

**SUCSESSES AND CHALLENGES OF THE BABY FRIENDLY HOSPITAL INITIATIVE
IN ACCREDITED FACILITIES IN THE CAPE TOWN METRO HEALTH DISTRICT**

NICOLETTE M HENNEY

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**UNIVERSITY of the
WESTERN CAPE**

Supervisor: Dr Brian van Wyk

Co-supervisor: Mrs Naeema Hoosain

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KEYWORDS

Baby Friendly Hospital Initiative

Assessment

Challenges

Experiences

Successes

Maintenance

Breastfeeding

Infant

Accreditation

Cape Town Metropole



ABBREVIATIONS

BFH	Baby Friendly Hospital
BFHI	Baby Friendly Hospital Initiative
BMS	Breastmilk Substitute
CODE	International code of Marketing of Breastmilk Substitutes
EBF	Exclusive breastfeeding
FGD	Focus Group Discussion
INP	Integrated Nutrition Programme
IYCF	Infant and Young Child Feeding
KZN	Kwa-Zulu Natal
MDG	Millennium Developmental Goals
MOU	Midwife Obstetrics Unit
NDoH	National Department of Health
PHC	Primary Health Care
SA	South Africa
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organisation

ABSTRACT

Introduction: Breastfeeding impacts on the health of both the mother and infant and has been noted as being influenced by physiological, physical, socio-economic and environmental factors. The undisputed benefit of exclusive breastfeeding for both the mother and child has led to the global prioritisation of the promotion, protection and support of breastfeeding with the adoption of the Baby Friendly Hospital Initiative (BFHI) strategy. Baby Friendly Hospital (BFH) status is awarded to a maternity unit when they are found to be complying with set criteria (“Ten Steps to successful Breastfeeding”). South Africa has implemented a re-evaluation system for retention of accreditation status, by reassessing accredited facilities every three years. The respective provinces are tasked with monitoring the implementation of BFHI in their public health facilities. Internal monitoring reports, completed by the Western Cape Provincial Department of Health, reflect erosion of key steps between national reassessments.

Aim: To describe the experiences, challenges and successes of BFHI implementation in the BFH accredited facilities in the Cape Town geographical health district.

Methodology: An explorative qualitative study was conducted. One key informant interview, ten in-depth interviews with champions for BFHI in the maternity facilities and two focus group discussions with frontline staff working at these facilities were used to collect data. The data was analysed using thematic content analysis to identify the main themes related to the successes and challenges experienced with the maintenance of the required practices related to BFHI accreditation.

Results: Participants reported that the implementation of the BFHI impacted positively on the health of both mothers and infants. Fewer children were being admitted for common childhood illnesses such as diarrhoea subsequent to BFHI implementation. Mothers were recovering more quickly after delivery and less complications related to delivery, such as postpartum bleeding, were observed after the implementation of BFHI. BFHI implementation had a positive impact on the attitudes of maternity staff to breastfeeding promotion, protection and support. Subsequent to being awarded BFH status, facilities are tasked with maintaining the implemented practices.

Challenges to maintaining the practices included lack of implementation of BFHI practices at clinics, lack of support from facility managers and support staff such as counsellors. The internal assessments implemented as supportive monitoring structures are considered by participants to be a demotivating process and concerns were raised about non nursing staff assessing nursing practices.

Conclusion: The potential impact of this strategy on infant and maternal health must be realized by the implementers of BFHI, before the strategized aim is achieved. Co-ordination and support by all role players is vital to the success and elimination of challenges experienced with implementation and maintenance of the BFH strategy.



DECLARATION

I declare that this thesis titled, “***SUCSESSES AND CHALLENGES OF THE ‘BABY FRIENDLY HOSPITAL INITIATIVE’ IN ACCREDITED FACILTIES IN THE CAPE TOWN METRO HEALTH DISTRICT***” is my own work, that it has not been submitted for any degree or examination in any other university and that all sources I have used or quoted have been indicated and acknowledged by complete references.



Signed by:

Date: 26 August 2011

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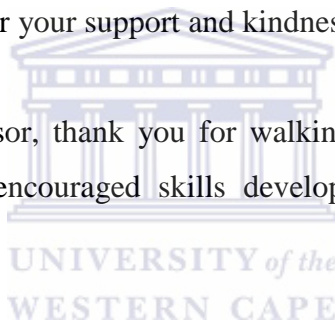
I humbly acknowledge and thank all who have supported me through this process, especially the Almighty for his love, care, guidance and protection through the highs and lows during this process.

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CONTENTS

KEYWORDS.....	ii
ABSTRACT.....	iv
DECLARATION	vi
ACKNOWLEDGEMENTS.....	vii
CHAPTER 1: INTRODUCTION.....	1
1.1 Background.....	1
1.2. Problem Statement.....	4
1.4. Aims and Objectives	5
1.4.1. Aim	5
1.4.2. Objectives	5
CHAPTER 2: LITERATURE REVIEW	6
2.1. Introduction.....	6
2.2 Implementation of BFHI in South Africa.....	6
2.3 BFH in the Western Cape Province.....	7
2.4 BFHI in the Cape Town Metropole.....	8
2.5 Resource Allocation for BFHI.....	8
2.6 Policy Implementation in the BFHI.....	9
2.7 Professional Staff and BFHI	10
2.8 Factors influencing the mothers choice to breastfeed.....	10
2.9 Conclusion	11
CHAPTER 3: METHODOLOGY	12
3.1. Introduction.....	12
3.2. Study Design.....	12
3.3 Description of the Study Setting	12
3.4. Study Population and Sampling.....	13
3.5 Sampling Strategy	14
3.6 Data Collection	15

3.7. Strengths of the Study	16
3.8. Limitations of this Study.....	17
3.9. Analysis.....	18
3.10. Ethical Considerations	19
CHAPTER 4: RESULTS	21
4.1 Introduction.....	21
4.2. Description of the Profile of the Participants.....	21
4.2.1. Description of the key informant	21
4.2.2. Description of the BFHI champions	22
4.2.3 Description of the Focus Group participants	22
4.3. Successes of BFHI	23
4.3.1. Positive attitudes of staff to breastfeeding	23
4.3.2. Improvements in health.....	25
4.4. Challenges to Maintain Implementation of BFHI	26
4.4.1. Staff-related Issues.....	27
4.4.2. Lack of support	29
4.4.3. Internal Assessments.....	31
4.5. CONCLUSION.....	32
CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS.....	34
5.1 Introduction.....	34
5.2 Staff and the Maintenance of the “Ten Steps to Successful Breastfeeding”	34
5.3 Implementation of Policies	37
5.4 Expansion of BFHI beyond the Borders of the Maternity Units	38
5.5 Impact of the Internal Assessment Process.....	38
5.6 Impact of Implementation.....	39
5.7 Conclusion	39
5.8 Recommendations.....	40

ADDENDA

Addendum A: Extracts from the Code 49

Addendum B: Operational Targets Set Forth in the Innocenti Declaration..... 49

Addendum D: Millenuim developmental goals influenced by the promotion of breastfeeding..... 50

Addendum E: Maternity services rendered at the different levels of care..... 50

Addendum F: Question used to guide the interview with the key informant 51

Addendum G: Open ended questions used to guide the interviews with the champion. 51

Addendum H: Open ended questions used to guide the Focus group discussions 52

Addendum I: Participants information sheet 53

Addendum J: Consent forms..... 55



TABLES

Table 1.1: The ten steps to successful breastfeeding	3
Table 1.2: Initial score table used in South Africa	4
Table 4.1: Staff description	21
Table 4.2: Category of FGD participants	22
Table 5.1: Classification of the “Ten Steps to Successful Breastfeeding”	35

SCHEMAS

Schema 2.1: National process to become Baby Friendly	8
Schema 4.1: Themes identified in analyses	32



CHAPTER 1: INTRODUCTION

Exclusive breastfeeding (EBF) is defined as providing breastmilk to an infant as the only source of nourishment, directly or indirectly from the breast while allowing for the provision of prescribed medication, vitamins and minerals (Snellen, undated; Labbok and Krasovec, 1990). Breastfeeding has been shown to impact positively on the health outcomes of both the mother and infant (Bartick, Steube, Shealy, Walker and Grummer-Strawn, 2009; Graffy and Taylor, 2005). Chezem, Friesen and Boettcher (2002) summarise the benefits of breastfeeding to be physiological and socio-economic as well as having a positive impact on the environment. Breastfeeding can be traced back to biblical times (Barness, 1987) and well into the Anglo-American society when the use of breastmilk was extended as part of medicinal treatments for pain and other ailments (Salmon, 1994). Barness (1987) however, noted that women have been looking for alternate feeding methods since “ancient times”, which was attributed to the industrial revolution and women realising their earning potential outside of wet nursing, societal needs and health (Barness, 1987). The development and refining of alternatives to breastfeeding was sparked by the discovery of the unsuitability of cow’s milk as an alternate to breastmilk and was capitalised on by physicians, chemists and scientists who collaborated to meet the needs of infant who could not be fed by their mother (Albanesi and Olivetti, 2009).

Despite the acknowledgment of breastfeeding as the optimal feeding method for infant, it is noted by (WHO, 2011) that worldwide less than 40% of infants younger than six months of age are being exclusively breastfed. Further highlighted is the aspect of breastfeeding support, which if provided adequately to the mother has the potential to contribute to saving the lives.

1.1 Background

Albanesi and Olivetti (2009) note the emergency of an acceptable replacement for breastmilk in 1910 when scientists produced a product which they referred to as “humanised infant formula because it was similar in macronutrient content to breastmilk. The discovery of “humanised infant formula” was preceded by the marketing of sweetened condensed milk and modified animal milk which was noted to cause death if fed in the first few days following birth (Barness, 1987; UNICEF, 2006). The connection between the medical profession and the formula industry as noted by Albanesi and Olivetti (2009) was formed when formative research for the development and

testing of breastmilk substitutes (BMS) was done in hospital settings and the developed products marketed by “manufacturing companies. Marketing campaigns for BMS were aggressive and claimed equivalence of BMS to breastmilk, contributing substantially to the erosion of breastfeeding.

Concerns pertaining the marketing and use of BMS was already noted in the late 19th century when physicians raised concerns about advertising claims used to market the use of the BMS (Greer and Apple, 1991). Dr Cecile Williams voiced her concern by presenting a paper “Milk and Murder” in 1939 at a Singapore rotary club meeting which described the dangers of not breastfeeding (Labbok, 2007). This created a snowball effect with many more doctors voicing their objection to the aggressive commercial marketing of the infant formula supported by observations in their practices and formal research documenting the negative effects of formula (Fazal and Holla, 2004).

This heightened awareness of the disadvantages of using BMS sparked the development of the International Code of Marketing of Breastmilk Substitutes (Code) (Addendum A). The Director General of the World Health Assembly (WHA) was tasked at the 33rd WHA meeting in May 1980 with drafting the Code subsequent to the prioritisation of the prevention of malnutrition in infants and children which included the regulation of the inappropriate promotion and sale of breastmilk substitutes (WHO, 1981). At the 34th WHA meeting held in May 1981 the Code was discussed and accepted as proposed by 118 votes from member states in favour, opposed only by one vote and three abstentions noted (International Code Documentation Centre, 2005). The Code has been amended over the years with the addition of relevant resolutions to strengthen its protection of breastfeeding and closing gaps in that were being exploited by the manufacturers of items under the scope of the code (Department of Health, 2001; International Code Documentation Centre, 2005).

A subsequent meeting held in 1990 and attended by 30 representatives from member states, agreed that it was time to take action against the continued erosion of breastfeeding (UNICEF, 2005). This acknowledgement of the identified need to cease the erosion of breastfeeding lead to the adoption of the Innocenti Declaration in 1990, which is based on two strategic documents and had four strategic operational objectives (Addendum B) (UNICEF, 2006; International Code Documentation Centre, 2005; Chapin, 2001). The first strategic document being a joint statement by WHO and UNICEF in 1989 on “Protecting, promoting and supporting breastfeeding: the special role of

maternity staff” and the second document was “Breastfeeding: Protecting a natural resource” with the associated video. The Baby Friendly Hospital Initiative (BFHI) was adopted as a global strategy launched by the World Health Organization (WHO) and United Nations Children’s Fund (UNICEF) in 1991 with the aim of improving the care given to mothers and infants as well as protecting, promoting and supporting breastfeeding (Southall, Burr, Smith, Bull, Radford, Williams and Nicholson, 2000). This strategy is based on the recommendations of the “Innocenti Declaration”, which recognizes breastfeeding as the ideal form of nutrition for infants (UNICEF, 2005) and the Code which addresses the marketing and distribution of free and low cost breastmilk substitutes. The strategy was adopted internationally by all the WHA members, who then undertook to implement the targets of the Innocenti Declaration which included the appointment of a national breastfeeding co-ordinator, implementing the Code of marketing of Breastmilk Substitutes, implementing the “Ten Steps to successful breastfeeding” (Table 1.1) and last but not least to enact legislation to protect the breastfeeding rights of working women (Greiner, 2000).

Table 1.1. The ten steps to successful breastfeeding (Department of Health, 2004).

Step 1: The development of a breastfeeding policy that is routinely communicated to all health care staff
Step 2: Training of all staff in the knowledge and skills necessary to implement the policy
Step 3: Informing all pregnant women about the benefits and management of breastfeeding,
Step 4: Helping mothers initiate breastfeeding within a half hour after birth,
Step 5: Showing mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants,
Step 6: Giving newborn infants no food or drink other than breastmilk unless medically indicated,
Step 7: Practice rooming-in by allowing mothers and infants to remain together for 24 hours a day,
Step 8: Encouraging breastfeeding on demand,
Step 9: Giving no artificial teats or pacifiers to breastfeeding infants and
Step 10: Fostering the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

BFHI promotes implementation of the second and aspects of the third operational goals of the Code and encourage the elimination of harmful maternity care practices which hinders breastfeeding (WHO, 1998).

WHA Resolution 45.3 (1992) promoted the implementation of BFHI in all public and private facilities providing maternity services (Department of Health, 2001). Birthing units are accredited

with Baby Friendly Hospital (BFH) status once they comply with the global assessment criteria, as measured against implementation of the 10 Steps to Successful Breastfeeding. Initially in South Africa (SA) facilities were assessed and measured against set standards to determine whether they can be accredited, issued with a certificate of commitment or only issued with a report (Table 1.2). This has subsequently evolved to stricter measures being put in place. Facilities are now required to score 100% in the assessment with the exception of the newly adopted Mother Friendly Care principles. SA NDoH has also implemented a re-evaluation system for retention of accreditation status, with national reassessments of the required standards occurring every three years.

Table 1.2: Initial score table used in South Africa (Department of Health, 2001)

<i>Score achieved out of 10</i>	
8 to 10	Facility awarded BFH status and allowed to display a BFHI plaque
5 to 7	Facility issued with a certificate of commitment
Less than 5	Facility issued with a report denoting findings of the assessment

1.2. Problem Statement

Formal (internal) assessments by trained BFHI assessors are routinely completed in the year preceding national reassessment by the South African National DOH (NDoH) and form part of the monitoring and evaluation plan of the BFHI strategy. The results of the internal assessments done in the past indicate that erosion of steps four to nine occurred; also referred to as the implementation steps which ensure that practices are adopted to promote and support breastfeeding. Lack of maintenance of the foundation steps (Steps 1 - 3) is also reflected in these reports. The decision taken at the national BFHI meeting in 2008 (Goeiman, 2008) indicated that with immediate effect, maternity facilities will lose their BFH status after the first failed re-assessment and will have to request national assessment for re-accreditation.

The BFH strategy is also implemented to contribute to achieving Millennium Developmental Goals (MDG) 1 (Eradicate extreme poverty and hunger), 4 (Reduce childhood mortality) and 5 (Improve maternal health) and maintenance of the implemented practices is important in contributing towards achieving these MDGs. It is thus necessary to identify formally the successes and challenges as

experienced by staff to the maintenance of the “10 steps” and explore why erosion of the practices are occurring, towards the development of long term sustainable solutions.

1.4. Aims and Objectives

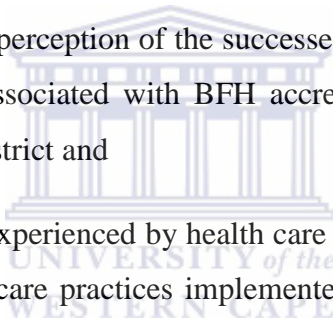
1.4.1. Aim

The aim of this study was to describe the experiences, success and challenges associated with the implementation of BFHI in accredited facilities in the Cape Town Metropole Health District.

1.4.2. Objectives

The objectives are threefold, namely

- to describe the experiences of health care staff working in the maternity wards of Baby Friendly accredited health care facilities in the Cape Town Metropole Health District,
- to describe the participants perception of the successes achieved with implementation of the quality of care practices associated with BFH accreditation in facilities within the Cape Town Metropole Health District and
- to describe the challenges experienced by health care staff working in the maternity units in maintaining the quality of care practices implemented for the accreditation of BFH status within BFHI accredited facilities of the Cape Town Metropole Health District.



CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The promotion, protection and support of breastfeeding has become a global priority with health benefits for both the mother and the infant and this is especially true in developing countries where it's benefits for child survival is undisputed (Bartington, Griffiths, Tate, Dezateux and the Millennium Cohort Study Child Health Group, 2006). The benefits of breastfeeding are widely known and published but all the scientific evidence is based on observational studies due to the ethical dilemma of randomly assigning a feeding method (breastfeeding or replacement feeding) to infants (Krammer, Chalmers, Hodnet, Sevkovskaya, Dzikovich, Shapiro, Collet, Vanilovich, Mezen, Ducruet, Shishko, Zubovich, Mknuk, Gluchanina, Dombrovskiy, Ustinovitch, Kot, Bogdanovich, Ovchinikova and Helsing, 2001). Despite this the benefits of breastfeeding remains one of the key drivers in the implementation of strategies aimed at reducing childhood mortality. Breastfeeding is also noted as being a contributor to the achievement of all the millennium developmental goals, especially goals 1, 4 and 5 (Addendum D) (UNICEF and WHO, 2009). BFHI was adopted to respond and reverse the erosion of breastfeeding by addressing the maternity care practices that discouraged breastfeeding and implement sections of the International Code of Marketing of Breastmilk Substitutes applicable to health care facilities.

2.2 Implementation of BFHI in South Africa

As one of the WHA members, SA adopted a slightly adapted version of the BFHI strategy in 1991 (Department of Health, 2004), and officially launched BFHI in Bloemfontein in 1994. The SA government however, only became actively involved in the strategy in 1995 (South African IYCF technical working group, undated). The now disbanded St Monica's Hospital, which was situated in the Western Cape, achieved BFH status in 1994 with the support of UNICEF and IBFAN (Department of Health, 2001; Provincial Department of Health, 2009). UNICEF and IBFAN continued to support another seven facilities over a period of two years. The end result of this support was the accreditation of two more facilities in 1996, one of which was Vergelegen Mediclinic a private facility also situated in Somerset West in the Western Cape.

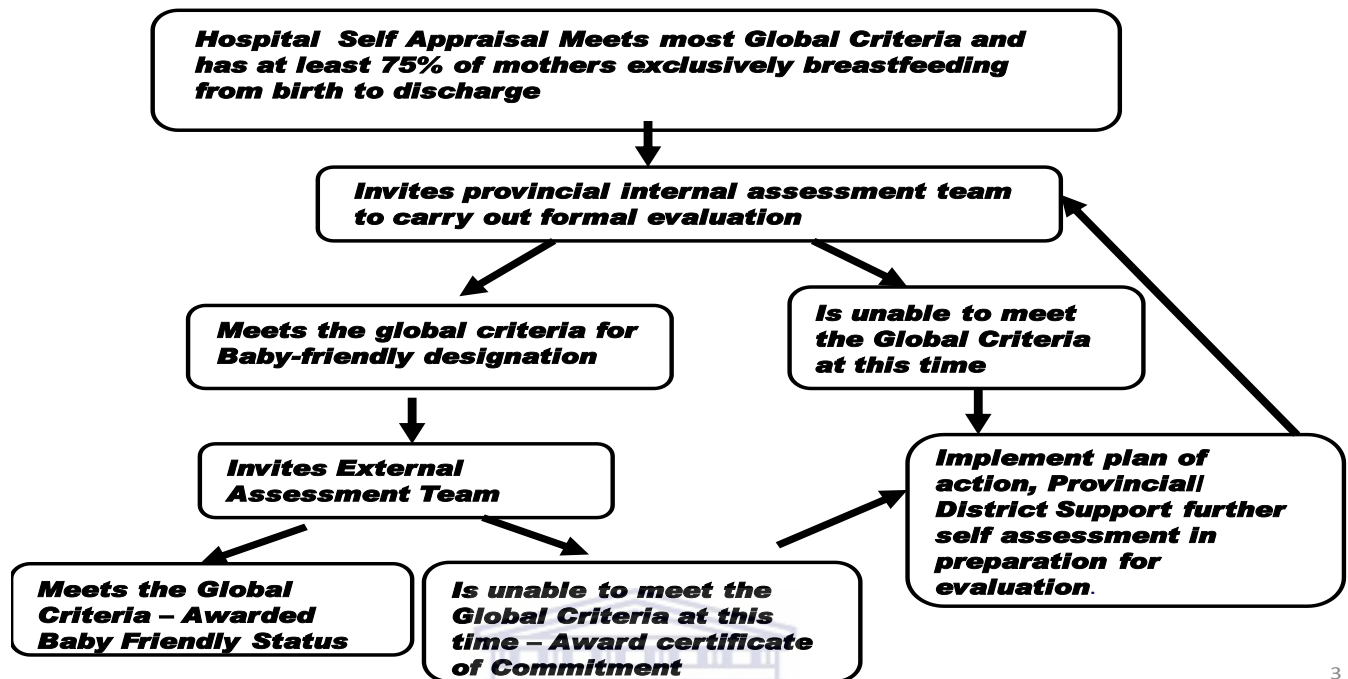
The initial goal for BHFH implementation as set by the Nutrition Committee convened in 1995 by the Minister of Health was to have 75% of the health facilities in SA accredited with BFH status

by the year 2000 (Department of Health, 2001). This goal was subsequently adjusted to 15% in 2001, translating to 15 facilities that needed to achieve BFH status yearly from 2001. The strategy for implementation of BFHI in SA (Department of Health, 2001) further states that this increment, of 15%, should increase yearly until all maternity facilities have achieved BFH status. To date (2010) 44% (239 / 545) of the facilities with maternity care in SA are accredited with BFHI status (Department of Health, 2010).

2.3 BFH in the Western Cape Province

The health care system in the WCP reflects that of SA and accommodates three levels of care, each with a range of maternity services focused on specific types of maternity patients (Addendum E). BFHI is implemented at all these levels of care and BFH accreditation is only awarded by the NDOH to facilities with maternity services (including a birthing unit), such as Midwife Obstetrics Units (MOU) and Hospitals. Accreditation is awarded after a structured assessment by a team of trained assessors deployed by the NDoH. Facilities meeting the global criteria for each of the ten steps of the BFHI are awarded BFH status and re-assessments are completed by the NDoH in a three year cycle subsequent to accreditation. Provinces in SA are tasked with the internal monitoring of the accredited facilities as a supportive monitoring mechanism and to ensure attainment of the BFHI goals (Department of Health, 2001).

The WCP as one of the nine provinces of SA uses the national implementation strategy (Schema 2.1) as the guide for the province (Department of Health, 2001). The WCP also informally implemented a monitoring system for facilities already accredited with BFH status and due for a reassessment by the NDoH (Provincial Department of Health, 2011). The district BFHI co-ordinator is required to co-ordinate two internal assessments, as supportive monitoring systems, for accredited facilities in the twelve month period prior to reassessments being due. A third internal assessment is then completed by the Provincial BFHI co-ordinator, who assesses the readiness of the facility for national external assessment by means of an internal assessment (Provincial Department of Health, 2011).



3

Schema 2.1: National process to become Baby Friendly (Department of Health, 2001)

2.4 BFHI in the Cape Town Metropole

Since the adoption of the BFHI, 16 maternity units (public and private) which fall within the geographical area of the Cape Town Metropole Health District have under the guidance of a multidisciplinary team (Dietitians and Midwives) been accredited with BFH status (Provincial Department of Health, 2011). Assessments as part of the internal monitoring of BFHI implementation is done by teams consisting of both midwives and dietitians who have been trained as BFHI assessors via training co-ordinated by the National and Provincial DoH, to use the standardised global tools as provided in Section 5 of the BFHI guidelines (UNICEF and WHO, 2009).

2.5 Resource Allocation for BFHI

Studies exploring the need for resource allocation to ensure adequate implementation of the BFHI strategy are limited to the rationalisation of the need for resources to be allocated for the success of this strategy (Moore, Gauld and Williams, 2007; Fallon, Crepinsek, Hegney and O'Brien, 2005;

Saunders, 2002). The argument is that the allocation of adequate human, time and financial resources is imperative to the success of any strategy notwithstanding the implementation of the BFHI strategy in an already burdened health facility. Fallon *et al.* (2005) who conducted a study in Australia on the impact of BFHI and breastfeeding rates, notes that the allocation of funds to facilitate BFHI implementation is imperative to the success of the strategy. Lack of resource allocation can hinder the maintenance of BFHI. Findings from a landscape analysis conducted by the National Department of Health in 2009 (Department of Health, 2009) identify the lack of strategic direction as one of the barriers to successful implementation of interventions that have the potential to impact on women and child health outcomes.

The implementation of the BFHI strategy in the New Zealand context was investigated by Moore *et al.* (2007) who utilised a qualitative study method to assess the implementation of the ten steps in New Zealand institutions. Significant findings in this study indicated that external stimulus in the form of incentives and adequate resource allocation was needed to encourage facilities to engage this strategy and ensure that the formulated policy was well implemented. These findings allude to requirements for the maintenance of steps 2 to 10 of the BFHI strategy, which hinge on the implementation of the policy. However a limitation of this study was the limited sample size of six participants, limiting the attainment of saturation in data collection and the use of telephonic interviews which lacked the dynamic human interaction that is an important element of qualitative research.

2.6 Policy Implementation in the BFHI

Step 1 of the “Ten Steps to Successful Breastfeeding” requires that a facility has a breastfeeding policy that is routinely communicated with all staff members in the maternity wards. Policy dictates the stance of the facility on a specific issue and dictates how situation arising in the facility will be addressed, including relevant practices. The lack of implementation of the formulated policy can hinder maintenance of the BFHI practices. Literature reflects that policy availability contributes positively to an increase in the duration of breastfeeding (Wright, Rice & Wells, 2009) but that formulation of the policy only partially met the requirement for BFHI (Moore *et al.*, 2007). Further noted by Moore *et al.* (2007) was that staff compliance with the policy was not guaranteed by its formulation, but takes time.

2.7 Professional Staff and BFHI

The Convention on the Rights of Children which came into law in 1990 in SA, states that “State parties recognise that every child has the inherent right to life and state parties shall ensure to the maximum extent possible the survival and development of the child” (Conventions of the rights of the Child, 1990, p.3). Health systems include those who are entrusted to deliver the service and those who need the service (Frenk, Chen, Bhutta, Cohen, Crisp, Evans et al., 2010). Frenk *et al.* (2010) further note that those professionals, whom they refer to as knowledge brokers, play an important role in applying knowledge to improve healthcare and give the health system a human face. Within BFH accredited facilities staff working at the coal face in the wards is the service providers while the mothers are those who need the service. Dennis (1999; 2002) reports that professional staff has the ability to negatively influence on the mother’s confidence to breastfeed by influencing her sources of information and misinforming her. Shannon, O’Donnell and Skinner (2008) who are all International Board-Certified Lactation Consultants (IBCLC), noted that health care professionals were perceived as trusted sources of information by women and are in a critical position to impact breastfeeding (Riordan and Gill-Hopple, 2000). Staff with neutral attitudes (DiGirolamo, Grummer-Stawn and Fein, 2003) and limited knowledge (Nakar, Peretz, Hoffman, Grossman, Kaplan and Vinker, 2007) impact negatively on the quality of the support given to the mother by professional staff.

2.8 Factors influencing the mothers choice to breastfeed

For women breastfeeding is a natural part of the reproductive system, contributing positively to the infant’s health (Riordan and Gill-Hopple, 2000) yet it is impacted upon by a multitude of factors. Pressing issues arise at every stage of a woman’s life and antenatal care ideally creates the opportunity to reach pregnant women with multi-faceted programmes to detect health issues (UNICEF, 2008). The education of mothers both before and post-delivery was found by Su, Chong, Chan, Chan, Fok, Tun, Ng and Rauff (undated) to impact positively on the exclusive breastfeeding for six months, while postnatal support yielded more adherence to breastfeeding than antenatal education. The opinions of significant people in the lives of mothers have the ability to impact on the mother’s confidence to breastfeed. Grandmothers (Grassley and Eschiti, 2008) as

well as mothers and partners (Pollock, Bustamante-Forest and Giarratano, 2002) were noted to be the most influential on the mother's confidence levels to breastfeed.

Graffy and Taylor (2005) reported that many women struggling with breastfeeding felt judged and unsupported when they needed help, despite reporting positive experiences. The lack of support from maternity staff contributes to mothers reverting to bottle feeding when confronted with common breastfeeding problems soon after delivery (Avery, Zimmerman, Underwood and Magnus, 2008).

Despite the acknowledgement of breastfeeding as a natural part of reproduction, external factors can impact both positively and negatively on the mother's confidence to breastfeed, including her experience in the maternity unit,

2.9 Conclusion

This chapter described BFHI in relation to professional staff, mothers, policy implementation, resource allocation as well as an overview of the implementation of BFHI in South Africa and the Cape Town Metropole. Available research focus mainly on the impact of implementation of BFHI on breastfeeding and exclusive breastfeeding but fails to explore the challenges experienced by staff members with the maintenance of the strategy. The lack of available research exploring challenges to the maintenance of BFHI in itself poses a challenge to decision makers who need insight into the dynamics of implementation and maintenance in order to plan strategically and enhance this child survival strategy.

CHAPTER 3: METHODOLOGY

3.1. Introduction

Health systems research is noted by Katzenellenbogen, Joubert and Kariem, (1997) to be applied research allowing assumptions to be replaced with evaluations with the aim of measuring and improving the elements of quality health care. Support and monitoring of BFHI implementation is co-ordinated by a Provincial co-ordinator, who in this instance is also the researcher. Anecdotal evidence and informal communication noted during meetings and support visits was used to identify the perceptions, barriers to maintenance and successes of BFHI implementation in facilities in the Cape Town Metropole Health district. The utilisation of applied research will thus engage the translation of assumptions about the strategy into fact and provide evidence for actions.

3.2. Study Design

The researcher undertook to utilise a Descriptive study design using Qualitative data which allowed the researcher to focus on the experience of the staff working in maternity wards in relation to their situation, which is working in BFHI accredited facilities. The choice of study design is supported by Beaglehole, Bonita and Kjellstrom (1997) when this study design is described as being one that makes no attempt to analyze the link before and after exposure.

Research into the implemented BFHI strategy, which aims to improve the care given to mothers and babies while promoting, protecting and supporting breastfeeding, was best done by researching the elements and activities in the maternity wards. The utilisation of a qualitative research method as noted by Green and Britton (1998) allows researchers to answer questions that are not answered when experimental methods are employed. Sofaer (1999) described qualitative research as an important component to the clarification of values, language and meaning of people's roles in structures by allowing participants to speak in their own voice rather than conforming to the imposed categories and terms. It is noted by Sofaer that this research method gives people a voice that is otherwise unheard because they are too far down in the hierarchical chain of command.

3.3 Description of the Study Setting

Within the geographical area of the Cape Town Metropole Health District there are 101 clinics, 39 community health centres and 13 hospitals that function at various levels of care (Provincial

Government of the Western Cape, 2007). Facilities providing the full range of maternity services (Antenatal, Labour and Delivery and Postnatal services) are under the authority of the Provincial Department of Health, while selected services (antenatal and postnatal care beyond 6/7 days) is also provided in facilities governed by the Local Municipality (City of Cape Town). Addendum E presents a summary of the healthcare facilities and the maternity services rendered at the different facilities (Department of Health, 2007).

Facilities providing the full range of maternity services at one site include tertiary, secondary and primary level facilities while clinics only provide antenatal and postnatal service. Antenatal services in the hospital settings are rendered on an outpatient basis either within the maternity wards or at the outpatients section. While labour, delivery and postnatal care is rendered on ward level.

Only maternity facilities rendering the full range of maternity care (antenatal, labour, delivery and postnatal care) in a hospital or Midwife Obstetrics Unit (MOU) setting can be assessed for BFH accreditation. This includes facilities, especially tertiary and secondary levels of care, that provide limited postnatal services and antenatal care to severely ill and difficult obstetric patients.

3.4. Study Population and Sampling

The study population for this study was maternity staff working in public health facilities accredited with BFH status in the geographical service area of Cape Town Metropole Health District. The sample included staff members with in-depth knowledge of the implementation of the BFHI who were selected using purposive sampling as noted by Rice and Ezzy (1999).

3.4.1. Sampling Method

The use of purposive sampling was noted to be successful by Mack, Woodsong, MacQueen, Guest and Namey (2005) when the analysis and collection of data was done in conjunction with one another. Purposive sampling was thus used to obtain the points of view from various stakeholders on the implementation and maintenance of the quality of care practices associated with the BFHI strategy.

Maximum variation, which according to Rice and Ezzy (1999) is the selection of participants with different levels of experience in relation to the research question, was obtained by targeting a key

informant, facility champion¹, and coal face staff implementing the strategy in facilities in the Cape Town Metropole Health District.

Inclusion criteria

Facilities situated within the geographical area of the Cape Town Metropole Health district. Facilities which achieved BFH accreditation prior to 2009 were included in the sample. Facilities at all levels of care with BFH accreditation were included in the sample. Staff members with maximum exposure who have worked in the maternity unit of the identified facility for at least twelve months prior to the data collection period were included in this study, to ensure that maximum exposure of the staff members to the strategy was achieved.

Exclusion criteria

Facilities with BFH accreditation outside of the geographical area of the Cape Town Metropole Health District were excluded. Staff members working in the maternity unit but booked off on study leave for 2009 or 2010. Staff members working in the maternity unit not directly involved with the care of mothers and babies.

3.5 Sampling Strategy

The implementation of the strategy is co-ordinated from a provincial level therefore the organogram of the Western Cape Department of Health was used to identify the staff member at provincial level who was overall responsible for the management of the BFHI strategy in the Western Cape. The person identified was the key informant for this particular study.

The key informant was requested to provide the researcher with a database of the facilities accredited with BFH status in the Western Cape. The database was then used to identify the ten facilities who had been awarded with BFH status prior to 2009.

Contact was made with the Managers of the facility or the Operational manager of the maternity section via email or telephone. The managers of the identified facilities were then requested to identify the staff member charged with overseeing the implementation of the BFHI in their facility, referred to as the champion.

¹ Champions are the staff member who co-ordinate the implementation of the BFHI in the facility.

The champions identified the staff members working in maternity at implementation level for a minimum of 12 months for participation in the focus group discussions (FGD).

3.6 Data Collection

Interviews and focus group discussions were used to collect the data for this study. Sofaer (2002) noted that the use of focus group discussions and interviews was of particular value when attempting to determine the extent of implementation of a strategy as planned for as well as the aspects hindering the implementation, which in this instance was the BFHI. Participants were informed prior to commencing the interview or FGD that an audio-digital recorder was being used to record all discussions.

3.6.1. Interviews

A key informant interview described by Marshall (1996) as being a “rich information source” was used as the point of entry for verification and to obtain a detailed description of BFHI implementation in the province. One key informant interview was held with the Provincial manager responsible for overseeing the implementation of the strategy in the province, as identified from the organogram. A semi structured questionnaire (Addendum F) was used to guide the interview using open ended questions. This interview was completed by a trained assistant due to the close working relationship between the researcher and the Provincial Manager ultimately responsible for BFHI in the WCP. The assistant, who was not involved with BFHI implementation, was trained by discussing the purpose of the study, clarification of why this interview needed to be done and discussion on the questions. The researcher also briefly discussed behaviour of the data collector and went through the questions and the manner in which they should be asked. The researcher herself had previously taken part in data collection for National surveys and for Master’s students. Thus she has been trained to complete interviews and focus group discussions in preparation for her role as a data collector in those instances. The researcher has also attended both in-service and SETA accredited training in counselling and communication, respectively. The researcher also undertook to “brush up” on her skills in preparation for the data collection by reading fieldworkers guides on data collection.

In-depth interviews which engages the participant on a one-to-one basis gives research a human face while providing a platform for self-expression based on the participants perceptions (Mack *et*

al., 2005). Ten in-depth interviews using probing questions (Addendum G) were conducted with the champions who were regarded as rich sources of information in the BFH accredited facilities.

3.6.2. Focus Group Discussions

Focus groups evolved to become a valuable tool to explore the attitudes, perceptions and needs of staff which is less possible in a one-on-one interview (Kitzinger, 1995). Two focus group discussions (FGD) using probing questions (Addendum H) were conducted to explore the challenges and successes experienced by implementation staff. For the purpose of this study the selected maternity units were divided into two groups according to the level of care they rendered, that is either High risk care (facilities that performs caesarean sections) and/or Low risk care (facilities that do normal vaginal deliveries only).

Snacks, juice and tea was available as an incentive during the FGD which lasted approximately 120 minutes. Email or telephonic communication was used to set up appointments with the key informant and champions of the respective facilities. Participation in the FGD was arranged via the champion and confirmed with the participants at least two days prior to the planned date and time. All interviews were conducted at the workplace of the participants with the exception of one participant who was interviewed at home with her permission, due to being booked off on extended sick leave.

Three participants from focus group 1 were transported from their place of work to the agreed venue due to the unavailability of transport. The venue for the FGD 1 was in a participating hospital and FGD 2 was in a participating MOU. The allocated space was volunteered by respective champions for convenience. The interviews were planned and completed at the convenience of all the participants. All participants were informed that an audio recorder was being used to record the interviews and FGD. No objections were raised but the researcher did however, notices that the presence of the recorder could or may have impacted on the willingness by participants to divulge information which could perhaps have been useful for this study.

3.7. Strengths of the Study

The principles of rigour were used to ensure that the study is credible and trustworthy, meaning it is confirmable and transferable in the sampling, data collection and analysis components.

Triangulation, which according to Gifford (1996) is the use of different methods of data collection to answer the same question, was used in this study to increase the rigour. Method triangulation which includes the use of a number of data collection methods was used in this study through the use of FGDs, individual in-depth interviews and key informant interviews. Data triangulation as noted by Guion, Diehl and McDonald (2002) is the use of different sources of information which will increase the validity of a study. Data triangulation was ensured by gathering data from staff working at the coal face of implementation, the champion for BFHI in the identified facility and the staff member ultimately responsible for BFHI in the WCP.

To ensure **credibility**, inclusion and exclusion criteria were set to determine which maternity units were being included in the study. The researcher visited the sampled facilities prior to the data collection period to ensure familiarity with the facility's environment and ensure minimal interference with the daily functioning of the unit during the data collection period.

Transferability described by Kuper, Lingad and Levinson (2008) as enabling the transfer the findings of a study into another setting. This was ensured by providing a detailed description of the setting of the data collection and participants. BFH accreditation is only bestowed on facilities rendering maternity services which include antenatal care (via in patient care or high risk clinic or outpatient care), labour and delivery services as well as postnatal services. The presented description of the environment in which the data was collected as well as the "background" of the participants enables the reader to understand the environment in which the data was collected. This description also allows for the replication of the study in a similar setting by another researcher. It further enables the transfer of the findings in the identified 10 sites on to facilities in other settings.

Dependability was ensured by validating the sampled facilities by verifying their BFH status with the key informant. All interviews and FGDs were recorded and responses from the participants were verified by the researcher by reflecting on the responses during the interview process.

3.8. Limitations of this Study

The Cape Town Metropole is one of the 6 health district in the Western Cape and is considered to be the urban district of the WCP. The urban setting of this District can present vastly different

challenges in healthcare when compared to a rural district such as the Central Karoo. One of the key differences is the number of facilities within the geographical area of the District as well as the proximity of the different levels of care to each other. Although this study cuts across all levels of care it was limited to exploring the reasons behind the erosion of the “Ten Steps to Successful Breastfeeding”. BFHI maintenance challenges and successes experienced by staff were only explored in facilities in this urban setting. Further research is required in the future to ascertain the reasons behind erosion of the “Ten Steps to Successful Breastfeeding” in facilities situated in a rural setting.

3.9. Analysis

As noted by Pope, Ziebland and Mays (2000) in qualitative research large amounts of data in the form of transcripts and field notes are generated which can be time consuming to analyse. A log was kept by the researcher throughout the study who noted all activities relating to the research. Analysis of the data occurred concurrently with the data collection and all interviews and focus group discussions were transcribed immediately once completed. Four of the thirteen audio recordings were transcribed by a volunteer but due to time constraints and work pressure on the part of the volunteer the transcription of the other nine audio recording were done by the researcher herself. Interviews were transcribed verbatim as soon as possible after each session. This allowed the researcher to constantly reflect on the collected data and identify emerging patterns between the interviews with the aim of comprehending, describing, classifying and comparing the data collected. Thematic content analysis which is described by Gifford (1999) is a process of identifying commonalities in the data set enabling the researcher to comprehend the “regularities and patterns” in the responses and was used to analyse the data collected in this study.

The researcher engaged this method by reading each transcript at least twice while identifying common issues and topics. The identified issues and topics were then further refined and grouped into categories relevant to the research question. Each group was then assigned a theme and transcripts were revisited to identify sub-themes. The occurrence of the identified sub-theme was noted and used to determine the most common factors identified as being barriers to maintaining the practices related to BFHI implementation and the successes of BFHI implementation.

3.10. Ethical Considerations

Irrespective of the type of research being conducted ethical consideration in the research design, methodology and reporting remain important. Qualitative research which explores the experiences of participants in their everyday environment is dependent on the willingness of the participant to share their experiences (Orb, Eisenhauser and Wynaden, 2001). The three ethical principles, autonomy, beneficence and justice were addressed to alleviate the inherent difficulties with qualitative research. Autonomy was addressed by obtaining informed consent from all participants.

Participants were told that their participation was voluntarily. However, the willingness of staff to participate was imperative in completion of this study. Each participant was provided with an English participant's information sheet (Addendum I) subsequent to a verbal explanation of the research. Participants noted their willingness to participate by completing individual consent forms (Addendum J). English and Afrikaans was the most commonly understood languages amongst the participants and thus they were advised to indicate if further explanation or clarification of the information sheet and verbal explanation of the research was needed. No indication was noted. Participants were also advised to partake in the discussion in the language they felt comfortable in. Some participants switched between English and Afrikaans during discussions.

All effort to maintain confidentiality of the participants was employed and only questions relating to the research topic were presented to the participant. A coding system linked to the name of the facility known only to the researcher was used to ensure confidentiality. Verbal permission to use direct quotes in the research paper while maintaining confidentiality was obtained from the respective participant and can be associated with both beneficence and justice which is the third principle of ethics. Participants were requested to inform the researcher in writing if they wished to withdraw any responses rendered in the interview process.

Since the researcher, who is also the coordinator for the BFHI in the Western Cape Province under the guidance of a Provincial Manager, has the ability to impact on the validity, reliability and meaningfulness of the data, her role as the researcher was clearly depicted in the information sheet which outlined the purpose of the research to the participants. To this end the researcher did not complete the key informant interview due to the close working relationship with the provincial

manager but had trained an assistant for this purpose. The researcher listened to the voice of the participants during the interviews or FGD and allowed the information or discussion between the participants and researchers to flow without purposefully leading the discussion but rather by asking open ended questions.

The research proposal as approved by the UWC ethics committee was submitted to the Western Cape Department of Health Research Committee and the respective facilities for approval to collect data within identified public health domain. This approval was granted by means of written communication by all parties concerned before data collection was commenced.



CHAPTER 4: RESULTS

4.1 Introduction

The implementation of BFHI is concluded with the formal assessment of the maternity unit using interviews (healthcare staff, pregnant women and postnatal mothers), observations and the perusal of documents by trained National BFHI Assessors. The assessment measures the implementation of the “10 Steps to Successful Breastfeeding” against the global criteria for BFHI (UNICEF & WHO, 2009). Also measured in this process is the adherence of the facility to the principles of the International Code of Marketing of Breast-milk substitutes. Facilities identified as implementing the stipulated criteria are then awarded with BFH status.

The achievement of BFH status in itself is a success for the maternity unit as it demonstrates their commitment to improve maternal and child health outcomes. In the first section, Description of the Profile of the Participants and further successes of the implementation of BFHI are described as these relate to the improved attitude of maternity staff and health outcomes of the mothers and babies.

After being accredited with BFH status facilities are tasked to maintain the implementation of the “10 Steps to Successful Breastfeeding” and to adhere to the principles of the International Code of Marketing of Breast-milk Substitutes. Facilities are reassessed by the National Department of Health every three years to ensure that they maintain the implementation of the 10 Steps to Successful Breastfeeding and principles of the International Code of Marketing of Breast-milk Substitutes of the BFHI. In the subsequent section challenges related to staff, workload and training are described in detail.

4.2. Description of the Profile of the Participants

4.2.2. Description of the key informant

The key informant was a woman who has held her current position for seven years and has thus been involved with the management of the BFHI as a child survival strategy in the Western Cape for at least seven years.

4.2.3. Description of the BFHI champions

The champions (10) interviewed were all female and had a long service in a maternity setting. The majority (9) of the champions interviewed was trained as nurses and held management positions at tertiary (2), secondary (2) and primary (5) levels of care; only one champion was a non professional staff member employed as a Health Promoter (Table 4.1). The nurses identified as champions were included nurses ranked as staff nurses, midwives and advance midwives in their profession.

Table 4.1: Staff description

<i>Job title</i>	<i>Number of champions</i>
Operational Managers	5
Clinical Co-coordinators - Breastfeeding - Clinical	3
Health Promoter	1
Mentor	1

Of the five operational managers interviewed, four worked in a primary setting and one worked in a secondary setting. Clinical coordinators (3) were in tertiary (2) and a specialised secondary (1) setting. The clinical coordinator in one of the tertiary settings was also responsible for the mentoring of obstetrics staff. The health promoter and mentor both worked in a primary setting.

4.2.4. Description of the Focus Group participants

Only nine of the ten facilities took part in the FGDs. Three of the four low risk facilities were represented at FGD 2 due to communicated severe staff shortages on the pre-arranged day. All participants of the FGDs were female and a total of 11 participated in these discussions. The majority of the participants were professional staff and three were non-professionals. According to the profile of the FGD participants (Table 4.2) the majority were nurses, while all the participants of FGD 1 (high risk) were professionals and three of the four participants in FGD 2 (low risk) were non-professionals.

Table 4.2: Category of FGD participants

<i>Category of staff</i>	<i>Number of participants</i>	<i>Participant of FGD</i>	
		High risk	Low risk
Nursing	7	6	1
Allied health professional	1	1	0
Health Promoter	1	0	1
NPO worker	2	0	2

4.3. Successes of BFHI

The internalization of the intervention by the champions equips them to understand the rationale behind the adoption of the strategy and enables them to effectively support a facility to implement the required changes. The implementation includes equipping staff and mothers with knowledge and skills in breastfeeding improve the health outcome of both the mother and baby.

4.3.1. Positive attitudes of staff to breastfeeding

Maternity staff was reportedly to be more optimistic about breastfeeding, promoting breastfeeding to mothers and supporting them to initiate and maintain exclusive breastfeeding, while protecting them from the “spill over” effect of breastmilk substitutes in the maternity units.

“I will say that BFHI has created a perception amongst the staff that we are a breastfeeding hospital and that we see ourselves as a hospital that promotes breastfeeding. There is that core positiveness.” (Champion C).

Promotion of Breastfeeding

Participants report that BFHI has created an awareness of the benefits of breastfeeding and contributed to greater uptake of breastfeeding amongst mothers utilizing their maternity units.

“I can see moms are much keener to breastfeed than when I started off here at ...” (Champion J).

Nurses who previously left mothers to their own devices because they accepted that mothers knew how to breastfeed, are now more optimistic and are equipping mothers with knowledge and skills on breastfeeding. With the acquisition of greater knowledge and skill about breastfeeding, mothers experienced less breastfeeding problems.

“...it is almost like women those years expected it to be like that... and as young mothers we were actually told even ourselves that the baby will suckle it properly; it would suck it right you know. So it’s almost as if mothers expected it’s going to be sore, it’s going to be painful. And yet with this you can see that it don’t have to be. And it’s not if it’s correctly done.” (Champion B).

Supporting breastfeeding

Participants note that an environment conducive to breastfeeding is created in the maternity ward with the implementation of BFHI, whereby mothers are being supported to initiate and continue breastfeeding while in the maternity ward.

“It is about the mom and the baby not just for the baby, baby friendly being there for the mom, supporting the mom, guiding her, helping her.” (Champion H).

The supportive environment created in the maternity units encourages mothers to approach counselors and seek support for issues outside of breastfeeding. Counselors are responding even if the problem is beyond their scope, by just listening.

“They come directly to you and ask you they got this problem. You can’t actually help the problem but you can listen.” (FGD 2).

Participants noted changes in maternity practices such as initiating skin to skin contact immediately after birth, not separating the mother and baby, encouraging feeding on demand, allowing the mother to move about, encouraging her to bring a companion and refraining from invasive procedures (when not medically indicated). This has created an environment in which the mother felt more comfortable and in control.

“I think it looks at all our practices to make it more conducive to the mother as well as the baby, so every aspect of our patient care” (FGD 1).

“All our patients’ care that we do we evaluate and see. Is it friendly for the patient? Is it painful? Is it causing discomfort? Is it causing her to...like dignity, patients lie on their backs in delivery and they open. We need to look at how can we make it more friendly so that she has more privacy and she keeps her dignity, that she doesn’t feel so violated with PVs and things we do” (FGD 1).

Protecting breastfeeding

Maternity units protect breastfeeding and breastfeeding mothers by not displaying or distributing any information, education, communication or promotional material produced or endorsed by companies producing breastmilk substitutes or items contained within the scope of the International Code of Marketing of Breast-milk Substitutes to the mothers in the ward. This includes the distribution of samples to the mothers and gifts to the staff being disallowed in the maternity units.

“And another thing of BFHI is also there’s another three steps that came in like the Code that tells us that there’s no formulas need to be advertised. No formula feeding is being given to them. We also tell the mothers, HIV mothers to exclusively breastfeed or exclusively formula feed for six months and no advertising of any milk products like Nestlé and all the other firms that is making milk. So there is no advertisement about them. Even no pens, and nothing is allowed, no free milk, no advertising of milk products or anything like pamphlets or anything. We don’t want any advertisement of that. No pens, no free substitutes must be given to staff or even no free milk products like many times we get people advertising a certain thing from Nestlé and they like to give to the staff so that is not allowed in a baby friendly hospital.” (Champion G).

4.3.2. Improvements in health

Staff has noted an improvement in the health of the mothers since the implementation of the BFHI strategy. Fewer mothers are observed with post delivery complications, e.g. postpartum bleeding and infections, including breast problems, e.g. engorgement, sore nipples, since the implementation of BFHI.

“For the mother ja... when we put the babies on the breast obviously the mother bleeding will be controlled...” (Champion D).

“I came to facility B in 1990 after working at another midwifery set up and from the time that we’ve implemented the strategy, we don’t see a lot of, if I can take back to my time as a midwife, and I did my midwifery about 30 years ago, and so if I think of that, there are less (sore) nipple, there is less engorgement, there are less nipple problems or sore nipples or bleeding nipples and things.” (Champion B).

Staff has noted that fewer children are being admitted with common childhood illnesses since the implementation of BFHI to promote breastfeeding. The number of children with diarrhoea admitted to the pediatric wards in the hospitals has decreased. Under utilization of special wards previously opened for severely ill children with conditions such as infection, necrotising enterocolitis and diarrhoea was noted.

“Ons het gaan kyk na die gastro stats vir 6 maande baie afgeloop teen die vorige jaar, vorige jare voor BFHI vir daai selfde tydperk.”² (Champion I).

“...there is now less infections because the baby is now with the mom not with all the other babies in a nursery.” (Champion B).

Maintaining the mentioned successes is not easier, as the next section that describes the challenges to implementation elucidates.

4.4. Challenges to Maintain Implementation of BFHI

The challenges to maintaining the practices required for BFHI accreditation related to staff- issues, lack of organisational support and the demotivating effects that the assessment process have on staff.

² We compared the gastro stats of the past 6 months with the stats of the previous year during the same time period before BFHI implementation.

4.4.1. Staff-related Issues

The staff in the maternity wards was challenged to maintain the BFHI related practices after accreditation due to the inconsistency in implementing the practices, workload and in-service training.

Inconsistent Implementation of Practices Post Accreditation

When faced with work pressures (ie. Staff shortages, overfull wards or resistant mothers), nursing staff, especially those who have worked in a maternity setting for most of their nursing career, were reported to revert back to their old routine practices, such as latching the baby instead of teaching the mother to latch the baby, rather than reasoning out what the expected practice within the implementation framework of BFHI would be.

“I think people try to go back to their habits. If they see that they are not successful in something, I think that was what happened.” (Champion J).

“... problem is a month later or two months later you go back to the same ward and it just becomes so much easier to fall back into old habits and that .. point for us it is very hard to keep the others going.” (Champion C, 2010).

Nurses are vigilant enough to recognize a mother in need of extra support but because of their routine culture (observations and medications done at regular time intervals) they will want to complete the routine tasks before engaging with the mother and providing her with additional support. Due to the wards being very busy, they often do not return to the mother’s bedside to assist her, as they initially intended.

“I think it is more pressure of getting done with everything that you are supposed to do. You do not focus on the specific. You got to do the more important stuff in your mind as a sister. Like I said let me keep her pain free and then I will come back and then you never come back” (FGD 1).

Participants reported that nursing staff allow personal opinions and previous practices to influence the information they are sharing with mothers infected with the Human Immunodeficiency Virus (HIV) which deters them from breastfeeding, even after staff members have been trained.

“The staff has this tendency if you are HIV positive, you must have formula feed. Yes and they come to me why did you put that child on the breast. That woman is positive. Even if they are trained.” (FGD 2).

“They just felt that if a mom wants to give her baby formula she can do it any way that it suites her.” (Champion H).

Maternity staff receives training to equip them with the skills and knowledge to implement the facilities formulated policy that guides implementation of the 10 Steps to Successful Breastfeeding, yet the staff has not internalized the knowledge they have gained in the training session. Furthermore, they seem to allow their personal view and previous practices to interfere with the BFHI accreditation standards.

Workload

Nursing staff have not integrated the ten steps to successful breastfeeding into the management of women in the maternity ward. So even if some of the steps were in place prior to the decision to implement BFHI, BFHI was seen as extra work.

“To make it their own as their daily work not an extra thing that we implement, it is their daily work. Most of the ten steps they already did but they think it was more extra work.” (Champion B).

In-service training

Adequate training opportunities are available but the release of staff to attend in-service training was found to be a challenge. However, champions report that in-service training on BFHI is a challenge because they struggle to release or get permission for staff to be released for training. This was attributed to the operational requirements in light of the high attrition and vacancy levels in the maternity wards.

“Training was a very very big challenge because of the shortage of the staff. And then awareness, there was a lot of staff turnover. So to keep everybody informed was also a big challenge”
(Champion B).

“Staffing ... to get staff to replace people who go for training, very very difficult.” (Champion J)

Facilities can make use of agency staff to fill the gap when there are staff shortages due to unforeseen reasons. However, operational managers are not allowed to request an agency staff member with specific skills such as training in the BFHI strategy.

“With our staff shortages we’re making use of agency staff, and although the option was given to agency staff to get trained in the 20-hours. Not all of them are prepared to go in their off time to go and get trained, so obviously implementation is always a problem of all these steps.”
(Champion F).



4.4.2. Lack of support

The implementation of intervention strategies is decided upon by management and the commitment to support not only the implementation but also the maintenance of the strategy is influenced by staffs' willingness to implement the required care practices. Maternity services have been expanded beyond the maternity unit into the clinics where antenatal care and postnatal care are also rendered and includes the placement of support staff in the maternity units.

Lack of management support

Health facility managers showed their commitment to the implementation of BFHI by endorsing the facilities formulated breast-feeding policy. However inclusion of BFHI monitoring as part of the implemented quality assurance system seems to be lacking.

“We do have a quality assurance officer but I understand their role, quality assurance is not around patient care other than coping with complaints. I do not see our quality assurance people on the wards.” (Champion C).

Lack of competency of counselors to support BFHI

Participants felt that the counselors placed in the maternity units to support the nursing staff with the maintenance of the BFHI strategy are not adequately skilled or knowledgeable enough to ensure mothers are adequately educated and supported to breastfeed.

“We do have counselor but the counselors also need training and also need to do the correct skill because there is a gap their by her the message is also not cross over to the mommies.” (Champion E).

Breastfeeding peer counselors in particular have been placed in the maternity units and Basic Antenatal Care (BANC) sites but this placement is only for facilities at the primary care level.

Lack of BFHI Implementation at Clinics Level

Key messages for breastfeeding, based on the required antenatal education, are compiled by facilities in a package called the “Standard minimum content of antenatal education on breastfeeding”. These key messages are used to educate mother in the antenatal and postnatal period and should be used by all facilities caring for pregnant women, mothers and infants. Mothers are also referred to clinics for antenatal and postnatal care but according to some participants clinics are not educating the mothers on the key messages of breastfeeding as required by BFHI. To make matters worse attempts have been made to involve the clinics in the implementation of the BFHI by inviting clinics staff to training and meetings to discuss BFHI have been met with resistance and “no shows”.

“They submit names but they don’t turn up for the training and at the end of the day the children go to the clinic.” (FGD 2).

“Feeder clinics because they are not baby friendly... so there is no information sharing in the clinics.” (Champion F).

The more specialised the maternity services the further they are removed from the facilities that refer pregnant women to them. There is an awareness of the lack of communication between the

clinics that provide the continuum of care at primary level and the maternity units but the establishment of links between referral sites and feeder clinics has not yet occurred.

4.4.3. Internal Assessments

Assessments are completed by trained assessors who use a standardized tool to complete the process. The manner in which the assessments are completed can impact negatively or positively on the staff in the maternity unit. Both nurses (preferable midwives) and dietitians undergo the same training to be accredited as a BFHI assessors and this is done in order to create a skill mix in the assessment teams.

Demotivating process

Internal assessments are not seen as supportive processes as assessors are taking authoritative stances during assessments. It is reported that assessors are perceived as focusing on the negative and not being supportive enough to encourage the staff to maintain practices that are in place. The process of the re-assessments impact negatively on staff morale as opposed to the supportive environment it is meant to foster.

“I feel that it shouldn't be almost like a Gestapo type of thing. It should be almost like a partnership and people shouldn't be scared of it. And I feel that the assessors could be a bit more friendly and not so angry you know” (Champion A).

Use of dietitians to assess nursing practices

Only professional staff (Dietitians and Midwives) with in-depth knowledge of infant feeding and experience with BFHI implementation are trained as BFHI assessors. Participants felt that dietitians could not assess nursing care practice as they have limited insight into nursing practice and assume that responses from nurses are being misinterpreted.

“... if it was not nursing staff interviewing us then they didn't always understand what we were trying to say”. (Champion J)

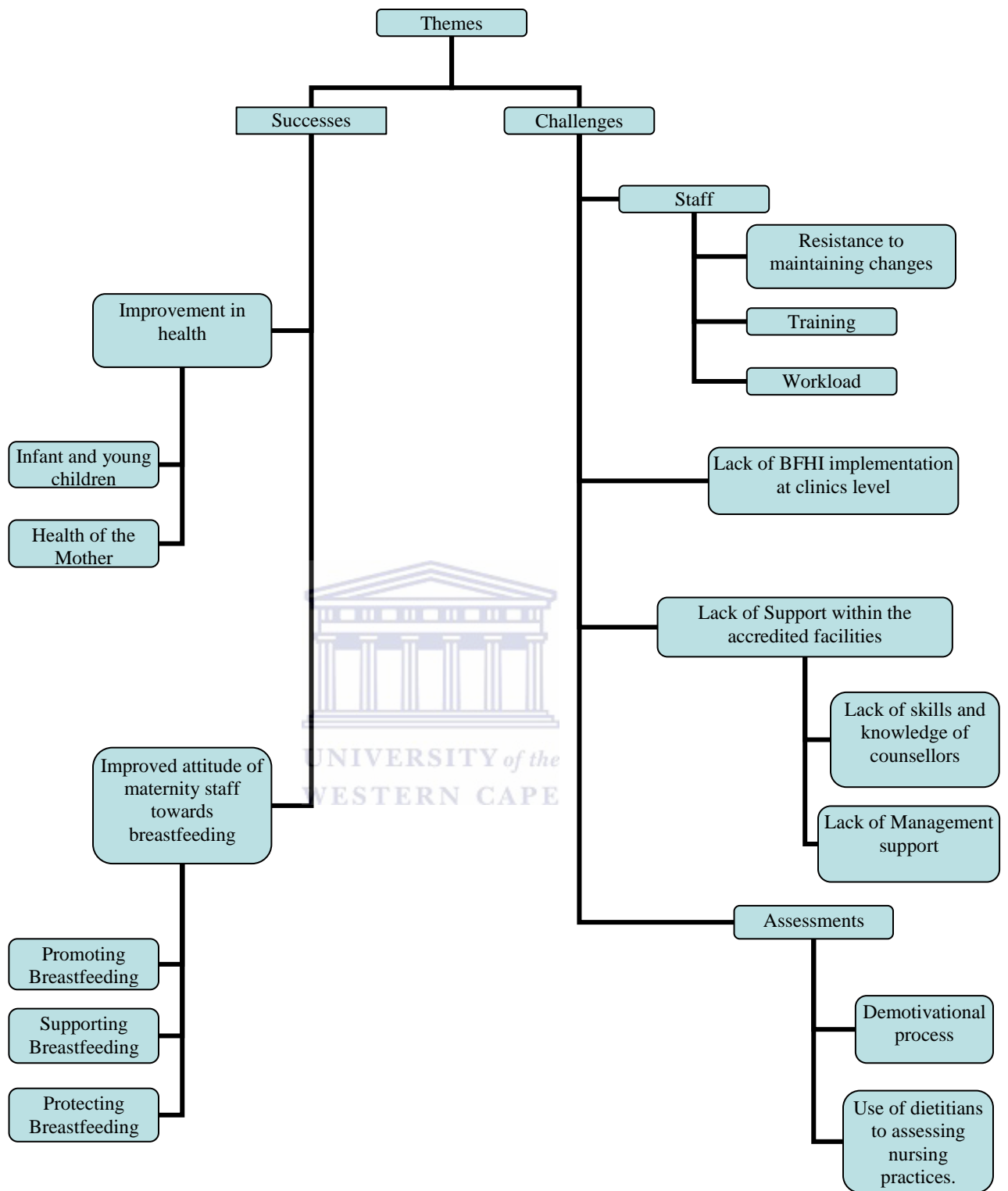
Nurses see maternity care practices as being nursing territory that cannot be assessed by any other category of staff even if it is the practice (to promote breastfeeding) that is being assessed and not the nursing technicality of the practice is being assessed.

4.5. CONCLUSION

This chapter presented the common factors found to be associated with the successes experienced since the implementation of BFHI and the challenges experienced in maintaining the standards associated with BFHI Accreditation (Schema 4.1).

The following chapter will discuss the successes and challenges with BFHI implementation and relate the experiences to current literature. Also presented in the next chapter will be a conclusion and recommendations regarding BFHI in the Cape Town Metropole.





Schema 4.1: Themes identified in analyses

CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The core of BFHI is the “Ten Steps to Successful Breastfeeding” which is a summary of the maternity care practices necessary to transform maternity practices to one that supports breastfeeding (WHO, 1998). There are numerous studies exploring the impact of BFHI on the breastfeeding rates pre- and post-implementation of the strategy (Bartington *et al.*, 2006; Braun, Guigliani, Soares, Guigliani, Oliveira and Danelon, 2003; Caldeira and Goncalves, 2007; Fallon *et al.*, 2005). Studies completed by Caldeira and Goncalves (2007) and Bartington *et al.* (2006) used a quantitative research method with a pre-set hypothesis and statistical analysis of the collected data. Neither of the studies reflected nor explored the challenges involved in the implementation and maintenance of BFHI on human, time or financial resources. It is nonetheless interesting to note that the findings of these studies indicate an increase in the initiation of breastfeeding after implementation of the BFHI strategy. Six key baby friendly practices impacting on the duration of breastfeeding have been identified by DiGirolamo, Grummer-Stawn and Fein (2002; 2008) who further reported that the more practices the mothers are exposed to the longer they breastfeed beyond six weeks. As noted by Heining (2004) breastfeeding must be acknowledged as a natural act as well as learned behaviour which required ongoing support for the duration of breastfeeding.

5.2 Staff and the Maintenance of the “Ten Steps to Successful Breastfeeding”

There are two components required for the implementation of the BFHI strategy, recipients who are the pregnant women, mothers, caregivers, mother and infant dyads and service providers who are the hospital management and staff in the maternity units. Identified as a challenge to the maintenance of the “Ten Steps to Successful Breastfeeding” in the previous chapter were issues relating to the staff in the maternity units. Nursing staff in the units were reported as not being consistent in their implementation of the maternity care practices and the reasons cited were “work pressures” brought about by high vacancies, attrition of staff and resistant mothers. Similar results was noted by Bartick *et al.*, (2009) who noted that the full use of breastfeeding support required a cultural change amongst nurses regarding care patterns, by illustrating the ease with which nurses resorted to offering a bottle in pressurized environments rather than solving the breastfeeding problems. Reddin, Pincombe and Darbyshire (2007) also reported that BFHI practices took the backseat in a pressured environment and with increased workload. Mothers /women in the wards

were exposed to less of the BFHI practices when the work pressure increased. The participants in that study were “Graduate Midwifery Programme” graduates from two Australian Universities and one hospital who spent time in eight maternity units as part of their training. A total of eight units of which seven were accredited and one was working towards accreditation were assessed by the participants.

Pregnant women are being sensitized on the key messages relating to breastfeeding during the antenatal period as required by step three but staff neglects to maintain the implementation of the required maternity care practices as required for accreditation. As reported by Nakar *et al.*, (2007) the lack of supportive practices in the maternity units while emphasizing the importance of breastfeeding is detrimental to the creation of an environment that promotes breastfeeding. Nurses were reverting back to their old practices when faced with increased patient loads rather than practicing consistently and continuing with BFHI implementation. The mothers were hearing the key messages around breastfeeding and practices that promote and support breastfeeding but when in the maternity unit the practices were not being implemented by the nursing staff consistently. Similarly Reddin *et al.* (2007) reported that participants noted that midwives have an attitude towards breastfeeding, seeing breastfeeding promotion as just another task in the already overloaded work environment. The inconsistency in implementation of the steps even if some were already in place prior to implementation can disadvantage the aim of the strategy. WHO (1998) notes that implementation of the steps in isolation from each other has limited effect compared to unified implementation of all the steps as a complete strategy. It is further noted that the omission of individual steps can hinder the impact of the remaining steps.

The ten steps to successful breastfeeding can be broken down into three key areas, foundational steps, implementation steps and supportive steps of which the recipients vary (Table 5.1). Of the three foundational steps, step 2 requires that maternity staff is trained in the skills necessary to the facility policy (step 1).

Table 5.1: Classification of the “Ten Steps to Successful Breastfeeding”

Category	Steps	Recipients
Foundations steps	1	Maternity staff
	2	Pregnant women, caregivers, grandparents and partners
	3	
Implementation steps	4	Mothers
	5	
	6	
	7	
	8	
	9	
Supportive step	10	Mothers

The training is mandatory for all staff working in maternity units that are striving to attain or maintain BFH accreditation. The aim of the training is to equip maternity staff with the knowledge and skills to implement the facilities breastfeeding policy (WHO 1998). Training was reported as being a challenge due to vacancies and attrition of staff in the maternity units. Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) reported that one of the factors which compromise the success of key health initiatives in South Africa was the inequality in staff distribution. According to a study commissioned by the South African Department of Labour completed by Wildschut and Mqolozana (2008) SA has enough nurses but disparities exist between provinces, urban and rural areas as well as between the public and private sector. Similar reports were made by Coovadia *et al.* (2009) who noted that compared to the WHO standard of 2.5 / 1000 population, SA has adequate numbers of physicians, nurses and midwives, namely 4.9 / 1000 (2004). This implies that even though SA seems to be producing adequate numbers of healthcare staff they are not necessarily entering the workforce.

The attendance of the training sessions does, however, not imply that clinical practice will be changed accordingly. Exposure to training (20 hour course for maternity staff) does not guarantee improved clinical practice as noted by Dennis (2002) citing a study conducted by Karipis and Spicer in 1999. The findings were based on the assessments of a combination of novice and experienced nurses using a breastfeeding knowledge questionnaire which reported little difference in the knowledge levels of the nurses.

The decision to breastfeed is made early in pregnancy and is impacted by cultural, personal and familial variable (Pollock *et al.*, 2002) and the implementation of strategies to improve breastfeeding rates cannot be made unless the influence of these factors is clearly understood by the service providers. Failure to understand the mother's home environment, social responsibilities, family demands and the relationship she has with her partner can create the impression that she is resistant to change. Making an infant feeding choice must include knowledge about the benefits and disadvantages of all options available to the mother, while being guided by a knowledgeable staff member.

Implementation of BFHI and maintenance of the standards required for accreditation is impacted on by the service providers of the maternity services. However, as stated by WHO (1998), a lack of co-ordination exists between decision makers and implementers within a health facility.

5.3 Implementation of Policies

Step One requires the staff in the maternity unit to compile a facility specific "breastfeeding policy" which reflects how the "Ten Steps to Successful Breastfeeding" will be implemented in the facility / hospital. This is usually driven by the BFHI committee formed within the facility with inputs from the staff working directly with the mothers after which it is approved and endorsed by the decision makers (administrators / management) with signatures and review dates. The model facility-specific policy is written in order to guide the staff and provide expected outcomes of the practices as well as how they will be evaluated (Dodgson, Allard-Hale, Bramscher, Brown and Duckett, 1999). When management endorses the policy they also undertake to ensure that the implementation and maintenance of the changes in the maternity care practices to promote breastfeeding occurs. Support from management was identified as a barrier to maintenance because monitoring of BFHI implementation has not been included into existing quality assurance systems. Staff are thus aware that a policy exists, have read the policy (which is part of the requirement for step 1), are aware of the required changes to maternity care practices but the monitoring of the implementation by hospital management has not been instituted. This is perceived by staff as a lack of management support which hinders maintenance of the change in practice as nobody in management is "watching".

5.4 Expansion of BFHI beyond the Borders of the Maternity Units

Reference is made by Bartington *et al.* (2006), Braun *et al.* (2003), Caldeira and Goncalves (2007) and Fallon *et al.* (2005) to the need for further strategies to improve the duration of breastfeeding which in effect is the strengthening of Step 10. Caldeira and Goncalves (2007) further notes the need for community support groups and further research into the reasons for the lack of the duration of breastfeeding for six months so as to inform stakeholders at community level and strengthen Step 10. Maternity services in the Western Cape has been expanded beyond the doors to the maternity unit yet the clinics offering the Basic Antenatal Care package are not aligned with the maternity units to which they refer the clients for further care or confinement. These same sites also see the mother and baby pair once they are discharged from the maternity unit and are not engaging in reinforcement of the key messages shared with the mother in the maternity unit. Staff rendering health care to the pregnant women takes responsibility for breastfeeding education and similarly in the postnatal period do they take responsibility for continuing the care and support for breastfeeding (Nyqvist and Kylberg, 2000). Failure by these staff members to initiate and continue the promotion of breastfeeding during these periods was seen by the staff in the maternity units as creating a challenge to maintaining BFHI standards. Similar results was reported by Hofvander (2005) who noted that for BFHI to contribute positively to the breastfeeding rates and duration the mother must receive the same key messages, counselling and support in the entire care-chain, maternity care and child health services, while in the healthcare system. The associated ten steps of BFHI are not all applicable in non labour and delivery sites and can thus not be implemented in its entirety. Thompson, Bilson and Dykes (2011) refer to an adapted version of the ‘Ten Steps’ developed by UNICEF UK which are referred to as the “Seven Point Community Plan”. The researchers of this study aimed to explore how the community Baby Friendly Initiative was implemented, from a professional viewpoint. Reported in the study was that engagement with professional on both an emotional and cognitive level using trustworthy leadership changed the attitudes and practices of staff at community level. Further advocacy for implementation of the adapted ‘Seven Point Community Plan’ in the clinics rendering basic antennal care must be explored by management.

5.5 Impact of the Internal Assessment Process

The internal assessments are part of the provincial BFHI monitoring and evaluation system. In the Western Cape internal assessments are initiated 12 months before national assessment by trained

BFHI assessors. In order to be trained as a BFHI assessor it is required that the participant is knowledgeable in infant feeding practices and the hospital practices required to promote, protect and support breastfeeding. Section five of the BFHI guidelines (UNICEF and WHO, 2009) does not stipulate that nominees to be trained as BFHI assessors are from any particular profession but rather seeks the in-depth knowledge and skills associated with infant feeding. Both nurse (usually midwives) and dietitian are trained simultaneously in training sessions, as BFHI assessors. Included in the training are the roles and responsibilities of the assessors during assessments. Participants are required to be impartial and unbiased while limiting criticism and encouraging good practices. However, when the BFHI assessor's complete internal assessments in the facilities in the Cape Town Metropole, the maternity staff experienced the assessors as being authoritative, which in turn, affected the morale of the staff. This created a hostile atmosphere in what is meant to be a supportive environment. Limited research is available on the impact of the assessor's attitude on the morale of the staff. However it was noted by El-Jardali, Jamal, Dimassi, Ammar and Tchaghchaghian (2008) that hospital accreditation impacted positively on quality of care and therefore it is important for the assessments to create a supportive rather than a destructive environment. Exploration into the inclusion of BFHI into existing quality assurance structures can enhance maintenance of the BFHI maternity practices, if focused on patient outcomes as suggested by El-Jardali, et al (2008) thereby reducing the number of assessments and boosting staff morale. Future research is needed to investigate the BFHI internal assessment process and integration of BFHI monitoring into existing quality assurance structures.

5.6 Impact of Implementation

Nursing staff in the maternity wards provide health care to the mothers while they are in the care of the facility. As noted by Humenick and Gwayi-Chore (2001) because women come in contact with nurses during their reproductive years, nurses have the opportunity to impact on the mother's knowledge and attitude towards breastfeeding. Implementation of BFHI promotes, protects and supports breastfeeding thus increasing the rates of breastfeeding. Similar results were noted by Dratva and Ackerman-Liebrich (2005) who concluded that a general increase in breastfeeding was noted as a result of the increasing number of BFH accredited health facilities in Switzerland.

5.7 Conclusion

The purpose of this study was to gain insight into the challenges and successes as experienced by staff with the implementation and maintenance of BFHI in BFH accredited facilities within the

Cape Town Metropole District. BFHI implementation in maternity units at all levels of care will ensure that the mother experiences the same BFHI related maternity care practices at all levels irrespective of whether she is referred up or down within the health care system. The noted successes related to implementation of BFHI, such as improved health outcomes for both mother and child and attitude of staff towards breastfeeding, contribute positively towards achievement of the MDG and improved child survival. While the challenges noted hinders the full potential positive impact of the strategy on child survival. Healthcare staff working in or managing maternity services is core to the success of the strategy yet remains the biggest challenge. The potential impact of this initiative as a child survival strategy must be realized by the decision makers (management) and implementers (staff) of BFHI at facility level, to ensure its success. Co-ordination and support by all role players is vital to the success and elimination of challenges experienced with implementation and maintenance of BFHI practices.

5.8 Recommendations

The following recommendations can be made based on the collected data and the findings of the study.

The Provincial Department of Health should:

1. Formulate a provincial strategy to inform and guide BFHI roll out to all birthing units in the province and submit the document to the management structures of the WCP in order to formalise implementation processors in the Province. This strategy if endorsed by management could be used as a strategic tool to enhance management support for implementation and maintenance of BFHI.
2. Instigate collaboration with the City of Cape Town in order to draft and submit implementation plans to facilitate roll out of the BFHI to the facilities under their management who offer health services to pregnant women and mother and infant dyands.

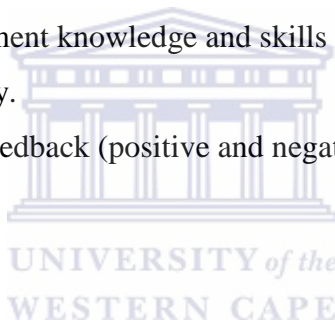
Facility management should:

1. Provide visible support for the maintenance of maternity practices associated with BFHI by implementing or integrating internal monitoring into existing monitoring and evaluation system.
2. Ensure discussions of BFHI at management meetings so as to create a platform at which champions can feedback progress and highlight constraints found at implementation level.

3. Note that support with lack of resources hindering maintenance of BFH standards.

Champions should:

1. Advocate for the improvement of working conditions for maternity staff (nurse: patient ratio's, counsellors).
2. Create platforms for staff to voice concerns and discuss solutions to identified barriers.
3. Ensure that BFHI maintenance is part of the performance plans / job descriptions for maternity staffs.
4. Include mentoring of lactation management skills and knowledge into existing staff mentoring structure in the facilities.
5. Increased advocacy for BFHI to management – place BFHI on all meeting agenda's.
6. Form links with feeder clinics and referral sites to get their buy in and advocate for implementation at these sites.
7. Maintain lactation management knowledge and skills needed to be effective mentors to the implementers of the strategy.
8. Ensure that staff receives feedback (positive and negative) from the monitoring and evaluation processes.



Maternity staff should:

1. Actively participate in maintaining implemented practices.
2. Voice concerns identified in the wards to the champion and contribute to finding solutions.
3. Use information for education sessions based on researched facts and not personal opinions.
4. Team together to optimise the support afforded a mother in a maternity unit.
5. Maintain working knowledge to ensure optimal support is provided to all mothers.

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ADDENDA

Addendum A: Extracts from the Code (WHO, 1981)

Article 5:

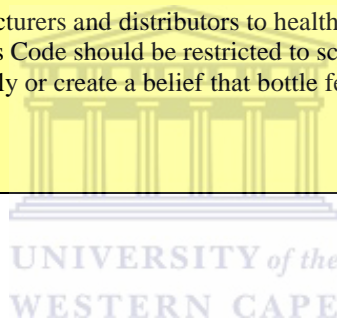
- 5.3 Manufacturers and distributors should not provide, directly or indirectly, to pregnant women, mothers or members of their families, samples of products within the scope of this Code.
- 5.4 Manufacturers and distributors should not distribute to pregnant women or mothers or infants and young children any gifts of articles or utensils which may promote the use of breast-milk substitutes or bottle-feeding.

Article 6:

- 6.2 No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code.
- 6.3 Facilities of health care systems should not be used for the display of products within the scope of this Code, for placards or posters concerning such products,

Article 7:

- 7.2 Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters, and such information should not imply or create a belief that bottle feeding is equivalent or superior to breast-feeding.



Addendum B: Operational Targets Set Forth in the Innocenti Declaration

All governments are encouraged to:

- ☞ Appoint a national breastfeeding coordinator with the appropriate authority and establish a representative (departments, nongovernmental organizations, and health professional) multisectorial national breastfeeding committee composed ;
- ☞ Ensure that every facility providing maternity services fully practices all 10 of the “Ten Steps to Successful Breastfeeding” set out in the joint World Health Organization/United Nations International Children’s Emergency Fund statement “Protecting, Promoting, and Supporting Breastfeeding: The Special Role of Maternity Services”;
- ☞ Effect the principles and aims of all the articles of the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety; and
- ☞ Enact imaginative legislation protecting the breastfeeding rights of working women and establish means for its enforcement.

Addendum D: Millennium developmental goals influenced by the promotion of breastfeeding (UNICEF & WHO, 2009).

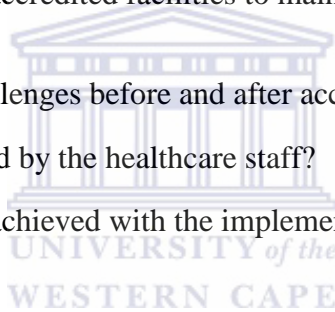
Goal	Target	Contribution of breastfeeding
1	Eradicate extreme poverty	Breastfeeding reduces the feeding costs in early childhood because it is low cost, readily available and sustainable food security for the infant.
4	Reduces child mortality	Breastfeeding reduces the incidence and severity of childhood infectious disease.
5	Improve maternal health	Breastfeeding is associated with decreased breast, ovarian and endometrial cancer as well as reduced maternal postpartum bleeding and post menopausal bone mass loss. Breastfeeding further promotes the return of the mothers body to her pre-pregnant form and improved involution of the uterus.

Addendum E: Maternity services rendered at the different levels of care

Level of the facility	Description	Services rendered
Clinic	Antenatal care is one of a number of services - also referred to as a facility offering Basic Antenatal Care	<ul style="list-style-type: none"> - Antenatal services for low and intermediate risk women - Postnatal checks - Referral of problems to hospitals - Management of emergencies
Community Health Centre	24 hour comprehensive obstetric unit run by midwives – also referred to as a Midwife Obstetrics Unit (MOU)	<ul style="list-style-type: none"> - Antenatal Care for low and intermediated risk women - Treatment of common problems in pregnancy - 24 hour labour and delivery service for low risk women - Vacuum extraction - Postnatal checks - Referrals of problems to hospitals - Management of emergencies
Primary	Normally the base hospital for a health district – also referred to as a District Hospital	<ul style="list-style-type: none"> - Antenatal care for high risk women - Antenatal ultrasound service - Treatment of pregnancy problems, including admissions - 24 hour labour and delivery for intermediate and high risk women - Vacuum extractions, caesarian sections and manual removal of Placenta. - Referral of complicated cases to level 2 and 3 - Counselling and support
Secondary	Base hospital for a region which can include a number of districts – also referred to as a regional hospital	<ul style="list-style-type: none"> - All the functions of a level 1 - Management of severely ill pregnant women - Multidisciplinary care - Referral centre for a level 1
Tertiary	Also referred to as a central or tertiary hospital	<ul style="list-style-type: none"> - All the services rendered at level 1 and 2 - Specialist combined clinics - Management of the severely ill or difficult obstetrics patient - Responsible for policy and protocol - Services are provided by trained maternity staff and specialists

Addendum F: Question used to guide the interview with the key informant

1. What is your position in the Province?
2. When was BFHI implemented in the Western Cape?
3. What was the motivation used to implement this strategy?
4. What is your role in the implementation?
5. Which facilities are accredited with the BFHI status, what is their level of care and when did they receive accreditation.
6. What process is followed for accreditation?
7. Are there any monitoring and evaluation systems in place?
8. What resources have been allocated from the Provincial office towards the implementation of this strategy?
9. What support is offered to accredited facilities to maintain implementation of the quality of care practices?
10. What are the perceived challenges before and after accreditation?
11. How is the strategy accepted by the healthcare staff?
12. What successes have been achieved with the implementation of this strategy?



Addendum G: Open ended questions used to guide the interviews with the champion.

Interview number: _____

Level of care: High risk care (facility performs caesarean sections) or Low risk care (facility does not perform caesarean sections).

Interview with driver of BFHI in facility: _____

1. What is your position in the facility?
2. When was this facility accredited with BFHI status?
3. Has the facility undergone a national reassessment?
4. What is your understanding of the Baby Friendly Hospital Initiative?
5. How was this strategy introduced into your facility?

6. What were the challenges experienced with implementation of this strategy?
7. What are the challenges experienced after accreditation with maintenance of the practices?
8. Has the implementation of this strategy made a difference in your facility?

Addendum H: Open ended questions used to guide the Focus group discussions

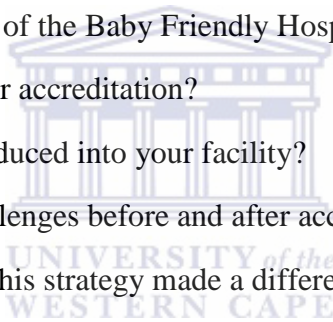
Focus groups number:

Number of participants:

Number of facilities represented:

Questions for Focus Group:

1. What is your understanding of the Baby Friendly Hospital Initiative?
2. What process is followed for accreditation?
3. How was this strategy introduced into your facility?
4. What are the perceived challenges before and after accreditation?
5. Has the implementation of this strategy made a difference in your facility?



Addendum I: Participants information sheet



UNIVERSITY OF THE WESTERN CAPE

School of Public Health

Private Bag X17 • BELLVILLE • 7535 • South Africa

Tel: 021- 959 2809, Fax: 021- 959 2872



PARTICIPANT INFORMATION SHEET

Dear Participant

Thank you for your willingness to hear about this research. What follows is an explanation of the research project and an outline of your potential involvement. The research is being conducted for a mini thesis. This is a requirement for the Masters in Public Health which I am completing at the University of the Western Cape. If there is anything you do not understand or are unclear about, please ask me. My contact details and those of my supervisor are recorded at the end of the memo.

TITLE OF RESEARCH

CHALLENGES, EXPERIENCES AND SUCCESSES EXPERIENCED BY STAFF IN 'BABY FRIENDLY HOSPITAL INITIATIVE' ACCREDITED FACILITIES IN THE CAPE TOWN METRO HEALTH DISTRICT



PURPOSE OF THE STUDY

To describe the experiences, success and challenges experienced in Baby Friendly accredited health facilities in the Cape Town Metropole Health District. To identify the reasons for erosion of the implemented 10 Steps to Successful Breastfeeding subsequent to Baby friendly status accreditation. Only questions related to Baby Friendly Hospital Initiative will be asked.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT

The study will include a key informant interview with the Provincial Manager responsible for implementation of the strategy in the Province, individual interviews with drivers of the strategy in the maternity units and focus group discussions with nursing staff working in Baby friendly accredited maternity units.

CONFIDENTIALITY

Your name will be kept confidential at all times. I shall keep all records of your participation, (the questionnaire and the signed consent form) locked away at all times and will destroy them after the research is completed.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Your participation in this research is entirely voluntary i.e. you do not have to participate. If you choose to participate, you may stop at any time. You may also choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.

BENEFIT AND COST

You may not get any benefit from this study. However the information we learn from participants in this study may help health facilities, unit managers and the nutrition directorate in supporting facilities to maintain their Baby Friendly status. There are no costs for participating in the study other than the time you will spend in the interview.

INFORMED CONSENT

Your signed consent to participate in this research study is required before I proceed to interview you.

QUESTIONS

Should you have further questions or wish to know more, I can be contacted as follows:

Nicolette Petersen

Student number: 9124446

Cellphone: 0837610515

Email: nmhenney@pgwc.gov.za

Telephone at work: 021 – 483 8664

Fax no. work: 021 – 483 2682

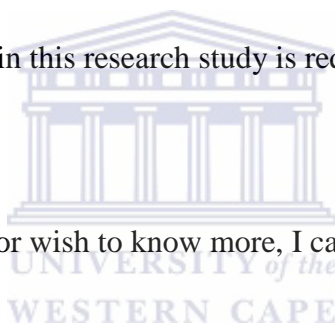
I am accountable to Dr Brian van Wyk, my supervisor at UWC. His contact details are:

Telephone: 021 – 959 2173

Fax: 021 – 959 2872

Email: bvanwyk@uwc.ac.za

Website: www.uwc.ac.za/comhealth/soph



Addendum J: Consent forms



UNIVERSITY OF THE WESTERN CAPE

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Tel: 021- 959 2809, Fax: 021- 959 2872

INFORMED CONSENT TO CONDUCT AN INTERVIEW WITH THE KEY INFORMANT OF BFHI IN THE PROVINCE

Date:

Interviewer:

UWC Student no: 9124446

Contact number: 0837610515

E-mail: nmhenney@pgwc.gov.za

Interviewee's pseudonym:

Place at which the interview was conducted: _____

Thank you for agreeing to allow me to interview you. What follows is an explanation of the purpose and process of this interview. You are asked to give your consent to me on tape when we meet to conduct the interview.

1. Information about the interviewer

I am Nicolette Petersen, a student at the SOPH, University of the Western Cape. As part of my Masters in Public Health, I am required to conduct a mini thesis. I am accountable to Dr Brian van Wyk who is contactable at **021 959 2173** or **c/o SOPH Fax: 021 959 2872** or by e-mail at **bvanwyk@uwc.ac.za**

2. Purpose and contents of interview

To gather information relating to the implementation and maintenance of the Baby Friendly Hospital Initiative in the Cape Town Metropole Health District. Only questions related to Baby Friendly Hospital Initiative will be asked.

3. The interview process

The interview will take place within your work environment, at your convenience during working hours and take no longer than 40 minutes. The content of the interview will be confidential and you may withdraw from the study at any time.

4. Anonymity of contributors

At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been analyzed.

5. Things that may affect your willingness to participate

If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see as intrusive.

6. Agreement

I shall keep the contents of the above research interview confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

Signed by interviewer:

Date:

Signed by participant:

Place:



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Tel: 021- 959 2809, Fax: 021- 959 2872

**INFORMED CONSENT TO CONDUCT AN INTERVIEW WITH THE DRIVER OF BFHI
IN THE HEALTH FACILITY**

Date:

Interviewer:

UWC Student no: 9124446

Contact number: 0837610515

E-mail: nmhenney@pgwc.gov.za

Interviewee's pseudonym:

Place at which the interview was conducted: _____

Thank you for agreeing to allow me to interview you. I am Nicolette Petersen, a student at the SOPH, University of the Western Cape. As part of my Masters in Public Health, I am required to conduct a mini thesis. I am accountable to Dr Brian van Wyk who is contactable at **021 959 2173 or c/o SOPH Fax: 021 959 2872 or by e-mail at bvanwyk@uwc.ac.za**

The purpose of this interview is to gather information relating to the implementation and maintenance of the Baby Friendly Hospital Initiative in the Cape Town Metropole Health District. Only questions related to Baby Friendly Hospital Initiative will be asked. The interview will take place within your work environment, at your convenience during working hours. It will take no longer than 40 minutes using a semi structured questionnaire. The content of the interview will be confidential and you may withdraw from the study at any time.

At all times, the source of the information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been analysed.

The interview may touch on issues which does not directly relate to BF status. If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see as intrusive.

Agreement

I shall keep the contents of the above research interview confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

Signed by interviewer:

Signed by participant:

Date:

Place:





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INFORMED CONSENT TO CONDUCT A FOCUS GROUP DISCUSSION

Date:

Interviewer:

UWC Student no: 9124446

Contact number: 0837610515

E-mail: nmhenney@pgwc.gov.za

Interviewee's pseudonym:

Place at which the interview was conducted: _____

Thank you for agreeing to allow me to interview you. You are asked to give your consent to me on tape when we meet to conduct the focus group discussion.

I am Nicolette Petersen, a student at the SOPH, University of the Western Cape and as part of my Masters in Public Health, I am required to conduct a mini thesis. I am accountable to Dr Brian van Wyk who is contactable at **021 959 2173 or c/o SOPH Fax: 021 959 2872 or by e-mail at bvanwyk@uwc.ac.za**

The purpose of this interview is to gather information relating to the implementation and maintenance of the Baby Friendly Hospital Initiative in the Cape Town Metropole Health District. Only questions related to Baby Friendly Hospital Initiative will be asked.

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The interview may touch on issues which does not directly relate to BF status. If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will be

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Signed by interviewer:

Signed by participant:

Date:

Place:

