Exploring the factors influencing exclusive breastfeeding within the first 14 weeks postpartum with mothers in the Khayelitsha-Eastern Substructure

by

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KEYWORDS

- Exclusive Breastfeeding
- Mixed Feeding
- Predominantly Breastfeeding
- Breastfeeding initiation
- Breastfeeding Support
- In-depth interviews
- Qualitative methods
- Primary Health Care facilities
- Khayelitsha-Eastern Substructure

ABBREVIATIONS

ART- Antiretroviral Treatment

BANC- Basic Antenatal Care

BCEA- Basic Conditions of Employment Act

BF- Breastfeeding

BFHI- Baby Friendly Hospital Initiative

BFPC- Breastfeeding Peer Counsellor

BMS- Breast-milk substitute

CBS- Community-Based Services

CDC-Community Day Centre

CHC- Community Health Centre

CHW- Community Health Worker

EBF- Exclusive Breastfeeding

EBM- Expressed Breastmilk

ECD- Early Childhood Development

EFF- Exclusive Formula Feeding

HCW- Healthcare worker

IMR- Infant Mortality Rate

IYCF- Infant and Young Child Feeding

HIV- Human Immunodeficiency Virus

LMIC- Low- and Middle-income country

MBFI- Mother Baby Friendly Initiative

MNCWH- Maternal, Newborn, Child and Women's Health, Nutrition

MOU- Midwifery Obstetric Unit

NDoH- National Department of Health

NPO- Non-profit Organisation

PHC- Primary Health Care

PI- Principal Investigator

PMTCT- Prevention of Mother to Child Transmission

SA- South Africa

SADHS- South African Demographic Health Survey

UIF- Unemployment Insurance Fund

UNICEF- United Nations International Children's Emergency Fund

WC DoH- Western Cape Department of Health

WCG- Western Cape Government

WHO–World Health Organisation

DEFINITIONS OF KEY TERMS

Exclusive Breastfeeding

Exclusive breastfeeding (EBF) means that the infant receives only breastmilk during the first six months of life. No other liquids or solids are given -not even water - except for oral rehydration solution, or drops/syrups of vitamins, minerals or prescribed medicines (WHO, 2008).

Mixed Feeding

Mixed feeding means that the infant receives both breastmilk and any other food or liquid including water, non-human milk and infant formula before 6 months of age (WHO, 2008).

Predominant Breastfeeding

Predominant breastfeeding means that the infant's predominant source of nourishment has been breastmilk. However, the infant may have received other liquids in addition to the breastmilk (WHO, 2008).

Early initiation of Breastfeeding

Early initiation of breastfeeding is defined when the mother initiates breastfeeding within the first hour after birth (WHO, 2008).

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ABSTRACT

Background: Despite evidence-based proof on the benefits of breastfeeding, little progress has been made globally to improve breastfeeding rates (The Lancet, 2016), including in South Africa. Despite many attempts to improve breastfeeding rates worldwide, women are still choosing to stop breastfeeding or avoid it due to various factors (The Lancet, 2016).

Aim: To explore the factors influencing the exclusive breastfeeding rate within the first 14 weeks postpartum with mothers in the Khayelitsha Eastern Substructure.

Objectives: (1) To describe the socio-demographic characteristics of mothers. (2) To determine facilitating factors to EBF practices in women during the first 14 weeks postpartum. (3) To determine the barriers to EBF practices in women during the first 14 weeks postpartum.

Study Design: An exploratory, descriptive study was conducted. A qualitative research approach was used to explore factors influencing mothers' decisions to EBF for the first 14 weeks postpartum, in the Khayelitsha-Eastern substructure and the reasons were for doing or not doing so.

Sampling: Sampling of mothers: Sampling in this study was purposive and was done at Site B Community Health Centre (CHC) and Macassar CHC. Eight mothers were selected that were still exclusively breastfeeding, 2 were partially breastfeeding and 6 were not breastfeeding. **Sampling of key informants:** Two staff members at each facility, (either a BFPC, midwife or clinical nurse practitioner with at least 5 years' experience in Maternal and Child Health) were interviewed as key informants.

Data collection: A semi-structured interview guide was used to conduct individual in-depth interviews with the mothers and key informants. The interviews were audio recorded and transcribed by the researcher and a professional transcribing company, based in South Africa.

Analysis: Audio recordings were transcribed into textual data, verbatim. Thematic Content Analysis was applied to this study and was used to identify key themes. Textual data was desegregated into themes and sub-themes. The content of the data was analysed and summaries of the influencing factors to EBF were made.

Results: The main findings show that facilitating factors of EBF in 14 weeks in this substructure are: breastfeeding promotion at the antenatal clinics, postnatal breastfeeding support in the birthing units, affordability; mothers feeling inclusive in society when they are

breastfeeding especially when breastfeeding in public is viewed as normal and the mothers' cognitive decision to continue breastfeeding based on her knowledge of breastfeeding benefits. Barriers to EBF within 14 weeks have been identified to be: HCW's uncertainty regarding IYCF guidelines; mother's uncertainty regarding HIV and breastfeeding; lack of postnatal BF support on community level; inconsistent postnatal support regarding the management of breast problems and inconsistent referral for postnatal support to CBS.

Ethical considerations: Participation in the study was voluntary for all research participants. Participants could withdraw from the study at any point if they wanted to, with no negative consequences.

Conclusion: This study has been carried out in response to the low EBF rates at 14 weeks in the Khayelitsha Eastern Substructure and a need to identify the main factors that facilitate the EBF practice and its barriers. Looking at the various facilitating factors and barriers mothers in the Khayelitsha Eastern Substructure are facing, it is evident that breastfeeding promotion and support is needed on an intersectoral platform.

DECLARATION

I declare that 'Exploring the factors influencing exclusive breastfeeding within the first 14 weeks postpartum with mothers in the Khayelitsha-Eastern Substructure' is my own work. 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.

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Signed: MC Marais Date: 27 November 2020

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Thank you all so much from the bottom of my heart.

DEDICATION

Firstly, God can make all things possible.

For many this degree would seem just like another qualification to add to my credentials. To me it means so much more. For a simple girl who grew up on the Cape Flats, having lived through poverty and communities where gangsterism and alcoholism is the social norm, this achievement means so much more. It is a constant reminder to myself that I am not my circumstances. I am capable of whatever I set my mind to.

This degree is dedicated to all the young women in those communities who may feel and think that the world is small and their capabilities are limited. My dear, if only you knew that you are worthy of so much and very capable of anything you want to achieve.

CONTENTS

CHAPTER ONE: INTRODUCTION

This chapter provides a background to this study. It includes the problem statement, the research setting and the purpose of the study.

1.1.Background

According to the Lancet Breastfeeding Series of 2016, breastmilk bridges the gap in inequality worldwide (The Lancet, 2016: 404). Breastfeeding contributes to short- and long-term health and economic benefits to children, women and society, irrespective of race, gender or social class (Rollins, et al., 2016). Children who are breastfed are known to have improved cognition and perform better at school, which will lead them to become part of a productive workforce and ultimately contribute to the country's economy (Rollins et al, 2016). Breastfeeding has the potential to reduce the mortality of 823 000 children and 20 000 mothers annually and is an integral part of the reproductive process. Moreover, breastfeeding impacts the mother's health including reducing the incidence of postpartum haemorrhage, a major cause of maternal mortality as well as reductions in breast and ovarian cancer (WHO, 2012b).

Despite evidence-based proof on the benefits of breastfeeding in scholarly literature, little progress has been made globally to improve breastfeeding rates (The Lancet, 2016), including in South Africa (SA). Despite many attempts to improve breastfeeding rates worldwide, women are still choosing to stop breastfeeding or avoid it due to medical, cultural, psychological or physical factors (The Lancet, 2016).

Notwithstanding efforts to eliminate poverty through various strategies, SA breastfeeding rates remain considerably low for a middle-income country (LMIC) (Martin-Wiesner, 2018). The National Department of Health's (NDoH) efforts to institutionalize the promotion, protection and support of breastfeeding includes the adoption of the Mother-Baby Friendly Initiative (MBFI) and the implementation of the R991 Regulations relating to foodstuffs for infants and young children (hereafter referred to as the R991 regulations) (Government Gazette, 2012) that govern the marketing of breast-milk substitutes (BMS). In 1998 already, government protected the rights of breastfeeding women in the workplace as stated in the Basic Conditions of Employment Act (BCEA) of 1972 and the Code of Good Practice on the protection of employees during pregnancy and after the birth of a child (from now on, referred to as The Code of Good Practice) (Government Gazette, 1998).

According to the South African Demographic and Health Survey (SADHS) of 2016, 82% of mothers initiate breastfeeding after birth (NDoH, StatsSA, SAMRC & ICF, 2017). The

proportion of infants who exclusively breastfeed (EBF) decreases as the infant grows older (NDoH, 2017). Data in the 2016 SADHS reveals that only 28.2% of infants under 3 months old are EBF and 23.7% are still EBF by the age of 6 months (NDoH, 2017). However, very few infants truly breastfeed exclusively for the first six months (Gray et al, 2016). In addition, many infants in SA are being introduced to solid foods before the age of six months (Gray et al, 2016). The technical support paper to one of the proposed Paediatric food-based dietary guidelines by du Plessis, et al. (2013) suggests that mothers introduce solids too early due to various cultural beliefs, incorrect advice given by family members or health staff, or a lack of maternal knowledge and perception that breastmilk is insufficient. du Plessis, et al (2016) posit the view that early introduction to solids predisposes South African children to poor health outcomes throughout their life cycle.

According to the WHO Global Nutrition Report 2017, all countries had to reach the EBF prevalence of >50% by 2025 (WHO, 2017). To date, only 18 African countries out of 49 are nationally on track to meet the global target of EBF prevalence of >50% (Bhattacharjee et al, 2019). Breastfeeding rates in SA reveal that breastfeeding initiation improved from 45% in 1998 to 80% in 2012. Although EBF rates at 6 months improved from 7% in 1998 to 32% in 2016, they are still considered to be low (Shisana et al, 2013; Statistics SA, 2016). EBF rates at 14 weeks nationally were 43% in 2012. (Shisana et al., 2013).

1.2 Problem Statement

Khayelitsha and Macassar are known to be home to many households with low incomes, resulting in many people living below the poverty line (City of Cape Town, 2016: 17). On average, 63% of households in Khayelitsha fall in the low-income range, of which 16.5% have no income (City of Cape Town, 2016). Macassar is situated in the Helderberg region and 45% of households fall in the low-income range, of which 13.8% have no income (City of Cape Town, 2016). The cost to exclusively formula-feed (EFF) an infant under the age of 6 months can put strain on the family income. The average Child support grant in SA is R410.00 per month per child (SASSA, 2018). In Khayelitsha, it can cost a household between R320.00 and R400.00 per month to EFF an infant under the age of 6 months (07 December 2018), in addition to other costs associated with raising a child.

All public birthing sites in the Cape Metropole Health District have been accredited by WHO and the NDoH as Mother-Baby Friendly facilities (Personal Communication: Henney, 2018). Given the accreditations, it is assumed that these facilities implement the 10 Steps to Successful

breastfeeding in addition to upholding the R991 Regulations, which legislate the International Code of Marketing of Breastmilk Substitutes (Government Gazette, 2012), supporting mother-friendly care practices and the latest HIV and Infant feeding recommendations in the SA context (NDoH, 2017).

The Khayelitsha Eastern Substructure is made up of the Khayelitsha and Eastern sub-districts and is one of four designated health areas within the Cape Metropole Health District, located in Cape Town. Currently, the Khayelitsha-Eastern Substructure is home to five birthing sites namely, Khayelitsha (Site B) Maternity and Obstetric Unit (MOU), Michael Mapongwana MOU, Macassar MOU, Khayelitsha District Hospital (KDH) and Helderberg Hospital. These birthing sites are all MBFI-accredited. Records at the birthing sites show that mothers who have delivered at these institutions have received in-depth antenatal education on breastfeeding promotion and protection and have successfully breastfed exclusively for the duration of their stay at the birthing sites. Traditionally, the length of stay at an MOU is 6 hours and at the hospital it is at most 3 days. The District Health Information System (DHIS) reveals that EBF rates at 14 weeks remain low in the Khayelitsha/Eastern Substructure. The DHIS shows that the EBF rates at 14 weeks varies between 25-40% quarterly in the Khayelitsha/Eastern Substructure (WC DoH, 2018). The practice of EBF for 14 weeks is therefore fragmented and it is important to understand why there appear to be interventions in place to ensure the protection, promotion and support of breastfeeding, however, when we evaluate the indicator of EBF at 14 weeks, this does not reflect that these interventions are working. An in-depth investigation into factors that influence infant feeding practices in the first 14 weeks could shed some light on this disconnect.

1.3 Purpose

The purpose of this study is to explore the reasons why mothers stop breastfeeding exclusively by 14 weeks and to understand what factors influence their decision to stop or continue the practice. The results of the study could potentially influence the current Western Cape Breastfeeding Restoration guidelines (Western Cape DoH, 2012) in which policies and resources can be reassigned to areas that need more attention.

1.4 Research Question

Why do mothers start mixed feeding or stop breastfeeding within the first 14 weeks after delivery?

1.5 Aim of the research

The overall aim of the study was to explore the factors influencing the exclusive breastfeeding rate within the first 14 weeks postpartum with mothers attending public health facilities in the Khayelitsha Eastern Substructure.

1.6 Objectives of the research

- To describe the socio-demographic characteristics of mothers included in the study.
- To determine facilitating factors to EBF practices in women during the first 14 weeks postpartum.
- To determine the barriers to EBF practices in women during the first 14 weeks postpartum.

1.7 Outline of the thesis

- **Chapter one** gives a brief introduction on breastfeeding practices globally, in South Africa and in the local geographical area where the study was conducted. It further articulates the research problem, the rationale of the study and its objectives.
- **Chapter two** discusses the literature review. It highlights the context of the research problem and provides a critical appraisal of the literature.
- **Chapter three** describes the research aim and objectives; methodology and study design, sampling of respondents; data collection methods; data handling and analysis; as well as study limitations and ethical considerations.
- **Chapter four** focuses on the results obtained from the study and their interpretation.
- **Chapter five** discusses the study findings in relation to literature.
- **Chapter six** outlines the conclusion and proposes recommendations based on the study results.

CHAPTER TWO: LITERATURE REVIEW

This chapter starts by reviewing what previous scholarly literature says about the infant feeding practices on a global scale. Secondly, it looks at the Breastfeeding promotion, protection and support in the South African context, elaborating on the implementation of Infant and Young Child feeding Policies and Guidelines. Thirdly, the literature summarises the current Infant and Young Child Feeding practices in South Africa. Lastly, the literature elaborates on already known facilitators and barriers to exclusive breastfeeding.

2.1 Global infant feeding practices

Globally, a vast range of health interventions have been introduced to improve nutritional status of children as depicted in table 2.1, which includes the promotion of early initiation of breastfeeding, to breastfeed exclusively for the first six months and the introduction of appropriate complementary foods after six months, while continuing to breastfeed until two years and beyond (Kramer & Kakuma, 2012). Despite the adoption of the recommendations made in 1990 by the Innocenti Declaration and the UN Convention on the Rights of the Child, breastfeeding practices remain sub-optimal in Low-middle income countries (LMICs) (Rollins et al, 2016).

Table 2.1 Global Framework for Breastfeeding Policies and Strategies

Timeline	Policy/Strategy
1981	International Code of Marketing of Breastmilk Substitutes
1990	Innocenti Declaration signed to promote, protect and support of breastfeeding
1991	WHO/UNICEF Global Baby-Friendly Hospital Initiative (BFHI) launched
1998	UN Convention on the Rights of the Child
2000	Millennium Development Goals International Labour Organisation Maternity Protection Convention
2003	Global Strategy for Infant and Young Child Feeding (WHO/UNICEF)
2005	Innocenti Declaration Revised
2006	Revised BFHI to include 3 additional Items (The Code, Mother Friendly Care and HIV and Infant Feeding)
2009	BFHI is revised, updated and expanded for integrated care
2010	WHO Guidelines and recommendations on HIV and Infant Feeding
2011	Global First 1000 days Campaign
2012	Campaign for Accelerated Reduction of maternal and Child mortality in Africa
2015	Sustainable Development Goals
2016	WHO HIV and Infant Feeding Guidelines are revised
2018	10 Steps to Successful Breastfeeding revised

(Source: NDoH, 2014)

The Breastfeeding Policy Brief by the WHO prioritised six global nutrition targets for 2025 at the World Health Assembly in 2012 (WHO/UNICEF, 2014:1). One of the six targets is to "increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%". The same report stated that only 38% of infants globally, are EBF in the first 6 months (WHO/UNICEF, 2014). Exclusive breastfeeding rates increased from 14% to 38% between 1985 and 1995 internationally (WHO/UNICEF, 2014). Sub-optimal EBF rates can be attributed to mixed feeding practices, policies and practices in a healthy system and workplaces that do not support breastfeeding, a lack of breastfeeding support in both health facilities and communities, and a lack of knowledge on the dangers of not breastfeeding (WHO/UNICEF, 2014).

Bradford, et al. (2017) examined supportive organisational breastfeeding policies specifically in hospitals, clinics, workplaces and education settings. The aim of their study was to explore

the facilitators and barriers to breastfeeding policies in the aforementioned settings (Bradford et al, 2017). In the USA, only 22.3% of infants are EBF at 6 months with the biggest barrier to EBF being poor breastfeeding environments (Bradford, et al., 2017).

Coetzee, et al. (2017) explored the factors affecting EBF among HIV-infected and non-infected mothers in Nigeria. The perceived facilitating factors to EBF included family support, disclosure of HIV status and the enjoyment of breastfeeding, as breastmilk is perceived as a natural form of food from God (Coetzee et al, 2017). The perceived barriers to EBF were non-supportive work environments, stigma regarding HIV and infant feeding and some physiological challenges in which mothers were concerned about milk supply (Coetzee et al, 2017).

The results of a study done by Das, et al. (2016) in India showed that out of 20 793 mothers with infants 0-5 months old, only 75% EBF in the previous 24 hours. However, breastfeeding practices decreased after 6 months. In this study, the proportion of infants who received breastmilk was found to be higher during winter months than other times of the year (Das, et al., 2016). Mothers who received counselling on EBF from frontline workers had a higher probability of EBF than the other age groups (Das et al, 2016).

A study by Draman, et al. (2017), aimed to determine the association between decision making for breastfeeding and associated factors for EBF practices among parents attending PHC facilities. The study included 196 parents who lived in suburban areas in Malaysia (Draman et al, 2017). Draman, et al. (2017) allude that the decision to continue breastfeeding is influenced by multiple factors which include psychological, emotional, social, and environmental factors. Such factors include a woman's concern about not producing enough milk and the possibility that the infant is not receiving enough milk discomforts the mother or the infant, mothers having to return back to work and previous difficulties with breastfeeding (Draman et al, 2017). As mentioned by Draman et al (2017), women who have either full-time careers or teenage mothers who have a lower income are less likely to continue breastfeeding within the first month of an infant's life. They report further that, with regards to education, women who are more educated tend to breastfeed their infants longer (Draman et al, 2017).

According to Rollins et al (2016) most women are biologically capable of breastfeeding, however, these practices are influenced by an array of factors which will determine the success of women to either fully breastfeed exclusively or which may be a barrier in doing so. Rollins et al (2016) examined the available literature on various breastfeeding interventions through

meta-analysis and systematic review to ascertain what the determinants are to breastfeeding practices on a global scale. The findings of the analysis concurred that the BHFI strategy in birthing sites increased breastfeeding initiation by 49%, however, this was only restricted to birthing sites (Rollins et al, 2016). Home- and family-based interventions were effective in increasing EBF rates (Rollins et al, 2016). Both antenatal and postnatal infant feeding counselling to mothers were found to be more effective than only one form of counselling (Rollins et al, 2016). However, there was no evidence found on the impact of community-based interventions on continued breastfeeding practices (Rollins et al, 2016).

Rollins, et al (2016) established a conceptual model that depicts the determinants that influence breastfeeding practices (see Figure 2.1). The structural factors encompass the socio-cultural and marketing of BMS (Rollins et al, 2016). Many women who choose to breastfeed are still faced with discrimination for breastfeeding in public spaces or in the workplace (Rollins et al, 2016). The settings' factors include the role of the health system, families and communities (including the workplace) in breastfeeding (Rollins et al, 2016). Health workers still require the confidence in knowledge and skills to assist mothers in making infant feeding choices (Rollins et al, 2016). The individual factors relate to the mother's own attitudes and attributes towards breastfeeding, specifically advice and practices that undermine maternal confidence in the mothers' ability to breastfeed (Rollins et al, 2016). Rollins et al (2016) mention that women who intend to breastfeed or have positive family support to breastfeeding, usually breastfeed for longer periods.

In this research, the components which were examined in-depth, focussed on the determinants in the settings sphere of this conceptual framework.

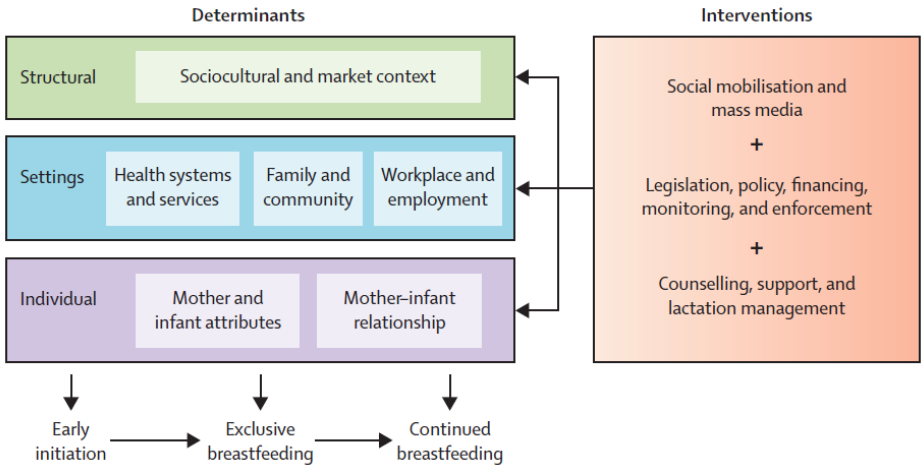

Figure 2.1: The components for an enabling environment for breastfeeding-a conceptual model. (Source: Rollins et al.2016.)

As reported by Rollins et al (2016), data on the effects of breastfeeding interventions are not always reported. Rollins et al (2016) mention that breastfeeding interventions are more common in the health sector and that the success of the breastfeeding outcomes will be achieved if interventions are directed at both the health systems and communities. Breastfeeding practices contribute to the reduction of childhood deaths under five years annually and it improves a child's learning capabilities during early childhood, which improves the likelihood of them becoming employed adults (Rollins et al, 2016).

2.2 Breastfeeding promotion, protection and support in South Africa

The SA government's efforts to institutionalize the promotion, protection and support of breastfeeding includes the adoption of the MBFI; the implementation of the national R991 regulations that govern the marketing of BMS (Government Gazette, 2012) as well as the adoption of the Code of Good Practice of the BCEA (Government Gazette, 1998).

Table 2.2: Framework for Breastfeeding policies and Strategies in South Africa:

Timeline	Policy/Guideline
1994	BFHI was introduced in SA
1997	The Basic Condition of Employment Act was legislated
1998	The Code of Good Practice on the protection of employees during pregnancy and after the birth of a child was legislated
2002	Prevention of Mother-to-Child Transmission (PMTCT) of HIV guidelines were introduced in SA
2005	Implementation of BFHI was encouraged at all birthing sites
2007	The IYCF policy was implemented
2009	BFHI was revised, globally and in SA
2010	South Africa National Department of Health renames BFHI to MBFI
2011	The Tshwane Declaration in support for Breastfeeding was signed
2012	Regulations relating to foodstuffs for infants and young children was legislated in SA.
2012	Western Cape Breastfeeding Restoration Plan was implemented
2012	The Western Cape DoH implemented a Breastfeeding in the Workplace Policy
2013	Revised National PMTCT guidelines
2013	Revised National IYCF Policy
Additional Policies and Guidelines after 2013	
2014	The NDoH Standardised the Breastfeeding Course for Health Care Providers
2015	PMTCT Policy was revised and consolidated
2016	WHO revised HIV and Infant Feeding Guidelines
2017	National DOH issued a circular that included an amendment to the Infant feeding policy
2018	Implementation of new Road-to-Health Booklet and Side-by-Side campaign.

(Adapted from : Du Plessis and Pereira, 2013)

In 1991, the Baby- Friendly Hospital Initiative (BFHI) was launched globally. This initiative incorporated the Global Criteria to the Implementation of the 10 Steps to Successfull Breastfeeeding (WHO, 2020). In 1994, South Africa adopted the BFHI strategy attempting to promote, protect and support breastfeeding. In 1998, the SA Government legislated the Code of good practice on the protection of pregnant and breastfeeding employees, and in 2002 the

first National Prevention of Mother-to-Child Transmission (PMTCT) Guidelines, including recommendation on IYCF in the context of HIV were implemented. Since 2005 all birthing sites were encouraged to implement the 10 Steps to Successful Breastfeeding and fully institutionalise MBFI, and the Minister of Health made a declaration of support for Breastfeeding in South Africa in 2011, now known as the Tshwane Declaration of 2011 (NDoH, 2014: 30). The SA Government legislated the Regulations relating to foodstuffs for infants and young children, better known as the R991, in order to protect breastfeeding in the country (NDoH, 2014). Since 2012, the Western Cape Government, under the leadership of the provincial Department of Health, mandated a Breastfeeding Restoration Plan with the focus on promoting breastfeeding at all levels in the health system (WC DoH, 2012a). In addition, the Western Cape Government's Department of Health, released a Breastfeeding in the Workplace Policy (WC DoH, 2012b).

Subsequently, a standardised Breastfeeding training package was launched by the National Department of Health, amendments were made to the IYCF guidelines, the new Road-to-Health Booklet was launched together with the Side-by-Side campaign and in the Western Cape, a big advocacy campaign was started on the importance of the First 1000 days. All these initiatives included the benefits and importance of optimal nutrition, specifically breastfeeding, during the early stages of life and adds to the attempts to promote, protect and support breastfeeding.

Despite all the policies and regulations (presented in Table 2.2) to improve breastfeeding rates at a National level, gaps still exist in the implementation of these policies (Martin-Wiesner, 2018). Rollins et al (2016) mentioned that factors that inhibit breastfeeding practices can be effectively addressed through a range of interventions. The social determinants of health, which may influence breastfeeding practices, need to be considered and addressed through various partners and society. Interventions to improve breastfeeding practices are recommended to be sustained at all levels of care which include the homes, community, workplaces and health facilities (Martin-Wiesner, 2018; Rollins, et al., 2016).

2.3 The Mother Baby Friendly Initiative (MBFI):

Regardless of the introduction of the Innocenti Declaration in 1990 and the launch of the Baby-Friendly Hospital Initiative (BFHI) in 1991, to date breastfeeding rates remain low on a global scale even though the global EBF rates increased from 23% to 37% between 1993 and 2013

(Rollins et al, 2016). The global rate of EBF increased to 40% in 2016 (WHO, 2017). Since 1991, the BFHI Strategy has been revised in 2009 and furthermore the 10 Steps to Successful Breastfeeding has been updated in 2018, all this in an effort to protect, promote and support breastfeeding internationally (WHO, 2018b). Globally, the WHO has set a target to increase EBF rates in the first six months of life to at least 70% by 2030 (WHO, 2018c). In the Western Cape Province, the current provincial target for Exclusive Breastfeeding at 14 weeks is set at 45%.

In SA, BFHI was renamed to MBFI, in order to shift the focus to mothers and babies, and to indicate that this is not only a hospital-based initiative. With regards to the MBFI strategy, Martin-Weisner (2018) elucidates the need to roll-out MBFI beyond the confines of a health facility and breastfeeding support is encouraged to be continued in the community. Although breastfeeding is initiated in full effect in birthing units, the exclusivity of the practice remains a challenge during the first six months postpartum (Martin-Weisner, 2018).

2.4 HIV and Infant Feeding in the South African Context:

According to Statistics SA (2019), 13,5 % of the South African population is HIV positive (StatsSA, 2019). More than a fifth of South African women in the age group 15-59 years are HIV positive (StatsSA, 2019). The HIV prevalence among antenatal women in the same age group has declined from 21,8% in 2010 to 18.5% in 2017 (Woldesenbet, et al., 2019). Despite the 2013 South African IYCF policy (NDoH, 2013) and Amendment (NDoH, 2017) and the 2016 WHO Guidelines on HIV and Infant Feeding (WHO, 2016), communities are still faced with high formula feeding rates among HIV positive women (Martin-Weisner, 2018). As per the 2016 WHO Guidelines on HIV and Infant Feeding in addition to the Tshwane Declaration of 2011, all South African women are encouraged to EBF for the first six months while receiving Antiretroviral Therapy (ART) (NDoH, 2011; NDoH IYCF Policy Amendment, 2017). The recommendation in the SA context allows mothers to make informed infant feeding decisions and advises them to EBF with ART (WHO, 2016). The WHO/UNICEF does not endorse mixed feeding, however, the updated recommendations state that any form of breastfeeding would still be beneficial to the infant (WHO, 2016). Many health care workers are still not confident on how to counsel mothers who are HIV positive in relation to promoting EBF (Martin-Weisner, 2018). The latest statistics on the HIV prevalence in SA indicates that only 21.17% of women aged 15-49 years are HIV positive (Statistics SA, 2018). Women who are HIV negative are therefore still the majority and should be encouraged to breastfeed.

2.5 Infant feeding practices in South Africa

SA has high rates of under nutrition, especially stunting which can be partially attributed to low breastfeeding rates and inappropriate introduction to complementary foods (Martin-Weisner, 2018). According the National Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition (MNCWH) in SA 2012-2016, it was recommended that the Infant Mortality Rates (IMR) reduce from 40 to 32 deaths per 1000 live births by 2016 (NDoH, 2011). This recommendation was strengthened through advocating for exclusive and continued breastfeeding as one of the interventions to reduce the IMR (NDoH, 2011). The IMR in SA is currently at 36,4 infant deaths per 1000 live births in 2018 (Statistics SA, 2018).

According to the SADHS (2016), only 32% of infants under six months are EBF and 25% of infants under the age of six months are not breastfed at all (Stats SA, 2018). The SADHS (2016) mentions that breastfeeding practices decrease as the child grows older and that only 47% of children aged 12-18 months are breastfeeding and 19% of children aged 18-23 months continue to breastfeed (Stats SA, 2018).

In SA the BFHI accreditation process and the Code of good practice, which allows women to breastfeed or have breastfeeding breaks during their workday, are some of the enabling interventions to promote women to breastfeed optimally (Rollins et al, 2016; Government Gazette, 1998).

2.6 Facilitating factors and barriers to breastfeeding

A study done by Nkonki and colleagues (2014) in South Africa, highlighted that home visits play a role in EBF promotion. The authors of this study recommend a simplified scenario by which mothers receive breastfeeding promotion messages at both health facility level and during home visits (Nkonki et al, 2014). This study also provides evidence of costs of promoting EBF through low-intensity interventions, in which mothers receive 1 antenatal visit by a Community Health Worker (CHW) and 4 postnatal support visits at 1 week, 4 weeks, 7 weeks and 10 weeks postpartum (Nkonki et al, 2014). Breastfeeding promotion is thus integrated into existing daily activities of the CHW (Nkonki et al, 2014).

Kavle, et al., (2017) wrote a systematic review about barriers to EBF in LMIC. Only 37% of infants under 6 months are EBF in LMIC (Kavle et al, 2017). Kavle, et al. (2017) identified barriers to EBF during the prenatal-, childbirth and first day of life and first 6 months of life. The most common barrier identified was having to return back to work.

Another contributing factor to low EBF rates according to Steyn et al. (2017) was insufficient milk supply. This Cape Town study by Steyn and colleagues (2017) looked at how galactogogues increase serum prolactin to enhance breastmilk supply in mothers. Considering that galactogogues may increase serum prolactin only in the first or second week postpartum, it has no effect on the breastmilk supply after 2 weeks postpartum (Steyn et al, 2017). In their research involving 108 participants, of which 50% of the sample were EBF, Steyn et al (2017) report that the most common reason for using alternative feeding methods was insufficient breastmilk supply as perceived by mothers in the private health sector. The top 3 reasons why the study sample chose to stop breastfeeding or interrupt the exclusivity within 6 months was: 1) insufficient milk supply 2) painful breastfeeding experience and 3) having to return back to work and not being able to express their breastmilk (Steyn et al, 2017).

Horwood et al. (2018) explored barriers to EBF and identified sociocultural, health systems, community and individual factors that contributes to low EBF rates in KwaZulu Natal, SA. The results of this study showed that only 49.8% of infants at 14 weeks were EBF among mothers interviewed and only 11.8% of infants at 14 weeks who were in the care of non-maternal caregivers, were EBF (Horwood et al, 2018). Moreover, in their research, du Plessis and Pereira (2013) mentioned some barriers to EBF which relate to lack of family and community support, workplace challenges and inadequate infant feeding counselling in health facilities.

2.7 Conclusion

The evidence in the literature suggests that multifactorial challenges can influence exclusive breastfeeding practices, whether at 14 weeks or 6 months. This research study aims to explore the facilitating factors and barriers that influence EBF practices during 14 weeks among postpartum mothers. The District Health System is used to monitor EBF rates at 14 weeks as it is the same age when infants receive their third immunisation in South Africa. In the Khayelitsha Eastern Substructure, more than 90% of the mothers breastfeed at discharge from a birthing site, however, the practice of exclusive breastfeeding is fragmented by 14 weeks.

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter will present the research methods used for this study. This chapter will first explain the research design and include a justification on why the design was deemed suitable to achieve the study aim and objectives as mentioned in Chapter 1. A description of the research setting will follow and will include a brief description of the study population and how the study sample was recruited. Then, the data collection methods, how the data was analysed and how rigour was ensured throughout the process will be described. Lastly it will explain the limitations of the study and how ethical considerations were adhered to.

3.1 Aim and Objectives

Aim: To explore the factors influencing the exclusive breastfeeding rate within the first 14 weeks postpartum with mothers attending public health facilities in the Khayelitsha Eastern Substructure.

Objectives:

1. To describe the socio-demographic characteristics of mothers attending public health facilities in the study sample,.
2. To determine facilitating factors to EBF practices in women during the first 14 weeks postpartum.
3. To determine the barriers to EBF practices in women during the first 14 weeks postpartum.

3.2 Research Design

This was an exploratory, descriptive study. A qualitative research approach was used as it sought to explore factors influencing mothers' decisions to exclusively breastfeed for the first 14 weeks postpartum as well as what the reasons were for not doing so. Exploratory study designs are used to explore situations in which the intervention being evaluated has no clear outcomes (Yin, 2003). In this thesis, the expected outcome is that mothers would breast their exclusively by 14 weeks, given all the breastfeeding promotion and protection and support interventions in the public health sector. These interventions can not be easily measured. Qualitative research methods are often used when seeking to explain how economic, political, social and cultural factors influence the health of populations and also to explore how the population perceives factors that influence their health (Baum, 1995). Mack et al (2005) describe qualitative methods as more flexible, allowing the researcher to ask open-ended

questions, which in turns allows participants to respond to questions in more detail. By using a qualitative approach, the Principal Investigator (PI) was able to develop a more in-depth understanding of the current EBF rates and practices in the Khayelitsha-Eastern Substructure and factors influencing the mothers' infant feeding decisions. Demographic profiles have been used to provide background context to the study and this information was collected using a standardised questionnaire (see Appendix 1).

3.3 Research Setting

As referred to in Chapter One, the Khayelitsha Eastern Substructure is one of four health areas within the Cape Metropole Health District. The Substructure is further divided into two subdistricts, hereon mentioned as the Khayelitsha- and Eastern subdistricts. Although there are characteristics unique to this area, the Khayelitsha-Eastern Substructure does share some similarities to other areas within the greater Cape Metropole.

Khayelitsha is the biggest township (informal settlement) in the Western Cape. Socio-demographics of the Khayelitsha population are depicted in table 3.1 below:

Table 3.1: Socio-demographics in the Khayelitsha Subdistrict

Source: Strategic Development, Information & GIS Department 2013

Socio-demographic	Percentage
Predominantly Black African Ethnicity	99%
20 years old who completed high school	36%
15-64 years who have some employment	62%
Average monthly income of R3 200 or less	74%

Khayelitsha MOU is the biggest of the two MOU's in the area, with a delivery rate of 1921 infants per year (Sinjani, 2018). Khayelitsha MOU is approximately 5km from Khayelitsha District Hospital and services the areas of Site C, Town Two, Zakhele, Site B and Mandela Park in Khayelitsha. Geographically, most of the town comprises informal settlements. Khayelitsha MOU's EBF rate on discharge is 100% (Western Cape DOH, 2017a).

The socio-demographics in the Eastern Subdistrict are depicted in table 3.2:

Table 3.2: Socio-demographics in the Eastern Subdistrict

Source: Strategic Development, Information & GIS Department 2013

Socio-demographic	Percentage
Predominantly Coloured Ethnicity Black African Ethnicity	47% 35%
20 years old who completed high school	47%
15-64 years who have some employment	78%
Average monthly income of R3 200 or less	46%

Macassar MOU is the only MOU in the Eastern Sub-district and has a delivery rate of 1550 infants per year (Western Cape DOH, 2018). The nearest hospital, Helderberg Hospital, is 14 km away. Macassar MOU services the areas of Macassar, Nomzamo, Ikwezi, Strand, Gordon's Bay, Sir Lowry's Pass Village, Somerset West, Firgrove, Faure, Eersteriver, Blackheath and Kuilsriver. Macassar MOU's EBF rate on discharge is 98% (Western Cape DOH, 2017b). The EBF rates at 14 weeks in the respective sub-districts from 2014 to 2018 are reflected in Figure 3.1:

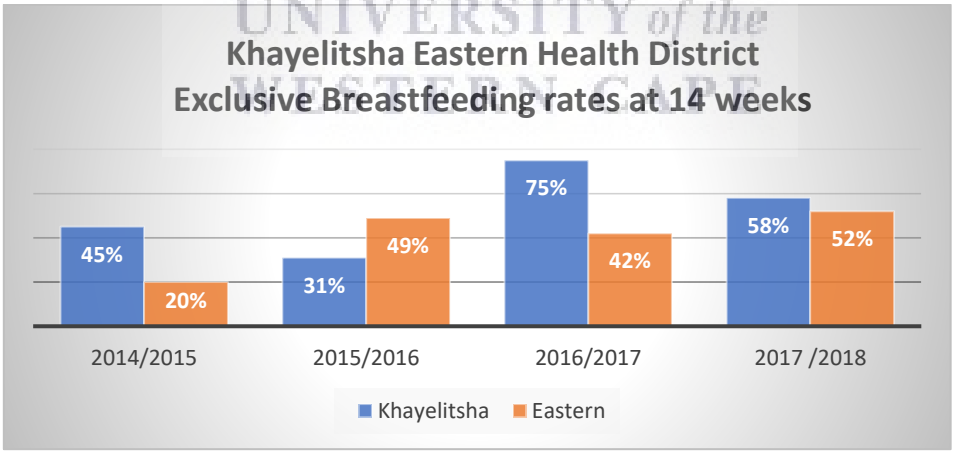

Figure 3.1: Khayelitsha Eastern Substructure Exclusive Breastfeeding rates at 14 weeks

Source: Western Cape DOH, Unpublished data. 2018. Sinjani, Exclusive Breastfeeding at 14 weeks

Even though the data presents a trend of increased EBF at 14 weeks rates, it is still unknown why so many mothers choose to stop the EBF practice or resort to mixed feeding. Since 2014,

many interventions and strategies have been implemented to increase the breastfeeding rates in this substructure. These include: clinical staff training on breastfeeding management every quarter of the year, training of community health workers (CHWs) in IYCF to enable them to provide breastfeeding support to mothers at home in addition to employing Breastfeeding Peer Counsellors (BFPCs) at all the birthing sites and Basic Antenatal Care (BANC) clinics. Breastfeeding promotion and education are therefore done on all platforms in the public health system in this area.

3.4 Study Population

The Khayelitsha Eastern Substructure was identified as the study population, since the two sub-districts are diverse in culture and socio-economic backgrounds, and it is the area in which the PI works. Khayelitsha Maternity and Obstetric Unit (MOU) and Macassar MOU are the biggest MOUs in each of the respective sub-districts. Khayelitsha MOU services 7 Basic Antenatal Care (BANC) sites and Macassar MOU services 13 BANC sites. Statistics from the District Health Information System (DHIS) showed that the total number of live births at each of the MOUs ranges between 106-194 per month (WC DoH, 2018).

Table 3.3: Total Live Births at Macassar and Khayelitsha MOUs per month from September 2017 – August 2018

Facility	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Grand Total
Macassar MOU	172	157	152	194	147	164	157	175	156	153	135	159	1921
Khayelitsha MOU	125	116	125	140	128	119	144	156	140	117	134	106	1550

Source: Western Cape DOH, Unpublished data, Sinjani, Total Live Births, 2018.

The study population included mothers who delivered at these two MOUs and staff members working at the MOUs and Child Health Departments of the Primary Health Care Facilities. The pool of staff members working in this area are heterogenous in nature (females and males, different socio-demographic groups, etc.), and while some may live in the area, others may travel from other areas. Key informants were included in the study sample to ascertain whether they can provide different insights on facilitating factors and barriers to EBF at 14 weeks in the substructure.

3.5 Sampling Strategy

3.5.1 Sampling of the mothers: Sampling in this study was homogenous and purposive as the PI identified participants with a specific trait (Etikan et al, 2016), that is, women with infants of 14 weeks old**.** Purposive sampling is a nonprobability sapling technique in which the researcher chooses a study sample from a large population (Etikan et al, 2016). This sampling technique can be useful when the researcher has limited resources, time and workforce (Etikan et al, 2016). In this research, sampling was done at Site B Community Health Centre (CHC) and Macassar Community Health Centre (CHC) which are the Primary Health Care (PHC) facilities where mothers attended for the 14 weeks immunisations. Also, at 14 weeks, infant feeding practices are recorded. Homogeneous samples have been used by sampling mothers who have delivered at Khayelitsha- and Macassar MOU 14 weeks prior to data collection of the study. Mothers were purposively selected in the waiting area of the Child Health Departments in the respective PHC facilities, based on the fact that they were attending their 14-week postnatal check-up and depending on whether they were EBF or not.

A date for data collection was arranged with the Facility Managers of the PHC facilities and a short presentation of the research proposal was done. The PI requested the names of the infants who attended the facility for the 14 weeks immunisation. On the day of the data collection, the PI went through the diary of the immunisation bookings and recruited mothers and infants for the interviews. Only one or two mothers were usually booked on a day and this caused a delay in data collection. The cold weather in Cape Town during the data collection period also influenced attendance of mothers at the PHC facilities. The clinical nurse practitioner at Macassar CHC recruited mothers who were booked for immunisations over one week and requested the mothers to all come on the same day in order to accommodate the PI with the data collection process. All mothers of infants who came to the facility for their 14 weeks' immunisation were sent to the PI to be interviewed. At Khayelitsha CHC, the PI requested the nurse who does the 14 weeks' immunisations to refer the mothers for the research study on the day of the scheduled visit. Mothers who attended the clinic for their infants 14 week immunisation were selected for the in-depth interview and out of the study sample, 8 mothers were still exclusively breastfeeding, 2 were partially breastfeeding and 6 were not breastfeeding.

3.5.2 Sampling of key informants: Two staff members, who were either a BFPC, midwife or clinical nurse practitioner with at least 5 years' experience in Maternal and Child Health from

each MOU/ PHC facility were interviewed as key informants. The key informants were selected and interviewed based on their availability at the time.

3.6 Data Collection Methods

Data collection took place between July and October 2019. A semi-structured interview guide was be used to conduct individual in-depth interviews with the mothers and key informants (See Appendices 2a and 2b). The interview guide was developed by the PI and the questions were based on the initial research question for this thesis. Questions were asked regarding how the infant was being fed, what the understanding of EBF was and factors influencing feeding during the first 14 weeks. The interview guide was piloted at Michael Mapongwana CHC in which 1 BFPC, a midwife and 3 mothers were interviewed and minor revisions were made by the PI in consultation with the research supervisors. In-depth interviews allowed participants to express themselves freely and aimed to combine structure with flexibility during the interview process (Legard et al, 2003). Face-to-face in-depth interviews were done by the PI which provided valuable data and allowed the PI to pick up on non-verbal cues (Legard et al, 2003). Most mothers preferred to read and speak English in Khayelithsa. The PI allowed the mothers in Khayelitsha to express themselves in isiXhosa should they struggle to articulate the English terms. A nurse, who speaks and writes isiXhosa was asked to translate the isiXhosa words to English after the interview. Mothers in Macassar felt more comfortable speaking in Afrikaans. The PI could speak and write in Afrikaans. The PI informed the mothers about the research and provided them with the necessary details if they were willing to participate in the research process. The interviews were audio recorded with a Samsung A5 2017 model mobile phone and transcribed by the PI and a professional transcribing company named Virtual Transcriber, based in South Africa. The transcribing company was used as assistance for the PI to commence data analysis earlier. The PI kept notes of each interview which served as supplementary information to the recorded data. The PI conducted one-on-one interviews with the key informants in the same manner. Seven interviews with mothers were conducted at Khayelitsha CHC and nine interviews were conducted at Macassar CHC. The duration of the interviews with the mothers ranged between 11- 25 minutes. These are mothers who attended postnatal visits at the same clinic they attended ANC and at which they had delivered. All individual in-depth interviews were conducted in a consultation room that was not being used at the time, and therefore all interviews were private and confidential. The interviews took place at each of the respective CHC's.

3.7 Data Analysis

In this qualitative study, analysis started once the data collection phase was completed. Data from each interview was described in detail, and audio recordings were transcribed into textual data, verbatim. Data analysis was done manually. Thematic Content Analysis was applied to this study and was used to identify key themes (Pope et al, 2000). Thematic Content Analysis through in-depth interviewing uses themes to manifest the content of a study and to interpret the level of content in a more in-depth way (Graneheim and Lundman,2004). The themes drew on questions derived from the aim and objectives of this study, using an inductive reasoning approach and also included issues raised by the participants (Pope et al, 2000). Textual data was desegregated into themes and sub-themes, which were utilised to give the data in-depth meaning. The PI analysed the content of the data by reading through individual transcripts and identifying themes and sub-themes from each in-depth interview and then making summaries of what the influencing factors were to EBF practices within the 14-week period postpartum across all interviews.

3.8 Rigour and Trustworthiness

Triangulation of the data sources with the participants and key informants served to increase the rigour of the study. Triangulation is used to increase the validity of a study by convergence of multiple sources of information (the mothers and the key informants in this study) to form the themes of the study (Creswell, 2000). Trustworthiness was ensured from the onset of the study. A clear use of criteria for recruitment and selection of the participants ensured credibility as only mothers with infants of 14 weeks was approached for the in-depth interviews as was key informants who worked in Maternal and Child Health for at least 5 years. Data collection was done by use of a voice-note recorder on a cellular phone which allowed the PI to analyse the transcripts after the interviews which provided rigour to the study. Debriefing sessions with the supervisors of the PI took place after data collection to increase the dependability and to ensure that the data is of a good quality. Supervisors randomly listened to an interview and / or read a transcription to ensure that content was being analysed and interpreted accurately. The PI declared the limitations of the study when the findings were interpreted. A diary was kept on the thoughts and feelings of the PI throughout the study process which served to increase reflexivity in order to decrease bias during data analysis. The results of the study include quotations from the study participants which serves to verify the themes identified and enrich the transferability of the study (Graneheim and Lundman, 2004). Although the study results

will arise for the Khayelitsha/Eastern Substructure, transferability can be referred the extent in which the results can be transferred to other settings/ groups (Graneheim and Lundman, 2004) within the Cape Metropole District, Western Cape or the broader South Africa.

3.9 Limitations

A limitation of this research was the small sample size, which is common in qualitative data collection. This means that findings are not necessarily generalisable to the whole study population. However, the aim of a qualitative study is not about generalisability of findings, and more about the rich and meaningful data which emerged during the interviews. The PI pursued the study until data saturation was reached. The study sample of only representative of the study population attending public health facilities and did not include mothers who attend clinics in the private health sector. The factors influencing the EBF rates in this research setting were only applied to women in the study areas and therefore may not be applicable to women living in other areas. As with a mini-thesis, the PI is limited with regard to the scope of the research.

3.10 Ethical Considerations

Participation in the study was voluntary for all research participants. The PI ensured that the participants had the right to choose to participate in the study or not (autonomy). The process was beneficial to the participant as the opportunity was created to voice her opinion about her feeding practice (beneficence). No harm was done to the participant (non-maleficence). The process of the study was fair (justice). Each participant was provided with a letter explaining the research study, requesting their participation and assuring their confidentiality. Data collection was commenced when the PI received ethical approval from the UWC Biomedical Research Ethics Committee (BMREC) with the Ethics number BM 19-5-11 (Appendix 6). Ethical approval to conduct the study in the health facilities was obtained from the Western Cape Department of Health (WC DoH, 2016b) with the ethics number WC_201907_017 (Appendix 7). The PI provided the Participant Information Sheet (Appendix 3) and requested consent from every participant, thereafter a Participant Informed Consent Form (Appendix 4) was made available for them to sign should they be willing to participate. No harm was caused to research participants. Participation was voluntary and no incentives were provided to study participants. Participants could withdraw from the study at any point if they wanted to, with no negative consequences. Records have been kept on a password protected electronic file and

hard copies of the questionnaires are locked in archives. These records will be kept for 5 years and then discarded appropriately.

CHAPTER FOUR: RESULTS AND FINDINGS OF THE STUDY

This chapter presents the findings of data collected from the in-depth interviews with mothers and key informants in the Khayelitsha and Eastern Substructure regarding factors influencing exclusive breastfeeding at 14 weeks postpartum.

The aim of the study was to explore the factors influencing the exclusive breastfeeding rate within the first 14 weeks postpartum with mothers in the Khayelitsha Eastern Substructure. The objectives of the study were: to describe the socio-demographic characteristics of mothers; to determine facilitating factors to EBF practices in women during the first 14 weeks postpartum; and to determine the barriers to EBF practices in women during the first 14 weeks postpartum.

This chapter presents a description of the study population, followed by the emerging themes as they relate to the objectives. Each theme is described in detail and is supported by quotations from the participants.

4.1 Description of the Study Population

4.1.1 Socio-demographic profile of the study participants

A total of 16 mothers and 4 key informants participated in this research study. Seven mothers were interviewed at Khayelitsha CHC along with 2 key informants (an enrolled nurse who works in the immunisation area and a professional nurse) and 9 mothers and 2 key informants (a midwife/professional nurse and a breastfeeding peer counsellor) were interviewed at Macassar CHC.

With regards to the ethnicity of the study sample, including the key informants, 50% identified as Black African women and 50% identified as Mixed-Race women. The mean age of the study sample was 28 years with the age range of 19 to 38 years. More detail will be provided on the socio-demographic characteristics of the mothers. Three mothers (18.7%) were first time mothers, and the remaining 13 mothers (81.3%) had a parity of more than one. Only five (31%) were employed and 11 (69%) mothers were unemployed. The monthly income of the employed mothers ranged from R430.00 to R14 000.00. The mother with the highest income was a construction site supervisor. Out of the 16 mothers, five (31%) reported to having not completed primary school, 10 (63%) mothers reported that they did not complete secondary

school with only one mother having completed secondary school. At the time of the data collection, nine (56%) of the mothers reported to be single, two (13%) reported to be married, four (25%) reported to be living with a partner and one (6%) reported to be divorced.

4.1.2 Antenatal Education Attendance

Out of the 16 mothers, 100% of the sample reported to have attended an antenatal clinic at least once during their pregnancy. One mother reported that she was unsure of how many times she attended antenatal clinic as she could not recall, three (18%) mothers reported to have attended 3-5 antenatal visits and 12 (75%) of the mothers reported to have attended more than 5 antenatal visits during pregnancy. Eight (50%) mothers reported not receiving any antenatal information related to the importance of exclusive breastfeeding in the first 6 months of an infant's life.

4.1.3 Infant Birth Characteristics

Out of the study sample, seven (44%) of the infants born were female and nine (56%) were male. At the time of the interview, all infants were 14 weeks old. The average birth weight was 3.2kg with the birth weight range of 2.4-4.6kg. Fourteen (88%) mothers reported to having a Normal Vaginal Delivery (NVD) and two (12%) mothers reported to having had Caesarean-sections. The mothers who had the Caesarean-sections at Khayelitsha District Hospital (KDH) were initially admitted to the MOU, but then transferred to KDH. All the mothers (100%) reported that they were encouraged by health care staff in the birthing units to initiate breastfeeding within 1 hour after birth. All mothers reported that their infants were placed skin-to-skin immediately after birth to assist in breastfeeding initiation. All mothers reported that they were breastfeeding at the time of discharge from the birthing unit.

4.1.4 Feeding practices at 14 weeks of the study sample.

The feeding practices of the study sample at 14 weeks are presented in Figure 4.1:

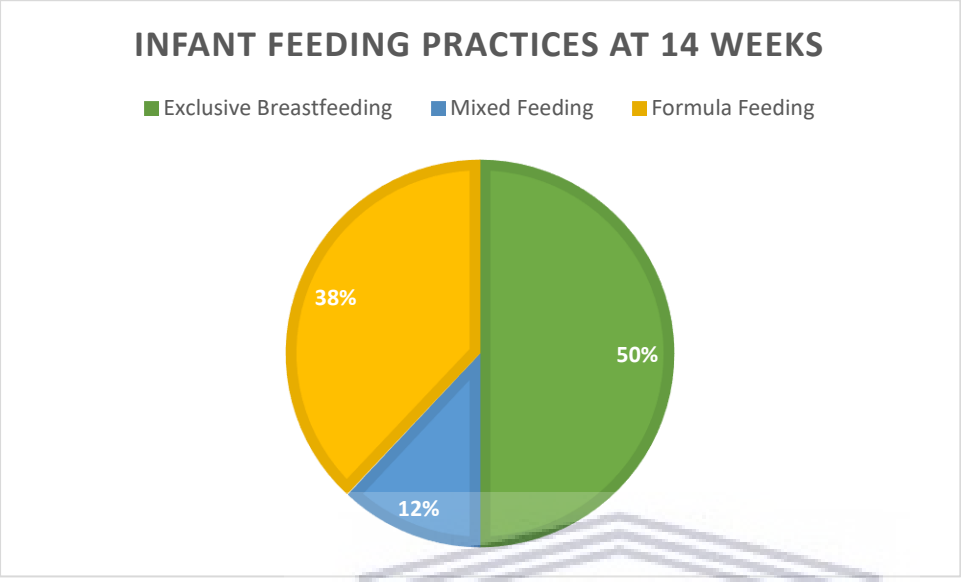

Figure 4.1: Feeding Practice at 14 weeks of infants in the study sample

As depicted in Figure 4.1, half of infants (n=8) reported to being EBF at 14 weeks, followed by 38% (n=6) who reported to be exclusively formula feeding (EFF) and 12% (n=2) mixed feeding at 14 weeks of age.

4.1.5 Study Results

The description of the themes that follow is based on the Rollins et al (2016) conceptual framework (See Chapter 2) which was used to group emerging themes.

Where quotations are utilised, the coding system is as follows: the first letter indicates which facility the participants was interviewed at (K = Khayelitsha Site B; Mac = Macassar MOUs); the second letter indicates whether the participant was a mother (M) or key informant (Staff) and the number indicates the order in which participants were interviewed. This is done to provide some context to the quotes, while retaining anonymity and confidentiality.

4.2 Identification of facilitating factors and barriers to EBF in the first 14 weeks: Influences by the Health System

4.2.1 Infant Feeding Guidelines

Mothers provided different reasons as to why breastfeeding should stop at 6 months that appear to be related to HIV and infant feeding guidelines as well as the MBFI strategy:

Facilitating Factors:

It appears that mothers have a good understanding that breastfeeding is important during the first 6 months of life. This health promotion message forms part of the MBFI strategy's key messages, whereby all mothers should receive education on breastfeeding during pregnancy. This health promotion message facilitates the EBF practice at 14 weeks.

"Because they (referring to the staff at the MOU) told us that if you are HIV positive you can breastfeed until six months it is alright. After six months then you are going to stop breastfeeding." (KM1)

"They say it is important to breastfeed until six months." (KM1)

"Yes, I want to breastfeed until 6 months. After 6 months I will stop the breastfeeding." (KM1)

Barriers:

Even though the health promotion message to exclusively breastfeed infants until 6 months was shared antenatally, the practice of continuing breastfeeding after discharge from the MOU is not clear.

This appears to be especially in the context of HIV, whereby mothers are aware that they should not be mixed feeding and therefore if they start mixed feeding, then they should stop breastfeeding:

"Because I am HIV positive so by the time they discharging me, the milk was not coming out. So before, by the time I was going to the clinic, they tell us if you mix breastfeeding and the milk and babies can be… that can be a problem. So I tell my friends that I must not give him, so I must give him only Pelargon." (KM2)

4.2.2 Provision of Antenatal Education

Some mothers in the study sample reported that they received antenatal education on the importance of breastfeeding, however, not all mothers could recall what exclusive breastfeeding means. Antenatal education appeared to be more consistent at Khayelitsha MOU than Macassar MOU .

Facilitating Factors:

Participants listed the following factors related to antenatal education that may facilitate EBF until 14 weeks. The following quotes provide examples of where one mother understood the concept and importance of EBF:

"I heard that breastfeeding is the best. By the clinic also. You hear it every time." (MacM8)

"Hulle sê mos babas wat ge-borsvoed word, is baie gesond en hulle develop gouer en so aan." (MacM8) [Translation: "They say babies who are breastfed is very healthy and develop quicker and so on". (MacM8)]

One of the key informants that was interviewed agreed that antenatal education could be a factor that might contribute to EBF until 14 weeks:

"At MOU, when that teenage mothers start (antenatal) the mothers-to-mothers person teach them so nicely about breastfeeding. So, when the grandmothers come here, I ask them what is in the bottle. They usually say it is breastmilk." (KStaff 2)

Barriers:

The following quote, from a key informant indicated confusion amongst mothers regarding infant feeding practices that could result from different health care professionals providing different information:

"Because when the mother is really delivered, certain times it can be that we have got different antenatal Sisters doing the pregnant ladies. It is not a constant one Sister doing the clinic. Previously it was us in the MOU doing the antenatal, so she knew what was said to her in the antenatal and yes, they go out breastfeeding here from the labour ward." (MacStaff1)

4.2.3 Postnatal Support of breastfeeding

Postnatal support of breastfeeding takes place in the hours immediately after an infant has been born, at the MOU where they were delivered and then after that most of the times at the primary health care centre that the mother attends. If postnatal breastfeeding support is frequent and of good quality, this can be a facilitating factor for EBF at 14 weeks. However, the opposite is also the case in that if the postnatal breastfeeding support is infrequent or of poor quality, this can be a barrier to EBF at 14 weeks.

Facilitating factors:

One mother highlighted how postnatal breastfeeding support in the health facility facilitated her breastfeeding experience, through the support that she received from a health care worker.

"… People easily give up when it is so sore but then they gave me a talk and they showed me how to handle it and what I must do to make it more healthier and that is why I continued and that helped me a lot. They showed me as well and I wanted to give up then and then I continued." (MacM5)

"Normally three weeks because that is when it starts but mine started earlier but luckily for me, they were here. Because I decided I can't, I can't because it was so sore but then the lady here (referring to the staff member at the PHC facility) that talked gave me a lot of encouragement to continue to breast feed while I had that problem." (MacM5)

Community Health Workers (CHWs) are trained in infant feeding support and mothers are referred to them on discharge from the MOUs.

"As I said, at the one side we have got the [CBS] workers who do go and do home visits and they show how breastfeeding is still going on because they are also trained now" (MacStaff1)

A key informant reiterated the importance of continued breastfeeding support after delivery and that mothers who attend postnatal clinics often have a better breastfeeding experience. The types of support provided include support groups, group talks and individual counselling.

"Well it can be – we have got a support group also on the premises – so you do get those mothers, can be those mothers who belong to the support group. Then we have a support antenatally and we do have mothers attending that postnatally and we have the group talks. So it can be that those are the mothers who carry on breastfeeding and see the benefits of it." (MacStaff1)

Barriers:

Despite the antenatal breastfeeding education at Khayelitsha MOU being of a good standard, some mothers at the Khayelitsha MOU reported that their postnatal breastfeeding support in the health facility was not favourable as they had breastfeeding problems which were not resolved by healthcare staff.

“Yes, I did tell the doctor that was [discharging] me that my breast there is nothing coming out. They said no, you must continue breastfeeding it is going to come out. Even now, it is 14 weeks, but nothing is coming out.” (KM2)

“No! No one was coming to show me to help me so that the milk can come out of my breast.” (KM2)

Although breastfeeding support is emphasised throughout the PHC platform, not all mothers who chose to formula feed receive the same type of support. Inadequate postnatal support at the PHC facilities can also be a barrier.

“It is because of who… by that clinic they said, "you say you don’t want to breastfeed but we don’t have milk and you don’t have milk so it is a must to breastfeed." (KM4)

However, follow up visits at the clinics may not be comprehensive or consistent as described by one of the key informants:

“As I said, at the one side we have got the [CBS] workers who do go and do home visits and they check how breastfeeding is still going on because they are also trained now. On the other hand it is the continuous follow up, when they come to the clinic at six weeks, if you ask them that question but many times that question is not even asked and there is a space where you ask the mother why and why not and if you can just strengthen the reasons and why and why and give her the reason why it is so important. If you can explain to the mother when she is doing her six week follow up. Show her if the baby has grown, if the baby has lost weight – what is the reason. You ask her how many times does she bring the baby to the clinic for gastro diarrhoea and what is the reason. All those kind of things.” (MacStaff1)

4.2.4 Summary

Mothers know about the benefits of exclusive breastfeeding, however, breastfeeding in the context of HIV remains a challenge for many mothers. Mothers who received postnatal support in the birthing unit had a more pleasant breastfeeding experience compared to those who did not. Breastfeeding education requires strengthening among health care staff in order for them to share their knowledge with mothers. Mothers can be supported by postnatal support at PHC clinics as well as CHW visits at their homes.

4.3 Identification of facilitating factors and barriers to EBF in the first 14 weeks: Influences by Structural Support (such as Family, Community and Workplace)

4.3.1 Role of Men in Breastfeeding

Some mothers identified men or fathers as being a barrier (and not a facilitating factor) to breastfeeding. Reasons for this included that men report to mothers that breastmilk has an unusual odour, and men feel they are financially contributing to the livelihood of the child if they purchase formula, which could be a barrier to EBF. These are illustrated in the below quotes.

Barriers:

"They (men) say the milk of breasts smell funny." (KM6)

A key informant reiterated that this is a common belief in the community, and this was only described by participants in the Khayelitsha area.

"Yes! "You are smelling breast milk so I won't get close to you." So the mother feels that "I can't breastfeed anymore because I won't see my boyfriend or my husband. She smelling of breast milk or that she is not sexy anymore because her breasts are outside or falling." (KStaff1)

"Most of the men are not there to help the child's mother. They are almost not there. They also need to be educated how important the breast milk of the mother of the child is because maybe they are the one also that create a barrier maybe they say, "I won't have sex with you if you are still breast milk is this or this or this, you are smelling of breast milk." (KStaff1)

"The father wants to buy other milk. I said no not now. I think he want to show support to the baby by buying milk" (KM6)

4.3.2 Family Support of Exclusive Breastfeeding

Mothers listed a few reasons why they chose to breastfeed that were related to the family structure, and family and community support.

Facilitating Factors:

One mother indicated that breastfeeding appears to be the norm in the community, and she would feel embarrassed if she were not breastfeeding:

"Even people outside that I don't know when we talk about breastfeeding or so, community wise, and there would always be encouragers. Because a lot of people I see come here,

breastfeed. They don't give bottle. They breastfeed. So one day I was at the clinic, I think he was three days and everyone around me was breastfeeding and I thought, I am not taking his bottle out because everybody is breastfeeding, and it is embarrassing to me." (MacM4)

A key informant mentioned that mothers choose to breastfeed as the social grant is insufficient to cover the costs of formula feeding a child. Many mothers who are unemployed or whose partners are unemployed, choose to breastfeed as they cannot afford to formula feed.

"I want to breastfeed because I'm saving money. I'm not working" (KM6)

"A lot of the mommies receive social grant. So that is too little to waste on formula. That is why mommies prefer to breastfeed."- (KStaff2)

Barriers:

One mother mentioned a possible barrier to EBF is the negative influence of grandmothers on infant feeding practices.

"Toe sê my ma ons moet vir haar 'n waterbottel maak en toe gee ons vir haar die water maar sy wou dit nie eintlik drink nie. Sy ken mos nou net die tiet" (MacM9) [Translation: "My mother told me to give her (referring to the infant) a water bottle, so we gave her water to drink but she didn't want it. She's just familiar with the breast." (MacM9).]

Key informants reiterated that the role that grandmothers play and the influence they have in infant feeding, could be a barrier to EBF.

"Most of the time it's the grandmothers. Some of them would give the babies rooibos tea" (KStaff 2)

"But many times you get the young ladies who get pregnant and you have got the grandmas, the gogos* that tell them that they have mix feeding and if the baby is crying and all the stories you hear, the myths…also the antenatal sister that is frequently being changed". (MacStaff1) (*gogos is a term used to refer to the grandmothers)

Some young mothers are separated from their infants in order to complete their schooling. The infants are often sent to live with their maternal grandmothers.

"The reason is the child is not getting enough milk. Some the child has got colic so they must give the remedies, so the child is maybe not staying with the mother anymore. Maybe the

mother is a school child so the baby is with the school child's granny or maybe go to Eastern Cape. So that are the most of the reasons." (KStaff1)

"Some mothers don't have support structure here so they send the babies over to Eastern Cape." (KStaff 2)

Another key informant highlighted that grandmothers can often take up the responsibility of parenting from the mothers which can be a barrier to EBF.

"That is one of the reasons we see will stop breastfeeding because you get younger grandmothers and you do get grandmothers or even great grandmothers who take care of the children and they totally take over the role of the children's mothers. They are not given a chance to be mothers of the children themselves and that is when they stop breastfeeding. Given advice as we said in advance, I think those mothers who really want to be a mother will breastfeed." (MacStaff1)

4.3.3 Community Support of Breastfeeding

Many mothers agreed that breastfeeding in public is normal, however, the woman's breast should be covered.

"Anywhere that you come I can breastfeed, yes." (KM1)

"Ja definitely. I must be covered" (MacM5)

"Party mense haal net die bors uit. Nee!! Beskaafde mense vat die kind, haal die bors uit, vat 'n nappy of kombers uit en dek dit (referring to the breast). Daar is mans mense wat ook rond beweeg. Nee ek gaan sit op 'n plek dan haal ek my bors uit dan maak ek toe. As sy klaar gedrink het, sit hom weer terug en dan gaan ons weer soos ons gekom het." (MacM1)

[Translation: "Some people just take out the breast. No! Civilised people take the child, take out the breast, then take a nappy or blanket to cover it (referring to the breast). There are men walking around. No, I go sit at a place then I take my breast out and cover it. If she's done drinking, then I just put the breast back and go as we came." (MacM1)]

"Dis mos nou 'n baba maar as jy in public is dan moet jy obviously nou 'n kombers of 'n ding oor jou gooi dat jy jou baba kan breastfeed. Jy kan mos nie net so die baba in public breastfeed nie." (MacM3) [Translation: "This is now a baby, but if you are in public, then you must obviously take out a blanket or something and cover yourself so your baby can breastfeed. You can't just feed your baby just so in public." (MacM3)]

Mothers from Macassar all stated that their infants should be covered when they breastfeed in public. This could be viewed either as a facilitating factor or barrier to EBF.

4.3.4 Workplace Support of Exclusive Breastfeeding

From the results, it appeared that when employers support breastfeeding, this can facilitate EBF until 14 weeks. However, if there is no support from employers, this could be a barrier to EBF until 14 weeks.

Facilitating Factors:

One specific mother (MacM3) works at a local shop in Macassar which is near her place of residence. Her family brings her baby to her to feed during her breaks then returns to her home after feeding. Her employer allowed MacM3 the opportunity to breastfeed her infant at work.

"Jy kan maar borsvoed. As my mense in die winkel is en sy is dors kan hulle vir haar bring en dan drink sy so 'n bietjie aan my en dan vat hulle haar weer." (MacM3) [Translation: "You can breastfeed. If my family is in the shop and she is thirsty, then they will bring her to me to breastfeed and take her back again." MacM3]

Mothers emphasised the need to express their breastmilk at work should they want to continue breastfeeding after maternity leave.

"I will give the express the breast so that she can give him." (KM1)

Barriers:

Mothers experienced various barriers to EBF at 14 weeks. The quotes below illustrate some of these barriers to EBF at 14 weeks in terms of workplace support. Mothers resorted to formula feeding as they did not have adequate support from their respective workplaces to continue breastfeeding. Mothers also perceived their breastmilk to be insufficient when they have to return back to work. It also seems that, amongst mothers, there was a lack of knowledge that women could express their breastmilk when they are away from their infants instead of providing infant formula.

"He had just turned two months. Because I wasn't receiving any money from my work and everything. So, I had to go to labour law to sort out with his birth certificate, all of that." So, he was drinking (referring to infant formula) from two months just when I was gone from him." (MacM4)

“So, I would have needed a lot of support not just from the people at work but from everybody if it was in terms of work.” (MacM4)

“Because they said the first six months, but most of the mothers go onwards but I will decide because of work issues. Ja so when I work, I will not be able to breastfeed normally. It depends how much milk I am able to express. That is why I say when I reach that mark, I will decide and see if I have enough milk to express”. (MacM5)

“When you go to work you are supposed to buy milk then after work you going to give breastmilk.” (KM5)

“as ek miskien nou werk kry in die ses maande- dan sal ek iets moet uit figure om nou vir haar die Infocare ook te laat gewoond raak aan want anders as ek nou nie werk kry in die ses maande nie dan breastfeed ek vir haar net so.”(MacM9) [Translation: “If I find a job in the next 6 months- then I need to figure out a way for her to get used to the Infacare because if I don’t find a job in the next 6 months then I will just breastfeed her.”(MacM9)]

Key Informants identified the most common barrier to EBF as being when mothers have to return to work.

“As I said before, the work. They need to go back to work. So, they will give breast at night and the bottle and the people that they pay to look after the baby so they prefer to buy milk so that person does not struggle.” (MacStaff1)

“Vir my is dit hulle moet tyd gee vir daai mammies om daai borsmelk uit te melk en hulle moet ’n spesiale kombuis hê waar die mammies hulle bors melk kan gee en dan kan hulle iemand kry wat die borsmelk kom haal of hou tot hulle huis toe gaan. Laat hulle toe om ’n cooler box – ek meen die melk in die yskas sit maar dan in ’n cooler box sit om huis toe te neem of huis toe te stuur.” (MacStaff2) [Translation: “For me, those mothers should be given the time to express their breastmilk and they must have a special kitchen where mothers can give their breastmilk and also have someone to collect the expressed breastmilk until they go home. Allow them to have a coolbox- I mean to put the milk in a coolbox to send home” (MacStaff2)]

“People are just doing their own thing and the younger the age, the people still need to go back to school and they don’t want to breastfeed and due to the low socio-economic standards outside. People need to go to work because the baby is not even three weeks yet then they want us to fill in forms so that they can go back to work because there is no money at home and they

need to go back to work. Yes, we do inform them about expressing and all those things but when they get home, they just do their own thing." (MacStaff1)

"Some mothers work long hours; they leave the house early and come back late. So, there is no time to express." (KStaff2)

"Most common reason why BF rates decrease is when mommies return to work. Then they are always afraid that someone else might feed their baby by mistake breastmilk. So that is why they rather change to bottle-feeds." (KStaff2)

4.3.5 Cultural Beliefs

In terms of cultural beliefs, only barriers, and not facilitating factors were identified as themes.

Barriers:

A cultural belief, specifically in Khayelitsha, is if a baby "blows" into their mothers' breast, it can become infected (usually referred to as mastitis or in one of the interviews, a breast abscess). In these cases, mothers usually choose to stop breastfeeding as they believe the breastmilk is not nutritious and this is therefore a barrier to EBF until 14 weeks

"He said it is an infection because of the baby… I forget I think because the baby blow it." (KM3)

One mother believed that their inability to breastfeed is hereditary.

"But of course, my mother didn't breastfeed, my sister didn't breastfeed we all have inverted nipples." (MacM4)

4.3.6 Substance Abuse

Key informants reported substance abuse (particularly drugs) to be a barrier to EBF at 14 weeks.

Barriers:

"As I say we do have a low socio-economic situation in the community and maybe drugs and those kind of diseases that people struggle outside and the grandmother is looking after the children and that leads to mothers leaving the children altogether and they stop breastfeeding because the grandmother has taken over the role of the mother." (MacStaff1)

"Ja hulle drink nie bors nie, want as ek mos nou uitgerook is, gaan ek mos nou nie worry oor my kind of my kind ge-eet het nie. Wanneer ek miskien gedagte kry oor my kind dan is daai kind al so uitgehonger en uitgedors." (MacStaff2)

[Translation: Yes if they (referring to the infants) don't drink breast, because if I (talking as if she's a mother) am drugged, then I won't worry about my child or if the child had a meal. When I get to the point of remembering my child, by that time the child is dehydrated and hungry." (MacStaff2)]

4.3.7 Summary

The role of men and how they perceive breastmilk influenced the mothers' decision to practice EBF until 14 weeks. Family and community support can positively or negatively influence EBF practices. Breastfeeding in public is generally accepted if the mother covers her breast. The workplace as a setting can either be a facilitator of EBF to 14 weeks, but appears most often to be quite a strong barrier and various examples were provided to illustrate this. Barriers to continue breastfeeding when mothers return to work include: inadequate support from an employer, the perception of insufficient breastmilk supply and mothers needing to return to work early post-partum as they are often not being paid during maternity leave. Moreover, cultural beliefs as well as drug abuse can negatively affect EBF practices.

4.4 Identification of facilitating factors or and barriers to EBF in the first 14 weeks: Influences by Mother's knowledge, perceptions and experience of breastfeeding

4.4.1 Knowledge of mothers regarding breastfeeding

When mothers were asked if they had heard of the term Exclusive Breastfeeding or if they had received information antenatally on EBF, 7 (44%) mothers reported that they received information on what EBF is and 9 (56%) mothers reported that they did not know what EBF is nor did they receive any antenatal information on the importance of EBF. Some mothers reported to have a good understanding of the benefits of EBF.

Facilitating Factors:

Mothers could recall some benefits of breastfeeding.

"Bonding with the baby and baby must get used to mom." (KM1)

“I chose breastfeeding because I know it is comfortable for me, I can [hold] my baby every time I feed him, and it is just comfortable for me.” (MacM5)

“Breast is number one and if you give breast her health is going to be right.” (KM5)

Barriers:

The following quotes are from a mother who believed that giving her baby a formula bottle makes him sleep better. This same mother believed if a woman drinks a lot of fluids, this will make a breastfeed better.

“Now this is the thing – I breastfeed or whatever – I place him on the bed he goes crazy! He wants to be on the arm or whatever. After that I gave him again a bottle and he fell... normally he lies like this on his back. He is very irritated. He doesn’t want to lie alone. He wants to see you; he wants to see you feeding him but when I gave him that bottle he just lay there and it was like twenty minutes and he was sleeping.” (MacM4)

“I would, if I can recommend if people want to breastfeed, they should eat healthy. They should drink what they should drink, drink a lot of water. I did all of those things; I drank a lot of tea which I don’t even like.” (MacM4)

4.4.2 Perceptions of mothers regarding breastfeeding

Barriers:

The following quotes are from mothers who had different perceptions on breastmilk supply, which could be barriers to EBF. This appeared to be quite a strong theme, as it was mentioned by a number of participants.

“my tepels was te klein gewees, dis hoekom sy nie die bors wou drink nie.” (MacM2)

[Translation: “my nipples were too small that’s why she didn’t want to breastfeed.” (MacM2)]

“Ek het verskriklik baie min melk gehad en ek het Stony gedrink en al daai alles gedrink het. Maar met my eerste kind het sy glad nie ge-borsvoed nie because ek het ook nie melk gehad nie”- MacM3 [Translation: “I had very little milk and I drank Stoney and everything. With my first child I didn’t breastfeed as all because I also didn’t have milk.” (MacM3)]

“Soms is my bors melk nie genoeg nie.” (MacM7) [Translation: “Sometimes my breastmilk isn’t enough” (MacM7)]

“Maar ek dink net daaraan bors melk is so asof sy addicted is aan dit. Dit sal beter wees as ek haar aan daai melk ook gewoond kan maak want dan weet ek dat as ek nie daar is nie dan het my ma nie ’n moeilike tyd met haar nie.” (MacM9) [Translation: “I think she may be addicted to breastmilk. It will be better if she can get used to the other milk because then I’ll know my mom won’t have a difficult time with her.” (MacM9)]

The following quotes from key informants relate to the perception of mothers and insufficient breastmilk supply.

“Baie van hulle sê hulle het nie melk nie of hulle melk is te min of die kind kry nie genoeg melk nie. Dis hoekom hulle formula gee tussenin of die kind totaal en al van die bors afhaal en vir hulle formula gee.” (MacStaff2) [Translation: “Many of them say that they don’t have milk or don’t have enough milk or the child is not getting enough. That is why the give formula in between or totally wean the child off the breast and give them formula.” (MacStaff2)]

“Party kom sê die melk is so of die melk is suur. Want ek vra vir hulle hoe weet hulle die melk is so of die melk is suur. Het hulle geproe? Want ’n mens kan mos net iets proe of dinges as jy weet.” (MacStaff2) [Translation: “some of them come to say their milk is like this or the milk is sour. Because I ask them how do they know if the milk is like that or if the milk is sour. Did you taste? Because a person can just taste or something if you know.” (MacStaff2)]

There were no perceptions of mothers regarding breastfeeding that were facilitating factors for EBF at 14 weeks.

4.4.3 Experience of mothers regarding breastfeeding

Facilitating Factors:

The following quotes from mothers highlight some of the favourable experiences with EBF.

One mother was challenged with infant jaundice. She continued breastfeeding and she reported the jaundice to have subsided.

“… he had jaundice and it just kept pushing up and pushing up and they said the only thing that can cure the baby right now is the breast milk. Then I started eating right and drinking right and I could see eventually that it was growing day by day and the jaundice actually went away because of the breast milk.” (MacM4)

The same mother reported that she was advised to treat her son’s red eye with breastmilk and the redness was healed.

“He had a red eye the one day and they said put breast milk in the eye and I did and it was gone. It was like, “Jo, it is amazing!” It was just a cure for everything. They say breast milk cures a lot of things and keeps a lot of things away and that is why it is the best milk.” (MacM4)

The quote below is from a mother who was adamant to breastfeed as she was worried that she may get mastitis. She followed the advice given by a healthcare provider and had a successful experience with breastfeeding.

“Want toe ek vir haar borsvoed toe wil sy mos nie die een bors gevat het nie. EN die bors het seer geraak. Ek het vir myself gesê “jong, jy moet maar nou net die bors vat”. Ek het kliniek toe gekom met haar en toe het die Sister gedruk toe sê sy “is dit seer?” toe sê ek “as ek die pyn kan gevat het toe sy uitgekom het, dan kan ek die pyn vat”. Soos sy vir my verduidelik, ek moet vir haar laat drink aan die borste want anders gaan dit nog seerder wees dan kan ek nie my arms oplig nie. En die Sister het gesê hy gaan daai klier maak en hy het nie kans om te dingese nie. Toe raak ek bang want waan toe gaan die melk” (Giggling) Nee sy drink lekker en ek is baie fine daarmee.”- MacM1 [Translation: “When I breastfed her, she only wanted to drink on the one breast and the breast got sore. I told myself “you will just have to take the breast”. I came to the clinic with her and the Sister pressed on my breast and asked if it’s sore. I responded “if I could withstand labour pains then I can handle this pain”. Like she (referring to the nursing sister) explained to me, I have to let her drink on my breasts otherwise it will become more sore then I won’t be able to lift my arms. And the Sister told me it will cause a gland and it won’t have time to thingie. So, I got scared because where is the milk going to? (giggling). No, she drinks just fine and I am fine with that.” (MacM1)]

“My base sal vir my laat in die kamer gaan en as my borste seer is…hulle sal laat ek my borste kan relax. Daar is ‘n yskas en alles dan sal ek dit in die yskas sit. Hulle sal nie’n problem het met my as ek my borste wil uit dingese nie.”(MacM1) [Translation: “My bosses will allow me to go in the room if my breasts are sore…they will allow me to relax my breasts. There is a fridge and then I will put it in the fridge. They won’t have a problem is I want to thingie my breast (showing expression demonstration).” (MacM1)]

The quote below from a key informant highlights the pleasurable experience of EBF of some mothers.

“Omdat dit vir hulle ’n plesier is om hulle kinders te borsvoed. Dit is goedkoop vir hulle om die kinders te borsvoed. Die kinders is minder in die hospitaal. Kinders het minder gastro as hulle mos vir hulle help met education en hulle aanmoedig. Baie hou daarvan om met hulle

kinders te cuddle en te borsvoed". (MacStaff2) [Translation: "Because it's a pleasure for them to breastfeed their children. It is cheap to breastfeed the children. The children are not in hospital that frequently. Children have less gastro if they (referring to the mothers) are educated and encouraged. Many of them like to cuddle with their children while they breastfeed." (MacStaff2)]

Barriers:

The following quotes emphasise the poor experiences during breastfeeding of some mothers which influenced their EBF experience.

"Yes! I wanted so badly. I even, by the time I got on the… because I am going to work, I even bought the, what do you call that thing? Breast pump so that I could breast pump the milk when I am going back to work… So the milk did not come out." (KM2)

"HIV – I told my sister. One sister. Other sisters – because we are four sisters and three brothers. I told one. But I am scared to tell my mother and my other sisters because of… it is only that one that is better than my sisters and my mothers. But I tried from 2013 to this time. I am taking ARVs, but she was shocked. But I tried to tell her please "don't be shocked because I tried the best because the guy… it was not easy for me. Sometimes I feel I can kill myself because my child's father he didn't assist by the time I am told." (KM4)

One mother indicated fear of HIV transmission through breastmilk a reason for not breastfeeding.

"It is because I was not comfortable to breastfeed him because I am using the HIV treatment. I am afraid to…give the baby the virus" (KM4)

4.4.4 Summary

Mothers have different perceptions and knowledge about the benefits of breastfeeding and what influences the breastmilk supply. Mothers who had a good breastfeeding experience, felt eager to continue EBF compared to mothers who had less favourable experiences.

4.5 Summary of the findings

Table 4.1: Summary of facilitators of and barriers to exclusive breastfeeding at 14 weeks, grouped according to the 3 settings chosen from the Rollins, et al (2016) Conceptual Model of the components for an enabling environment for breastfeeding

Setting	Facilitators	Barriers
Health systems and services	• Breastfeeding promotion done during antenatal visits • Postnatal Breastfeeding support in the birthing units	• HWCs' uncertainty regarding HIV and ICYF guidelines including the duration of breastfeeding • Mother's uncertainty regarding HIV and breastfeeding recommendations • Lack of detailed explanation of the importance of EBF • Inconsistent Antenatal Education • Lack of postnatal BF support post discharge from the birthing units, including inconsistent postnatal support regarding the management of breast problems and inconsistent referral for postnatal support to CBS
Family, community and workplace	• Affordability of breastfeeding • Importance of Breastfeeding is well-known and accepted in the communities • Mothers feel inclusive in society if they are breastfeeding • Breastfeeding in public is viewed as normal • Local employers allow breastfeeding at work	• Some men dislike the smell of breastmilk; makes women feel unwanted • Men's belief it is only the woman's responsibility to take care of a child • Some men feel they are the financial providers if they purchase formula • Lack of family support; young mothers send their children to the Eastern Cape • Influence of grandmothers on infant feeding practices; grandmothers often take over the care of the infants • Belief that infants must be weaned off the breast before mothers return to work • Lack of paid maternity leave • Anxiousness around wet-nursing in the absence of the mother • Inaccurate cultural beliefs (e.g. regarding infants "blowing on the breast"; that the inability to breastfeed is hereditary; that a mother cannot breastfeed if she is using tobacco and drugs)
Mother's knowledge, perception and experience	• Affordability of the breastfeeding practice • Cognitive decision made by mothers based on their knowledge of the benefits of breastfeeding (bonding, good nutrition)	• Mothers' perception of HIV and breastfeeding • Non-disclosure of HIV status impact mother's infant feeding decision • Concern regarding maternal mental health in terms of her HIV diagnosis • Belief that breastfeeding is only recommended for the first 6 months of an infants' life • Belief that their milk supply is insufficient • Belief that that they are unable to continue breastfeeding when they return to work/become employed • Belief that infants sleep better if they are formula-fed

4.6 Summary in terms of the study aim

The aim of the study was to explore the factors influencing the exclusive breastfeeding rate within the first 14 weeks postpartum with mothers in the Khayelitsha Eastern Substructure. The main findings of the results show that facilitating factors of EBF in this substructure relate to breastfeeding promotion at the antenatal clinics, postnatal breastfeeding support in the birthing units, the affordability of the practice; mothers feeling inclusive in society when they are breastfeeding, especially when breastfeeding in public is viewed as normal, and the mothers' cognitive decision to continue breastfeeding based on her knowledge of the benefits of breastfeeding.

In contrast, barriers to EBF within the 14 week period have been identified in term of HCW's uncertainty regarding IYCF guidelines; mother's uncertainty regarding HIV and breastfeeding; lack of postnatal BF support post discharge from the birthing units; inconsistent postnatal support regarding the management of breast problems and inconsistent referral for postnatal support to CBS.

Most barriers were found in terms of family and community support in which mothers reported that some men dislike the smell of breastmilk and women feel unwanted by them. Men also believe it is a woman's responsibility to care for children and that men are financial providers if they purchase infant formula. The influence of grandmothers on breastfeeding has also been reported to be a barrier; the lack of support from employers and anxiousness around wet-nursing posed as barriers to EBF within 14 weeks. Lastly, the mother's own perception and knowledge of infant feeding, particularly in the context of HIV, has been identified as a barrier to EBF within the 14-week period.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This chapter provides a detailed interpretation of the factors that were reported to influence EBF rates in the Khayelitsha Eastern Substructure, from the participants (mothers and key informants) interviewed. This chapter also discusses the influencing factors reported associated with EBF rates at 14 weeks in relation to the health system, the family-, community-, and workplace structures. Lastly, it discusses the influencing factors reported associated with EBF at 14 weeks in terms of the mother's knowledge, perceptions, and experience with breastfeeding.

5.2 Breastfeeding Influencing Factors

5.2.1 Breastfeeding Education

As per the Western Cape Government's (WCG) circular H2 of 2015, aligned with the MBFI strategy, it was mandated by WC DoH that all Basic Antenatal Clinics (BANC) provide infant feeding (including breastfeeding) education (WC DoH, 2015). This process starts when a woman's antenatal journey starts at the clinic. The BANC guidelines of the WCG recommend that when a woman attends her first visit to the clinic after she has found out that she is pregnant, she should receive all the necessary breastfeeding promotion messages. Information overload at the first visit may be overwhelming to any person, and too much information, regarding a woman's pregnancy, in addition to breastfeeding information can become too much for a first visit. As reflected in the results, antenatal education in the Khayelitsha and Eastern Substructure appears to be done inconsistently. All staff are trained on breastfeeding management which includes the global criteria related to the 10 Steps to Successful Breastfeeding. Some staff members may share information regularly with mothers and pregnant women during antenatal and postnatal visits, while some staff members may omit sharing their knowledge due to other operational constraints. A recent systematic review and meta-analysis conducted by McFadden, et al. (2019) indicates that breastfeeding counselling is still considered an effective public health intervention to improve EBF rates. Bhutta et al. (2008), in the Lancet Maternal and Child Undernutrition Series of 2008, already identified 'Promotion of breastfeeding (individual and group counselling)' as a key intervention to prevent maternal and child undernutrition and ensure survival. McFadden et al (2019) also recommend that breastfeeding counselling is done face-to-face both antenatally and at least 4 times postnatally.

The Western Cape Postnatal Care Policy (2016) states that integral care for both mother and baby must be provided at 6 hours-, at minimum in the first week -, and six weeks postpartum. Additional visits according to the mothers' risk assessment can be done and the promotion of BF is integral to the postnatal care period (WC DoH, 2016a). The policy also states that support should be offered

throughout the postnatal care period and not only at scheduled visits (WC DoH, 2016a). Since both MOU's where participants were recruited from are MBFI accredited, it would be assumed that antenatal education should be done consistently, and all mothers should have received antenatal education/information on the importance of breastfeeding. Similarly, postnatal support is assumed given the MBFI accreditation of both birthing sites. However, some mothers reported that postnatal support, especially after discharge from the birthing site, is lacking. It is hence evident that greater emphasis should be placed on breastfeeding education, and even more so postnatally.

5.2.2 Early initiation of breastfeeding

As referred to in the literature review (Chapter 2), the SADHS reported that in South Africa, breastfeeding rates decline as a child grows older (NDoH, StatsSA, SAMRC & ICF, 2017). According to the WHO (2018), the early initiation of breastfeeding aids in facilitating breastmilk production in addition to other benefits like bonding between mother and child, adequate nutrition and breastmilk provides antibodies that offers immune protection to newborns (WHO, 2018a). The SADHS (2016) also reported that 67% of infants received breastmilk within 1 hour after birth and 80% of the infants received breastmilk within 1 day of birth (NDoH, StatsSA, SAMRC & ICF, 2017). Moreover, breastmilk initiation increased from 39% in 1998 to 67% in 2016. In this study, all mothers reported that their infants were breastfeeding within 1 hour after birth, in addition to being placed skin-to-skin to assist the practice of early initiation, which is in line with best practices. This is expected, as both birthing sites are MBFI accredited and this finding is consistent with national surveys that have been conducted.

5.2.3 Feeding Practices at 14 weeks of the study sample

Despite mothers breastfeeding during their stay at the MOUs, it was found in the current research, that, when they return back to the PHC facility for the 14-week immunisation, the breastfeeding practice is inconsistent. Although mothers reported having attended antenatal clinics (in which it was expected of the health care workers to teach them about the importance of exclusive breastfeeding), it has been unknown as to why the EBF rates decrease after birth, which is what this research sought to explore.

As reported in the results, only half of the study population still breastfed exclusively at 14 weeks postpartum. A qualitative, longitudinal cohort study done by Jama, et al. (2017) reported that health workers play a crucial role in providing mothers with infant feeding information and support. Mothers in the Jama, et al. (2017) study were interviewed monthly for the duration of 6 months postpartum and this type of support assisted mothers to successfully breastfeed

exclusively. Both antenatal and postnatal support is crucial to encourage mothers to breastfeed exclusively. Currently, mothers in Khayelitsha Eastern are supported regarding infant feeding while they stay in the hospital, however, there is not an official programme or statistics collected on postnatal breastfeeding support, like there is for the EBF at 14 weeks rate.

5.3. Identification of facilitating factors of and barriers to EBF in the first 14 weeks: Influences by the Health System

5.3.1 Infant Feeding Guidelines

Currently, the HIV prevalence among women in the Western Cape has declined to 15.9% in 2017 (Woldesenbet, et al., 2019). The current HIV prevalence among pregnant women in the Khayelitsha and Eastern Subdistricts is 8,2% and 2,5% respectively (Personal Communication: Pauline Peters PMTCT Coordinator, 11 May 2020). In the Public Health Sector, as advised by the NDoH, all mothers are encouraged to exclusively breastfeed for the first 6 months of life irrespective of HIV status. This is consistent with the WHO HIV and Infant Feeding Guidelines (WHO, 2016) and the National Infant and Young Child Feeding Guidelines with the amendment of 2017 (NDoH, 2017). However, both health care workers and mothers still appear to be uncertain about the recommended duration of exclusive breastfeeding and the duration of the continuation of breastfeeding once complementary foods are introduced in the context of HIV. As per the amended IYCF policy guidelines of 2013, mothers who are HIV positive are encouraged to continue breastfeeding after 6 months, given they are on ARV treatment (NDoH, 2013; 2017). It is still perceived by mothers in this study that if women are HIV positive, they can only breastfeed for 6 months. This is one of the factors that negatively influences the EBF rates at 14 weeks in the health district.

A local study by Mnyani, et al. (2017) described that not having HIV was positively associated with the intention to BF. A study done by Coetzee et al (2017) conducted in Nigeria, looked at factors of adherence to EBF practices in both HIV infected and non-infected women. Mothers in this Nigerian study chose to BF irrespective of their HIV status. More than half of the mothers in the Nigerian study sample were worried about whether they could adhere to the 6 months EBF adherence, as they were concerned about HIV transmission (Coetzee et al, 2017). Mothers disclosed their status to their partners and their partners trusted the information healthcare providers offered to them with regards to safe infant feeding practices (Coetzee et al, 2017). These factors were facilitating of the EBF practice.

Tuthill, et al. (2020) investigated the association between HIV infection, hunger, BF self-efficacy, depression and EBF among women in western Kenya. Their study results revealed that 52.3% of the mothers exclusively breastfed for 6 months. HIV positive mothers were associated with a 64%

decline in EBF cessation at the age of 6 months (Tuthill et al, 2020). Factors such as maternal depression and hunger contributed to 98-100% rate of EBF cessation (Tuthill et al, 2020). Similar to the findings in the current research, HIV positive mothers in western Kenya chose to stop EBF at the age of 6 months.

Participants interviewed in this study made no mention of the importance of continued breastfeeding, especially in the context of HIV. Mothers were not asked if they are HIV positive or negative. Therefore, even though most women delivering babies in Khayelitsha/Eastern and indeed in South Africa, are HIV negative, the HIV pandemic has had an adverse impact on breastfeeding practices.

5.3.2 Provision of Antenatal Education

The importance of antenatal education and the promotion of breastfeeding with its benefits has been made well known (Sankar et al, 2015). Even though mothers in this thesis research reported to have heard about the benefits of breastfeeding at some point during their antenatal care, not everyone could recall what EBF means.

Piro and Ahmed (2020) did a recent experimental study that looked at the impact of antenatal nursing interventions on mothers' BF self-efficacy. They reported that barriers to BF promotion as stated in scholarly literature includes i) mother's inadequate BF self-efficacy ii) incompetent BF services and iii) non-supportive family to the breastfeeding practice (Piro and Ahmed, 2020). The study results revealed that pregnant women in the experimental group had a higher level of knowledge and more positive attitude in terms of BF self-efficacy compared to the control group (Piro and Ahmed, 2020). The findings of their study concluded antenatal BF education is effective to increase BF self-efficacy.

It is unknown what the level of BF self-efficacy was among mothers interviewed for the purposes of this thesis. Most of the mothers received information on the importance of breastfeeding in general, but not all could recall what EBF is. The overloading of mothers with information at one (or the first) antenatal visit requires further investigation, as well as the impact it has on the quality of BF education. If mothers present to the clinic late in their pregnancy, they do not attend the recommended number of visits and therefore may receive all required breastfeeding information in one or two sessions.

5.3.3 Postnatal Support of Breastfeeding

Mothers receive postnatal breastfeeding education and support at the birthing site as part of the implementation of the MBFI. Each PHC facility has a Breastfeeding Peer Counsellor (BFPC) in

the Khayelitsha Eastern Substructure, who provides ongoing breastfeeding education and support. The BFPC is employed full-time by a local NPO. The BFPC has received breastfeeding training and therefore is expected to do breastfeeding talks in the morning, assist mothers with breastfeeding problems in the postnatal wards/facility and is expected to establish support groups in the afternoons. The Principal Investigator works in the area and is aware that the allocated BFPCs were previously employed as CHWs, which means that many times they are absorbed in the facility to render other functions such as HIV testing and TB screening in the community as well, and do not only provide breastfeeding support.

Mothers in this study reported that postnatal infant feeding support assisted them in breastfeeding successfully. Whether it was 3 days or 3 weeks postpartum, the support they received was reported to aid in their success of breastfeeding. However, in this study, some mothers were discharged without having their breastfeeding problems resolved and some mothers felt breastfeeding was forced upon them. Therefore, postnatal support was not favourable at both MOUs and postnatal breastfeeding support was also not consistent.

A Bangladeshi study by Mannan et al. (2008) examined whether postpartum visits by CHWs could aid in BF support. The results of the study revealed that the group of mothers and infants who did not receive postpartum BF support by the CHW were 11.4 times more likely to develop infant feeding problems by the 6th or 7th day postpartum compared to the mothers who received support. Based on these results it is hence evident that postnatal breastfeeding support may be regarded as a facilitator of EBF in the first 14 weeks.

From personal work experience and as per the Western Cape Government Health policy, it is known that the Community-Based Service (CBS) platform assists with postnatal infant feeding support in both the facility and community. However, due to service delivery demands, the CHWs are often tasked with other responsibilities. This appears to decrease the priority allocated to postpartum breastfeeding support. It is anticipated that postnatal infant feeding support can positively influence EBF rates. Further investigation regarding community postnatal infant feeding support and the impact on the duration of EBF in the South African context is needed.

5.4 Identification of facilitating factors of and barriers to EBF in the first 14 weeks: Influences by Structural Support (Family, Community and Workplace)

5.4.1 Role of Men and Breastfeeding

In many societies, breastfeeding can be viewed as the mother's responsibility alone. Extant literature also suggests that a key barrier to EBF in some low- and middle-income countries (LMIC) is a lack of knowledge and support from household members, specifically members who

have authority over other household practices such as income, that is, the father and grandparents (Yourkavitch, et al., 2017) – in other words, family members.

A descriptive review done by Yourkavitch et al (2017) looked at how men can be engaged to promote and support EBF. The researchers reviewed 28 projects in LMIC over a period of 10 years. The review did not find consistent associations between intensities or types of male engagement strategies to increase EBF rates (Yourkavitch et al, 2017). Generally, across all the programmes, there was a gap in understanding how male involvement can impact women's health behaviour (Yourkavitch et al, 2017). Local gender norms, such as decision-making, autonomy and including men in women's health topics were recommended to support programmes that promote and support EBF (Yourkavitch et al, 2017).

Bulemela, et al. (2019) explored the knowledge and attitudes towards EBF among Tanzanian men. This qualitative study used focus group discussions to assess the knowledge and attitudes of men on the benefits of breastfeeding, disadvantages of replacement feeding and how men can support their partners' BF practice (Bulemela et al, 2019). Some of the findings of this study concurred that most men felt the need to build loving relationships with their babies and wives (Bulemela et al, 2019). Some men felt that they did not need to care for the babies if the mother is around and some mothers did not view infant care as the father's responsibility (Bulemela et al, 2019). Many men felt a sense of belonging when they felt needed by the family, however, they did not experience a sense of belonging when it came to breastfeeding (Bulemela et al, 2019). Some men did not want to discuss breastfeeding as they viewed infant care as only the mother's responsibility (Bulemela et al, 2019). It can be seen from the literature that there are varying cultural attitudes and beliefs regarding the role that different family members have when it comes to caregiving (including feeding) of an infant, and these cultural attitudes and beliefs can therefore influence the support that a breastfeeding mother does or does not receive.

The findings from the in-depth interviews in this study display controversial and concerning messages about the role of men in breastfeeding support. When asked what the reason was for mixed-feeding during the first 14 weeks after delivery, certain responses in Khayelitsha were directed to the belief that some men do not like the smell of breastmilk on a woman as they perceive it to be unattractive. No scholarly literature was found on men's perception of breastmilk and this finding can be unique to cultural beliefs of women and men in Khayelitsha, or it could be a cultural attitude in other communities too. This is a factor influencing EBF that requires further investigation. Some men also believe it is a woman's job to take care of a child. One of the staff members suggested that men also need to be educated on the importance of EBF. It was also felt that men believe that they are the financial providers if they purchase formula milk. This demonstrates how cultural attitudes and beliefs have an important role to play in breastfeeding

support. It is therefore important that family members, including male partners or fathers, are included in breastfeeding promotion and education efforts.

5.4.2 Family and Community Support of EBF

In Khayelitsha 18,8% and in Macassar 12,7% of the population have no income (Municipal Elections 2016; Census 2011). On average, 54,9% of the population in Khayelitsha and 36,7% in Macassar earn less than R38 000 per annum (Municipal Election 2016; Census 2011). The facilitating factors to EBF in this study are mainly reported to be attributed to the affordability of breastfeeding. It is clear from the statistics provided, that in these sub-districts, many families simply cannot afford infant formula (which is a product that has been consistently demonstrated to be inferior to breastmilk). Mothers also chose to breastfeed as the breastfeeding practice was common in the community and its importance was well known.

The role of the family and community support is vital in the success of exclusive breastfeeding. Cisco (2017) reiterates that social support can influence BF duration and the person who offers BF support to mothers should be educated on BF to prevent premature weaning (Cisco, 2017). However, some mothers find it difficult to practice exclusive breastfeeding as they lack the support structure of a family. When asked what the reason was for stopping breastfeeding before 14 weeks, responses highlighted that some young mothers send their infants to the Eastern Cape, often to be looked after by the infant's grandmother, while the mother completes her education or works. The Eastern Cape is approximately 750km from the Cape Metropole, which means that it would not be possible for mothers to express their milk and send it to their infants for feeding. This physical separation between mother and infant therefore means that breastfeeding will stop.

Horwood et al (2019) sought to explore childcare practices among mothers in informal work in Kwazulu Natal. A part of the results indicated that 90.7% of the mother and child dyad live together (Horwood et al, 2019), enhancing the EBF rates. No other literature was found on the impact on breastfeeding by sending infants to the Eastern Cape specifically, nor was any literature found on the impact on breastfeeding by the geographic separation of mother and infants. It does not appear that other research reports state this as a factor contributing to breastfeeding cessation. This might be something unique to South Africa and could be influenced by South Africa's political history.

Grandmothers have an influence on infant feeding practices in society. Their knowledge, experience and perceptions of BF can influence a mother's decision to initiate or continue BF (Grassley and Eschiti, 2008). An American study by Grassley and Eschiti (2008) explored the mother's perceptions of grandmother's BF knowledge and support. The results of the study concluded that mothers needed and wanted the support of their mothers (that is, the infant's

grandmother), however, the advice and concerns given to them may reflect cultural beliefs that do not necessarily protect BF (Grassley and Eschiti, 2008).

Another qualitative study conducted in the Eastern Cape by Dasheka and Rala (2020) explored the kind of support first time mothers needed to practice EBF. Support during the early initiation period came from nurses and other mothers and was well received by first-time mothers (Dasheka and Rala, 2020). Social support from family members, friends and community members was both well received and rejected (Dasheka and Rala, 2020). Mothers in that study cited that friends and community members, often older females, would often encourage them to mixed-feed (introduce something other than breastmilk) when their infants cry too much (Dasheka and Rala, 2020). The literature therefore shows that grandmothers and other family members can either facilitate or interrupt EBF.

As per the in-depth interviews with mothers during this research, when asked other reasons why mothers mixed-feed or stop exclusive breastfeeding within 14 weeks postpartum, some responses alluded to the influence of the grandmothers on infant feeding practices. Grandmothers often take over the care of the infant in some communities, for example, when a mother returns to work. The mother may therefore have less control over what the baby is fed, even if she were to leave expressed breast milk for the grandmother to feed the infant. Similarly to the results from the literature, the findings of this thesis shows that the grandmothers' influence negatively impacted the duration of EBF at 14 weeks.

Emmott and Mace (2015) explored the associations between different types of social support mothers receive from fathers and grandmothers in terms of BF in the UK. Their study highlighted a difference between practical- and emotional support. Their findings suggested that the father's presence, considering offering emotional support, is associated with greater BF initiation (Emmott & Mace, 2015). In contrast, if fathers and grandmothers get directly involved in the parenting of the infant, it may discourage BF, that is, paying for formula or grandmothers playing a prominent role in informational support (Emmott and Mace, 2015). The literature found in relation to family and community support, is aligned with the findings of this study, as the communities in the Khayelitsha Eastern Substructure face similar concerns. Family and community support in terms of breastfeeding can be both an advantage or disadvantage to EBF rates at 14 weeks, depending on what type of support and information the mother receives from her peers or elder family members.

5.4.2.1 Breastfeeding in Public

The freedom to BF in public has been a battle for women in many diverse societies. Women who choose to comfortably BF in public have been ridiculed for sexualising BF in an attempt to

normalize the practice in public open spaces (Mathews, 2019). Woollard (2019) used various methods of analytical philosophy to justify why women have a right to BF in public. She concludes by saying "Mothers have an unconditional, moral right to breastfeed and to feel welcome to breastfeed in public even if they are not able to breastfeed discreetly" (Woollard, 2019: 1). Nyaloko (2020) looked at the perceptions of mothers and the community members regarding BF in public spaces in urban Gauteng in South Africa. Generally, the findings of the study concurred that both mothers and the community had no objections with respect to mothers who BF in public (Nyaloko, 2020).

As in this research, when asked about how mothers felt about breastfeeding in public, most responses were positive. Many mothers did not have a problem breastfeeding in public, however, they strongly felt that their breasts must be covered. Although many women felt the need to breastfeed in public, they should not feel judged or ridiculed if they do so openly on public. Having to feel the need to cover up in public may be a possible barrier to BF in public and cause them to feel pressured to give the infant something else when they are in public.

5.4.3 Workplace Support of EBF

The mothers who were employed relayed that having to go back to work was a barrier to exclusive breastfeeding. Some mothers felt that they needed to wean the infant off the breast completely before they recommence their duties at their place of employment. Other mothers prefer breastfeeding at night, while the caregivers of their infants feed alternative milk feeds during the day, leading to mixed feeding.

Daniels, du Plessis and Mbhenyane (2020) assessed the breastfeeding support practices in designated workplaces in the Breede Valley Sub-district in the Western Cape, South Africa. The results of the study concurred that BF support practices in designated workplaces were limited and inadequate (Daniels et al, 2020). Common practices at these workplaces included limited access to onsite or nearby creche facilities, BF counsellors, inadequate promotion of the benefits of BF to employees and inadequate provision of a private space for expressing (Daniels et al, 2020). Workplace BF policies were also uncommon (Daniels et al, 2020).

Some mothers interviewed in this research felt eager to continue breastfeeding after 14 weeks, if they were given the opportunity to express their breastmilk at work. The lack of an opportunity to express breastmilk at work could be a barrier to EBF, especially in low-income areas. Similarly, a Pakistani study by Hirani and Premji (2009) concurred that BF rates decrease due to mothers returning back to work and a lack of support of BF at workplaces.

One mother also felt pressured to return to work because she was not getting paid maternity leave. In SA, it is not mandatory for maternity leave to be paid. Mothers have to claim from the Unemployment Insurance fund (UIF), if they are registered and have been contributing to it. South

African legislation should change so that mothers of any employment status obtain paid maternity leave in order to continue their EBF practices, and this would be in line with International Labour Organisation recommendations (ILO, 2000).

An Ethiopian study by Chekol, et al. (2017) assessed the extent of EBF and a mother's employment status. EBF was higher among unemployed mothers than employed mothers (Chekol et al, 2017). Therefore, being unemployed or not working was a facilitator of EBF. Social support was a facilitating factor of EBF while poor knowledge of BF was a barrier to EBF among employed mothers (Chekol et al, 2017).

Irrespective of the antenatal education provided on hand expression and the promotion of storage of expressed breastmilk, health care workers think that mothers convert to mixed-feeding or alternative feeding methods within the first 14 weeks due to their own personal reasons, seemingly related to the inconvenience of, or additional time involved in expressing breast milk. As stated by one of the staff members during the pilot study of this thesis, another reason why mothers stop breastfeeding when they return to work, is that they feel anxious that a caregiver might breastfeed their infants (that is, wet-nursing) in their absence without knowing their HIV status.

Workplace challenges generally remain a barrier to EBF and therefore could be an important area for interventions to support BF. Similarly, such barriers interfere with the EBF at 14 weeks in this study population group.

5.4.4 Cultural Beliefs

A cultural belief, specifically in Khayelitsha, is if a baby "blows" onto their mothers' breast, it can become infected (usually referred to as mastitis or in one of the interviews, a breast abscess). In these cases, mothers usually choose to stop breastfeeding as they believe the breastmilk is not nutritious. Nyoni, et al. (2019) reviewed how infant feeding counselling can increase EBF among HIV positive women. Their review concluded that women would practice EBF when they feel confident about the information they receive, despite the opposing feeding related cultural beliefs. In the survey done by Mnyani et al (2017), most women perceived breastfeeding to be difficult, and cultural factors were perceived to be a barrier to EBF in Johannesburg, South Africa.

Some mothers believed that their inability to breastfeed is hereditary. This is a unique finding that has not been reported elsewhere and the mothers could have other cultural beliefs that might not have been raised in these interviews and that also arise as barriers to EBF.

One respondent in this study spoke about Stoney and Ginger Beer, and the fact that when she drank Ginger Beer, she had more milk. This perpetuates a common yet incorrect cultural belief in South Africa that Ginger Beer somehow increases milk production. This is still a cultural myth and therefore if mothers cannot afford to purchase Ginger Beer, they might think that they will not be able to breastfeed. Other literature could not be found on the perception of drinking ginger beer

and so this might be unique to South African communities and is possible an area where more research is required. It is an especially concerning myth when one considers that over two-thirds of South African women are overweight or obese and Stoney/Ginger beer is a heavily sweetened beverage. One of the barriers to EBF in Tanzania, as reported by Mgongo, et al. (2018), was also the perception of insufficient milk supply among mothers with infants aged 0-12 months. Mothers often associated crying with hunger or thirst of a child (Mgongo et al, 2018). Mothers also introduced solid foods as early as one month old because of the perception that the infant 'was not getting enough' (Mgongo et al, 2018). Similarly, in South Africa, the early introduction of solid foods is high and problematic (du Plessis et al, 2016).

Health professionals might often suggest that expressing breast milk is easy, but sometimes forget that it takes time, and often means that mothers skip meals or sacrifice their own well-being to be able to express. Johns, et al. (2013) aimed to explore the scholarly literature related to breastmilk expression by women with healthy infants including the reasons and methods for expressing. The authors found limited evidence specifically focussed on the prevalence and outcome of hand expression of breastmilk among mothers with healthy infants (Johns et al, 2013). In essence, if a mother needs to return to work or leaves her child in the care of someone else, having to express her milk including the logistics around expression of breastmilk, could be a barrier to EBF at 14 weeks.

5.4.5 Tobacco and Drug Abuse

The issue of drug abuse in the Macassar area came up as a barrier to exclusive breastfeeding within the first 14 weeks postpartum. Both staff members at the facility alluded to the concern regarding this social problem. They described that mothers would stop breastfeeding due to drug or tobacco abuse as the infant would be in the care of another family member, who could resort to other methods of feeding. Drug abuse and its influence on EBF at 14 weeks was not mentioned in any of the interviews with participants in the Khayelitsha subdistrict. A Canadian study by Schroeder, Larsen and Byrd (2019) draws attention to the value of BF and care-giving in terms of substance addiction. This study used a longitudinal study design in which indicators of empowerment observed with BF included increased self-esteem among primary caregivers and more involvement in infant care which in turn resulted in the cessation of substance abuse (Schroeder et al, 2019). Building the self-esteem of the mothers and their ability to BF their infants could potentially contribute to the continuation of EBF at 14 weeks in the Khayelitsha Eastern Substructure.

Smoking during pregnancy and postpartum remains a global health concern (Disantis, Collins and McCoy, 2010). Disantis, et al (2010) examined the associations among BF, smoking relapse and

prenatal factors in a brief postpartum smoking intervention. The authors relayed that if smoking cessation advice and BF counselling is enhanced at the same time, it could increase smoking abstinence and BF rates (Disantis et al, 2010).

Further research is required in terms of substance abuse and how it influences BF in South Africa. It is possible that some women could stop EBF before 14 weeks because they are using substances, including alcohol.

5.5 Identification of facilitating factors of and barriers to EBF in the first 14 weeks: Influences by Mother's knowledge, perception and experiences of BF.

5.5.1 Knowledge of mothers

In this research study, it is not known whether the responses were from HIV positive or negative mothers. The infant feeding recommendation as discussed in Chapter 2 is the same for all mothers with infants under the age of 6 months, irrespective of their HIV status. Some mothers who chose to continue breastfeeding made a cognitive decision to do so as they experienced the benefits of breastfeeding, namely the affordability of breastfeeding, comfortability of the practice and knowing the benefits of breastfeeding in general.

Mothers know that breastfeeding is good but could not describe the benefits of EBF, however it is unknown whether they understand the concept of demand feeding. One mother particularly felt that her baby sleeps better when he is bottle-fed instead of breastfed and also thinks that everything she eats, or drinks will go into the breastmilk. This highlights inaccurate beliefs about breastfeeding, thus is a barrier to breastfeeding.

A South African study by Madiwana (2017) explored the 6 months EBF compliance in the Vhembe district. Even though the WHO recommended that all mothers should EBF for 6 months, the EBF rate in South Africa remained low (Madiwana, 2017). The study revealed that 93,7% of the study sample (n-=160) did not comply with EBF for 6 months (Madiwana, 2017). Many mothers were found to mixed-feed and started complementary feeding too early (Madiwana, 2017). Reasons for not BF exclusively varied; the main reason was mothers believing that they had insufficient milk supply, even though they agreed that they have enough knowledge on EBF and its importance. This shows a disconnect between the mothers' knowledge and practices. This is a barrier to EBF at 14 weeks as mothers are not confident in their ability to BF and often resort to mixed-feeding or choosing other alternative feeding methods.

5.5.2 Perceptions of mothers

The results of this study reveal that many mothers still believe that their breastmilk alone is insufficient to meet their infants' nutritional requirements.

One mother had a perception that the baby is "addicted" to breastmilk if it was feeding so often and thought it would be best to introduce alternative feeds. This is an example of where the understanding of 'demand feeding' may not be clear. A Brazilian study by Moraes, et al. (2020) reported on the mothers' perceptions of the importance of breastfeeding and difficulties encountered in the process of breastfeeding. Similarly, one of the difficulties that mothers perceived was that the limited satiety of their infants on breastmilk only, therefore, they introduced other foods to the infants' diets (Moraes et al, 2020).

Some mothers think that if they are not consuming an adequate diet or if they are drinking alcohol and smoking that they should not breastfeed. One mother alluded that she thinks everything she eats and drinks goes into the breastmilk. This highlights the inaccurate beliefs that contribute to the barriers to breastfeeding. The health promotion message from the NDoH clearly states that mothers should not drink alcohol or use any substances while breastfeeding. While South Africa has a very high prevalence of alcohol consumption, there can be controversy on what is best for the infant. To receive breastmilk from a mother who is using substances, or to receive overdiluted infant formula or other inappropriate substances because the mother cannot afford BMS and does not want to breastfeed while using substances, remain areas that require in-depth research, specifically the impact on the growth of the infant if mothers continue to use substances.

Both a mother's perception of her HIV status and the disclosure of a mother's HIV status can impact her decision to breastfeed or not. A quote by one mother indicated that HIV status could influence a woman's mental health as well. The mental health of women diagnosed with HIV requires more in-depth research since HIV infection and cultural factors remain an important influence on safe infant feeding practices (Mnyani et al, 2017). Within the public health sector, healthcare workers are the main source of information (Mnyani et al 2017), therefore it is imperative that they highlight the need for accurate and consistent messaging for both women with and without HIV. In the Western Cape, various initiatives such as First 1000 Days Campaign, and then nationally, the MomConnect Programme where mothers receive SMSs and the Side-by-Side Campaign, have been institutionalised in the health sector with a large social media presence. The social media presence refers to mainly women who have access to a phone or smartphone with data or airtime. These advocacy campaigns could be important facilitators of EBF and play a role in the promotion of EBF, but their impact needs to be evaluated.

5.5.3 Experience of mothers.

Many of the mothers believed that breastfeeding is only recommended for the first 6 months of life and that they must resort to other feeding methods after the age of 6 months. Although this study focused on Exclusive Breastfeeding in the first 14 weeks, it is important to consider this

within the context of the overall optimal infant and young child feeding recommendations. Some mothers think that they are unable to breastfeed should they become employed or if they must return to work. Dombrowski, et al. (2018) sought to discuss the challenges mothers face while wanting to continue BF, while their children are at the early childhood development (ECD) centre during the day. Findings of the study highlighted that BF was perceived as solely the mother's responsibility and did not include the ECD practitioners (Dombrowski et al, 2018). In this qualitative study, ECD practitioners relayed that they are willing to support BF by allowing the mothers to BF at the ECD centre during their breaks, however, they did not wish to take a proactive role in the support process (Dombrowski et al, 2018). These findings can be relatable to the current challenges in the Khayelitsha Eastern Substructure, therefore it is seen as a barrier to EBF. The National Guidelines for Nutrition Interventions at ECD centres has a section that recommends that women should be able to send EBM to the ECD, however, the feasibility of this has not been investigated (NDoH, 2016).

One mother discussed her challenge with jaundice, and she was advised to continue to breastfeed. She continued to practice EBF and the jaundice subsided. The mother received the correct information and support is therefore a facilitating factor to EBF.

Similar findings to this study reveal the reasons for non-compliance and includes the following: 1) Baby crying often 2) Insufficient milk supply 3) Going back to work or school 4) lack of knowledge (Madiwana, 2017).

5.6 Conclusion

The aim of this research was to explore the factors influencing the EBF rates within the 14 weeks postpartum with mothers on the Khayelitsha Eastern Substructure. As discussed in the results and discussion chapters, it appears that the barriers to EBF at 14 weeks in the Khayelitsha Eastern Substructure outweigh the facilitating factors. The facilitating factors include antenatal education, BF support in the birthing unit approximately 6 hours postpartum, the affordability of BF; BF in public is well received in the community and the mother's knowledge and experience with BF appears to be good. The barriers include, inconsistent antenatal breastfeeding education, inadequate BF support in the community, confusion regarding the duration of BF in the context of HIV, information overload at the antenatal visits, inadequate support about BF by men, lack of family support structure, influence of grandmothers on infant feeding practices, lack of BF support in the workplace, cultural beliefs that negatively influence BF practices and the mother's own perceptions about BF.

CHAPTER SIX:

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

In the final chapter, conclusions are drawn from the findings of this study, limitations are mentioned, and recommendations are made.

6.1 Conclusion

This study has been carried out in response to the low EBF rates at 14 weeks in the Khayelitsha Eastern Substructure and a need to identify the main factors that facilitate the EBF practice and its barriers. Looking at the various facilitating factors and barriers mothers in the Khayelitsha Eastern Substructure are facing, it is evident that breastfeeding promotion and support is needed on an intersectoral platform. This study unveils the deeper insights into the challenges being faced by mothers with regards to EBF practices within the first 14 weeks postpartum.

6.1.1 Identified facilitating factors to EBF at 14 weeks

Various facilitating factors to EBF at 14 weeks in the Khayelitsha Eastern Substructure were identified. Mothers have a good understanding about the importance of breastfeeding during the first 6 months. Most participants could mention the benefits of breastfeeding. Postnatal support from CBS (if mothers are referred) has been beneficial in the continuation of EBF. The BF practice is a cultural norm in communities and is well received by community members. BF in public is still accepted with the caveat that the mothers' breasts are covered. One mother reported that she could continue to EBF because her employer was supportive of the practice, therefore the workplace could be a facilitating factor to EBF at 14 weeks if employers are supportive of BF at work.

6.1.2 Identified barriers to EBF at 14 weeks

More barriers than facilitating factors to EBF at 14 weeks in the Khayelitsha Eastern Substructure were identified. Mothers focussed on the benefits of EBF in the first 6 months, however, the message of continued breastfeeding after 6 months was not clear. HCWs messages about infant feeding have an impact on mothers' infant feeding decisions. If the infant feeding messages are not standardised among HCWs, it can have an impact on the mothers' skills and knowledge of appropriate infant feeding practices. BF problems not being resolved in the health facility postpartum were a barrier to EBF at 14 weeks. Inadequate postnatal BF support at PHC facilities if follow-up visits are not comprehensive, was also highlighted as a barrier. The role of men and their support in BF requires additional research but was also highlighted as barrier to EBF at 14 weeks. The influence of grandmothers on infant feeding remains a challenge as well as separation of mothers and infants in situations where the infant is sent to the Eastern Cape while the mother completes her schooling or in search of employment. BF in the workplace remains a challenge to

EBF especially if the employers are not supportive or if the work environment is not conducive to BF. Cultural beliefs and substance abuse may negatively influence EBF rate at 14 weeks. Misconceptions about the satiety of the infant which relates to milk supply remains a barrier to EBF at 14 weeks. Moreover, HIV and infant feeding practices and maternal mental health remain a challenge for EBF rates at 14 weeks.

6.2. Limitations

A key limitation of this research includes the small sample size and qualitative nature of the research which means that the results cannot necessarily be generalised to the whole study population and beyond. Although data saturation was reached with the given study sample, there may be some beliefs, attitudes and practices in the community that are not reflected in the results. Subjectivity of the interviewer (also Principal Investigator) can be present in this qualitative research as the interviewer works in the area. The factors influencing the EBF rates in the Khayelitsha Eastern Substructure are only applicable to women in the respective areas. As with a mini- dissertation, the scope of the research is limited.

6.3 Recommendations

Many of the recommendations require the mandate at a National and Provincial level and the institutionalisation of the strategies require buy-in from local district management. The results of this research should be shared with all relevant stakeholders. These recommendations are not only aimed at the health departments, however, and are required to be adopted by various sectors.

6.3.1 Breastfeeding Advocacy

Breastfeeding promotion and advocacy are recommended in the Khayelitsha and Eastern sub-districts and this can be done through Social Marketing. Social Marketing is an approach that can be used to advocate behavioural change in social settings that can be both feasible and acceptable to the public (Favin and Griffiths, 1996). Breastfeeding support forums in the form of social media can be initiated to encourage mothers to breastfeed. This can be initiated by the National and Provincial Department of Health, as well as NPOs involved in breastfeeding protection, promotion and support, as social media is commonly used by the public. According to Statscounter (2020), 48,6% of South Africans make use of Facebook. The platform can be used to share experiences between mothers and to motivate each other to continue the practice and share breastfeeding messages.

- Standardised breastfeeding messages should be strengthened through the integration of the MBFI and BANC at facilities and encouraged by/through trained staff at the health facilities. All health professionals are trained with standard messaging on breastfeeding support. Antenatal preparation and education of pregnant women will impact the initiation of breastfeeding after birth.

- Strengthening of the concise messages on the importance and benefits of continued breastfeeding practices after 6 months can be advocated to mothers through pamphlets, health talks in clinics, community groups, posters, newspaper or magazine articles, incorporating breastfeeding as the norm in local television shows, using as celebrities as ambassadors of breastfeeding and local radio talks.

6.3.2 Policy and Legislation

The national Infant and Young Child Feeding (IYCF) public health policy (NDoH, 2013) must be revised and updated to reflect global and national research and best practices, by all sectors which relate to maternal and child health care. Standardised practices to support IYCF are encouraged throughout the public and private sector. These sectors include the health, social development and labour departments, amongst others. Currently in South Africa, the IYCF Policy is specifically directed to IYCF support and implementation within public health facilities. The policy must be written in a way that would ensure that mothers make breastfeeding their first and easiest choice of feeding. Policies should encourage 6 months paid maternity leave benefits in all sectors to encourage the practice of exclusive breastfeeding because many women struggle to continue breastfeeding when they return to work. In South Africa, the Basic Conditions of Employment Act 1997: Code of Good Practice (Government Gazette, 1998) on the protection of employees during pregnancy and after birth, should be amended to include the aforementioned. Currently the Act only states that payment of maternity benefits is determined according to the provisions of the Unemployment Insurance Act. If the employer only offers a percentage of employment benefits, the worker can claim UIF. Women resort to return to work earlier, after birth due to financial constraints thus influencing the exclusive breastfeeding practices.

Strict implementation of the Regulation 991 to decrease the marketing of BMS and stringent monitoring thereof should apply to the trade industry and private sector. Globally the International Code of Marketing of Breast-milk substitutes aims to protect and promote breastfeeding by inhibiting the marketing of BMS in the public health sector and ensuring appropriate distribution of BMS if it is needed. Subsequently, South Africa has adopted the Code and legislated the Code into a law known as the Regulations Relating to Foodstuffs for Infant and Young Children, R991. Currently, health care workers in the public health sector are trained on the scope of the R991. Emphasis should be placed on educating workers in the trade and industry and commercial sector. Frequent advocacy on the aim and scope of the R991 in all sectors should be encouraged to increase public awareness Given the challenges women faced in this study sample, it is recommended that the commercial sectors protect and promote breastfeeding in this manner in addition to supporting women who are breastfeeding after they return to work.

All sectors should encourage a Breastfeeding in the workplace policy and breastfeeding-friendly public spaces in all public and private sectors should be promoted. The Code of Good Practice on the protection of employees during pregnancy and after birth mentions that women are allowed 30 minute breaks to either breastfeed or express their breastmilk twice per day during working hours for the first six months of an infant's life. The Western Cape Government Department of Health has a Breastfeeding Policy which allows mothers two 30-minute breaks to express their breastmilk. The National Government is encouraged to mandate all sectors to implement such a policy to encourage all working mothers to continue breastfeeding when they return to work. Strong advocacy on the woman's right to do so is encouraged in all sectors. Awareness campaigns by the National Government, about the benefits of breastfeeding to both the employer and lactating employees, should be strengthened. The National Department of Health has developed a booklet entitled "Supporting breastfeeding in the workplace: A guide for employers and employees" (NDoH, 2018). This resource should be used and promoted. Breastfeeding-friendly public spaces, for example, a breastfeeding room in shopping malls or restaurants should be advocated by policy-makers in both the public and private sector on a macro level. Creating supportive environments by making breastfeeding in public spaces the norm is encouraged, specifically through mainstream media such as popular television series, radio or advertisement campaigns.

6.3.3 Breastfeeding Education

Breastfeeding education, offered by trained health care staff, should focus on the skills of breastfeeding (correct positioning, attachment and expressing of breastmilk) and strong emphasis should be placed on building the mother's confidence in her ability to breastfeed successfully. The Department of Social Development on a local level could offer a programme on psychosocial and physical support to mothers by offering community parenting skills workshops and ways to deal with stress.

6.3.4 Community Development to support Breastfeeding

Re-orientate health services by training Community Health Workers (CHWs) in Infant and Young Child Feeding for them to render postnatal breastfeeding support home for postnatal mothers. The institutionalisation of this practice into the Service Level Agreement between the Health Department and the local NGOs requires a mandate from the Provincial Authorities. Breastfeeding Education should be encouraged in all health facilities and public spaces (churches or community groups) where the target audience is women. Breastfeeding support groups should be coordinated by breastfeeding housewives in the community. Emphasis should be placed on supporting mothers especially when they have difficulty feeding their infants. The aim of the support groups could be

to give practical assistance with other household tasks to allow the mother to develop the necessary skills for breastfeeding. The district health management team should encourage community leaders and male advocates to promote BF by lobbying local business employers to adhere to the Regulation 991 and support breastfeeding as a health promotion strategy. Health leaders together with local business forums are encouraged to advocate safe, clean and accessible breastfeeding or expressing facilities to business owners.

6.3.5 Health System

Healthcare workers are advised to stay informed about policy changes or amendments regarding infant and young child feeding. Regular training should be prioritised and conducted by District health teams to ensure the healthcare staff are updated. Healthcare workers can in turn share the knowledge with mothers and caregivers on the matter. Optimal IYCF messaging and support should be integrated into all health systems programmes (MBFI at birthing units, antenatal education at BANC facilities, during IMCI training, etc).

6.3.6 Research Opportunities

Further research is required into the role that men can have in promoting and supporting EBF. Given what the literature recommends in alignment with the results of this study, mental health of women diagnosed with HIV and breastfeeding requires in-depth research. More evidence around substance abuse among women and the impact on breastfeeding in South Africa requires research. Lastly, further research is required into the physical separation of mothers and infants after birth, specifically in South African context.

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APPENDICES

Appendix 1: Questionnaire

Exploring the factors influencing exclusive breastfeeding within the first 14 weeks postpartum with mothers in the Khayelitsha-Eastern Substructure.

Questionnaire	Code number.

Health Establishment Details

Name of MOU	
Sub-District	Date:

1. Maternal Demographic Data

1.1 What is your age?					
1.2 Are you working? If yes, please proceed to Q 1.3			Yes		No
1.3 What is your estimated income per month					
1.4 What type of work do you do?					
1.5 What is your highest education level?	Primary School		Secondary School		Tertiary Education
1.6 How many births did you have previously?					
1.7 What is your marital status?	Single	Married	Living with partner	Widowed	Divorced

2. Antenatal Education

2.1.	Did you attend antenatal clinic while you were pregnant?	Yes	No	Specify:		
2.2.	On average, how many antenatal visits did you have during your pregnancy?	Less than 3	3-5 times	More than 5 times	Unbooked	Unsure
2.3.	What information did you receive about feeding your baby, when you were pregnant?	Specify:				
2.4.	Did you receive any information about the importance of exclusive breastfeeding for the first 6 months, during your antenatal visits?	YES		NO		
2.5	Why do you think exclusive breastfeeding is important?	Specify:				

3. Infant Birth characteristics

3.1 What is the gender of your baby?	Girl	Boy
3.2 How many weeks old is your baby now?		
3.3 What was the birth weight of your baby?		

3.4 What type of delivery did you have?	NVD	C-Section
3.5 Was breastfeeding started within 1 hour after birth?	YES	NO
3.6 Was the baby wrapped in a cloth or placed skin-to-skin on your chest?	Wrapped	Skin-to-Skin
3.7 Were you breastfeeding at discharge?	YES	NO

Appendix 2a: Interview Guide for Mothers

Factors influencing EBF until 14 weeks for mothers in the Khayelitsha-Eastern sub-district.

- How are you currently feeding your baby? Is your baby receiving anything else besides milk?
- How do you understand Exclusive Breastfeeding?
- Was there perhaps a period where you were giving Breastmilk and something else to your baby? If yes, when, what and for how long?

If Breastfeeding
• Why did you choose to breastfeed your baby?
• What do you think influenced you to decide to breastfeed your baby?
• How do you think, it will be possible for you to breastfeed when you need to return to work or school OR now that you are already back at school/work?
• How do you think you will know when your baby is drinking enough milk?
• Have you ever tried cup feeding? What was your experience with it? Would you or your baby's caretaker cup feed- what do you think?)
• What would help you to continue breastfeeding, if you wanted to when you go back to work or school?
• How long do you plan on trying to continue EBF?
• What kind of support do you think you would need to be able to continue breastfeeding for longer than 14 weeks?
• What do you think about breastfeeding in public?
• Is there anything else you would like to say?
If Mixed Feeding
• What made you decide to introduce something else other than breastmilk?
• How old was your baby when you started giving something other than breastmilk?
• What would help you to continue breastfeeding, if you wanted to when you go back to work or school?
• What kind of support do you think you would need to be able to continue breastfeeding or give breastmilk only for longer than 14 weeks?
• What do you think about breastfeeding in public?
• Is there any else you would like to say?

If not Breastfeeding
• What did you feed your baby with when you stopped breastfeeding? If you started with infant formula, are you still only giving infant formula or are you giving something else as well?
• Would you have wanted to continue breastfeeding?
• Would you mind explaining the reason why you chose to stop breastfeeding?
• How old was your baby when you stopped breastfeeding?
• What could have helped you to continue breastfeeding?
• What support would you have needed to breastfeed?
• Is there anything else you would like to say?

Appendix 2b: Interview Guide for Key Informants

- How would you define Exclusive Breastfeeding?
- Do you think you have a role to play when it comes to supporting breastfeeding? If so, what do you think you can do?
- Based on your experience and practice, why do you think that the rates of EBF decrease at 14 weeks?
- What do you think are factors that encourage women to continue EBF after 14 weeks?
- What are some of the barriers that women have reported to you and that have resulted in mixed feeding within this 14week period? (Probe of determinants of Breastfeeding i.e health system, support, workplace)
- Why do you think that some women stop breastfeeding altogether?
- Anything else you would want to mention?

Appendix 3: Participant Information Sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Researcher: Ms MC Marais Telephone: 021 360 4707

E-mail: 2407189@myuwc.ac.za

PARTICIPANT INFORMATION SHEET

Dear Participant,

Thank you for your willingness to hear about this research. The information in this memo is an explanation of the research project and an outline of your potential involvement. The research is being conducted for a mini-thesis of my studies. This is a requirement for the Masters in Public Health Nutrition programme which I am completing at the University of the Western Cape.

If there is anything that you don't understand, please do not hesitate to ask me. My contact details and those of my supervisors are stated at the end of this letter.

Project Title: Exploring the factors influencing exclusive breastfeeding within the first 14 weeks postpartum with mothers in the Khayelitsha-Eastern Health District

What is this study about?

This is a research project being conducted by Ms Megan Marais at the University of the Western Cape. The purpose of this research project is to understand the reasons why mothers either choose to continue to breastfeed or what made them not to breastfeed exclusively at 14 weeks after delivery.

What will I be asked to do if I agree to participate?

You will be asked to explain what influenced your decision to either continue the exclusively breastfeed or what made you decide to not to it. There is no right or wrong answer. The interview will be done at either Khayelitsha MOU or Macassar MOU. The interview should last between 30 minutes to one hour. The questions will only be about what you think about breastfeeding. The interview will be tape recorded but will only remain with the researcher.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, you name will not appear on the question sheet. The researcher will show you before the interview to confirm your anonymity. (1) your name will not be included in the audio or written recordings and other collected data; (2) a code will be placed on the survey and other collected data; (3) through the use of an identification key, the researcher will be able to link your survey to your identity; and (4) only the researcher will have access to the identification key.

To ensure your confidentiality, the interview will take place in a quiet room in the MOU. The tape recording and notes will only be kept with the researcher. All recordings will be kept on password-protected filed on the computer. Once the research report is completed the questionnaires stored for 5 years and then destroyed.

If we write a report or article about this research project, your identity will be protected.

What are the risks of this research?

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about what factors influences the decision of mothers to continue the exclusive breastfeeding practice or not. We hope that, in the future, other people might benefit from this study through improved understanding of the factors that contributes to the mother's decision to practice exclusive breastfeeding.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

If you need any kind of assistance or health care, the researcher will make an appropriate referral to the Medical department at each PHC clinic for professional medical/psychological management. However, the risk of any negative outcome is very minimal and steps will be taken to avoid any negative outcome.

What if I have questions?

This research is being conducted by Ms Megan Marais, a part-time, post-graduate student at the Department of Dietetics and Nutrition at the University of the Western Cape. If you have any questions about the research study itself, please contact Megan Marais at: Telephone number: 021 360 4707 email: 2407189@myuwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Ms Catherine Pereira – Supervisor and Lecturer
Department of Dietetics and Nutrition
University of the Western Cape
Private Bag X17
Bellville 7535
Telephone number: (021) 959 2760
Email: cpereira@uwc.ac.za

Prof Ernesta Kunneke
Head of Department
Department of Dietetics and Nutrition
University of the Western Cape
Private Bag X17
Bellville 7535
Telephone number: (021) 959 2760/2232
E-mail: ekunneke@uwc.ac.za

Prof Anthea Rhoda
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
Telephone number: (021) 959 - 2852
Email: chs-deansoffice@uwc.ac.za

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office
University of the Western Cape
Private Bag X17

Bellville 7535
Tel: (021) 959 2988
Email: research-ethics@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee [BM19/5/11].

Bylaag 3: Deelnemer Inligtingsblad

UNIVERSITEIT VAN DIE WESKAAP

Privaatsak X 17, Bellville 7535, Suid Afrika

Navorser: Me MC Marais Telefoon: 021 360 4707

E-pos: 2407189@myuwc.ac.za

DEELNEMER INLIGTINGSBLAD

Beste Deelnemer,

Dankie vir u bereidwilligheid om te leer oor hierdie navorsing. Die inligting in hierdie blad bied 'n verduideliking van die navorsingsprojek asook 'n oorsig van jou potensiële deelname. Die navorsing word uitgevoer as deel van 'n tesis as 'n vereiste vir die Meesters Graad in Publieke Gesondheidsvoeding wat voltooi word deur die Universitieit van die Weskaap.

Indien daar enigiets is wat u nie verstaan nie, moet asseblief nie huiwer om te vra nie. Die navorser se kontakbesonderhede en dié van die toesighouers word aan die einde van die inligtingsblad verskaf.

Projek Titel: Verkenning van die faktore wat bydra tot eksklusiewe borsvoeding binne die eerste 14 weke na-geboorte met moeders in die Khayelitsha-Oos-gesondheidsdistrik.

Waaroor gaan hierdie studie?

Hierdie is 'n navorsingsprojek wat uitgevoer word deur Me Megan Marais by die Universitiet van die Weskaap. Die doel van die navorsingsprojek is om die redes te verken waarom moeders aanhou borsvoed of waaarom hulle besluit om nie ekslusief borsvoed vir die eerste 14 weke na geboorte nie.

Wat sal ek gevra word om te doen indien ek instem om deel te neem?

U sal gevra word om te verduidelik wat u keuse om eerder aan te hou ekslusief borsvoed, of nie te borsvoed nie, beïnvloed het. Daar is geen regte of verkeerde antwoord nie. Die onderhoud sal plaasvind by eerder Khayelitsha MOU of Macassar MOU. Die onderhoud sal tussen 30 minute tot 'n uur duur. Die vrae dek slegs u meening oor borsvoeding. Die onderhoud sal met 'n bandopnemer opgeneem word, maar dit sal slegs by die navorser bly.

Sal my deelname aan hierdie studie vertroulik gehou word?

Die navorser onderneem om u identiteit en die aard van u bydrae te beskerm. Om u anonimiteit te verseker, sal u naam nie op die vraestel verskyn nie. Die navorser sal u voor die onderhoud wys om u anonimiteit te bevestig. (1) u naam sal nie op die opnames en ander versamelde data ingesluit word nie; (2) 'n kode sal op die opname en ander versamelde data geplaas word; (3) deur die gebruik van 'n identifikasie sleutel, kan die navorser u opname koppel aan u identiteit; en (4) slegs die navorser sal toegang tot die identifikasie sleutel hê.

Om u vertroulikheid te verseker, sal die onderhoud in 'n stil kamer in die MOU plaasvind. Die bandopname en aantekeninge sal by die navorser gehou word. Alle opnames sal op ‘n rekenaar gestoor word, en beskerm word met ‘n wagwoord. Sodra die navorsingsverslag voltooi is, word die vraelyste vir 5 jaar gestoor en dan vernietig.

As 'n verslag of artikel oor hierdie navorsingsprojek geskryf word, sal u identiteit beskerm word.

Wat is die risikos van hierdie navorsing?

Alle menslike interaksies en praat van menself dra ‘n sekere mate van risiko. Die navorser sal egter mik om sulke risiko's te verminder en dadelik op te tree om u te help as u enige ongemak, sielkundig of andersins, ervaar tydens die proses van u deelname aan hierdie studie. Waar nodig, sal 'n gepaste verwysing na 'n geskikte professionele persoon vir verdere bystand of ingryping gedoen word.

Wat is die voordele van hierdie navorsing?

Hierdie navorsing is nie ontwerp om u persoonlik te help nie, maar die resultate kan die navorser help om meer te leer oor watter faktore die besluit van moeders beïnvloed om die eksklusiewe borsvoedingspraktyk voort te sit of nie. Die navorser hoop dat ander mense in die toekoms dalk voordeel kan trek uit hierdie studie deur beter begrip van die faktore wat bydra tot die moeder se besluit om eksklusiewe borsvoeding te beoefen.

Moet ek deel wees van hierdie navorsing wees en mag ek op enige stadium my deelname onttrek?

U deelname aan hierdie navorsing is heeltemal vrywillig. U mag kies om glad nie deel te neem nie. As u besluit om aan hierdie navorsing deel te neem, kan u enige tyd onttrek. As u besluit om nie aan hierdie studie deel te neem nie, of as u op enige stadium u deelname onttrek, sal u nie gepenaliseer word, of enige voordele wat u andersins voor sou kwalifiseer, verloor nie.

Is daar enige hulp beskikbaar as ek negatief geraak word deur deelname aan hierdie studie?

As u enige hulp of gesondheidsorg benodig, sal die navorser 'n gepaste verwysing na die mediese afdeling by die primêre gesondheidskliniek doen vir professionele mediese/sielkundige ondersoek en behandeling. Die risiko van enige negatiewe uitkoms is egter baie min en stappe sal geneem word om enige negatiewe uitkoms te voorkom.

Wat as ek vrae het?

Hierdie navorsing word uitgevoer deur Me Megan Marais, 'n deeltydse, nagraadse student aan die Departement van Dieetkunde en Voeding aan die Universiteit van die Weskaap. As u vrae het oor die navorsingstudie self, kontak gerus Megan Marais by:

Telefoonnommer: 021 360 4707
e-pos: 2407189@myuwc.ac.za

Indien u enige vrae rakende hierdie studie en u regte as 'n navorsingsdeelnemer het, of as u enige probleme rakende die studie wil aanmeld, kontak asseblief:

Me Catherine Pereira – Toesighouer en Dosent
Departement van Dieetkunde en Voeding
Universiteit van die Weskaap
Privaatsak X17
Bellville 7535
Telefoonnommer: (021) 959 2760
E-pos: cpereira@uwc.ac.za

Prof Ernesta Kunneke
Hoof van Department
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Universiteit van die Weskaap
Privaat Sak X17
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E-pos: ekunneke@uwc.ac.za

Prof Anthea Rhoda
Dekaan van die Fakulteit Gemeenskaps- en Gesondheidswetenskappe
Universiteit van die Weskaap
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BIOMEDIESE NAVORSINGSETIEK ADMINISTRASIE
Navorsingskantoor
Universiteit van die Weskaap

Privaatsak X17
Bellville 7535
Tel: (021) 959 2988
E-pos: research-ethics@uwc.ac.za

Hierdie navorsing is goedgekeur deur die Universiteit van die Weskaap se Senaat Navorsingskomitee en Etiekkomitee [BM19/5/11].

Izihkomelo 3: Ulwazi nge nxaxheba

UNIVESI YASE NTSHHONA KOLONI

Private bag X 17, Bellville 7535, Mzantsi Afrika

Uphundo: Me MC Marais **Nombolo: 021 360 4707**

E-mail: 2407189@myuwc.ac.za

ULWAZI NGE NXAXHEBA

Abathandekayo Ngenxaxheba,

Siyabulela ngoluvo lwenu ngokuzimisela ngalenxelo. Olu lwazi kulenawadi isixelela ngophando lwe projekthi kunye nokhangelwa ukubandakanyeka ezinokubakho. Olu phando luye kwenziwa ubuncinci bemfundo. Ezi zimfuneko kwi nkosi zempilo zesondlo kuba ngokugawalisa kwi Uinvesi yase ntsona koloni.

Ukuba kukho into ongayiqondiyo, siyakela unqoyiki ukubuza. Umnxeba wami kunye naba semvakami zibhalilwe ekuqubeleni kulencwadi.

IProjekti Tayitile: Ukuhlola kubelula nemiqobo yokuncancisa kuphela ibele ngange veki leshumi dinêsine kukundandatheku ko mama abase Khayelitsha-empumdanga bezimpilo yesithili.

Esisifundo singantoni?

Olu luphando lwe projekti olwenziwa ngu Ntombanzana Megan Marais kwi Univesi yase ntshona koloni. Umdla wale projekti kukucacelwa inxaki kutheni oMama bekhetha ukuqubela ngokuncancisa okanye yintoni ebenza bona banga ncancisi kuphela kwi veki zelishumi elinesine emva bebelekile.

Yintoni endinobuzwa ndiyenze ukuba ndivume kuthatha inxaxheba?

Uzokubuzwa ucacise impembelelo ngesiqibo okanye uqubeke. Ngoku ncancisa kuphela okanye yintoni ekwenze ucinge njalo.Akukuo engambanga okanye embi ngombuzo. Uvano ndlebe luyaba khona okanye Khayelitsha MOU okanye Macassar MOU. Olu ndliwano ndlebe kufuneka lihlale phakathi kwe mizuzi elishumi mathamu ukuya kwiyuve. Le mibuzo iyakuba ngento oyithi uyicinge ngayo ukuncancisa. Olu ndiwano-ndlebe luzoba rekhondi yetape. Kodwa kizoba kwabaphandi.

Oluphando nxaxheba lunqaba yimfihlo?

Olu phando bekungeko losicina isidima kunye nohtobo kwi galelo. Ukuqinisekiso kwemfihlelo,Igama alizobekwa kumqube we nxaxheba. Abaphandi bazobonisa phambi kwesiqinisekiso semfihlelo.(1) Igama lakhoeliyokuze libekhona kwi saveyi kunye nakwi idatha eqokelelwe;(2) Ikwowudi izobewki kwi isavaeyi kunye nakwi idatha eqokelelwe; (3) nge msebenzi lokusazisa isitixo, aba phandi bazokwazi uku dibaniso noqhagamsheto kwi saveyiyi lokuzazisa; kunye (4) uphando lodwa oluzovumeleka kwelokuzazisa lweqhosha. Ukuqinisekiso oluyimfihlo , udlwano-ndlebe kiyobakho kwindawo ethule e MOU. Irekhodi tap no phawula luzobe kucinwe ngophando. Zonke irikhodingi zizobe zicinwe ngemfihlo ngendlela kwi khampyutha. Kanye uphando luqibe umvano ndlebe olukho kwi minyaka emihlana ukuze kuyeke.

Ukuba sibhala incazelo okanye inqacu malunga nophando, imfihle yakho iyakukhuselwa.

Zintoni ingozi ngoluphando?

Bonke abantu bokusebenzisana bathetha ngobona okanye abanye baquba ngemali zezinqozi. Kuzo kwena konjalo kunciphise ingozi ngokukhanuleza ukuncedakala wena ukuba ngumhlengi ongafanele,kwezengqondo okanye kwezinqe endaweni kwe nkqubo Iwenxaxheba kule Mfundo. Apho kwumeleke, abathunyelwe ngokufanelekileyo bazo kwenza incazelo efanele kwabadleli ukwazi ngcono lwabancedi okanye ukungenelela.

Uzozuzani koluphando?

Oluphando alwenzelanga ukunceda wena, kodwa uphumo lunga nceda kuqopholo lofundo ngokwenzakakuyo kwizinto zempembelelo zambono ko Mama baqubeke kuphela ngoncanciso lofunda okanye. Siya fiselela njalo,ebomini,abanye abantu bangakwazi ukuzuza kule nxelo ukuze izokuphumelela ngokuyiqonda izinto ezi negalelo ko mama sokwenza isinqumo sokuphela ko ncanciso.

Kunyanzelekile ukuba koluphando ndingakwazi ukuyeka ukuxasa noba kunini?

Inxaso lo phando luphelela ngokuzithandela. Ungakhethanga ukuthatha inxaxheba. Xa uvuma kuxasa koluphando, ungayeka ukuxasa nanini. Xa uqonda awukwazi kuxasa kulemfundo okanye ufuna ukuyeka koluxasa nanini. Awuzo hlawuli-swa akanye uyeke inzazo apho uzobe uphumelele khona.

Kukho uncedo olukhoyo ukuba u negative ngomsulelo nqokuthatha inxaxheba nakweliphi ixhesa?

Ukuba yinxaxheba koluphando okanye kwezampilo, uphando luzokwenza bathenyelwe ngokutanelekileyo kwezo nqonqoshe isebe ngalinye kwi PHC kliniki zabaphati bezo nyanqo/nezengqondo zabaphati. Kunjalo, ezingozi kakubi zinempumelela ebalekayo encinci nezi tepisi zizokwenzeka zinqenzi kakubi kwimpumelelo.

Ukuba ndinemibuzo?

Olu phando lwenziwe ngu Ntombazane Megan Marais, we ngxanye, wabanye besithwalanowe kwisebe kwezikhwepheshe kunye nowe sondlo sase Univesi sase ntshona koloni. Ukuba unemibuzo malunga nolu phando,ungaxhugamisdana no Megan Marais ku: le nombolo: 021 360 4707.

Ukuba unemibuzo ngetifundo kunye namalungelo kuphundo lwenxaxheba okanye ucinga ukuxela nayiphi inxaki othi wadibana nalo kwesisifundo, Ungatsalela:

Intombi Catherine Pereira- Umphathi kunuye noTishala

Kwiseba Lokhwepheshe kunye nabesondla base

Univesi sase Ntshona koloni

Provate Bag x17

Bellville 7535

Nombolo: (021) 959 2760

Email: cpereira@uwc.ac.za

Prof Anthea Rhoda

Lokhuthazwa lwase khono laba hlali kunye nezimpilo zenzuluwazi

Univesi lwase Ntshona Koloni

Private Bag x17

Bellville 7535

Nombolo: (021) 959 2852

Email: chs-deansoffice@uwc.ac.za

BIOMEDICAL UPHANDO ZOKUZIPHATHA LWEZO LAWULO

UPHANDO OFISI

Univesi lwase Ntshona Koloni

Private Bag x17

Bellville 7535

Nombolo: (021) 959 2988

Email: research-ethics@uwc.ac.za

Olu phando luye lwavunyelwa yi Univesi yase Ntshona Koloni wo phando lwamadoda lwabanlali kunye ne loziphatha lwabahlali (BM19/5/11).

Appendix 4: Participant Informed Consent Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Researcher: Ms MC Marais Tel: 021 360 4707

E-mail: 2407189@myuwc.ac.za

INFORMED CONSENT FORM

Title of Research Project: **Exploring the facilitating factors and barriers to exclusive breastfeeding within the first 14 weeks postpartum with mothers in the Khayelitsha-Eastern Health District.**

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will and agree that the interview may be recorded. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

Participant's name……

Participant's signature…….

Date……

Biomedical Research Ethics Committee

University of the Western Cape

Private Bag X17

Bellville

7535

Tel: 021 959 4111

E-mail: research-ethics@uwc.ac.za

Bylaag 4: Deelnemer Ingeligte Toestemmingsvorm

UNIVERSITEIT VAN DIE WESKAAP

Privaatsak X 17, Bellville 7535, Suid Afrika

Navorser: Me MC Marais Telefoon: 021 360 4707

E-pos: 2407189@myuwc.ac.za

INGELIGTE TOESTEMMINGSVORM

Titel van die Navorsingsprojek: **Verkenning van die fasiliterende faktore en hindernisse tot eksklusiewe borsvoeding binne die eerste 14 weke na-geboorte met moeders in die Khayelitsha-Oos-gesondheidsdistrik**

Die studie is aan my beskryf in ‘n taal wat ek verstaan. My vrae oor die studie is beantwoord. Ek verstaan wat my deelname sal behels en ek stem in om deel te neem van my eie keuse en vrye wil. Ek verstaan dat my identiteit nie aan enigiemand bekend gemaak sal word nie en gee ook toestemming dat die onderhoud aangeteken mag word.. Ek verstaan dat ek enige tyd van die studie kan onttrek sonder om 'n rede te verskaf en sonder vrees vir negatiewe gevolge of verlies aan voordele.

___ Ek gee toestemming dat ek op band opgeneem mag word gedurende my deelname in die studie.

___ Ek gee nie toestemming dat ek op band opgeneeem word durende my deelname in die studie.

Deelnemer se naam……

Deelnemer se handtekening…….

Datum……

BIOMEDIESE NAVORSINGSETIEK ADMINISTRASIE

Navorsingskantoor

Universiteit van die Weskaap

Privaatsak X17

Bellville 7535

Tel: (021) 959 2988

E-pos: research-ethics@uwc.ac.za

Izihkomelo 4: Inxaxheba ngokwazisa ngokwemvume lomnavaliso phepha

UNIVESI YASE NTSHHONA KOLONI

Private bag X 17, Bellville 7535, Mzantsi Afrika

Uphundo: Me MC Marais **Nombolo: 021 360 4707**

E-mail: 2407189@myuwc.ac.za

Eyolowazi lwemvume lomcwaliso phepha

Isihloko so phando se Projeckti : Ukuhlola pu na kube lula kunye nemiqobo kuphela kuncanciso ngange veki yokugala ezishumi elinesine kukudandatheka ko mama kwi Khayelitsha zempilo mase Macassar yesithili.

Esi sifundo siphalwe sacaciswa ngolwimi endilivayo. Umbuzo malnga ngesifundo sesicaziwe. Ndiya landela ngenxaxheba ezingalento kwaye ndiyavuma ukuthatha inxaxheba ngendlela zam kuze ndifile ndikhululekile.

Ndinolwazi ukuba imfihlo zam azizocazwa nakonye umntu. Ndinolwazi ukuba ndingakwazi ukuyeka ukusuka kwimfundo nangeliphi ixesha ngaphanole kokunika incazelo nangaphandle koyiko kakubi nemiphumelo okanye ukwaphula lo zuzo.

__ Ndiyavuma ukuba i-audiotaped ngexesha lokuthatha inxaxheba kweso sifundo.

__Andivumelani ukuba i-audiotaped ngexesha lokuthatha inxaxheba kweso sifundo.

Igama lomntu othathe inxaxheba :……

Umntu othathe inxaxheba atuatyele :……

Usuku :……

BIOMEDICAL UPHANDO ZOKUZIPHATHA LWEZO LAWULO

UPHANDO OFISI

Univesi lwase Ntshona Koloni

Private Bag x17

Bellville 7535

Nombolo: (021) 959 2988

Email: research-ethics@uwc.ac.za

Appendix 5: Letter to Department of Health to request approval to conduct research in facilities in the Khayelithsa-Eastern Substructure

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Researcher: Ms MC Marais Telephone: 021 360 4707

E-mail: 2407189@myuwc.ac.za

15 February 2019

The Director : Khayelitsha Eastern Substructure

3rd Floor, Khayelitsha Shared Services Office Building

C/o Steve Biko & Walter Sisulu Avenue

Khayelitsha

7580

RE: Request to conduct research in the Khayelitsha Eastern Health District by Ms MC Marais

Dear Dr Phillips,

I trust this correspondence will find you well.

Thank you for your willingness to hear about this research. This letter serves to request permission to conduct the research project in the Khayelitsha Eastern Health District. The research is being conducted for a mini-thesis of my studies. This is a requirement for the Masters in Public Health Nutrition programme which I am completing at the University of the Western Cape.

Research Title: Exploring the factors influencing exclusive breastfeeding within the first 14 weeks postpartum with mothers in the Khayelitsha-Eastern Health District

The purpose of this research project is to understand the reasons why mothers either choose to continue breastfeeding or what made them not to breastfeed exclusively at 14 weeks after delivery.

I applied for ethical clearance from the UWC Biomedical Research Ethics Administration and I am awaiting an ethics clearance number once my proposal has been reviewed and approved by the Higher Degrees Committee.

I wish to conduct the research at Khayelitsha- and Macassar MOU. To ensure the privacy and confidentiality of the participants, the interviews will take place in a quiet room in the MOU. The tape recording and notes will only be kept with the researcher. All recordings will be kept on password-protected files on the computer. Once the research report is completed the questionnaires will be stored for 5 years and then destroyed.

Hereby, I kindly request your assistance in the process of applying for ethical clearance through the Western Cape Department of Health. If you are interested in the reading my research proposal, I will gladly share the information with you.

Yours Sincerely,

MC Marais

Senior Community Dietitian: Khayelitsha-Eastern Substructure

Appendix 6: BMREC Ethics Clearance Letter

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 4111/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

09 July 2019

Ms M Marais
Dietetics and Nutrition
Faculty of Community and Health Sciences

Ethics Reference Number: BM19/5/11

Project Title: Exploring the factors influencing exclusive breastfeeding within the first 14 weeks postpartum with mothers in the Khayelitsha-Eastern Health District

Approval Period: 09 July 2019 – 09 July 2020

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

BMREC REGISTRATION NUMBER -130416-050

Appendix 7: Approval Letter for the Western Cape Department of Health

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
Tel: +27 21 483 9866; fax: +27 21 483 6050
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_201907_017
ENQUIRIES: Dr S Petros

Private Bag X17,
Bellville 7535
South Africa

For attention: **Ms Megan Candice Marais**

Re: Exploring the factors influencing exclusive breastfeeding within the first 14 weeks postpartum with mothers in the Khayelitsha-Eastern Health District.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries in accessing the following sites:

Khayelitsha (Site B) CHC	**Mr David Binza**	**021 360 5207**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress date (**Annexure 8**) to the provincial Research Co-ordinator.
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M Moodley
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE:
CC

Dr Melvin Moodley
Director: Health Impact Assessment
09 OCT 2019