crucial provisions. The Code of Good Practice on the Integration of Employment Equity into Human Resource Policies and Practices (Employment Equity Act, 1998) states that

employers should accommodate parents with young children, and this should include health and safety adjustments and antenatal care leave. In addition employers should attempt to provide flexible, working hours and supportive environments for employees, who have family responsibilities. In addition, the Code of Good Practice on Arrangement of Working Time (South Africa. Basic Conditions of Employment Act 75 of 1997) states shift rosters should consider employees and their childcare needs. Planning should also provide for particular needs for pregnant and breastfeeding workers. These provisions were not made for women within the two companies studied, possibly because this was “soft” legislation and enforcing these rights would be difficult. Employers and employees, who could demand their implementation, are unaware of the legislation. Company A assured me they were abiding by all the legislation regarding breastfeeding women in the workplace.

The Constitution of South Africa Act 108 of 1966 protects gender equality and policy to promote breastfeeding exists (See Figure 1, pg 3), but there needs to be greater understanding of the practical implications to specific industries and jobs. The problem appears to be the capacity and will to implement these policies. Dancaster (2006) highlights the need for integrated policy in South Africa combining work and family. Legislation providing for extended maternity leave options and flexible working arrangements is needed (Dancaster and Baird, 2008). These would enable women to nurture and care for their children without the stress of trying to juggle both roles simultaneously while working long hours. Legislation would be the lever for management to take these gender issues seriously.

The Department of Health in South Africa has signed up to numerous international policies which promote breastfeeding and has drawn up its own breastfeeding and infant feeding guidelines which is commendable (See Chapter 2.4, pg. 35) This does not go far enough however, as no one specifically champions breastfeeding and sees to the implementation of the guidelines. This is in spite of the suggestion in the Innocenti Declaration (1990) that each country should appoint a National Breastfeeding Co-ordinator. The Nutrition Directorate in the Department of Health is responsible for breastfeeding and government took a conscious decision not to have such a Breastfeeding Co-ordinator. The idea was that breastfeeding would supposedly be covered in facility-based programmes and community-based programmes, and in liaison with the Directorate of Maternal, Child and Women's Health. So, in effect, no one took final responsibility for breastfeeding. This explains the current dilemma we face.

4.5.2.2 Union policies

Unions were also not applying pressure, so companies assume it is not important to them. This view was confirmed by Dancaster a senior researcher at the Health Economics and HIV/AIDS division of the University of KwaZulu-Natal. *“Sadly there is no pressure from any quarter on our government to do so (sign the ILO convention on Maternity Protection and the Convention on Workers with Family Responsibility) this is not an issue the unions are interested in”* (Dancaster, 2008) There is almost an element of indifference about the matter. The right to breastfeed can be seen as a basic human

right (See Chapter 2.9, pg. 44) so one could argue that this matter is not something society, government, unions or business can afford to be indifferent about. Breastfeeding is a life and death issue, especially in resource poor settings like South Africa so we cannot afford this “sanctioned negligence” of not supporting breastfeeding (Morrison, 2008).

In a statement to the press the then Minister of Public Service and Administration, Geraldine Fraser Moleketi said that the lack of breastfeeding facilities in the workplace was a contributing factor to why fewer women occupied senior positions in government (Witten, 12 May 2008). She said government could not reach its target of 50% of women in senior management positions because of the lack of breastfeeding facilities in the workplace. In the same article the Congress of Trade Unions (COSATU), the largest trade Union in South Africa, reportedly agreed with her and said that child-care facilities in the workplace were very important. COSATU'S gender coordinator Elma Geswindt said working mothers constantly worried about their babies and this had an adverse effect on their work (Witten, 2008). COSATU'S Gender Policy for Parental Rights and Child Care (2003) states that core demands for employed women are; paid maternity leave, flexible working time, provision of child care and breaks and facilities for breastfeeding women. Although the Unions support the principle of facilities for breastfeeding women, there is no evidence of action on the issue. Despite this Geswindt (2008) said, “As far as I know in the Western Cape where I am based there are no such facilities in the workplaces. I cannot speak for nationally as I have no records of them”.

4.5.3 Physical constraints

4.5.3.1 Observations of companies

The visits to Company A provided an opportunity for me to observe the environment and the employees. It was not a mother or baby friendly atmosphere because of the strong smell of chemicals and one could understand the comments made by the participants of the focus group about the environment not being conducive to breastfeeding. Management were welcoming, friendly and open to discuss issues. The participants in the focus group were more reticent but felt strongly about leaving their babies and returning to work (Recorded in Research Journal, 21 June, 2007).

Observations on visits to Company B revealed a more relaxed approach; people were greeting each other and chatting happily. Something I did not observe in Company A. The very open plan office layout would make expressing in privacy very difficult. While waiting I noticed an employee receiving some professional assistance. I learned later that this was the Vitality Programme which allowed employees to access free professional help from outside consultants. What was of particular interest was large wall hanging in the entrance which had been signed by men in the company. It stated that they believed all women were free to enjoy the human rights enshrined in our constitution. I mentioned the wall hanging to number of the women I interviewed and although they walked past it every day, none had read or taken much notice of it (Research Journal, 4 December 2008).

4.5.3.2 Womens' Experiences

While most managers were open to the idea of providing facilities to enable women to express milk while at work, companies are not proactively looking for ways to accommodate women returning to work after maternity leave and there was a lack of awareness of their needs. Women who were still breastfeeding had to express in a variety of places; empty offices, at their desks in an open plan office, in the storage room, in a communal change room, in the toilet, some rushed home to feed as there was no facility at work. This lack of privacy was stressful for them and it affected their milk supply and many abandoned breastfeeding as a result.

Cindy, from Company A tried to express when she returned to work. She initially tried to use the change rooms which were used by 30 other staff, she had no privacy and there were no plug points for an electric pump. She finally moved to an office where she locked the door but had people knocking to come in while she was busy. :” *It was difficult even to get time to go and express milk and I would run out of milk and my mum would phone and say there’s no milk and my baby’s crying. And I would be stressed at work..... I think I lasted two weeks and then I couldn’t. There was nothing (no milk) left.*” She found this stressful and difficult and it affected her milk supply. “...*at work there is no facility. You can’t sit in the toilet...very uncomfortable, very stressful.*” (Cindy, Focus Group A, 21 June 2007).

Lee from Company B had to come back for a meeting while she was still on maternity leave and ended up breastfeeding in the toilet which she described as a “*horrific experience*”. When she was about to return to work, she added “*I had actively put some plans in place..to wean her off and get her onto the bottle...it really was a result of having to come back to work and there not being any other options for continuing it (breastfeeding).*” (Lee, Focus Group, Company B, 4 December 2007). This was echoed by Karen, (Focus Group B, 4 December 2007) who introduced a bottle a week before she returned to work. “*And I wasn’t ready to do that, I would have been happy to have carried on feeding her ’til probably nine months or so.*”

The workplace is a male-dominated environment which women felt would make it unlikely that breastfeeding would be a factor they would even consider.

“It’s also still fairly male dominated business...of eleven board members only two are women.....But decisions like this are predominately fed under HR function and our HR manager is um a male.... so it’s not high on the agenda...they’ve got other priorities.” (Lee, Focus Group B, 4 December 2007).

The interviews and focus group discussions revealed that mothers were not pushing for time and space to express breast milk while at work. Instead, they relied on the line managers within the companies to make the decision with regards to family needs, hence the uncertainty. They were never sure of what their particular manager’s attitudes would be with regards to their needs. The companies wanted to be seen as family

orientated and caring yet women were not proactive, forming support groups and championing the call for facilities to meet their needs.

A manager agreed, *“The women are strong corporate women who are not shy about anything. If they want it.....they would have made a big noise about it.”* (Jane, Interview, Company B, 26 January 2008). This was confirmed by the Human Resources Manager for Company B, who said women had many forums to raise these issues in the workplace and she did not feel they would feel worried about doing so (Pria, Interview Company B, 13 October, 2008). So why are women not raising the issue about support and facilities for breastfeeding in the workplace? It appears to be because either they feel it is not appropriate in the workplace to talk about personal issues, or these issues are not a priority for them.

The other factor which women faced was finding the time to express during the working day. Lee said that if you are in meetings all day it is difficult to find time to go and express (Focus Group Company B, 4 December 2007).

The findings confirm that in order to successfully combine breastfeeding and work women need to have support in terms of facilities in the workplace which include, space, time and supportive attitudes (Rojjanasrirat, 2004). There was a lack of role models in the workplace of women who have successfully combined work and breastfeeding and encouraged other women to do this.

A manager commented that a role model would also be helpful in helping women adjust and cope when they return from maternity leave. *“From a management perspective there definitely issues around mothers who have difficulty with planning their family life, because it impacts business..... So there is an obvious need but there is also the benefit of the company gain if they perhaps even provided some basic training... kind of the role model behaviour for a mother like that...”* (Helen, Interview Company A, 10 December 2007).

Both companies in the study were involved in community upliftment projects and Lee, (Company B Focus group, 4 December 2007) felt that they should consider supporting their own employees as a priority and providing facilities for them, before reaching out to the wider community. It was clear that facilities in themselves would not be enough but would have to be accompanied by a supportive environment where there was a positive attitude towards breastfeeding from the employer and colleagues and flexibility in the work schedule to allow time off to express (Payne and James, 2008).

Employee Wellness is an important issue in companies and it is hard to see how breastfeeding can be excluded from wellness of the mother and her infant given all the research that exists.

4.6 Societal influences

The lack of discussion and information around breastfeeding indicated that breastfeeding and work are not considered the norm by society; and this in turn could influence women's expectations, priorities and choices with regard to breastfeeding.

4.6.1 Societal attitudes to breastfeeding

Society and the process of socialisation influence attitudes, norms and behaviours in breastfeeding. In the Western world we are exposed to bottle feeding as the norm and there is little exposure to breastfeeding in families, in the media and in society at large (Swanson, et al. 2005). This was pointed out by women in Focus Group B when they commented about the lack of facilities for breastfeeding mothers in shopping centres.” *But I would have felt more strongly about shopping centres, you know anywhere that you go in public, and you end up sitting perched on a toilet trying to breastfeed a baby in a cubicle this big. And it stinks and it's a loo, you know that's not where you want to breastfeed your baby. Then you'd rather just not go to that shopping centre.”* (Karen, Focus Group B, 4 December 2007). This lack of support and consideration for breastfeeding mothers makes everyday activities like shopping a stressful event as outings have to be planned very carefully so they are not caught with a hungry baby that needs feeding and only a toilet to feed him/her. When societies value breastfeeding, large shopping centres have breastfeeding rooms for mothers, usually on every floor. These rooms are equipped with comfortable chairs and changing mats and are easily accessible to mothers with prams (Personal experience in Singapore).

4.6.2 Mothers' attitudes

4.6.2.1 Stress

Returning to work after having a baby was clearly an emotional and difficult time for many mothers. Women expressed the need and wish for more support in the workplace as they eased back into their jobs. Acknowledging these facts and providing facilities for women who wished to continue breastfeeding would help these women to continue to provide optimum nutrition for their babies.

Women find expressing and working stressful. The constraints of space and time seem to affect the ability to relax and the amount of milk they are able to express. *"You get so little milk from expressing at that time. I couldn't relax; you'd get such a fright, waiting for someone to knock on the door... you get half the amount..... If I'd had to go back full time, I wouldn't have carried on breastfeeding. It's just too much to express that much in a day."* (Sandy, Pilot Focus Group 4 June 2007).

Lee, (Focus Group B, 4 December 2007) said, *"I remember trying to express milk...the whole experience of coming back to work was so stressful, that you know my milk was drying up at a rate and I was desperately trying.... that was like really drawing blood out of a stone."* This expression indicates something which is extremely difficult, almost impossible to do. Lee's experience was so desperate that with her subsequent baby she planned well ahead of time not to even attempt to express; instead she stopped breastfeeding when she returned to work.

Stress affected the milk production and women found that breastfeeding was difficult to sustain under the circumstances (Cindy, Focus Group A, 21 June 2007).

A manager at Company A struggled unsuccessfully to maintain her milk supply after she returned to work following her second child. She felt that enabling women to continue breastfeeding would help alleviate the stress of working and some of the “*Tons of guilt you carry.*” (Helen, Interview Company A, 10 December 2007).

4.6.2.2 Secrecy

Women often hid the fact that they are breastfeeding and then had to find a private place and time to express milk which was very difficult (See Chapter 2.11.2, pg 38). Added to this was the emotional trauma of separation from their babies, their physical tiredness and bodies still adjusting post pregnancy. Most felt overwhelmed by the complexity of working and caring for a small baby. The seclusion and loneliness felt by these mothers had a negative effect on breastfeeding.

4.6.2.3. Sorrow

“I didn’t have the energy, I couldn’t cope, everything I was confronted with overwhelmed me.” (Lee, Interview Company B, 6 December 2007).

This view was reinforced by one of the managers, herself a mother, who admitted returning to work, was loaded with emotional challenges and difficulties (Helen, Interview Company A, 10 December 2007).

Many women felt that the special bond which breastfeeding provided between a mother and her baby was broken when they stopped breastfeeding and this caused a sense of loss and guilt and emotional separation in the mother. Grief is an emotion which has been identified with the cessation of breastfeeding, especially before the mother was ready for it (McGuire, 2007). Other colleagues grieving in the workplace would be handled with respect and consideration on their return to work after a death in the family. But no such consideration is afforded a mother newly separated from her baby. The close physical contact of breastfeeding via touch and frequent eye contact and gazing is said to promote bonding between a mother and her baby. During lactation the hormone, oxytocin is released and this both reduces anxiety and fosters bonding (Else-Quest, et al. 2003)

..”When you stop and use the bottle..anybody can just feed your child the bottle and taking that bond that you feel..you feel like you are leaving your child..” (Dee, Company A, Focus Group, 21 June 2007).

Most women found the experience of returning to work and leaving their baby traumatic, *“To come back to work for the first time is excruciatingly painful...obviously that you can’t continue breastfeeding him until at least a year, you know, so you have to stop. Because I had to stop.”* (Cindy, Focus Group A, 21 June 2007).

Having to stop breastfeeding made them feel guilty and added to their anguish. *“So you do feel guilty about that... I think as women you all want to breastfeed, ultimately.... It’s not easy.”* (Pam, Focus Group A, 21 June 2007).

Lee (Interview, Company B, 6 December 2007) felt overwhelmed when she returned to work after her first baby and started with panic attacks and depression and a sense of not being able to cope. *“I had no idea stopping breastfeeding would result in post-natal depression for me. So you are trying to operate emotionally normal, but your body is not..still not coping with all that...”* (Lee, Focus Group, Company B, 4 December 2007).

Rojjanasrirat (2004) found that women who combined breastfeeding and work suffered from psychological stress. Breastfeeding enabled them to maintain the close physical bond with their babies and so helped alleviate the stress and depression so many women experienced on returning to work. McCarter-Spaulding (2008) took the argument even further and said that when companies only provided facilities for women to express breast milk in the workplace, they were not acknowledging the importance of the mother and infant dyad. Breastfeeding was more than just providing breast milk to a baby. It created a unique mother- infant bond, which promoted secure attachment of the baby and provided a sense of well being to the mother. So the ideal was to have generous maternity leave and on-site day care and the flexibility for women to go and breastfeed their babies during the working day.

4.6.2.4 Baby's voice

Breastfeeding requires a mother-infant dyad and what was lacking from the mother's discussion was the baby's voice. None of the mothers commented on what it must have been like for the babies to be separated from their mothers, and be given bottles of artificial milk after having enjoyed the close breastfeeding relationship. They were very focused on their own feelings of guilt, stress, pressure and disappointment. None commented on how the baby reacted to being left. They did not develop the discussion laterally to extend the problem to the experiences of the babies. Is this because it was too painful even to begin to consider the impact on their babies of this deprivation, or lack of mother's milk and skin and voice? So they won't "go there"? Or is it because they too (rather like the employers, and society at large) assume that babies will cope, that they are so adaptable, that they are passive little malleable things, that they just eat and sleep? As long as they are getting some form of milk everything will turn out okay?

If women are in either of these two responses to the situation; too painful, so ignoring or denying; or believing in the conventional wisdom that babies are not really affected, then it makes it very difficult for them to become agents for change. They will not be emotionally or intellectually strong enough to "champion the cause", either each one on her own behalf, or more widely on behalf of other women too. So, as much as the women need support, it emerges that it is the babies who need advocates for their rights (Peer reviewer's insights, see Chapter 3.12, pg 100).

4.6.3 Cultural influences

Society generally views the breast as an aesthetic object rather than as a source for nutrition. This adds to the negative perception of breastfeeding in public, albeit, discreetly. So lifestyle factors such as convenience influence women when making infant feeding decisions. These played a greater role in the decision making than ensuring the health of their children (Ruowei, et al. 2002).

There were differing views in the focus groups on breastfeeding in public. Some saw it as embarrassing, *“I think in our culture, ...you don’t show yourself like that...I would be too embarrassed to actually breastfeed in public. Even when I had people round at home I wouldn’t breastfeed in front of them.”* (Cindy, Focus Group A, 21 June 2007) Others felt, *“Our culture is to breastfeed, to breastfeed is like eating.”* (Win, Focus Group A. 21 June 2007).

“There are some places where you don’t expect to be accepted (breastfeeding) even on the beach you know. But ..as a parent it’s only human to accept and welcome. I mean it’s a beautiful thing to see, a mother breastfeeding her child. It’s a warm feeling.” (Dee, Focus Group A, 21 June 2007). How far society has moved from accepting breastfeeding as normal, when we can accept woman exposing themselves on a beach, but a mother does not feel she can discreetly breastfeed her baby there.

So women modify their behaviour according to their culture and practice to what is deemed “acceptable”. The Canadian woman in the pilot group expressed at her desk in

an open plan office, something that horrified the South African women in the group who said they would never do that.

What was also of interest was that the African and Asian mothers in Company A were unsuccessful at breastfeeding and fed for the shortest period of time; one did not manage to breastfeed her twins, the other two breastfed for two weeks (See Table 10, pg 104). Yet they were the ones who felt that breastfeeding was as natural as eating and were happy to do this in public. The fact that they were unsuccessful breastfeeding challenges the conventional wisdom that Black women were natural breast feeders and breastfeeding was the norm in their culture. The World Bank Technical Paper (Berg and Brems, 1989) made the point that it was dangerous to assume that breastfeeding promotion was not needed in areas where it was regarded as the norm. The paper also states that where there was an absence of a supportive environment, successful breastfeeding was not guaranteed. These women possibly did not receive the support they needed to enable them to successfully breastfeed. This was evident in a comment by Pam, *“You feel so guilty that you can’t do this thing that you are meant to do as a mother... so I think not enough information is out there.”* (Focus Group A, 21 June 2007).

4.7 Extension of the framework

Yet as discussed in the BASNEF model (See Chapter 2.15.9, pg 67), even knowing the facts about the benefits of sustaining breastfeeding will not change behaviour. It is

attitudes that change behaviour. In order for breastfeeding behaviour to change the attitudes about breastfeeding in society and in the workplace have to change. The model goes on to describe how in order for a motivated person to change her behaviour certain enabling factors have to be in place. In the workplace the enabling factors which need to be in place in order for women to successfully combine breastfeeding and work appear to be a supportive environment which provides facilities, time and space and managerial and collegial support (Bar Yam, 1997). In order to include these important elements, the Situation Specific Theory of breastfeeding (Nelson, 2006(a)) has been extended (See Chapter 5.8, pg 154).

Chapter 5- Conclusions and Recommendations

5.1 Introduction

Multiple factors affect breastfeeding practices in the workplace, this study only looked at the factors which affected women within two companies in Durban. It would be incorrect to presume that these findings can be generalised for all companies in South Africa or even in Durban. Rather this study offers a perspective of the situation to gain meaning and understanding of these particular women's experiences. This chapter also provides a summary of the research findings discusses the theoretical frameworks used and makes recommendations.

5.2 Overview of the research findings

The findings have been discussed in relation to the objectives of the study.

5.2.1 Outcomes for objective one

Describe employers' attitudes and knowledge about providing breastfeeding support.

The themes that emerged from the enquiry into the employers' attitudes and knowledge about providing breast feeding support are summarised in this section.

Employers are influenced by current trends in society and what they believe to be important and will benefit their company and employees. The issue of breastfeeding

facilities for women returning to work was not high on the list of priorities. In fact employers interviewed had not considered it at all. The first time such a possibility was brought to their attention was when it was raised in the discussions with them. It is not regarded as a high impact issue. Intellectually they accept the benefits of breastfeeding, in as far as they know these, but it was not an activity they believed in strongly. The profile of breastfeeding was low and there were other popular issues taking precedence in the workplace for instance, employee wellness. It is only once breastfeeding becomes an emotive issue or pressure is applied by legislation for example, that employers will adopt policies. Once the profile of breastfeeding is raised they are likely to make the necessary changes. In essence this means that what is needed is a “trigger” to spark the implementation of breastfeeding support and facilities. There was an apprehension about having a formal policy in place when there seemed no apparent need and where there was a danger women may take advantage of it. The preference was to deal with each woman and her needs on a one to one basis. This amounted to contrived isolation so there could be no group pressure on the company.

5.2.2 Outcome for objective two

Identify mother’s attitudes towards breastfeeding and the workplace environment.

One main theme from the investigation into mothers’ attitudes towards breastfeeding and the workplace, was the influences in society which contributed to women’s attitudes towards breastfeeding. The other key theme was the pressures in the workplace environment which affected their choices.

Overwhelmingly negative influences against breastfeeding in the workplace cause women to 'suppress what they know is best' in favour of 'fitting in' with what society dictates is acceptable behaviour. Those women who tried to sustain breastfeeding faced barriers, both physical and emotional, which were too rigorous to overcome. It was difficult for them to stand alone in the face of so many voices and pressures. Women did not consider how their babies were affected by the loss of the breastfeeding relationship. Extraordinary women are needed to become role models to others and break the current cycle. In fact the cycle is becoming increasingly entrenched. Champions are needed who have the commitment, vision and willingness to make this a high profile issue. Some women believed that six months of breastfeeding was enough and were happy to stop when they returned to work; although they did indicate that had facilities been available they may well have continued.

5.2.3 Outcome for objective three

Describe the practices of the breastfeeding mothers in the workplace.

The themes from the practices of breastfeeding mothers in the workplace focused on the physical and psychological factors.

Those women who wanted to continue breastfeeding or expressing breast milk once they returned to work really tried hard but quickly discovered they were alone and

circumstances countered their preferred path. Initially they believed they could play the dual role of breastfeeding mother, with all the incumbent emotional attachments associated with the role and that of 'reintegrated employee'. However the energy required fulfilling both roles successfully, quickly drained their resolve and they found they had to choose one or the other. If employers' played an active role in supporting these women it would have required less emotional and physical energy to cope, as they tried to balance these two important roles.

5.2.4 Outcome for objective four

Identify factors that influence breastfeeding practices within the workplace.

The themes which influenced the breastfeeding practices in the workplace are expectations and support.

The two parties involved in the workplace, the employees and the employers, were poles apart when it came to the issue of support for breastfeeding at the workplace. The employer had no notion of the world of the breastfeeding mother. In fact they expected that world to be left at home. Many managers felt inherently uncomfortable discussing the issue of breastfeeding, let alone providing understanding and support.

Breastfeeding women returned to work mainly unprepared with poorly defined expectations and plans on how they would cope. It is vitally important that these two

parties begin a dialogue prior to the woman returning to work. They need an open discussion about the barriers, support, expectations and facilities. The employer has the broader perspective of the company needs and should also have an understanding of the large number of employee needs. So if they value their employees they need to take this issue seriously and begin to engage on the subject.

5.5 Addressing the theoretical framework

The conceptual map in Figure 8 summarizes how the themes from the data addressed the framework (STB, Nelson, 2006(a)). These will be described below.

- The infant-feeding decision making of the women in the study was influenced by the attitudes the mothers had towards breastfeeding and the lack of support and information regarding breastfeeding. The lack of societal support for breastfeeding also played a role. The fact that these women returned to work meant that some women only breastfed for a few weeks in preparation for this time. Lack of facilities in the workplace also affected these decisions.
- Infant readiness and capacity. The age of the baby when a woman returned to work and an initial successful breastfeeding experience, were positive determinants of continued breastfeeding. The older the baby was, the less frequently they needed feeding. Short maternity leave and long working hours made it very difficult for women to sustain lactation once they returned to work. Part-time work helped women continue breastfeeding for a longer period of time.

- Maternal readiness and capacity. Again here the length of maternity leave affected the mother's ability to successfully establish lactation as did long absences during the working day. A lack of facilities in the workplace made it difficult for a mother to express milk for her baby.
- Informal psychosocial network. Social support from role models and significant others in the workplace on an ongoing basis is essential for breastfeeding women. Without support they stop breastfeeding.
- Institutional networks did not provide support for breastfeeding mothers neither did they have breastfeeding policies. No breastfeeding breaks were given to mothers who were breastfeeding. Workplaces were male-dominated environments and women felt uncomfortable asking for facilities to express breast milk for their babies.
- Professional and formal network. Women found little or no support from professional health care providers or Occupational Health Nurses on-site about combining work and breastfeeding. The difficulties they faced relating to finding a time and place to express milk were so onerous that they had a direct effect on their ability to express and produce milk for their babies.

5.6 Theoretical prepositions from the data analysis

- Seemingly companies do not see breastfeeding as a benefit in itself and will not take the initiative to provide support.

- Societal influences play a greater role and influence than women's personal beliefs about breastfeeding - this will only change if someone champions the cause.
- Breastfeeding women in the workplace find themselves isolated and will never cope unless they receive support. This support could be called the enabling factors of place, time and support.
- The subject of breastfeeding in the workplace is taboo and nothing will change until the two parties engage in dialogue.

5.7 Factors and influences affecting breastfeeding in the workplace

Figure 11 (pg. 152) was developed from the data analysis and conclusions drawn from the study. The concentric circles depict the influences on the mothers' breastfeeding practices in the workplace.

- The outer circle represents government and their ability to influence legislation which would have a knock-on effect on all other circles. At the moment there is no legislation protecting a woman's right to breastfeed in the workplace (apart from the suggested breaks in the Basic Condition of Employment Act 75, 1997) and nobody championing breastfeeding. It is not a priority for government or unions. Guidelines adopted and policies which S.A is a signatory to have not been fully implemented.
- The workplace represents the next circle. Here the lack of knowledge, support, facilities and support for breastfeeding are mainly as a result of no societal or government agenda with regards to breastfeeding. It is a non- issue in the workplace and nobody is

championing its cause and nobody sees the need to do so. This provides barriers to women wanting to sustain breastfeeding when they return to work.

- The next circle represents the family, the community and health care professionals. Again generally the attitudes here towards breastfeeding are apathetic. Support from health care workers for breastfeeding mothers is inconsistent and often lacking.
- The mothers' represents the next circle. All the outer circles have an influence on her attitudes, choices, priorities, expectations and knowledge about breastfeeding and combining breastfeeding and work.
- Finally the baby is at the very core of all these influences His/her voice is not been heard or considered by any of the outer circles. If the baby's voice and needs were considered the mother would make different decisions, society would accommodate breastfeeding mothers and make this a priority, as would the workplace. Government would introduce legislation to ensure breastfeeding was protected and supported in society in general and in the workplace specifically.

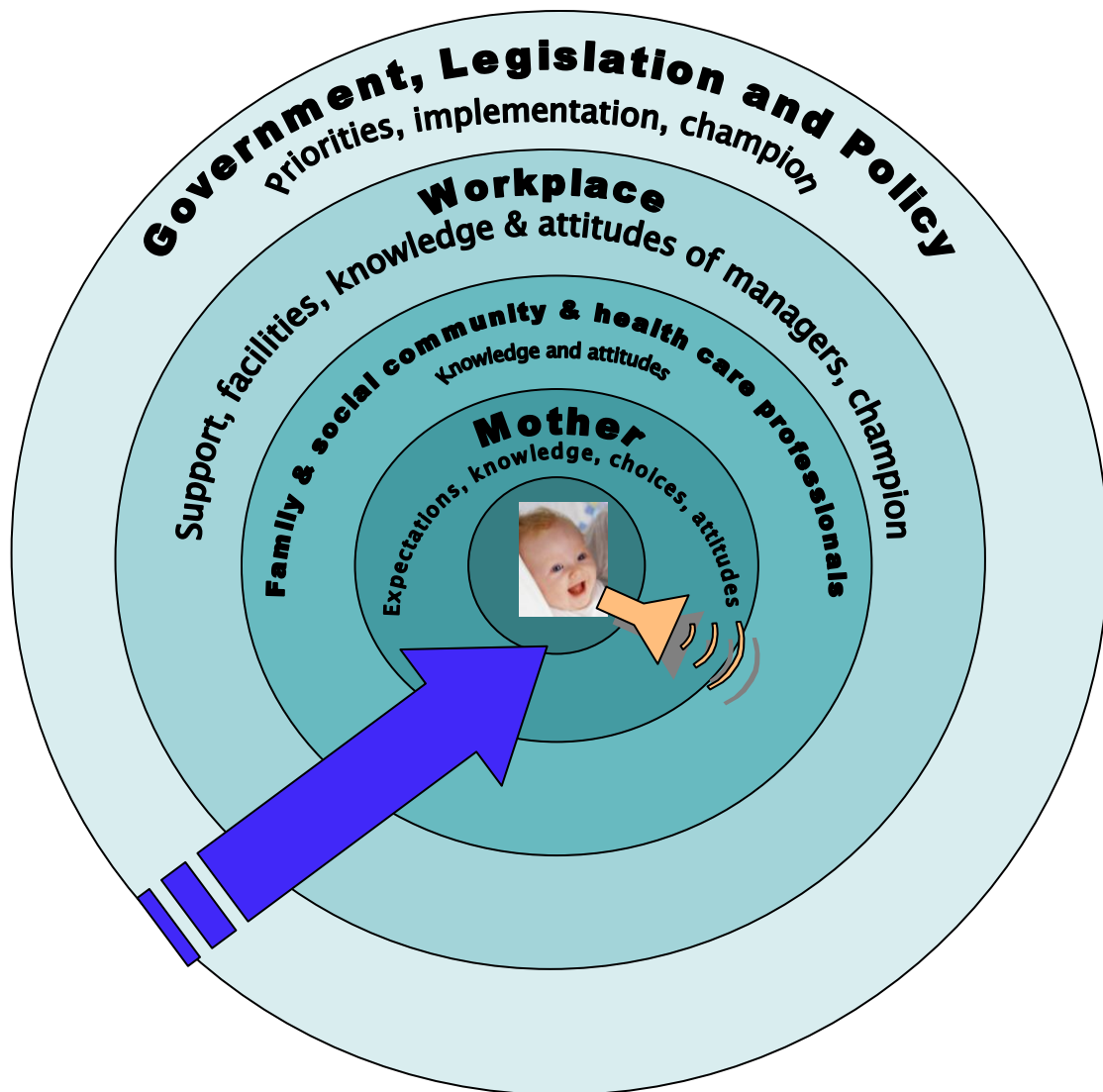


Figure 11. Factors and influences on breastfeeding practices in the workplace

5.8 New model of a situation-specific theory of breastfeeding

In order for women to enjoy the salutary breastfeeding experience within the workplace environment (Nelson, 2006(a)), they need additional enabling factors within the workplace to provide the necessary support and to help change their current attitudes, beliefs and practices

around breastfeeding (Hubley, 1993). The enabling factors identified in this study include; policies within the workplace supporting breastfeeding, a private space and time to express breast milk. This includes a supportive environment within the workplace, accurate information and support from health care professionals, other role models and positive socio-cultural attitudes to breastfeeding.

Below is Nelson's Mode (2006 (a)) extended by outcomes of this study.

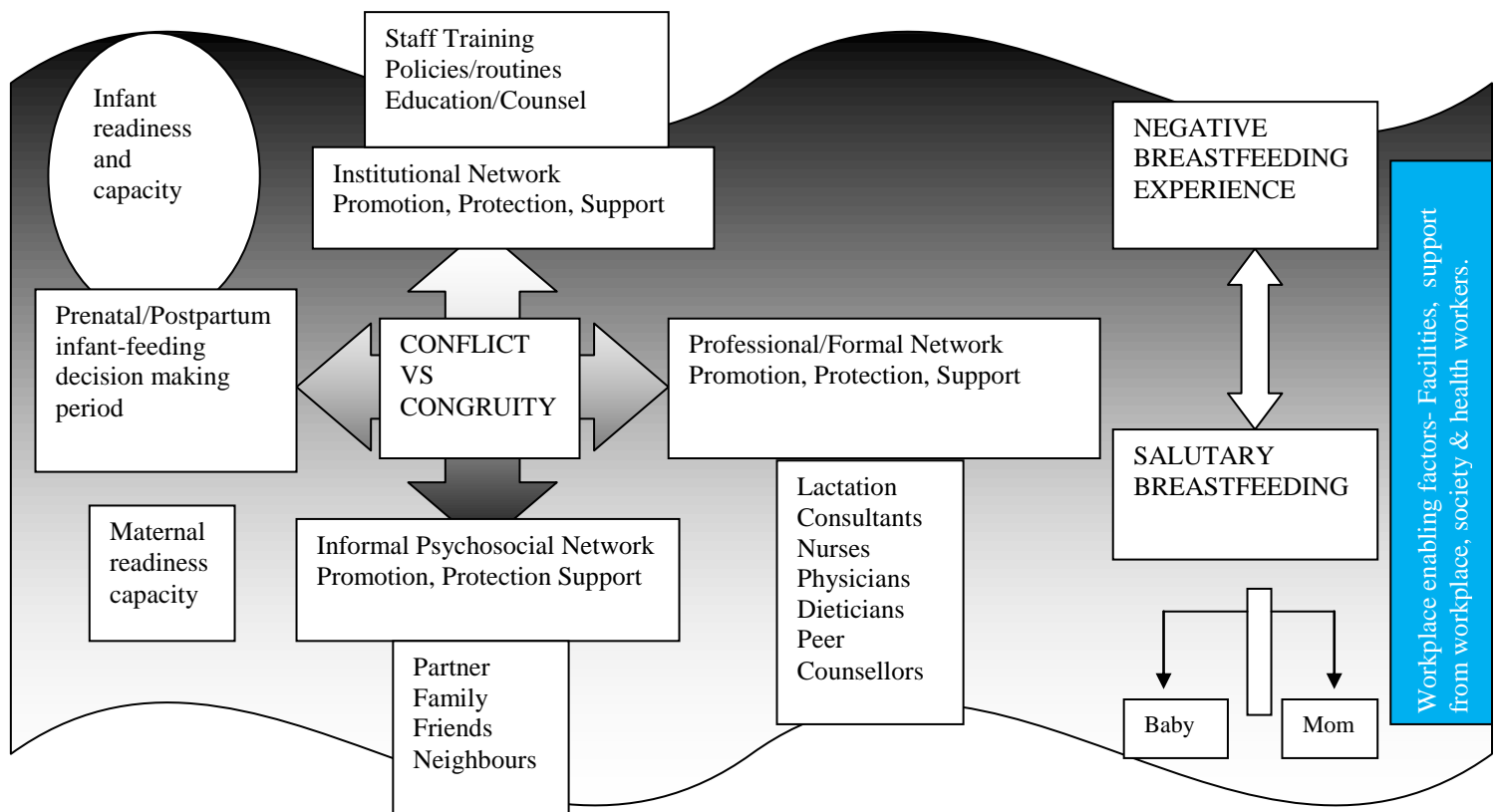


Figure 12.The extended situation-specific theory of breastfeeding

5.7 Conclusion

Breastfeeding in South Africa today is in “a baffled sense of drift” (Lasch 1991:22). There is no strong voice championing its cause and no real vision in the future for this either. Nothing will change unless we have champions willing to put effort and energy into improving the apathy surrounding this issue. Negative attitudes towards breastfeeding need to be challenged openly. On the one hand employers need to value the mothers returning to work enough to step into their world and understand their needs. On the other hand breastfeeding women need to be willing to raise their needs and that may even mean going against the societal norms and pressure.

The third element is for government and NGOs to act as catalysts for the cause. They can introduce interventions to raise the profile of breastfeeding mothers in the workplace and introduce policies and legislation which benefit the well being of the mother and her child and the society at large. The reduced incidence of disease both in the short and long term would lead to reduced absenteeism of mothers.

The fact that the country is in the grips of an HIV/AIDS pandemic and the resources are stretched is no reason for neglecting breastfeeding; in fact it is all the more reason for breastfeeding to be given the highest priority. Exclusive breastfeeding for six months can significantly reduce infant mortality and morbidity and reduce mother-to-child transmission (See Chapter 1.6. pg. 9). The research has been done: breastfeeding should be promoted, protected and supported. This will not only improve child and maternal health, but will also substantially reduce health care costs in our country. A

breastfeeding culture will not only save lives but will also prevent the prevalence of malnourished and underweight children. One third of children who died in S.A. last year were severely malnourished and 60% were underweight for their age (Every Death Counts, 2008).

The broader societal impact of supporting breastfeeding would result in a healthier society, women would be empowered, employment and financial security for women and their families would improve, there would be reduced stress levels for women and reduced postnatal depression.

The media plays an important role here in providing accurate information about breastfeeding. Advertising artificial formulas and bottles creates the 'norm'; it makes the abnormal to appear to be normal. We become desensitized.

I would argue that government, every institution, every non-governmental organisation, every business and every health care worker has a moral responsibility to ensure that every mother and child in this country has the right, the knowledge and support to successfully breastfeed. Paid employment should not strip away the right of a mother to provide optimum nutrition, which in many cases is life-giving to her baby, nor should it deny a baby the right to receive it.

5.6 Recommendations

It is recommended that every mother be supported by every available means to breastfeed her child in accordance with the WHO recommendations.

In order to do this the following recommendations are made:

- Adopt as a matter of urgency the Draft Regulations relating to Foodstuffs for Infants and Young Children (2007) (See Chapter 2.4 pg. 35).
- Government and Non-Governmental Organisations should overtly protect, support and promote breastfeeding in society and the workplace.
- Appointment of a National Champion for breastfeeding
- Educate and update all health care professionals regarding breastfeeding in accordance with WHO and UNICEF guidelines, which include counselling skills.
- Use of trained peer counsellors for providing breastfeeding support in the community
- Raise awareness of the risks of artificial feeding through advertising campaigns in all forms of media and the distribution of promotional material
- Development of educational material on combining work and breastfeeding
- Government to provide incentives for companies to provide childcare and support breastfeeding in the workplace
- Companies to develop breastfeeding policies, appoint Lactation Consultants, provide flexible working schedules to allow women to sustain breastfeeding and provide a positive supportive environment in the workplace.

- Working women to lobby for facilities and support for breastfeeding in the workplace through Human Resource department and unions if necessary.
- Raise awareness and educate management on the benefits of providing breastfeeding support in the workplace by presenting evidence based research information in the form of articles or presentations. This can be done by health professionals within the companies.
- Training of the Occupational Health Nurses to include the support of breastfeeding in the workplace

5.7 Further research

- A quantitative study to examine the situation regarding breastfeeding and the workplace in a number of companies in South Africa.
- A case study of a company that is successfully running a corporate lactation programme in South Africa, to determine the benefits and challenges of such a programme.
- Research on the economic benefits of supporting breastfeeding in the workplace in South Africa
- A study examining the socio-cultural factors that influence a woman's breastfeeding behavior.
- A qualitative study looking at how women view their infants experiences when they stop breastfeeding and return to work.

- A study highlighting the factors that would enable women to successfully combine full-time employment and breastfeeding in South Africa.

Many of the things we need can wait.

The children cannot.

To them we cannot answer tomorrow.

Their name is today.

Gabriela Mistral, Chile, Nobel Prize for Literature, 1945



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Appendix 1

Framework and permission to use.

The Situation-Specific theory of breastfeeding was developed by A. Nelson (2006) in her dissertation. Below are the letters of permission for this theory to be used in this study. Attached is a diagram with a summary of the theory.

21 November 2006

Dear Ms Nelson,

I was delighted to read your above research on Proquest Medical Library.

I am at present registered to do my Masters Degree in Nursing at the Durban University of Technology in South Africa. I am a qualified Nurse, Midwife and Lactation Consultant. I am presently the coordinator of the iThemba Lethu Breastmilk Bank which is a community based breastmilk bank for babies orphaned by AIDS. I work closely with Prof Anna Coutsooudis in the Paediatrics Department at the Medical School here in Durban. She has done much of the research into HIV and breastfeeding.

My research is looking at : The effects of the workplace environment and attitudes on the breastfeeding practices of mothers returning to work: A Case study of two companies in KwaZulu Natal. I have for a number of months been searching for a suitable Theoretical Framework for my study. I think your framework will be very suitable and I was so pleased to read your paper. So I am writing to ask you if you ever

considered implementing it in industry/the workplace and wondered if you had any thoughts in this regard?

I would be most grateful for any thoughts relating to this and would also like to ask your permission to use your framework for my study.

My supervisor has suggested that I could possibly look to adding a second wave to the framework to include another pillar which would relate to the workplace.

Thank you for your time and I look forward to hearing from you.

Kind Regards,

Penny Reimers

RN. RM. B. Tech(Nursing) IBCLC.

-----Original Message-----

From: rob reimers (mailto:reimers@wol.co.za)

Sent: Tue 11/21/2006 5:53 AM

To: Nelson, Antonia

Subject: Re: Situation Specific Theory of Breastfeeding

Dear Penny, I am very pleased that my theory will be able to forward your work, and you have my permission to utilize and/or revise it as you see fit. I guess I conceptualised the workplace as part of the "situational context" within which breastfeeding occurs, but your interest in this vital area makes me re-consider because of course it certainly is a key factor that impacts a woman's ability to continue breastfeeding (longevity) - and a key concern to the WHO/UNICEF that many women

worldwide initiate breastfeeding but few continue beyond a few months or after they return to work. Although I had originally conceptualised the "institutional" network as the hospital, clinics, etc. I suppose it could be revised to be the "Institutional/workplace Network" - this would help to acknowledge the significance of not only network support in the immediate postpartum but throughout the period when we want to encourage women to breastfeed. This is just an initial thought, I will consider this some more. I would very much like to hear more of your ideas and about your project and assist you further with your work if I am able. I am also interested in finding ways to work with colleagues in other countries on joint projects so perhaps we might also find a way to work together in the future. Toni Nelson

Appendix 2

Question Probes for working mothers

1. Marital Status
2. Ethnicity
3. Age
4. Number of children breastfed and duration of breastfeeding
5. Highest Educational Qualification
6. Occupation
7. Maternity Leave (available/ duration)
8. Reasons for stopping breastfeeding
9. Expression of breast milk (option/ duration)
10. Workplace environment facilities, supports and barriers
11. Professional Support (availability and manner)
12. Psychosocial support (who and how)

Question Probes for Managers

1. Marital Status
2. Ethnicity
3. Age
4. Gender
5. Number of children and ages
6. Highest Educational Qualification
7. Job title
8. Perception of responsibilities of the Company
9. Attitudes to breastfeeding in the workplace
10. Personal / family experience re breastfeeding
11. Perception of benefits/ liabilities of breastfeeding in the workplace to the Company
12. Perception of type of facilities available/needed for salutary breast feeding
13. Incentive needed to encourage the company to establish a policy for breastfeeding mothers?

Appendix 3

A selection of statements for introducing discussion in focus groups

The researcher will provide three statements as a stimulus for discussion in the focus groups on organizational responses to issues concerning working mothers. By introducing the subject this way, it is hoped that the responses will be honest and without bias. The stories will also elicit the participants' receptiveness to breastfeeding and generate discussion about personal views on matters instead of the participants giving answers which they feel are expected.

Newsweek- November 2006

Mother kicked off plane in USA for breastfeeding her child.
Texas Restaurant refused to serve a breastfeeding mother.
Many US state laws state that breastfeeding in public is obscene.

United Press International-May 2006

Rome- An Italian member of parliament member, Dontello Paretti won a court case and installation of a nursery allowing her to safely breastfeed her 3 month old baby while at work. She had threatened to breastfeed her daughter in front of her colleagues unless a place was found.

The Scotsman- January 2006

The Scottish Executive were ridiculed for a waste of money when they sent leaflets on breastfeeding to all firms in the country, giving advice to employers on the Breastfeeding Act of 2005, which supports breastfeeding in the workplace.
Some companies only employ men.

The Monitor- Kampala- June 2006(Kihaule,2006)

Plan Uganda's HR assistant said that an employer is part of an organization and so is her family. As a breastfeeding mother, she may be stressed and psychologically affected if she is deprived of the opportunity to feed her baby. This will impact on her performance at work.

Appendix 4

Letter of Information to Companies

Masters Programme Research

I am presently enrolled as a student at the Durban University of Technology in the Post-graduate Nursing Department and am currently registered for a Masters in Nursing. I am a registered nurse and midwife with qualifications in Occupational and Community Health and Primary Health Care. I am also a registered International Lactation Consultant.

As part of the Masters Programme I am required to complete a research project.

The focus of my research study is on the relationship of the work environment to the breastfeeding practices of mothers returning to work.

In the interview phase I would like to interview potential respondents on their attitudes and knowledge on breastfeeding practices. Each participant participates voluntarily and is free to withdraw at any time. Data will be collected by means of a tape recorder and structured interviews. Confidentiality will be maintained at all times. Results will be analyzed and made available to the company. Companies will only be identified by the sector they represent.

Breastfeeding is a key public health issue. The important benefits to be derived from this practice have led to a global commitment to protect, promote and support breastfeeding. The Lancet Child Survival Series states that exclusive breastfeeding for the first six months of life and continued feeding for 12 months is the single most effective prevention in reducing child mortality with the potential of saving millions of lives annually.

However, as an increasing number of women are now spending their childbearing years in active employment, breastfeeding duration rates are low.

To address this issue, the trend in Europe and the USA is to have Corporate Lactation Programmes in the workplace to encourage mothers to continue breastfeeding by providing them with time and privacy to express milk for their infants while at work.

The Lactation Programmes offer the following benefits to business:

- Less illness among breastfed children of employees
- Reduced absenteeism to care for ill children
- Lower health care costs
- Improved employee productivity
- Employee retention through multiple pregnancies
- Higher morale and greater company loyalty
- Improved ability to attract and retain valuable employees

Should you be in agreement, I would like to meet with you to discuss the way forward and then organize for interviews to take place in February/ March 2007.

My supervisors for the project are Maureen Harris at DUT (maureenh@dit.ac.za) and Ruth Searle of University of KZN (searle@ukzn.ac.za)

Penny Reimers

B. Tech (Nursing) RN IBCLC.

reimers@wol.co.za

Tel: 031-266 0567

082 701 3444

Appendix 5

Durban University of Technology
Department Of Postgraduate Nursing
Informed Consent for Participation in Research

This research focuses on the workplace environment and working mothers.

Description of the procedure

You will be asked to be available: to participate in a semi-structured interview/for a focus group discussion. The time and place will be arranged with you. The semi-structured interview should take about twenty to thirty minutes to complete and the focus groups will take approximately 30 minutes.

Content of the semi-structured interview/focus group

An informal, unstructured focus group and semi-structured interview will be used to gather information and descriptions about experiences and attitudes to mothers in the workplace.

Rights to participate

Your participation is entirely voluntary and you can withdraw at any time.

Risks

There will be no risks involved in your participation.

Anonymity will be respected at all times; your name will not be used or identified with any comment made when the data is published.

Advantage for you as a respondent

The findings of the study will be made available to you.

Informed Consent:

I,----- hereby acknowledge that this research study
has been explained to me by-----.

I am informed with regard to the nature of the study. I understand the above completely.
I voluntarily agree to participate in this study and have had an opportunity to ask any
questions I may have.

I may at any stage, without prejudice, withdraw my consent and participation from this
study. I fully understand the above mentioned information.

I hereby:

Willingly agree to participate in the research.

Respondents Name:

Respondents Signature:

Date:

Researcher: Penny Reimers

Supervisors: Maureen Harris

Tel: 031-2660567

Email : maureenh@dut.ac.za

Email: reimers@wol.co.za

Ruth Searle

Email: SEARLE@ ukzn.ac.za

Signed on this----- Day of -----2007, at

Appendix 6

Ethics Committee Approval



D U R B A N
UNIVERSITY of
TECHNOLOGY

Please Return To:
Faculty Officer
Faculty of Health Sciences
Durban University of Technology
P.O.Box 1334
Durban
4000

DECLARATION IN RESPECT OF
MASTER'S DISSERTATION / DOCTORAL THESIS
M-TECH: NURSING

I, MRS PENELOPE REIMERS
Full name of student

We, DR MAUREEN HARRIS
Full name of Supervisor

We, RUTH SEARLE
Full name of Joint Supervisor

Declare that in respect of the dissertation/thesis (Title):

The influence of the workplace environment on breastfeeding practices of working mothers returning to work: A case study of two companies in Kwa Zulu Natal.

confirm that

- a) recommended correction/s has/have been carried out. ~
- ✓b) recommended minor revision has/have been carried out. ~
- c) minor extension/s of the dissertation thesis has/have been carried out. ~

in accordance with the Examiners Report Form

Y Tick where applicable

P. Reimers

Signature of Student

28/3/2009

Date

[Signature]

Signature of Supervisor EXECUTIVE DEAN

28/3/2009

Date

[Signature]

Signature of Co-Supervisor

MA (Zim) MSc (Surrey)

27/3/09

DATE

Appendix 7

Framework for the Situation Specific Theory of breastfeeding and data analysis

1. Infant feeding Decision making period

- 1.1 Information received
- 1.2 Past experiences
- 1.3 Influence of culture/society
- 1.4 Influence of significant other
- 1.5 Return to work
- 1.6 Other issues

2. Infant readiness

- 2.1 Successful initiation of breastfeeding
- 2.2 Level of knowledge of mother
- 2.3 Full-time or part-time work
- 2.4 Other issues

3. Maternal readiness

- 3.1 Skills and knowledge of mother
- 3.2 Length of maternity leave
- 3.3 Role conflict
- 3.4 Choices /Goals
- 3.5 Organisation
- 3.6 Rights
- 3.7 Other issues

4. Psychosocial Network

- 4.1 Influence of partner
- 4.2 Immediate family support
- 4.3 Peer group

4.4 Role models

4.5 Accessible support

4.6 Other issues

5. Institutional Network

5.1 Policies

5.2 Attitudes

5.3 Facilities

5.4 Separation of work and home

5.5 Other issues

6. Professional Network

6.1 Knowledge of professionals

6.2 Workplace enabling factor

a) Time

b) Support

c) Space

d) Gate-Keepers

6.3 Environment

6.4 Other issues