THE EXPERIENCES AND PERCEPTIONS OF MIDWIVES AT PROVINCIAL HOSPITALS IN THE NELSON MANDELA METROPOLITAN MUNICIPALITY REGARDING EXCLUSIVE BREASTFEEDING BY HIV POSITIVE FIRST-TIME MOTHERS

By

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DEDICATION

THIS STUDY IS DEDICATED TO

MY MOTHER SALOME MOEKETSI, MY AUNT GRACE MOOBI & MY UNCLE JOSEPH DITLHAKANYANE

FOR THEIR TREMENDOUS SUPPORT
I thank GOD our Father for His Grace, mercy love and peace and Jesus Christ our Lord.

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SUMMARY

The Department of Health in South Africa, as in many countries, has developed a policy guideline and recommendations for feeding of infants of HIV positive mothers. This is aimed at providing midwives with detailed and sound information about HIV and infant feeding practices based on current understanding of HIV and exclusive breastfeeding for the first six months of the infant’s life. The policy states that breastfeeding is a significant and preventable mode of HIV transmission to infants and there is an urgent need to educate, counsel and support women and families, so that they can make decisions about how best to feed infants in the context of HIV (http://www.doh.gov.za/aids/doc/feeding/html.2005-03-07).

Speaking to midwives from the Provincial Hospitals in the Nelson Mandela Metropole, the researcher became aware of the midwives’ often-expressed unhappiness about the new policy from the Department of Health on exclusive breastfeeding. Midwives complained about the dilemma with which they are faced regarding infant feeding practices. They could not understand the advocacy of exclusive breastfeeding, when breastfeeding is recognised as one of the modes of Mother-to-Child Transmission (MTCT) of HIV.

The aim of the study was to help, support and encourage midwives to implement the policy of exclusive breastfeeding. The objectives of the study were to:

- Explore and describe the experiences and perceptions of midwives related to promoting exclusive breastfeeding in HIV positive first-time mothers.
- Make recommendations to the Department of Health regarding the support and help that can be given to midwives to encourage their implementation of the exclusive breastfeeding policy.

The researcher made use of a qualitative, phenomenological, descriptive, explorative and contextual design. Permission for conducting the research was
obtained from relevant authorities, and participants were asked to sign a consent form before the researcher proceeded with the study. Collection of data was done by means of unstructured interviews using an audiotape recorder. Once data was saturated, the interviews were transcribed verbatim and analysed, using the steps described by Tesch’s (1990 in Creswell, 1994: 153) method of descriptive analysis. Field notes were also taken to record non-verbal communication during the interviews. In order to ensure trustworthiness of the study, the ethical principles of Guba’s model (in Krefting, 1991:215), namely truth-value, applicability, consistency and neutrality were used.

The services of an independent coder were utilised and a consensus meeting was held between the researcher and the independent coder in order to discuss the identified themes. Prior to the consensus meeting, the independent coder was provided with interview transcripts and a protocol to guide the data analysis. Following the data analysis, a literature control was undertaken to highlight the similarities and differences found in the data analysis.

Three themes with sub-themes were identified. The participants expressed positive views on the policy of exclusive breastfeeding in HIV positive first-time mothers. They were satisfied with the policy and viewed the policy of exclusive breastfeeding as an effective contribution to feeding options of babies born of HIV positive first-time mothers. However, the participants identified several factors hindering the effective implementation of the policy of exclusive breastfeeding in HIV positive first-time mothers. Factors identified were staff-shortages, lack of cooperation among staff members regarding promotion of exclusive breastfeeding, lack of information regarding the CD4 count of patients on admission in the ward, cultural beliefs, lack of training among staff members and inadequate counseling facilities to ensure privacy and confidentiality for mothers. Participants also experienced a variety of emotions related to exclusive breastfeeding such as happiness, confidence, helplessness, frustration, worry and concern, stress and exhaustion.
Based on the findings of the study, guidelines were developed and recommendations made concerning nursing practice, nursing education and nursing research.

**KEY WORDS:** exclusive breastfeeding, policy, Mother-to-Child Transmission, first-time mother, recommendations and guidelines.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>iii</td>
</tr>
</tbody>
</table>

## CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction........................................................................................................... 1
1.2 Background and Literature Review................................................................. 3
1.3 Problem Statement................................................................................................. 7
1.4 Research Questions............................................................................................... 8
1.5 Research Objectives............................................................................................... 9
1.6 Terminology............................................................................................................ 9
1.7 Paradigmatic Perspective....................................................................................... 10
  1.7.1 Metatheoretical assumptions........................................................................... 10
  1.7.2 Man.................................................................................................................. 11
  1.7.3 World............................................................................................................... 11
  1.7.4 Health............................................................................................................. 11
  1.7.5 Nursing........................................................................................................... 12
1.8 Research Design and Methodology....................................................................... 12
  1.8.1 Research design.............................................................................................. 12
    1.8.1.2 Qualitative research................................................................................. 13
    1.8.1.3 Exploratory research................................................................................. 13
    1.8.1.4 Descriptive research................................................................................. 13
    1.8.1.5 Contextual design..................................................................................... 14
    1.8.1.6 Phenomenological approach..................................................................... 14
  1.8.2 Research methodology....................................................................................... 14
    1.8.2.1 Research population................................................................................. 14
    1.8.2.2 Sampling................................................................................................. 15
  1.8.3 Data gathering.................................................................................................. 15
    1.8.3.1 Interviews............................................................................................... 15
    1.8.3.2 Observations and field notes................................................................. 16
    1.8.3.3 Personal journal..................................................................................... 17
CHAPTER 3: DISCUSSION OF RESULTS AND LITERATURE

3.1 Introduction.............................................................................. 43
3.2 Description of the Sample...................................................... 43
3.3 Data Collection and Analysis................................................... 44
3.4 Discussion of Results and Literature Control......................... 46

Theme 3.4.1: Midwives had positive views on the policy of exclusive breastfeeding in HIV positive first-time mothers.......................... 46

Sub-theme 3.4.1.1: Midwives are satisfied with the policy of exclusive breastfeeding in HIV positive first-time mothers................ 49

Sub-theme: 3.4.1.2 Midwives view the policy of exclusive breast-feeding as an effective contribution to feeding options of babies born of HIV positive first-time mothers........ 52

Theme 3.4.2: Midwives experience factors hindering the effective implementation of the policy of exclusive breastfeeding in HIV positive first-time Mothers................................. 53

Sub-theme: 3.4.2.1 Staff shortages make coping with the work load difficult and cause increased work pressure resulting in insufficient time to sit and counsel mothers........ 54
Sub-theme 3.4.2.2: Uncooperative Attitudes Exist Among Staff Members Regarding The Promotion Of Exclusive Breastfeeding. ............... 56

Sub-theme 3.4.2.3: There is a lack of information regarding the CD4 count of patients on admission to the ward............................ 57

Sub-theme 3.4.2.4: Cultural beliefs influence the choice of a mother regarding breastfeeding........ 59

Sub-theme 3.4.2.5: Lack of training among other staff members regarding exclusive breast-feeding hinders the implementation of the policy........................................ 61

Sub-theme 3.4.2.6: Counseling facilities to ensure privacy and confidentiality for mothers are inadequate............................. 63

Theme 3.4.3: The midwives experience a variety of Emotions related to exclusive breastfeeding........................................ 63

Sub-theme 3.4.3.1: The midwives experience the emotion of 64

- Happiness that the policy promotes breastfeeding..... 64
- Confidence when mothers start to trust and open up to them......................................................... 65
- Helplessness when the mother or baby is sick and breast-feeding cannot be initiated......................... 66
- Frustration when, after being counseled, mothers stop breast-feeding and start formula feeding....... 67
- Worry and concern about the patient being stigmatized and not supported by the family............. 68
- Stress due to work overload................................................. 69

3.5 Conclusion........................................................................... 70
CHAPTER 4: GOALS, FINDINGS, GUIDELINES, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION OF THE STUDY

4.1 Introduction

4.2 Objectives of the Study

4.3 Findings of the Study

4.4 Guidelines for the Implementation of the Policy of Exclusive Breastfeeding

4.4.1 Implement the policy of exclusive breastfeeding as it is

4.4.2 Communicate infant feeding policy

4.4.3 Infant feeding practices awareness

4.4.4 Ensuring effective Counseling

4.4.5 Stress management of midwives

4.4.6 Documenting Care

4.5 Recommendations

4.5.1 Nursing education

4.5.2 Nursing practice

4.5.3 Nursing research

4.6 Limitations to the Study

4.7 Conclusion

Bibliography

Annexure A

Annexure B

Annexure C

Annexure D

Annexure E

Annexure F
LIST OF TABLES

Table 2.1: Strategies to Ensure Trustworthiness.......................... 38

Table 3.1: Identified Themes And Sub-Themes Related To The Views And Experiences Of The Midwives Regarding The Policy Of The Department Of Health Of Exclusive Breastfeeding In HIV Positive First-Time Mothers......... 46
CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The focus of this research is to explore and describe the experiences and perceptions of midwives regarding exclusive breastfeeding in human immunodeficiency virus (HIV) positive first-time mothers. Breastfeeding has long been recognized as central to the health and well being of children, especially in developing countries. The benefits of breastfeeding for both mother and infant are well documented, as are the consequences of breastfeeding for HIV-infected mothers and their infants. In the pre-HIV era, breastfeeding was an important factor in maintaining child health by providing optimum nutrition and protection against common childhood infections, especially respiratory and diarrhoeal infections, and by promoting child spacing (Ogundele & Coulter, 2003:92).

Given the well-documented benefits of breastfeeding to the child and mother, progress cannot be made with regard to human rights, women’s rights, the right to health and the rights of children without attention to policies on breastfeeding. Worldwide attention, in the form of policy statements, turned to breastfeeding with the International Code of Marketing of Breast Milk Substitutes (World Health Organisation (WHO) 1981:22). The aim of this Code is to contribute to the provision of safe and adequate nutrition of infants by protecting and promoting breastfeeding and by ensuring the proper use of breast milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution (WHO, 1998:22).

The Code states the following:

- No advertising of breast milk substitutes to the public.
- No free formula milk samples to mothers.
- No promotion of products in health care facilities.
• No company “mothercraft” nurses to advise mothers.
• No gifts or personal samples to health care workers.
• No words or pictures idealizing artificial feedings, including pictures of infants on the products.
• Information to health workers should be scientific and factual.

With the emergence of HIV and increased awareness of the risk of HIV transmission through breastfeeding, policy makers have grappled with the need to develop appropriate and feasible guidelines to help HIV positive mothers decide if they should breastfeed their babies. The latest United Nations (UN) policy statement on HIV and infant feeding was issued in 2001, following an expert consultation on Mother-To-Child Transmission (MTCT) of HIV. Regarding the balance of risks between breastfeeding and replacement feeding, the UN statement says: When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first six months of life (The Joint United Nations Program on HIV/AIDS (UNAIDS); 1998: 2).

To minimize HIV transmission risk, breastfeeding should be discontinued as soon as feasible, taking into account local strife to improve conditions that will make replacement feeding safer for HIV infected mothers and families (Morrison & Greiner, 2000:28). In order to help countries implement this policy, guidelines for policy makers and health care managers were published by the UN agencies in 1998 and updated in 2003. Most countries offer voluntary counseling and testing as part of antenatal services. Pregnant women who test positive for HIV receive counseling on infant feeding, among other things (Linkages, 2003:4).

According to the South African Policy Guidelines and Recommendations for Feeding of Infants of HIV Positive Mothers, breastfeeding is a significant and preventable mode of HIV transmission to infants and there is an urgent need to educate, counsel and support women and families so that they can make

1.2 BACKGROUND AND LITERATURE REVIEW

More than 800 000 children under 14 years contracted HIV worldwide in 2001 (WHO; 2003: 8). According to the UN, 90 percent were infected with HIV transplacentally, during their birth or by breastfeeding. Breastfeeding, therefore, poses a concern for all HIV positive mothers. Women constitute an estimated 58 percent of the 29.4 million people infected with HIV in sub-Saharan Africa. This region leads the world in MTCT of HIV. The evidence that breastfeeding transmits HIV is based on the detection of HIV in the breast milk (Nduati, John & Richardson, 1995:1461).

In developing and industrialized nations, infant and child morbidity is much lower in breastfed than in bottle fed infants. A study in Kinshasa amongst children of both uninfected and infected mothers showed that morbidity was significantly higher during the first 6 months of life in 237 HIV uninfected children who were not exclusively breast fed, compared with 81 HIV uninfected children who were exclusively breastfed (Ryder, Manzila & Baende, 1991:5).

Exclusive breastfeeding for the first six months of an infant’s life is recommended worldwide. The World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) recommend that exclusive breastfeeding should be continued for 6 months (180 days) after birth (Kassier, Maunder & Senekal, 2003:5). The infant is exclusively breast fed when it receives only breast milk from the mother or a wet nurse, or expressed breast milk, and no other liquids or solids with the exception of drops or syrups consisting of vitamin or mineral supplements, or medicines.
A UNICEF report (1998:23) states that breastfeeding combines the three fundamentals of sound nutrition namely food, health and care and is the next critical window of nutritional opportunity after pregnancy. It is a bulwark against malnutrition and infant mortality. For the first 4 - 6 months of life breast milk provides clean, pure, adequate nutrition at optimal temperature and with the right balance of proteins, carbohydrates and micronutrients as well as hormones and nucleotides. Breast milk contains long-chain polyunsaturated fatty acids thought to be essential for the developing brain. It can also provide a significant degree of nutrition over the next 6 months of life or more. Breast milk protects against a host of environmental insults to which the growing infant has not been exposed previously, thus allowing the immune system to develop naturally without undue premature stress (Ogundele & Coulter, 2003:92).

Very little is known about the impact of not breastfeeding in communities where breastfeeding is the cultural norm, such as in Africa. Scant attention has been given to the social stigma of not breastfeeding, which would immediately identify or at least imply a woman as HIV positive, nor to the implications for increased fertility and population growth. Even with optimal hygiene, artificially fed infants suffer three to four times the rate of diarrhoeal infection of breastfed infants and have higher rates of respiratory, ear and other infections (Morrison & Greiner, 2000:28).

In a workshop facilitated by Constanza Vallenas, MD, of the WHO, participants shared their experiences in communities ranging from large cities in the United States of America, Europe and Africa to rural villages in Zimbabwe, Botswana and South Africa (SA). Real impediments to exclusive breastfeeding were a focal point of the discussion. During the course of the workshop, participants concurred that infant feeding counseling done on a regular basis was beneficial in promoting healthy feeding methods and, therefore, exclusive breastfeeding and reduced MTCT (Morrison, 1999:5).

Sore nipples are often a reason for mothers providing their infants with other feeds. However, teaching mothers how to help their babies attach to the nipple
(‘latch’) properly, or how and when to simply switch breasts, for example, helps them maintain adherence to exclusive breastfeeding. Ideally, counseling should begin during pregnancy (at around 26 weeks) and be provided twice a week during the infant’s first two weeks of life (Morrison, 1999:5).

In 1987 (WHO 1987:3) and 1992 (UNAIDS 1992:5) the WHO global programme on Acquired Immune-Deficiency Syndrome (AIDS) recommended that, where malnutrition and infectious diseases are prevalent, both HIV infected and sero-negative women should be counseled to breastfeed their infants because the risk of HIV infection through breastfeeding was considered lower than the risk of death from other causes resulting from failure to breastfeed (Ogundele & Coulter, 2003:97).

In 1990, a number of breastfeeding guidelines for health workers and health facilities were proposed. These guidelines, as stated in the Innocenti Declaration (1990:1), are:

- All women should be enabled to practice exclusive breastfeeding;
- All infants should be fed exclusively on breast milk from birth to six months of age; and
- Thereafter, infants and young children should continue to be breastfed for up to 2 years of age or beyond, while receiving appropriate complementary foods.

In order to support the attainment of the above goals in South Africa, the Department of Health (DOH) proposed an infant feeding policy that would:

- Protect, promote and support breastfeeding and encourage the use of appropriate complementary foods.
- Reduce the impact of practices that negatively affect breastfeeding.
- Create a health care system free from commercial pressures regarding infant and young child feeding.
- Encourage all health care facilities to implement the Baby-Friendly Hospital Initiative (Department of Health, 18 February 2000).
The aforementioned guidelines apply to all health facilities and health workers in SA engaged in health care of pregnant and lactating women, newborns, infants and young children.

Ten years ago, WHO/UNICEF launched the Baby-Friendly Hospital Initiative (BFHI) to improve breastfeeding practices in hospitals. Each hospital must comply with ten steps for training and supporting mothers pre- and post-partum (Morrison, 1999:6). According to the BFHI, every hospital providing maternity services and care for newborn infants should:

i. Have a written breastfeeding policy that is routinely communicated to all health care staff.

ii. Train all health-care staff in skills necessary to implement this policy.

iii. Inform all pregnant women about the benefits and management of breastfeeding.

iv. Help mothers initiate breastfeeding within half hour of birth.

v. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.

vi. Give newborn infants no food or drink other than breast milk, unless medically indicated.

vii. Practice rooming-in (allow mothers and infants to remain together) 24 hours a day.

viii. Encourage breastfeeding on demand.

ix. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

x. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital clinic. (http://www.who.int/dsa/cat98/z10steps.htm.2005-03-07).

Under the BFHI, no donated or subsidized infant formulas are allowed in an effort to promote breastfeeding over formula feeding. Infant formulas would not be available in hospitals, yet with respect to the vagaries of HIV policy (that recommends avoidance of breastfeeding by HIV infected women in the developed world), the WHO recognises that infant formulas offer a valuable alternative for some HIV positive women (Morrison, 1999:6).
Since 1999, the Department of Health has identified a number of pilot sites for the implementation of the Prevention of Mother-To-Child-Transmission of HIV (PMTCT) programme. Within this programme all pregnant women presenting at public hospitals and clinics are entitled to voluntary confidential counseling and testing. If the mother agrees and tests positive for HIV, she has the option to join the PMTCT programme. In addition, the mother is offered free milk formula for the first 6 months of her infant’s life to ensure her infant is not at risk of MTCT from breast milk (Department of Health, 2001:7). Stopping HIV positive mothers from breastfeeding will prevent some infants from becoming infected with HIV. However, on the other hand, depriving some infants in resource-poor settings of breast milk significantly increases their risk of infections and death (Morrison, 1999:7).

1.3 PROBLEM STATEMENT

Significant efforts have been made in recent years to promote breastfeeding by all mothers. There are considerable risks associated with not breastfeeding, particularly in resource-poor settings. Poverty and cultural norms are the main concerns and some mothers from these groups can afford to buy formula milk. In addition, a new mother who fails to put her baby to the breast may publicly brand herself HIV positive, a stigma that may cut her off from community support. In addition, formula is expensive, hard to come by and potentially lethal for infants if mixed with contaminated water. Consequently, it has been difficult for midwives to advise HIV positive women how best to feed their infants.

The “South African Policy Guidelines and Recommendations for Feeding of Infants of HIV Positive Mothers” was published in 2003. According to the policy, breastfeeding is a significant and preventable mode of HIV transmission to infants and there is an urgent need to educate, counsel and support women and families, so that they can make decisions about how best to feed infants in the
context of HIV (http://www.doh.gov.za/aids/doc/feeding/html.2005-03-07). In the following year (2004), in conversations with midwives from the provincial hospitals in the Nelson Mandela Metropole (NMM), the researcher became aware of the midwives’ often-expressed unhappiness about the new policy from the DOH on exclusive breastfeeding. The problem is that the midwives, who must implement the policy, are confronted with a dilemma regarding infant feeding practices; they could not understand the advocacy of exclusive breastfeeding, when breastfeeding is recognized as one of the modes of MTCT of HIV.

It appeared that some of the midwives encountered by the researcher had not received adequate information or education on the subject. Furthermore, a literature search on the topic revealed a lack of existing research into:

- The midwives’ experiences and perceptions regarding exclusive breastfeeding in the context of the new policy; and
- How individual provincial hospitals are currently managing these potentially confusing health messages.

The midwives’ dilemma concerning what advice to give to HIV positive first-time mothers about infant feeding, and the lack of previous literature on this topic, have led the researcher to identify the exclusive breastfeeding programme for HIV positive first-time mothers as a target for research, in order to determine where it might be improved.

1.4 RESEARCH QUESTIONS

In the light of the preceding information, the researcher formulated the following research questions:

- What are the experiences and perceptions of midwives of promoting exclusive breastfeeding in HIV positive first-time mothers?
• What guidelines can be developed to help midwives implement the exclusive breastfeeding policy of the Department of Health?

1.5 RESEARCH OBJECTIVES

The objectives of this study are to:
• Explore and describe the experiences and perceptions of midwives related to promoting exclusive breastfeeding in HIV positive first-time mothers.
• Make recommendations to the Department of Health regarding the support and help that can be given to midwives to encourage their implementation of the exclusive breastfeeding policy.

1.6 TERMINOLOGY

The following terms are defined for the purpose of this study:
• **Breastfeeding**: The infant receives breast milk direct from the breast or expressed breast milk (http://www.lalecheleague.org/ba/feb00.html.2005-03-07).
• **Bottle-feeding**: The infant receives liquid or semi-solid food from a bottle with a nipple/teat (http://www.lalecheleague.org/ba/Feb00.html.2005-03-07).
• **Exclusive breastfeeding**: The infant receives only breast milk from the mother or a wet nurse, or expressed breast milk, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines (http://www.lalecheleague.org/ba/ Feb00.html. 2005-03-07).
• **Infant**: A child between the ages 0 – 12 months (Department of Health, 2001:5).
• **Human immunodeficiency virus (HIV)**: The virus that attacks the immune system leading to AIDS (Department of Health, 2001:5).
• **HIV-positive mothers:** The women who are infected with HIV and have taken an HIV test, whose results have been confirmed as positive and have been made known to the individual that they are positive (Department of Health, 2001:5).

• **Experience:** What happens to a person; what is seen, done, felt or lived (World Book Millennium: Volume A-K, 2001:749).

• **Perception:** A belief or opinion often held by many people and based on appearances (World Book Millennium: Volume A-K, 2001:1032).

• **Midwife:** A person who, having been regularly admitted to a midwifery educational programme duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery (De Kock & Van der Walt, 2004: 4).

### 1.7 PARAGMATIC PERSPECTIVE

The theoretical model that will be adopted in the study is Kotzè’s Anthropological Nursing Science Model: Nursing Accompaniment Theory. This theory is based on the scientific approach that is facilitated throughout the interactional process between the midwife and her client. Accompaniment is postulated as a deliberate systematic intervention by the nurse to assist the patient to overcome the need for help and support, by recovery of self–reliance and the acceptance of responsibility for the purpose of giving meaning to personal life (Kotzè, 1998: 3).

#### 1.7.1 Metatheoretical Assumptions

The research will incorporate Kotzè’s Anthropological Nursing Science Model: Nursing Accompaniment Theory as a paradigmatic perspective for this research. This includes Kotzè’s views on man, world, nursing and health.
1.7.2 Man

“Man” is accepted as a multidimensional being who is openly and constantly choosing between right and wrong on the basis of personal view of world, life, man, work and a personal value system. Man is continually concerned with norms, which he either obeys or disobeys. Man is indivisibly body-psyche-spirit, continuously becoming within an inseparable dynamic relationship with world, time, fellow beings and God (Kotzè, 1998:4).

In this study, “man” refers to the professional midwives who are multidimensional individuals in body-mind-spirit who are continually becoming, are in relationship with their fellow health team members as well as the HIV positive first-time mothers, and who have a unique value system which influences their thoughts, decisions and actions.

1.7.3 World

“World” refers to the world in which man exists, which consists of the objective or external world, including the world of science, technology, nature, ecology, astronomy and microorganisms. The subjective or life-world includes the personal world, the intra personal world, the world of co-existence, and the dimensions of time in which man exists (Kotzè, 1998: 4).

In this study, “world” refers to the external world of the clinic where the midwife works and where a decision by the mother to breastfeed exclusively might be taken. It is also the world of co-existence (relationships), where the midwife meets the mothers who might need counseling and where the midwife might be called upon to do counseling.

1.7.4 Health

“Health” refers to the state of wellness or illness of an individual: it is a dynamic process relating to the degree of mobility of a person as body-psyche-spirit to maintain himself or herself optimally in his or her relationships (Kotzè, 1998:4).
In this study, health refers to the mental health of the midwife who might experience value conflicts related to the counseling she gives the mother regarding exclusive breastfeeding.

1.7.5 Nursing

“Nursing” is an interpersonal, comprehensive service to man at all stages of life, ill or well, which encompasses a dynamic systematic process of management, clinical care and teaching, of which accompaniment is inherently part, so as to effect change that would facilitate prevention of illness, disability and suffering, promotion and regaining of wellness, and where this is not possible, would facilitate a peaceful, dignified death (Kotzè, 1998: 4). In this study, “nursing” refers to the intervention carried out by the professional midwife in terms of promoting and supporting exclusive breastfeeding.

1.8 RESEARCH DESIGN AND METHODOLOGY

An overview of the research design and method will now be presented.

1.8.1 Research Design

Botes (1994:4) states that the research decisions that are made in the design phase deal with the research strategy (overall approach), methods of data collection, methods of data analysis, the target population and methods of sampling, as well as methods of validity and reliability. The research design and method are described according to strategy, models, trustworthiness and strategies of reasoning.

In this research study, a qualitative, exploratory, descriptive and contextual design with a phenomenological approach will be used, reflecting the experiences and perceptions of midwives of exclusive breastfeeding in first-time HIV positive mothers.
1.8.1.2 Qualitative research

In qualitative research, subjective methods are used as researchers in this field are not interested in casual laws, but in people’s perspectives as far as beliefs, experiences and personal meaning systems are concerned. By bringing into the equation the perceptions of the interests of the participants themselves, issues are viewed in a way that could not be realized through other techniques (Ritchie, 1999:253). Phenomena are viewed in their primary, holistic and social context (Brink, 1992:35). Qualitative researchers are primarily concerned with process, rather than outcomes or products (Creswell, 1994:145). Kirk and Miller (1986:9) describe qualitative research as a particular tradition in social science that depends essentially on watching people in their own territory and interacting in their own language, on their own terms. In this research the observations will be made on professional midwives in their territory, namely the clinic. Qualitative research requires personal rather than detached engagement in the context. It requires multiple, simultaneous actions and reactions from the human being (the researcher) who is the research instrument (Meloy, 1994: 68). The qualitative researcher is the primary instrument for data collection and analysis and the research often involves fieldwork. Qualitative research methods are descriptive and result in rich, thick, complex and holistic descriptions of participants’ subjective experiences (Creswell, 1998:15).

1.8.1.3 Exploratory research

Exploratory research is research in a relatively unknown field in order to gain insight and understanding into the problem (Uys & Basson, 1996:28). The researcher wants to become familiar with the experiences and perceptions of professional midwives in promoting and supporting exclusive breastfeeding in HIV positive first-time mothers. It is well suited to explore a topic of which the variables and theory base are apparently unknown or there is a lack of theory and previous research apparently does not exist.

1.8.1.4 Descriptive research

Descriptive research refers to the methodical collection of accurate data on the domain phenomenon to be studied (Uys & Basson, 1996:28). The purpose is to
explore and describe phenomena in real life situations (Burns & Grove, 1999:24). The experiences and perceptions of professional midwives will be described in this research so that a complete and accurate account can be given. Methodology and literature review will also be discussed.

1.8.1.5 Contextual design
Contextual design involves the immediate environment and physical location of the people being studied (Holloway & Wheeler, 1996:192). The researcher will, in this study, explore and describe how the midwives experience their personal environment in the antenatal and postnatal departments of provincial hospitals where the MTCT programme has been instituted and where HIV positive women and HIV positive first-time mothers receive education on infant feeding methods.

1.8.1.6 Phenomenological approach
The phenomenological approach examines human experiences (lived experiences) through the description that is provided by the people involved. The purpose of this approach is to describe what people experience with regard to a phenomenon, how they interpret it and the meaning they attach to it (Brink, 1996:119). These lived experiences will be explored and described so as to enable the researcher to have a better understanding of them.

1.8.2 Research Methodology
The process of data collection, analysis of data and developing of guidelines and recommendations will now be discussed.

1.8.2.1 Research population
In this study, the target population will consist of midwives working in those provincial hospitals in the Nelson Mandela Metropole where HIV positive first-time mothers seeking information on methods of feeding their newborn babies are being counseled. The professional midwives must have counseled HIV
positive first-time mothers concerning methods of feeding options for a period of at least 6 months, be fluent in English and be willing to participate in the research study.

1.8.2.2 Sampling
A purposive sampling technique, as described in Burns and Grove (1997: 245), will be used as the researcher will use midwives who can give meaningful information on their experiences and perceptions of promoting exclusive breastfeeding to the HIV positive first-time mothers who seek information on feeding their newborn infants. The sample size will comprise at least 5 (five) midwives working in antenatal care and at least 5 (five) midwives working in postnatal care. Data collection will continue until saturation of data occurs.

1.8.3 Data Gathering
A variety of techniques will be used in data gathering.

1.8.3.1 Interviews
Data will be gathered by interviewing participants. An interview is a particular field research data gathering process designed to generate narratives that focus on specific research questions. It is personal and intimate, with the emphasis on depth, detail, vividness (intensity) and nuance (subtle difference in meaning) (Crabtree & Miller, 1999: 93).

Unstructured phenomenological interviews will be conducted with the midwives who meet the criteria stipulated for participation in the research study. The researcher will use verbal, open and direct questions to elicit the experiences and perceptions of the participants in promoting the Department of Health policy on exclusive breastfeeding. The questions that will be posed as a basis for discussion are:
1. “What is your personal opinion with regard to exclusive breastfeeding and HIV?”

2. “How do you feel about implementing the policy on exclusive breastfeeding when you are dealing with pregnant women and new mothers whom you know to be HIV positive?”

Each interview will last approximately 45 to 60 minutes. The researcher will use facilitative communication techniques such as listening, reflecting, clarifying and summarizing and minimal verbal responses to encourage the participant to vent his or her experiences and thoughts (De Vos, 1998: 284). An audiotape recorder will be used to record interviews during data collection. Recordings will be transcribed verbatim thereafter. The researcher will keep on interviewing participants until data saturation is reached. These transcriptions will form the database, together with the field notes.

1.8.3.2 Observation and Field Notes

Field notes will be made during and immediately after the interview as an aid to enrich the data collected. De Vos (1998:285) interprets field notes as additional techniques employed to record events. Schartzman and Strauss’s model (1973 in De Vos, 1998:285) describes three categories of field notes namely, observational notes, theoretical notes and methodological notes.

- Observational notes provide an account of what happened; that is the who, what, when, where and how of human activity (De Vos, 1998:285). In this study, the researcher will make observational notes at each interview describing the setting, the actions and the behaviour of the participants, as well as the interview process (coded to ensure anonymity).

- Theoretical notes are attempts by the researcher to derive meaning from the observational notes (De Vos, 1998:286). In this study, the researcher will attempt to interpret and attach meaning to the content of the observational notes made while interviewing participants.

- Methodological notes are reminders, instructions and critical comments to the researcher by the researcher (De Vos, 1998:286). In this study, the
researcher will make methodological notes as the study progresses regarding conduct or performance during the interviews and analysis. Field notes will be added to the transcriptions to form the database.

1.8.3.3 **Personal journal**

In addition to the field notes, the researcher will also keep a personal journal during data collection to document her thoughts, feelings, insights and reactions. These reflections will provide the foundation for later in depth analysis.

1.8.4 **Data Analysis**

The purpose of data analysis is to identify themes emerging from the data (Brink, 1994:15). Data will be analyzed using Tesch’s method (1990 in Creswell, 1994:153) of systematic description and theme analysis. According to Tesch, data analysis is eclectic because there is no right way to analyze the data (1990 in Creswell, 1994:153). The researcher chose to use the steps described by Tesch to objectively and systemically organize the content of the interviews. The most interesting interview will be selected to start off with. Themes and sub-themes will be identified as the transcriptions are read through repeatedly. Themes, according to Woods and Catanzaro (1988:438), are ideas or experiences that appear repeatedly as the participants verbalize their experiences. Words depicting themes will be underlined in every transcription. The identified themes and sub-themes will be categorized. The categorized data and the transcribed interviews, together with the audio taped recordings, will be presented to an independent coder for verification. A consensus discussion between the researcher and the independent coder will ensure greater accuracy, reliability and trustworthiness of the results. Field notes will also be analyzed (Woods & Catanzaro, 1988:38).
1.8.5 Literature Review

After data collection and analysis have been completed, a literature review of other studies done on exclusive breastfeeding will be carried out to enable the researcher to confirm the findings of this study. This will be done after completion of data collection to prevent the researcher’s objectivity from being influenced by the information gleaned from the literature (Burns & Grove, 1993: 142).

1.9 MEASURES TO ENSURE TRUSTWORTHINESS

Guba’s model on trustworthiness, as discussed in Polit and Hungler (1995:362-363), will be used to ensure the trustworthiness of this study. Guba’s model consists of four criteria, namely credibility, transferability, dependability and confirmability. Measures to ensure trustworthiness will be discussed in detail in chapter 2.

1.10 ETHICAL CONSIDERATIONS

The ethical acceptability of the study will be considered throughout the research process. The primary considerations are informed consent, privacy, confidentiality and anonymity (De Vos, 1998: 24). Steps taken to ensure a high standard of ethics will be discussed in details in chapter 2.

1.11 CHAPTER SEQUENCE

Chapter 1: Overview Of The Study
Chapter 2: Research Methodology And Design
Chapter 3: Analysis Of Findings And Literature Control
Chapter 4: Recommendations And Conclusions
1.12 CONCLUSION

Exclusive breastfeeding for the first six months of an infant’s life is recommended worldwide. However, a certain degree of confusion has arisen amongst midwives with regard to breastfeeding by HIV positive first-time mothers, which could be due to policies and guidelines issued by the Department of Health that seem to contain conflicting information in this regard. The purpose of this study, therefore, is to explore and describe the experiences and perceptions of midwives with regard to promoting exclusive breastfeeding by HIV positive first-time mothers with a view to using the findings to develop guidelines to assist midwives in implementing the policy of the Department of Health in this regard. The reason for this is that midwives play a vitally important role in advising their clients with regard to the best and safest ways of providing nutrition for their infants.
CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

The purpose of this chapter is to present clearly the research design and methodology used to fulfil the objectives of the study. Each aspect will be dealt with as a separate topic in order to give a clear understanding of these processes. Accordingly, this chapter will provide a description of the rationale, the objectives, the research design and method, steps to ensure trustworthiness and ethical considerations.

The research design and method should be based on scientifically accountable principles. Qualitative research has emerged as a scientifically relevant method applicable to social sciences and, because nursing, as a human health care science, is closely aligned to social sciences, the qualitative research method is relevant to nursing research. Qualitative research discovers properties of a given phenomenon using an analytical set of procedures. The explanatory nature of qualitative research can provide intricate details of phenomena as well as suggest open-ended pathways for discovering explanation and understanding of human behaviour that can assist the nurse to improve the care delivered (Creswell, 1994: 143).

The aim of this study was to explore and describe the experiences and perceptions of midwives related to promoting exclusive breastfeeding in HIV positive first-time mothers. This information was then used as a basis for the development of guidelines to help midwives implement the exclusive breastfeeding policy of the Department of Health.
2.2 RATIONALE

Midwives have a responsibility to inform women of the social, economic and health advantages and disadvantages of different feeding methods, including both exclusive breastfeeding and artificial feeding (Dorhn, 2004: 3). It is not clear how knowledgeable midwives are about appropriate child feeding practices, especially exclusive breastfeeding in HIV positive first-time mothers.

South Africa has a national infant feeding policy that supports, protects and promotes exclusive breastfeeding. This policy is a lifesaver and is critical for the well being of many infants nationally. Exclusive breastfeeding during the first six months of life carries greater benefits than mixed feeding with respect to morbidity and mortality from diseases such as respiratory tract infections, allergies and gastrointestinal disorders and infectious diseases other than HIV (Department of Health, 2003: 4). Exclusive breastfeeding is a major factor in enabling many infants to survive the first year of life, especially those from low resourced areas where there are high incidences of morbidity and mortality from malnutrition and diarrhoeal diseases.

The researcher regards the midwife as a professional person who needs to be knowledgeable about the advantages and disadvantages of different feeding methods when dealing with HIV positive first-time mothers. Little research has been done to date to explore and describe the experiences and perceptions of midwives related to promoting exclusive breastfeeding in HIV positive first-time mothers. The dynamics of the promotion of exclusive breastfeeding in HIV positive first-time mothers by midwives was the focus of this study.

Through explorative description of midwives’ experiences and perceptions regarding exclusive breastfeeding in HIV positive first-time mothers, the study provided information that was used to make recommendations to the DOH regarding the support and help that can be given to midwives to encourage their implementation of the exclusive breastfeeding policy. This information was then used as a basis to make recommendations to the Department of Health.
regarding the support and help that could be given to midwives to encourage them implement the policy of exclusive breastfeeding.

### 2.3 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Explore and describe the experiences and perceptions of midwives related to promoting exclusive breastfeeding in HIV positive first-time mothers.
- Make recommendations to the Department of Health regarding the support and help that can be given to midwives to encourage their implementation of the exclusive breastfeeding policy.

### 2.4 RESEARCH DESIGN

A qualitative, phenomenological, explorative, descriptive and contextual approach was used in this study.

#### 2.4.1 Qualitative Perspective

There is little known about the nature and cause of the experiences and perceptions of midwives related to promoting exclusive breastfeeding in HIV positive first-time mothers, hence the use of a qualitative research design (Morse & Field, 1996:8). By using this approach the researcher was able to examine the underlying assumptions and attitudes, and elicit the rationale for these assumptions and attitudes, within the context in which they occur.

Qualitative research is used to study people in their natural environments and is characterized by the researcher trying to get to the heart of an issue in order to understand it (Mouton & Marais, 1996:15). Qualitative research is more
concerned with the process than the outcomes or products (Creswell, 1994:145). In this study, the process was mostly inductive with the researcher building abstractions, concepts, hypotheses and theories from details given by the midwives who met the selection criteria. Therefore, the researcher was able to establish meaning in respect of how the midwives lived, talked and behaved, what captivated and distressed them (Tutty, Rotheny & Grinnell, 1996:4) and how they made sense of their lives, experiences and the content and structures of their world (Creswell, 1994:43).

The qualitative approach was used in this study to gain a holistic picture of the experiences and perceptions of the midwives regarding exclusive breastfeeding in HIV positive first-time mothers.

2.4.2 Phenomenological Perspective

Phenomenological studies focus on the lived experiences of people (in this study midwives), how they interpret these experiences (Brink, 1996:119), what they think concerning them and how they perceive certain situations (promoting exclusive breastfeeding in HIV positive first-time mothers) (Heagert, 1997:49). In this study, the researcher was able to examine these experiences through the descriptions made by the midwives during the interviews.

2.4.3 Exploratory Perspective

An exploratory study attempts to uncover and explore the relationships and dimensions of a phenomenon and, by so doing, gain new insight into the phenomenon under discussion (Uys & Basson, 1996:28), discover new ideas and/or increase knowledge of other phenomena (Cormack, 1991:17), gain perspective regarding the character of the problem situation and gain more knowledge about other relatively unknown phenomena (Mouton & Marais, 1996:43).
As mentioned previously in this chapter, there was an apparent dearth of information on the nature of the feelings and experiences of midwives related to promoting exclusive breastfeeding in HIV positive first-time mothers; for that reason, the researcher attempted to gain more insight into this area by exploring these feelings and experiences through face-to-face interviews with midwives.

2.4.4 Descriptive Perspective

In a descriptive research study, the researcher aims to provide an accurate and detailed description of the characteristics of a particular phenomenon (Burns & Grove, 1993:38). Accordingly, a descriptive perspective was used in this study to reach a better understanding of the midwives’ experiences and perceptions relating to promoting exclusive breastfeeding in HIV positive first-time mothers (Mouton & Marais, 1989:43). For this reason, the interviews were recorded to allow the researcher to concentrate on what was being said by the participants.

The researcher provided the midwives with an opportunity to describe their feelings about their experiences and perceptions concerning exclusive breastfeeding in HIV positive first-time mothers. Based on the information gleaned from the research study, recommendations were made to the Department of Health regarding the support and help that can be given to midwives to encourage their implementation of the exclusive breastfeeding policy.

2.5 RESEARCH METHODOLOGY

The data collection methods used in this research study will now be discussed.
2.5.1 Research Population
According to Burns and Grove (1993:235), population refers to an identification of a group of persons, agencies, places and other units of interest that can by definition be placed together. The research population refers to those participants that may realistically be selected as research participants, that is those that are potentially accessible to the researcher (Yegidis & Weinbach, 1996:114). The accessible target population can be defined as *the entire aggregation of cases that meet a designated set of criteria* (Burns & Grove, 1993:236; Polit & Hungler, 1995:470). In order to be included in this study, the following selection criteria had to be met, namely participants had to be midwives:
  - Employed at a public hospital in the Nelson Mandela Metropole.
  - Who had counselled HIV positive first-time mothers for a period of at least 6 months concerning methods of feeding options.
  - Who were fluent in the English language medium.

These selection criteria ensured that the sample used was well exposed to the experiences and perceptions to be explored and described in this study.

2.5.2 Sampling Method
Sampling in qualitative research, according to Polit and Hungler (1995:468), is the process by which the researcher selects a certain portion of the population in order to discover meaning and uncover multiple realities. The participants are selected on the basis of the researcher’s personal judgement concerning who will be most representative and also most productive.

In this study, purposive sampling was used. Purposive sampling is judgemental sampling that involves the conscious selection by the researcher of certain subjects or elements to include in a study (Burns & Grove, 1999:233). In order to maintain objectivity, the researcher enlisted the assistance of a gatekeeper to select the sample, while also ensuring that confidentiality and privacy were maintained. The sample size comprised at least five midwives working in antenatal care and at least five midwives working in postnatal care. Data
collection continued until saturation was reached, which was evidenced by recurring themes, no new or relevant data emerging on specific categories, a dense development of categories and the relationship between categories having been established and validated (Strauss & Corbin, 1990:188).

2.5.3 Data Collection

After obtaining permission to do the study (see Annexure A, B & C) from relevant authorities together with the policy or any means that gave the researcher an indication of the type of sample that was suitable for this study, for example, names of participants by the gatekeeper and a list of telephone numbers; telephonic appointments were made with potential participants to discuss participation in the study, after which private meetings were held with each of them to explain the objectives and methodology of the study to ensure that they understood the ethical implications associated with this. Written consent was then obtained from each voluntary participant (see Annexure D). A variety of techniques were used in data collection, which will now be discussed.

2.5.3.1 Interviews

An interview is a particular field research data gathering process designed to generate narratives that focus on specific research questions. It is personal and intimate, with the emphasis on depth, detail, vividness (intensity) and nuance (subtle difference in meaning) (Crabtree & Miller, 1999:93). In this study, information was gathered by means of unstructured phenomenological interviews, which were essentially exploratory in nature (Tutty et al., 1996:55). This type of interview is sometimes called an open-ended interview and does not use an interview schedule containing a common set of standardized questions. All of the participants were questioned as follows:

- “What do you think of the policy on exclusive breastfeeding and HIV?”
- “What is your experience with regard to exclusive breastfeeding when you are dealing with pregnant women and first-time mothers whom you know to be HIV positive?”
The interviews were conducted in a quiet room in the hospital setting where the participant was employed. The latter was seated in a comfortable chair. A “Please do not disturb” sign was hung on the door and the staff members working in the unit were also informed to ensure that privacy was maintained. The researcher sat opposite the participant to establish eye contact and to ensure rapport between them. She greeted the participant and introduced herself prior to commencement of the interview. During all the interviews the researcher adopted an open, friendly and professional manner. The research interview was concluded appropriately by thanking the interviewee for her time and cooperation and greeting her by hand (Kvale, 1996:174-178).

Communication skills were implemented to encourage the interviewee to express her feelings during the interview. Open-ended questions provided a frame of reference for the participants’ responses, while at the same time putting a minimum restraint on the responses and their expression. There were, therefore, no restrictions placed on the content of the response or the manner in which the respondent answered (Kerlinger, 1996:442). The researcher guided the interview around the research questions and encouraged the participants to talk using the following verbal and non-verbal communication skills:

- **Paraphrasing:** Paraphrasing refers to the interviewer repeating in her own words the ideas, opinions and feelings of the participant to make sure that she understood the interviewee correctly (Okun, 1987:76).

- **Reflecting:** Reflecting means that an understanding of the participant’s concerns, ideas and non-verbal behaviour was communicated to the participant by the researcher (Okun, 1987:76).

- **Minimal verbal response / attending behaviour:** Minimal verbal response / attending behaviour was a technique used to show the participant that the researcher was listening to her. Examples of minimal verbal response include the use of eye contact and facial expression, encouraging communication by leaning forward slightly, nodding agreement and using minimal utterances such as “um” “hmm” or “yes.” This type of attending behaviour demonstrated to the participant that the
researcher was honest, sincere, empathic and understanding and had respect for her (Okun, 1987:76).

- **Clarifying:** With the technique of clarifying, an attempt was made to understand the nature of the participant’s statement. Information was also verified (Okun, 1987:76).

- **Summary:** Summary as a communication technique was used throughout the interview session as well as at the end of the session in order to identify the most important affective and cognitive highlights of the interview. The respondent was encouraged to share her feelings after having evaluated the session (Okun, 1987: 76-77).

- **Non-verbal behaviour:** The researcher also utilised non-verbal behaviour such as: occasional nodding; smiling; touching and hand gesturing; maintaining a moderate rate of speech; and a firm, supportive tone of voice. With these signs of non-verbal behaviour, the researcher attempted to convey warmth, understanding, attentiveness and efficacy, which were congruent with verbal behaviour, to the participant (Okun, 1987:64).

- **Bracketing and intuition:** The researcher observed the principle of bracketing and intuition, which refers to developing one’s consciousness through looking and listening without forcing any previous knowledge or preconceptions about the phenomenon (Brink, 1996:120). Although the researcher endeavoured tactfully to maintain the focus of the interview when necessary, there was no leading of the participants either by suggesting or asking about aspects not mentioned.

Each interview lasted approximately 45 to 60 minutes. The researcher obtained permission from participants to use an audiotape recorder to capture the interviews. The audiotapes were transcribed verbatim thereafter. The tapes were coded to ensure anonymity and no names appeared on them. The tapes were erased after the research study. The interviews were concluded when themes showed an indication of data saturation (Strauss & Corbin, 1990:188). These transcriptions formed the database, together with the field notes.
2.5.3.2 Observations and field notes

Direct observation was also a method of gathering data as the researcher went physically into the clinical environment where the midwives gave Counseling. Researchers take field notes regarding their unstructured observations made in the field. They include the interpretation of these observations, for example if a participant frowns, is hesitant, becomes emotionally upset and/or displays nervousness by wringing of the hands (this is not easily captured via a tape recorder). Polit and Hungler (1993:216) state that it is essential for the researcher to record observations whilst still in the process of collecting information since memory failures are bound to occur. The researcher must also develop the skill of making mental notes that can later be put on paper and used to make more detailed field notes. The use of these field notes, and the reason for them, was explained to the participants before the interviewing commenced. Types of field notes that were kept and recorded by the researcher included:

- **Observational notes:** These notes contained a description of events, as they were experienced through watching and listening. They contained the who, what, where and how in a situation and as little interpretation as possible (De Vos, 1998:285). In this study, observational notes reflected on events that occurred on the day of the interview and the non-verbal communication of the midwives.

- **Theoretical notes:** Theoretical notes are purposeful attempts to derive meaning from the observational notes (De Vos, 1998:286). On completion of the interviews, the researcher utilized these notes to make her own interpretations and inferences upon which to build analytic themes.

- **Methodological notes:** Methodological notes are instructions to the researcher, critiques of own tactics and reminders about methodological approaches that may be fruitful (De Vos, 1998:286). In this study, the researcher remained mindful of own conduct during the interviews and kept the research design and method in mind.

- **Personal notes:** According to Wilson (1993:223), these notes serve as a memo about the researcher’s reactions, reflections and experiences during the fieldwork. In this study, the researcher kept personal notes to gain both
a deeper understanding of own experiences and a deeper insight into the study being conducted.

- **Peer examination:** Peer examination is a technique that involves the researcher discussing the research process and findings with impartial colleagues who have experience in qualitative research. Peer examination, which is central to the credibility of the research, was implemented; the researcher consulted with research supervisors as well as the independent coder (Krefting; 1991: 10-11). This strategy ensured that the researcher had translated accurately the midwives viewpoints and experiences and had not misinterpreted the events obtained from the interviews (Kemppainen, 2000:1265).

### 2.5.4 Data Analysis

The purpose of data analysis is to identify themes emerging from the data (Brink, 1994:15). The tape-recorded interviews were transcribed verbatim and then analysed descriptively according to Tesch’s method (1990 in Creswell, 1994:153) of systematic description and theme analysis. Data analysis requires the development of categories, making comparisons and forming contracts. It also requires openness to possibilities and to seeing contrary or alternative explanations for the research findings. In this study, the researcher used the data analysis method suggested by Tesch (in Creswell, 1994:155), which consists of the following eight steps:

- Getting a sense of the whole;
- Picking one document at a time, reading it through, making meaning of its contents;
- Making a list of all the topics after going through several documents;
- Clustering similar topics together and forming them into columns that can be arranged as major topics, unique topics and leftovers;
- Abbreviating the topics as codes and writing these codes next to the appropriate segments of the text to see whether new categories and codes emerge;
Finding the most descriptive wording for the topics, turning them into categories and grouping related topics together;

Arranging categories alphabetically; and

Assembling the data material belonging to each category in one place, performing a preliminary analysis and, if necessary, re-coding existing data.

The protocol for the method used was given to the independent coder (see Annexure E), together with a clean set of transcriptions and field notes, for independent coding. After the analysis, the researcher and the independent coder met to discuss the findings and reach consensus on the themes and categories reached independently (De Vos, 1998:345).

### 2.5.5 Pilot study

The study was tested (compare De Vos, 1998:179), by means of a mock interview, for feasibility and the measure of success that could be achieved. This pilot study was conducted in order to enhance and improve the success and effectiveness of the investigation by:

- Ameliorating problems associated with the interviews.
- Assisting in developing a better approach to the target population; and
- Helping the researcher to develop meaningful methods of categorizing data to be collected.

The research questions were tested by videotaping a sample interview (using a colleague as the participant). A copy of the videotape was submitted to the research supervisors for assessment purposes. A pilot interview was executed with a participant who fulfilled the suggested criteria for inclusion in the study.

### 2.5.6 Literature Control

The results of the study were discussed and supported by means of relevant literature and information obtained from similar studies so as to verify the study
results and highlight similarities and differences between this study and other similar studies conducted in the past. The use of referential checks is a strategy to ensure scientific trustworthiness of the study by means of triangulation (Poggenpoel, 1993:3) and also to predict whether the study is believable, accurate and right (Creswell, 1998:193). Stuart and Sundeen (1991:118) support this thinking and declare that literature provides a mechanism to assist in demonstrating the usefulness and implications of the study findings. The goal is to place the results in the context of established knowledge and to identify clearly those results that support the literature or claim a new contribution. Reflection of the content was used to clarify ideas expressed by the midwives and also to validate consistency.

2.5.7 Developing Guidelines

The identified themes and categories, together with relevant literature, were used as a basis for developing guidelines to assist the midwives in implementing the Department of Health policy concerning Counseling of HIV positive first-time mothers seeking information on feeding their newborn babies.

The guidelines were presented for evaluation to nurse specialists with additional qualifications in advanced midwifery and neonatal nursing science, and who hold posts as nursing directors, to determine appropriateness with regard to the Counseling given to HIV positive first-time mothers by midwives. The evaluation of these guidelines was based on the following principles set out by Chinn and Kramer (1991:127):

- **Clarity**: for ease of understanding and according to whether all concepts and links between concepts were easily defined.
- **Simplicity**: to ensure that all elements of the guidelines were kept to a minimum and that the relationship between them was indicated in a simple manner.
- **Generality**: To ensure that the identified guidelines were of value to other midwives involved in research.
• **Applicability**: To ensure that the defined concepts and developed guidelines were identifiable with reality.

• **Consequences**: To appraise how practical, useful and sufficient the guidelines were to assist the midwives with their experiences and perceptions regarding exclusive breastfeeding in HIV positive first-time mothers.

### 2.6 MEASURES TO ENSURE TRUSTWORTHINESS

Polit and Hungler (1997:470) describe trustworthiness as a term used in the evaluation of qualitative data; they state that trustworthiness is assessed via the criteria of credibility, transferability, dependability and confirmability. In order to ensure trustworthiness of the research in this study, the researcher used the trustworthiness model described in Lincoln and Guba (1985:290). According to Guba’s model, rigor and reliability of a qualitative study can be ensured (Streubert & Carpenter, 1995:318), based on the identification of four aspects of trustworthiness, namely:

#### 2.6.1 Credibility/Truth-value

Truth-value is usually obtained from the discovery of human experiences as they are lived and perceived by participants. The strategy for establishing truth-value is credibility, which is achieved through the unique authority of the researcher, triangulation, member checking, and peer examination (Krefting, 1991:219).. These strategies are described by Leininger (in Krefting, 1997: 7-12) as follows:

• **Unique authority of the researcher**: Miles and Huberman (in Krefting, 1991: 11) explain this as viewing the researcher as a measurement tool, using the following identified characteristics to assess trustworthiness:
  - The degree of familiarity with the phenomenon and the setting under study (the researcher works in a maternity and neonatal unit); and
• **Triangulation**: This strategy is based on the idea of convergence of multiple perspectives for mutual confirmation of data to ensure that all aspects of the phenomenon have been investigated (Krefting; 1991: 9). The triangulated data sources are assessed against one another to crosscheck data and interpretation. This is aimed at minimizing distortion of data from a single data source or from a biased researcher. The researcher gathered information by using interviews, field notes and a literature control to ensure triangulation.

• **Member checking**: This involves consulting the participants to check on research findings to ensure the truthfulness of what they experienced. This was a direct way of improving the credibility of the study. The researcher did a follow up regarding the interview with the participants, and gave them a chance to review the data collected (Krefting; 1991: 10).

• **Peer examination**: This is based on the same principle as the member checking, but involves the researcher’s discussing the research process and findings with impartial colleagues who have had experience with qualitative research methods or are seen as experts with regard to the phenomenon being investigated. In this study, the researcher consulted with research supervisors as well as the independent coder (Krefting; 1991: 10-11).

### 2.6.2 Transferability/Applicability

Transferability is the important criterion and the study was conducted in its natural environment in order to control the variables. Applicability was ensured by comparing the results of the study to those of similar studies, as transferability requires that the results of a study apply to the findings of another study in a similar context but with different participants (Krefting, 1991:216-217).
The researcher used the nominated sample and dense description strategies as follows:

- **Nominated sample**: Field and Morse (Krefting; 1991: 12) define this strategy of sample selection as being *how the selection of participants’ representative of the phenomenon being studied may determine the uniqueness of the situation in the study conducted*. The participants were selected according to specifically set sampling criteria.

- **Dense description**: This refers to the researcher providing dense background information about the informants, the research context and the setting to allow others to assess how transferable the findings are (Krefting; 1991:12). This involves a complete description of the methodology, literature control, transcribed interviews and field notes of interviews to maintain clarity.

### 2.6.3 Dependability of Data/Consistency

This means that if the same study were to be repeated under identical conditions, the findings would remain the same. In qualitative research the participants, the researcher and the specific circumstances of the study can vary greatly within the research process. It is, therefore, acknowledged that it is difficult to expect consistency in results if a study is replicated even if the same subjects or similar contexts were used. The criterion for consistency is, thus, dependability. This refers to the researcher attempting to account for the changing conditions to the chosen research phenomenon and the changes in design. The researcher used the code-recode procedure and triangulation strategies as described by Lincoln and Guba (in Krefting, 1991:13), to establish dependability.

- **Code-recode procedure**: This is done during the analysis phase of data. After coding a segment of data, the researcher should wait at least two weeks and then return to recode the same data and compare the results (Guba in Krefting; 1991:13). The researcher, together with the independent coder, did the coding and recoding of the data to establish dependability.
• **Triangulation:** This strategy is based on the idea of convergence of multiple perspectives for mutual confirmation of data to ensure that all aspects of a phenomenon have been investigated (Krefting; 1991: 9). The triangulated data sources are assessed against one another to crosscheck data and interpretation. This is aimed at minimizing distortion of data from a single data source or from a biased researcher. The researcher gathered information by using interviews, field notes and a literature control to ensure triangulation.

2.6.4 Confirmability/Neutrality

Confirmability refers to the objectivity or neutrality of data (Polit & Hungler; 1995: 363). Neutrality is defined as freedom from bias of the findings. It also refers to the degree to which the findings are a function solely of the interviewees and conditions of research and not the biases, motivations and perspectives of researcher (Krefting; 1991: 215-216). The strategies used in this study to ensure confirmability are confirmability audit and triangulation (Krefting, 1991: 217-221).

• **Confirmability audit:** This strategy involves an external auditor attempting to follow through the natural history or progression of events in a project to try to understand how and why decisions were made (Krefting; 1991:13). The auditor considers the process of research as well as the product, data findings, interpretations and recommendations (Guba in Krefting; 1991: 14). The researcher used an independent coder to audit the process of research, data findings, interpretations and recommendations.

• **Triangulation:** Data collected by means of phenomenological interviews and field notes were verified by means of a literature control. Analysis of data was done by the researcher, but consensus was sought on themes identified by use of an independent coder (Krefting; 1991: 9). Quoting supportive extracts from interviews ensured confirmability of analysed data.
The strategies used to ensure trustworthiness, as applied in this research study, will now be summarised in table 2.1.

**Table 2.1: Strategies to Ensure Trustworthiness**

<p>| STRATEGY     | CRITERIA                                         | APPLICABILITY                                                                                                                                 |
|--------------|                                                 | --------------------------------------------------------------------------------------------------------------------------------------------- |
| Credibility  | Unique authority of the researcher               | The researcher incorporated information from the course work previously done in Advanced midwifery and neonatal nursing science.                |
|              |                                                  | The researcher's supervisors are experienced in qualitative research. The researcher has experience in midwifery and neonatal nursing science.     |
| Triangulation| Triangulation of data gathering through conducting interviews, compiling field notes and doing a literature control. | Triangulation of data analysis by the researcher, the supervisors and the independent coder. Nursing journals were accessed.                 |</p>
<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
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<tbody>
<tr>
<td>Peer examination</td>
<td>An independent coder, who is a nurse with experience in qualitative research, was used to help with data analysis. The researcher had discussions with the independent coder to reach consensus.</td>
</tr>
<tr>
<td>Member checking</td>
<td>Participants listened to the recorded audiotapes immediately after the interviews were conducted. Member checking was done through undertaking a literature control with regard to policy of the Department of Health on exclusive breastfeeding and HIV, as experienced and perceived by the participants.</td>
</tr>
<tr>
<td>Transferability</td>
<td>Nominated sample The researcher gave the gatekeeper the sampling criteria to identify and select participants representative of the sample population to ensure that data of high quality was collected.</td>
</tr>
</tbody>
</table>
Dense description

A dense description of the research design and methodology was given, a literature control was done and the findings were described.

<table>
<thead>
<tr>
<th>Consistency</th>
<th>Code-recode procedure</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>The researcher used Tesch’s methodology (1990 in Creswell, 1994: 14) to code the data, then left it for few days and then recoded it to ensure that trustworthiness was maintained.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Neutrality</th>
<th>Confirmability audit</th>
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<tbody>
<tr>
<td></td>
<td>An expert independent researcher did an audit.</td>
</tr>
</tbody>
</table>

| Triangulation | As discussed above. |

Adaptation of tables from Krefting (1991: 216-222)

### 2.7 ETHICAL CONSIDERATIONS

Conducting the research ethically starts with the identification of the research topic and continues through the publications of the study. Ethical codes and regulations provide the researcher with guidelines for protecting the rights of human subjects, balancing benefits and risks in a study and obtaining informed consent (Burns & Grove, 1993:89). In this study, the researcher adhered to the standards of research as prescribed by the South African Society for Nursing Research (SASNR, 1996:74-75). The ethical measures that were implemented will now be discussed.
2.7.1 Freedom from Harm

In this study, the researcher ensured the principle of freedom from harm by ensuring an environment that was conducive to interviewing. The interviews commenced after the researcher had met with the participants to establish rapport and put them at ease regarding data gathering. If the interview proved to be too distressing to the participant, it was to be abandoned. The participants were informed of their right to withdraw from the study at any time, even after data gathering had commenced, without fear of being victimized.

2.7.2 Informed Consent

Informed consent embraces the provision of sufficient information to the participant regarding the research topic to be dealt with and the role he/she is to play in this research project. According to Brink and Wood (in Brink, 1996:42), the three main distinct elements of informed consent are the type of information needed by the research subject, the degree of understanding required in order to give consent and free choice in giving consent.

The researcher required informed consent from relevant health authorities to gain access to the site, as well as from the participants before embarking on the interviews. The researcher requested this informed consent by means of written letters before embarking on the data gathering stage of the study and each letter was accompanied by a clear summary of the research protocol and any other relevant requirements from either the authorities or participants in the study. Written consent was requested from the medical superintendent of the hospital where the research was conducted (see annexure A and B). A copy of the research proposal accompanied the request to the medical superintendent. This was done to ensure that the relevant authorities, as well as the research participants, were fully informed about the nature and purpose of the research.
2.7.3 Anonymity and Confidentiality

Protection of the participants’ well being and interests is a major concern within a research study. Rubin and Barbie (1997:62) state that anonymity is achieved when the researcher cannot identify a given respondent. This explanation makes it impossible for the participants in qualitative research interviews to be anonymous. Nevertheless, the researcher can assure confidentiality to protect and enhance anonymity.

Confidentiality is maintained when the researcher protects (does not divulge) the identity of the participant but makes public the findings of the research (interviews) (Rubin & Barbie, 1997:62). Confidentiality means that the names can be mentioned or attached to a response by an interviewee, but the researcher is not in any way permitted to link those names to the identity of the participant (Neuman, 1997:452).

The researcher in this study maintained anonymity and confidentiality by approaching interested participants confidentially by telephone and conducting interviews privately. No mention was made of names of either people or the hospital where the study was conducted. Interviews were conducted in a single hospital ward with only one participant and the interviewer present at the time of the interview. The participants were informed about the importance of anonymity and confidentiality and how it would be maintained in this study (interview), as this enhanced the rich in-depth information needed by the researcher. The audiotape cassettes used during the interviews were wiped clean by the researcher personally as soon as the research report had been written.

2.7.4 Right to Privacy

Maintenance of privacy is crucial in a research study. In this study, the participants were interviewed in a private room without outside interference. The dignity of the participants was ensured throughout the interview and the study. The researcher upheld the participant’s right to privacy during the research by
ensuring that only data necessary to reach the objectives was collected (SASNR, 1996:74). After transcribing the interviews, the researcher erased the audiotapes and assigned a code, rather than the hospital name, to each of the transcripts. Identifying data was removed from the transcripts to ensure anonymity of the data gathered. Once the treatise had been marked, the transcripts were destroyed.

2.7.5 Publication of the Results

Results and findings of the study were published and written copies of the results provided to the participants, health authorities that were involved and the Department of Nursing Science at the Nelson Mandela Metropolitan University (to be kept in the University’s library).

2.8 CONCLUSION

In this chapter the researcher described and explained the research design and method of this study. The aspects of trustworthiness and ethics were discussed as the cornerstones of nursing research in order to enhance credibility of the findings and protect the well being and interests of the participants respectively.
CHAPTER 3

DISCUSSION OF RESULTS AND LITERATURE CONTROL

3.1 INTRODUCTION

In chapter two, a full description of the research design and method was given. In this chapter, a discussion of the results of the unstructured interviews and field notes is presented. Themes and sub-themes derived from the data collected are discussed and supported by relevant quotations from the interviewees. A literature control is also included. The aim of the literature control is to re-contextualise the themes identified during data analysis and indicate the extent to which they have been documented previously.

3.2 DESCRIPTION OF THE SAMPLE

The sample included in this study comprised a total of ten participants (one of whom was involved in the pilot study) employed in the maternity department of a public hospital in the Nelson Mandela Metropole. Five of the participants were allocated in the antenatal clinic and five in the postnatal wards. All of the participants were females and their ages ranged between forty-three and fifty-nine years. Eight were Xhosa speaking, one was English speaking and one was Afrikaans speaking. The participants had all been exposed to HIV positive first-time mothers in the course of their duties.
A purposive sampling method was used and sample participants met all the inclusion criteria described in chapter one. The maternity supervisor of the hospital was asked to act as a gatekeeper and was given the inclusion criteria, which enabled her to identify the participants. The gatekeeper selected only midwives who had already attended the Prevention of Mother-To-Child Transmission (PMTCT) programme, which may have influenced their views and experiences. According to the problem statement, the researcher expected participants to be unsupportive of breastfeeding for HIV positive mothers, but all of the participants in the study supported the policy of exclusive breastfeeding.

The gatekeeper asked the prospective participants for their contact details, after which the researcher telephoned them. During the telephone conversation between the researcher and each prospective participant an agreement to participate in the study was gained after the information about the research and the nature of the midwives’ participation was explained clearly. The prospective participants were informed that participation was voluntary and that they could withdraw at any stage of the study. Dates and times of interviews were arranged to suit the prospective participants.

3.3 DATA COLLECTION AND DATA ANALYSIS

The participants were interviewed individually at their work place after informed consent was obtained. Interviews were conducted in English, as this was the language with which the participants, the researcher, the study leader and the independent coder were familiar. All of the interviews were audio taped, as agreed with the participants. The identities of the participants were protected in the research report by applying the principles of confidentiality and anonymity. No quotation used in the report could be attributed to any particular participant. The ethical principles described in chapter two were maintained at all times by the researcher. The themes and sub-themes were discussed with the researcher’s supervisors who were experienced in qualitative research and midwifery and neonatal nursing science
All interviews were transcribed verbatim by the researcher. The transcriptions, together with the field notes, formed the database. Analysis of data was done using Tesch’s (1990 in Creswell, 1994:153) method of data analysis (see chapter two). Themes and sub-themes related to the views and experiences of the participants concerning the policy of the Department of Health regarding exclusive breastfeeding in HIV positive first-time mothers emerged. An independent coder was utilized to assist with the analysis of data and identification of themes and sub-themes. The role of the independent coder was to confirm that all possible themes had been identified. The independent coder was provided with a protocol describing the method of data analysis (see Annexure E) as well as a clean set of transcriptions. During consensus discussions, the independent coder confirmed that data saturation had been reached and that no further interviews were necessary. Agreement was reached between the researcher and the independent coder on the themes and sub-themes.

Field notes were used to enrich the recorded data. The field notes were important in capturing the context of any observations made during the interviews. A description of any non-verbal behaviour giving deeper insight into the phenomenon being studied was included as data with the same importance as the recorded, verbal data. Body language and tone of voice when verbalizing any feelings or observations are examples of information included in the field notes to enrich the data gathered and recorded by the researcher as soon as possible after the interview.

Further insight into the working lives of the participants was obtained by conversation and observation before and after the audio taped interviews. As transcription of data gathered was done independently, the field notes were important in assisting the researcher to remember the context of the observations and the feelings expressed by the participants during the interview process. Field notes were analyzed together with the transcribed interviews to obtain a deeper insight into the comments made by the participants.
3.4 DISCUSSION OF RESULTS AND LITERATURE CONTROL

The views of the participants were categorized into themes and sub-themes. The results are presented in table 3.1 and interpreted in more detail in the following discussion. The identified themes were supported by verbatim quotations from the participants with further support from relevant literature. The quotations are presented as transcribed without corrections.

Table 3.1 Identified Themes And Sub-Themes Related To The Views And Experiences Of The Midwives Regarding The Policy Of The Department Of Health Of Exclusive Breastfeeding In HIV Positive First-Time Mothers

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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</thead>
<tbody>
<tr>
<td>1. Midwives had positive views on the policy of exclusive breastfeeding in HIV positive first-time mothers.</td>
<td>1.1 Midwives are satisfied with the policy of exclusive breastfeeding in HIV positive first-time mothers.</td>
</tr>
<tr>
<td></td>
<td>1.2 Midwives view the policy of exclusive breastfeeding as an effective contribution to feeding options of babies born of HIV positive first-time mothers.</td>
</tr>
<tr>
<td>2. Midwives experience factors hindering the effective implementation of the policy of exclusive breastfeeding in HIV positive first-time mothers.</td>
<td>2.1 Staff-shortages make coping with the workload difficult and cause increased work pressure resulting in insufficient time to sit and counsel mothers.</td>
</tr>
<tr>
<td></td>
<td>2.2 Uncooperative attitudes exist among staff members regarding the promotion of exclusive breastfeeding.</td>
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<td></td>
<td>2.3 There is a lack of information</td>
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</tbody>
</table>
regarding the CD4 count of patients on admission to the ward.

2.4 Cultural beliefs influence the choice of a mother regarding breastfeeding.

2.5 Lack of training among other staff members regarding exclusive breastfeeding hinders the implementation of the policy.

2.6 Counseling facilities to ensure privacy and confidentiality for mothers are inadequate.

| 3. Midwives experience a variety of emotions related to exclusive breastfeeding. | 3.1 Midwives experience the emotion of:
| - **Happiness** that the policy promotes breastfeeding. |
| - **Confidence** when mothers start to trust them and open up to them. |
| - **Helplessness** when the baby or mother is sick and breastfeeding cannot be initiated. |
| - **Frustration** when, after being counselled, mothers stop breastfeeding and start formula feeding. |
| - **Worry and concern** about the patient being stigmatized and not supported by family. |
| - **Stress** due to work overload. |
The themes and sub-themes identified during the interviews will be discussed in the sequence reflected in table 3.1.

**THEME 3.4.1 MIDWIVES HAD POSITIVE VIEWS ON THE POLICY OF EXCLUSIVE BREASTFEEDING IN HIV POSITIVE FIRST-TIME MOTHERS**

All of the participants worked with HIV positive mothers in the maternity department of a Nelson Mandela Metropole hospital and had attended the Prevention of Mother-to-Child Transmission (PMTCT) programme at least once. All participants expressed an interest in exclusive breastfeeding when caring for HIV positive mothers and the effect of the situation on the patient in their care. In fact, all of the participants expressed a need for extra care for the HIV positive mothers and their babies due to the implications of this condition on the lifestyle of the patient and also because of the increased risk of serious complications for patients with this condition. All participants expressed definite views on the policy of exclusive breastfeeding.

“I think exclusive breastfeeding is the best”

The norm for the Black community in South Africa is for all women to breastfeed; this is in line with cultural practices and also due to economical and environmental reasons. According to UNICEF (2004:11), mothers practise exclusive breastfeeding because they cannot afford the alternative feeding options. In a study undertaken in Khayelitsha by Chopra and Sanders (2000:20), mothers of unknown HIV status said they practised exclusive breastfeeding by default because they could not afford other milks or they did not have the means to boil water or sterilise utensils.

In rural areas, access to safe water is often limited and infant formula is too expensive for the majority of the population. The current policy recommends exclusive breastfeeding for six months after birth followed by rapid weaning, or exclusive bottle-feeding. The policy supports the traditional understanding of the nutritive values to the baby of breast milk (Dorhn, 2004:3).
Participants were positive, and expressed satisfaction concerning the Department of Health policy on exclusive breastfeeding as an effective alternative feeding option for infants born to HIV positive first-time mothers. These views will now be discussed.

**Sub-theme 3.4.1.1 Midwives Are Satisfied With The Policy Of Exclusive Breastfeeding In HIV Positive First-Time Mothers**

The national infant feeding policy for HIV positive mothers is intended for the feeding of well infants whose mothers are known to be HIV positive (Department of Health, 2003:1). The economic burden of formula feeding on the mothers as well as their families can be high due to the price of buying formula milk. In SA, only 39% of the population has access to piped water inside the home and even fewer have access to electricity (Statistics SA, 1999:1). Mothers need access to clean water, equipment and appropriate environmental conditions, including the facilities to wash their hands and clean and sterilize feeding utensils on a continuing basis. Midwives have been leaders in promoting and supporting breastfeeding. Almost all women come into contact with midwives during their childbearing years; hence midwives have the opportunity to influence breastfeeding knowledge and attitudes.

The participants expressed their sympathy towards the HIV positive mothers and appeared excited about the exclusive breastfeeding policy when dealing with them. This is illustrated by the following quotes:

"The policy is good because I love breastfeeding, I am passionate about breastfeeding."

"I think exclusive breastfeeding is good because, according to the book, they say when the mother is HIV positive and her CD4 count is more than two hundred, there is less risk for HIV virus to be in the milk...which I think is good because the baby won’t get any virus through the milk and it is less work for the mother to make the milk, to prepare it and most of the mothers come from low
socio-economic class, they don’t have money to buy milk, no electricity. So really, they need to breastfeed.”

According to Hull and Simpson (1990:625), breastfeeding is regarded as the best way to feed infants. Its multiple benefits for the health of the infant outweigh formula feeding. Breastfeeding is recognized as the best method to feed newborn babies and young children. Some participants in this study regarded the policy of exclusive breastfeeding as a practice guideline as illustrated by the following quote:

“Department of Health is on the right track...the policy does not discriminate nor stigmatize those mothers who are HIV positive. The policy is right, it acts as a guideline for both of us, for instance if we didn’t have the policy like before, we will never know what we are supposed to say to our patients at the same time, so it serves as a guideline between us and the patient as well.”

Woods (1999:7) states that the aim of the policy of exclusive breastfeeding is to provide health care workers (in this instance midwives) with detailed and sound information about HIV and infant feeding practices, based on the most recent research and current understanding of HIV and breastfeeding.

The cost of formula is prohibitive for many women due to unemployment or limited financial resources. Many live in regions where clean water for mixing formula is either unavailable or obtained with great difficulty. Women living in townships outside city centres may have to rely on water sources such as communal taps or pumps with contaminated water; many living in rural areas may have to draw water from polluted streams that are often located long distances from where they live. Other tools routinely used in urban areas as infant feeding aids, such as refrigerators and freezers or stoves and microwaves for heat-treating, are also often unavailable to mothers in townships and rural areas.
“Like some mothers do not have the facilities so if you are not having all the facilities, running water, the hot water to wash and sterilize the equipments then it is going to be very difficult.”

It is recognized that, where appropriate, formula feeding will be promoted amongst many HIV positive women. For HIV negative women, and many HIV positive women, breastfeeding will still be the method of choice. In general, breastfeeding should be vigorously promoted and should remain the dominant method of infant feeding in South Africa. Health care workers and others involved in maternal and child care should continue to adhere to the international codes of practice with regard to formula feeding and the promotion of formula feeding. The need to recommend formula feeding to HIV positive women in appropriate situations must not be confused with or deter from the general promotion of breastfeeding in South Africa (Department of Health, 2003: 9).

Participants mentioned that there were less chances of infection with exclusive breastfeeding. One participant remarked:

“With exclusive breastfeeding there is no danger of introduction of infection in the first three months because with PMTCT cases it is strictly for three months exclusive breastfeeding”

All participants said that the type of nutrition provided by breast milk is complete. Colostrum, the type of breast milk produced for the first few days after birth, is especially rich in antibodies. As one participant elaborated:

“Breastfeeding is the best because, like I said, breast milk has got antibodies, it’s got...there is vitamin A, there is iron there is a lot that is in breast milk, especially the colostrum that is the first milk that comes out that is clear like, it is the one that is rich in everything.”
There are children who are vulnerable to malnutrition in South Africa (Department of Health, 2003:4). The incidence of malnutrition and diarrhoeal disease is directly related to access to safe clean water and sanitation and adequate nutrition. In these situations infant formula, especially via feeding bottles, is dangerous. Breastfeeding is, indeed, a lifesaver and is critical for the well being of many infants in South Africa. In these situations breastfeeding is a major factor in enabling many infants to survive the first year of life. In low-resourced areas, infant formula feeding is strongly discouraged and breastfeeding vigorously promoted (UNICEF, 2004:8).

In this study, the participants had an overwhelming satisfaction with the policy of exclusive breastfeeding in HIV positive first-time mothers.

Sub-theme 3.4.1.2 Midwives View The Policy Of ExclusiveBreastfeeding As An Effective Contribution To Feeding Options Of Babies Born Of HIV Positive First-Time Mothers

The policy guideline and recommendation for feeding of infants of HIV positive mothers regard breastfeeding as a significant and preventable mode of HIV transmission to infants (DOH, 2003:1). Participants recognized the policy of exclusive breastfeeding as an effective feeding option for babies born to HIV positive mothers if implemented correctly. All the participants stated that breast milk forms a protection in the babies gut.

“We strongly believe that breast milk makes a layer in the gut, so it is making that layer continuously in the gut and prevents anything to come in or to go into the baby’s stomach. So if she is giving breast milk only there is no risk that can happen”.

“I feel strong about the policy because I think exclusive breastfeeding should be practised. The most important thing about exclusive breastfeeding, there is no chance of introduction of infections to the baby, which now means it is very important because if you mix with formula feeds the introduction of the infection to the gut will be increased.”
Breast milk contains specific and non-specific immunologic and non-immunologic factors, which provide passive and active protection to the baby. Studies in various countries have shown that the antibody content of breast milk related to enteric microbial agents reflects the gut microbial flora prevalent in that country (Achi, 1992:86). It is likely that these antibodies are important for protecting breastfed babies against the pathogens present in their environment. Immunoglobulin A (IgA) has been found to form antibodies against a variety of antigens such as Escherichia coli, respiratory syncytial virus, as well as antibodies against bacterial toxins such as A and B Clostridium difficile. In addition, IgG and IgM also form antibodies against bacteria and viruses (Xanthou, 1998:121).

A study by Coutsoudis (1999: 486) suggested that non-exclusive breastfeeding might increase the risk of transmission; this author argued that the integrity of the intestinal mucosal barrier is not compromised with the exclusive use of breast milk, thus lowering the risk for the transmission of the virus. This research concluded that babies who were exclusively breastfed for three months had a lower risk for transmission than babies who received breast milk with other foods and fluids.

**THEME 3.4.2 MIDWIVES EXPERIENCE FACTORS HINDERING THE EFFECTIVE IMPLEMENTATION OF THE POLICY OF EXCLUSIVE BREASTFEEDING IN HIV POSITIVE FIRST-TIME MOTHERS**

Strategies for preventing Mother-to-Child Transmission (MTCT) in developing countries are challenged by inadequate infrastructure, overwhelming demand, limited facilities for HIV Counseling and antibody detection in the early neonatal period, the cost and logistics of providing antiretroviral drugs and the unavailability of safe alternatives to breast milk (Ogundele & Coulter, 2003: 100). In many places where HIV testing is offered, the quality of Counseling is poor. The reluctance of women to be tested for HIV because of the widespread associated stigma is another difficulty (Ogundele & Coulter, 2003: 100).
With regard to the factors hindering the effective implementation of the policy of exclusive breastfeeding in HIV positive first-time mothers, six sub-themes were identified and these will now be discussed.

**Sub-theme 3.4.2.1 Staff Shortages Make Coping With The Work Load Difficult And Cause Increased Work Pressure Resulting In Insufficient Time To Sit And Counsel Mothers**

All participants felt strongly about staff shortages and the impact that this has on the maternity department. They felt that most of the problems underlying midwives not coping with implementation of the policy of exclusive breastfeeding arose from staff shortages.

“So really we can’t cope, we are not coping. It’s a matter of not coping. You can’t cope with the numbers”

“Because of the shortage of staff, then if they are two, one can not work alone in this ward that is having twenty five or thirty patients…We are burned out we are just working and we are only saved by GOD so that we cannot get medico legal hazards here, because really this institution, the work load is unbearable, is too much…is too much”

Ramaleba (1992:6) asserts that burned-out workers feel a sense of disenchantment with, and alienation from, the work. They feel discouraged, hopeless and pessimistic about the work and what they are doing and there is a loss of enthusiasm and excitement about it. This has direct consequences for the organization as the performance of the individual deteriorates. Most participants expressed concerns about excessive workloads, precipitated by staff shortages.

“The pressure…I will say now the shortage of staff, sometimes you are alone in the ward then even if you wish to take the baby to the mother you cannot leave
Ross and Altmaier (1994: 2) state that work overload is the interaction of work conditions with characteristics of the worker to the extent that the demands of work exceed the ability of the worker to cope with them. Participants recommended that more hands be employed to implement the exclusive breastfeeding policy. The following verbatim response reflects this viewpoint:

“I am sure if we can have …in this unit of ours, we can have more hands it will be better”

A shortage of midwifery staff affects the level of service offered. According to Cullinan (2004:4), the midwife:patient ratio in the Eastern Cape is 1:1278, whereas the national average is 1:916. Furthermore, participants mentioned that there was insufficient time to sit and counsel the pregnant women and the new mothers properly. The lack of staff, together with the increasing number of HIV positive first-time mothers, has resulted in midwives having very little time for patient education.

“We don’t have time to sit for long with the patient you know…because of shortage of staff we don’t have enough time to sit with them and you know because of shortage of staff.”

“When you do Counseling you must be relaxed and you cannot do Counseling in a rush, you must be relaxed so it is still a problem, because we are also having a shortage of staff.”

“But by Counseling one patient and leaving one Sister with twenty five patients you also feel as if now you are going to sit and be relaxed as if you are running from the situation in the ward, because when you are doing Counseling you must be sitting and you must be relaxed and now the other one feels like you
are leaving her with the work load, so you don't feel comfortable, but you are forced to do the Counseling."

According to Nolte (1998:230), midwives play an important role in supporting the mother in her decision, assisting with her problems and giving her self-confidence in respect of her ability to breastfeed; however, the problem is that due to work pressure, the midwife sometimes find it difficult to spend enough time on Counseling individual mothers about breastfeeding. Sanders (1998:865) mentioned that the pressures on health care providers are threatening to overwhelm them.

Sub-theme 3.4.2.2 Uncooperative Attitudes Exist Among Staff Members Regarding The Promotion Of Exclusive Breastfeeding

In every country where breastfeeding and related complementary feeding have been implemented, some health care workers have made active decisions that saving children’s lives is worth the time and energy involved (UNICEF, 2004: 35). The will was there to truly support women and families to make informed and unbiased choices regarding feeding their children. Health care workers need to work together and cooperate to achieve sustainable results, and support for infant feeding must continue. According to UNICEF (2004:35), child survival strategies need the cooperation of all health care workers, especially midwives; this includes active promotion, protection and support of early, exclusive and continued breastfeeding with age–appropriate complementary feeding.

A few participants expressed their concern regarding uncooperative attitudes among some staff members. They felt that some midwives were not putting the effort required into delivering an effective service to implement exclusive breastfeeding. Participants reported that it was the mothers and their children who suffered as a result of this. The following verbatim response reflects this viewpoint:
“Sometimes you can’t control, if you win the mother, you go off. The second person that comes in does not take over from what you did. That mother is doing whatever she wants to do. Now she does not breastfeed and you are not there, you are at home. Sometimes you do lose them.” (Another midwife will sway her).

It is widely accepted that continuity of care is desirable for health service users, and this has been (perhaps most vigorously) promoted in maternity care (Sandall, 1995:106). One participant expressed concern about the lack of continuity of care by other midwives:

“Because you will find that you are fighting a losing battle in the ward, because we are the only one that has been to the course. The rest has never been there so they got no idea. So if you win this mother, you have won this mother then you go off, the next shift does not do what you have done, does not continue. That is another problem, does not continue with what you have done because she has never been to the PMTCT course. She does not know anything about it even if you can try to instill in their mind they don’t understand. I think the institution management should send everybody, from top to bottom, even the general assistant should go for this breastfeeding, for PMTCT, for VCT, so that everybody can sing one song.”

The advice regarding infant feeding options given by midwives is essential and needs to be consistent. WHO (2003:7) states that the mother should choose the method of infant feeding; however, this decision should be based on the best information available from midwives. Cooperation between midwives is important so as to provide the essential information and to give the support needed to make the mother’s choice of infant feeding as safe as possible.

**Sub-theme 3.4.2.3 There Is A Lack Of Information Regarding The CD4 Count Of Patients On Admission To The Ward**

Participants mentioned that there is lack of information regarding the CD4 count of each patient on admission to the ward. The CD4 count is a measurement of a
group of the cells in the immune system known as T-Helper cells and is affected by any and all the other infections, vaccinations, and other insults suffered by the immune system on a daily basis (http://www.aidforaids.co.za/Newsletters/AfA-newsletter.PDF 2005.12.08). In addition, the CD4 count has a diurnal variation, being highest late at night and lowest first thing in the morning. The degree of variation diminishes as the HIV disease progresses. The T-cells of the immune system can be considered a principal line of cellular defence and are significantly affected in HIV disease.

The CD4 count informs the midwife how strong the mother’s immune system is, how far the HIV disease has advanced (the stage of the disease) and helps predict the risk for complications. Normal CD4 counts in adults range from 500 to 1,500 cells per cubic millimeter of blood. The Center for Disease Control and Prevention considers HIV-infected persons who have CD4 counts below 200 to have AIDS, regardless of whether they are sick or well (http://www.labtestsonline.org/understanding/analytes/cd4/test.html 2005.11.30)

The CD4 count guides the infant feeding advisors and the health educators. Participants mentioned that when the mother’s CD4 count is two hundred or less, she is not advised to breastfeed due to increased chances of infecting her infant. The participants expressed the need to be informed about the CD4 count of each patient when advising the mother regarding exclusive breastfeeding.

“I will tell you last week the other Sister was giving health education and she included a topic of exclusive breastfeeding in HIV positive mothers and then one mother came and said “Sister I have opted for breastfeeding but my CD4 count was never checked so I am not sure now if I must still breastfeed.” So that is one of the challenge we have here in the ward and here we don’t check the CD4 count. Everything is done in the Antenatal Clinic and so we had to refer the patient to the Sister that is doing PMTCT.”

“When the mother comes we don’t know the CD4 count.”
According to Gerrard (2003:1), women with CD4 cell depletion (less than 200 cells/ml) may be at increased risk of transmitting HIV to their infants through breast milk. Mother to Child Transmission (MTCT) from breastfeeding is also influenced by the stage of the HIV condition in the mother. It is more likely during the acute HIV infection if the CD4 cell count is low, the viral load is high and there is Vitamin A deficiency in the HIV positive mother and child during the breastfeeding period (Dunn & Newell, 1992: 585). No literature could be found on the views of midwives.

Sub-theme 3.4.2.4 Cultural Beliefs Influence The Choice Of A Mother Regarding Breastfeeding

Cultural factors may be crucial when promoting exclusive breastfeeding everywhere, but are particularly so in traditional rural communities (Morse & Gamble, 1990:303). African perceptions of what constitutes optimal infant feeding practices may differ greatly from international recommendations. Globally, prelacteal feeding is a common practice that includes giving the infant various liquids as well as water prior to initiation of breastfeeding (Morse & Gamble, 1990:313).

Current South African policy regarding Mother-to-Child Transmission recommends either exclusive breastfeeding with rapid weaning at six months, or exclusive bottle-feeding (Department of Health, 2003:2). Cultural practice favours breastfeeding with the addition of cereals (in effect, mixed feeding). One participant shared:

“People believe that you have to give the baby water and some medication.”

These practices lead to an increased risk of transmission of the HIV virus and all kinds of infection in the newborn. Another participant said:

“Our customs also are the ones that are trying by all means not for this exclusive breastfeeding to be maintained because with us we believe that the baby must drink water.”
In a study undertaken by Dorhn (2003:3) in a public maternity clinic in Durban, participants said that a woman would opt to breastfeed (rather than formula feed) her infant so as not to be identified as HIV positive by her family and community by giving formula to her baby. The woman would probably not breastfeed exclusively but also, as is customary, give maize to the child within the first few weeks. A woman who takes the infant formula would most likely still breastfeed in front of her in-laws, as is also customary, but may formula feed the infant in the privacy of her own home. A woman who bottle-feeds is at risk of identifying herself to her family and community as HIV positive with the potential consequences of social and economic isolation and even abandonment.

The breast-milk of HIV infected women might still protect infants against early death from various infectious diseases other than HIV. In a retrospective analysis of data pertaining to hundred and seventeen (117) vertically infected infants in Italy, Ogundele (in Tossi, 2003:95) found that breastfeeding was significantly associated with longer survival and delay in progression to AIDS, with increased median duration of the incubation time (19 versus 9.7 months).

It has been speculated that breastfeeding supplemented by water, other fluids and foods (including allergens) might contaminate and injure the immature gastro-intestinal tract and predispose the infant to a higher risk of gut penetration by the milk-borne HIV virus (Ogundele, 2003:95). Davies-Adetugbo (1997:113), in a study on socio-cultural factors and the promotion of exclusive breastfeeding in rural communities, concluded that exclusive breastfeeding totally lacked credibility among communities, with even health workers not believing that it was possible or feasible. Until recently, health care professionals were encouraging HIV positive mothers to give only formula milk to their babies. Therefore, promotion of optimal breastfeeding practices, including exclusive breastfeeding in HIV positive mothers, cannot be successful if the cultural barrier is not adequately addressed.
Sub-theme 3.4.2.5 Lack Of Training Among Other Staff Members Regarding Exclusive Breastfeeding Hinders The Implementation Of The Policy

Participants reported a lack of training among other staff members regarding exclusive breastfeeding, which resulted in the exclusive breastfeeding policy being unsuccessful. The exclusive breastfeeding policy is a good example of an intervention where Counseling on infant feeding forms an important part of the interaction between a midwife and a mother. According to the Department of Health (2003:11), Counseling and information is needed by the mother in order for her to make an informed and correct choice regarding an infant feeding method that will suit her and her infant’s needs. Counsellors should be a source of accurate information about HIV and infant feeding and help the woman to make an informed choice on infant feeding options. Some of the participants mentioned that not all midwives are familiar with the content of the policy on exclusive breastfeeding. One participant said:

“The problem is that not all staff members do the Counseling; it is done by only those who have done the PMTCT course…Its still a problem, because sometimes you will find that like in other wards there is nobody who has done the course. Now the patients who need Counseling they must go to another Sister in another ward who has done the course. So it is inconveniencing and now you are also having your duties in your ward, but you still need to do the Counseling for these patients.”

Some participants said the policy of exclusive breastfeeding is not practised correctly. All health care workers and support workers in the hospitals and clinics need to be educated adequately regarding exclusive breastfeeding in HIV positive mothers, so that everyone working in the hospital and clinics understands why unusual measures such as exclusive breastfeeding in HIV positive mothers, are being recommended. A participant shared:
“The policy is not successful because everybody must be trained, so in my ward is only me who has done the course and even with me I just done the course last month, so we were all not trained in my ward for PMTCT, so in other wards I think is one or two who have done the course.”

Participants felt that the Department of Health staff members were not doing enough to train and develop the midwives, as is evident in the following comment:

“They have made the policy and we would like to adhere to the policy but the very people who made the policy and say people must be trained, they don’t avail those workshops.”

In-service education is that part of continued learning which the agency offers to increase the employees’ skills and knowledge in relation to role expectations (Weinbach, 1994:102). Training and ongoing education of midwives should emphasize the significance of current policies, such as exclusive breastfeeding. As role players in shaping infant feeding decisions, health care professionals in midwifery situations should receive ongoing education that reflects the national infant feeding policy as well as the latest developments in the field of infant nutrition.

A study undertaken in the public maternity care sector in Kwazulu-Natal demonstrated that in-service education increased the knowledge of staff members who were PMTCT counsellors regarding PMTCT and the importance of promoting safe infant feeding practices (Kassier & Maunder, 2003:4). The in-service trainers stated that the scope and content of infant nutrition knowledge that staff obtained during the in-service training and after attendance of refresher courses were in accordance with the statement made by WHO/UNICEF (Greiner, 2001:28) that health personnel often have insufficient knowledge to provide appropriate support to mothers.
Sub-theme 3.4.2.6 Counseling Facilities To Ensure Privacy And Confidentiality For Mothers Are Inadequate
Participants indicated their concern about the lack of facilities for Counseling of HIV positive mothers. They felt that the inability to ensure privacy and confidentiality hampered the implementation of the policy on exclusive breastfeeding. They felt that they were not provided with facilities such as Counseling rooms where midwife and patient could converse in privacy.

The following quotation highlights this aspect:

“I wish we can have a Counseling room. We do have a room but it doesn’t have the equipment for it to be a proper Counseling room. We don’t have even a desk; it’s just an open room. So we are not using that room for Counseling, so we must have a desk, a table for us to do the Counseling”

Uys and Middleton (2004:228) state that the physical facilities for Counseling should be acceptable to the patients, their families and the community. The Counseling environment can promote or impede normal or healthy communication. For instance an attractive room with chairs cozily arranged encourages socialization. According to the authors Counseling facilities should have the following:
- Adequate privacy
- Acceptable standards of hygiene
- Facilities for work, recreation, socialization, therapy and safety

THEME 3.4.3 THE MIDWIVES EXPERIENCE A VARIETY OF EMOTIONS RELATED TO EXCLUSIVE BREASTFEEDING

Various emotional experiences, including some negative and positive emotions related to exclusive breastfeeding, were demonstrated. The midwife has been especially trained to deal with the physiologic, psychologic and social changes affecting a new family. According to Kaplan and Sadock (2003:83), an emotion is a complex feeling state with psychic, somatic and behavioural responses.
Emotions refer to the experience of such feelings as happiness, fear, concern, stress and worry. Emotions activate and direct behaviour. An emotional experience is said to be an event with particular psychological and affective significance. There may be positive and/or negative elements present. A positive emotional experience is one that is joyous, worthwhile, desirable and special, whereas a negative emotional experience is seen to be shattering, disappointing and too much to cope with (Kaplan & Sadock, 2003:83).

The variety of emotions related to exclusive breastfeeding experienced by the midwives will now be discussed.

Sub-Theme 3.4.3.1  The Midwives Experience The Emotion Of:

- **Happiness** that the policy promotes breastfeeding. According to Schlebusch (2000:134), people experience their greatest happiness when they focus on the frequency rather than the intensity of positive events in their lives. The author further adds that happiness also involves cultivating the perception that people contribute to the cause of the little pleasures and events and that they can prevent negative ones that make them unhappy. The participants in this study mentioned that they were glad that the policy promotes exclusive breastfeeding because of economic and environmental barriers or resource issues that could compromise the mother’s ability to feed the infant.

  "I am glad that breastfeeding is also exclusive to HIV positive mothers because really it is advantageous than formula feeding, and it is said that the chances of the baby getting the virus are very minimal."

Happiness, according to the Oxford Concise English Dictionary (1998: 245), is a deep pleasure in, or contentment with, one’s circumstances. In this study, the reason for experiencing the emotion of happiness varied from participant to participant. While some participants believed that the policy of exclusive breastfeeding was meant to counteract discrimination against the HIV positive mothers, others often felt that the policy of exclusive breastfeeding increased bonding of the mother and her child.
• **Confidence** when mothers start to trust them and open up to them. Husted and Husted (2001: 181) state that, in nursing practice, confidence is dependent on the development of mutual trust in all relationships. As the agent of a patient, the midwife offers the values of confidence and strength to the mother and to herself. The author further states that confidence and trust characterise the relationship between the patient and the nurse; such a relationship is based on the nursing profession’s implicit and explicit commitment to value human life and health. Participants mentioned instances where mothers desired and adhered to their advice regarding feeding options.

“They have confidence on what the Nurses are telling them, giving them the advantages

“The others will come back if they have a problem or they will phone us...they turn to trust the person that they have been with for a long time.

It was clear to the researcher that some participants were confident when talking about their abilities regarding their helping relationship with the mothers, a relationship where the midwife makes and keeps commitments and shares responsibilities with others. During Counseling sessions, mothers were reported to often share their personal information about themselves. Participants found this satisfying, but it was nevertheless seen as a great responsibility,

Confidence is a very special quality that fosters trust without dependency and communicates trust without violence (Husted & Husted, 2001:183). Morgan (1999:1) stated that midwives experience a deep pleasure when helping a mother and baby experience the joy of breastfeeding, despite the HIV disease. They build a relationship based on trust and openness that survives the grief of a lost breastfeeding relationship.
• **Helplessness** when the mother or baby is sick and breastfeeding cannot be initiated. Helplessness is defined as the psychological state that results when events in life are uncontrollable; it is associated with a perceived lack of control (Furlow & Bushy, 2004:1). According to Morris and Maisto (1998:483), people who feel in control of their lives are deeply committed to their work and their own values and may experience difficult demands from the environment as challenging. They suggest that people’s responses to challenges depend partly on whether they believe that they have some control over events or whether they feel helpless.

Participants mentioned that sickness is a barrier to the successful implementation of the policy of exclusive breastfeeding. They expressed feelings of helplessness when the mother’s condition deteriorated and breastfeeding ceased.

“In this case of the mother that was sick. There was nothing that we could do, because really we couldn’t go and get milk from her and she was just coughing, she needed to be isolated. So nobody could go over to her”.

“In my unit exclusive breastfeeding is not maintained, because most of the time we accept babies that are delivered by caesarean section, and then they are done under general anaesthesia of which it is very difficult to implement breastfeeding immediately...in that case we feed them formula milk because we have a fear of hypoglycaemia”

A study conducted in Cape Town revealed that nurses had an overwhelming feeling of helplessness in the face of the sheer size of the challenge confronting them when dealing with HIV/AIDS patients; many nurses said that they had chosen the nursing profession to help and heal, whereas now they had to watch patients die and suffer without being able to help or at least alleviate suffering (Lehmann & Zulu, 2005:6). No literature could be found related to midwives' feelings of helplessness in dealing with HIV infected patients.
• **Frustration** when, after being counselled, mothers stop breastfeeding and start formula feeding. Participants spoke of their frustrations when the mother stopped breastfeeding and start to feed her child formula after she had been counselled and told about the advantages of exclusive breastfeeding.

“If she has opted for breastfeeding then she must ...she must...she must give breast milk only, but at the same time they are very few that are doing that. I am sure out of ten is only one who exclusively breastfeed, you will find that nine is taking formula milk”

“But because there is no nurse who can go and express milk from that mother you find out that people end up giving formula feed, so it breaks everything, there is no chain now, you understand, so it just vanish disappears or whatever”

One participant mentioned that the availability of formula milk played a role in unsuccessful exclusive breastfeeding as it led to increased mixed feeding.

“But I see this problem of others that have opted for formula, but is also giving...it is a problem, in maintaining exclusive breastfeeding as these mothers are first-time. They are not clear about the whole procedure, so they turn to copy what is done by the one next to her, because the others are opting for formula in front of them”

Van Der Walt (2002:4) stated that the morale of nursing staff working in the tuberculosis programme was often lower because nurses were frustrated when patients failed to adhere to the full tuberculosis treatment regime. Furthermore, this author mentioned that nurses spoke with great frustration about non-compliance and, in order to enforce compliance, they were keen to increase control over their patients.

In a study undertaken in a public hospital in South Africa by Smit (2005:26), nurses mentioned their frustrations with patients who were unappreciative of
the health education and the care they received from the nursing staff. They voiced their frustration and annoyance since they were expending much effort in helping and caring for their patients and they were frustrated with the way in which the government dealt with HIV/AIDS. No literature could be found related to midwives’ feelings of frustration in dealing with HIV infected patients.

- **Worry and concern** about the patient being stigmatized and not supported by the family. An aspect that emerged clearly from this study was the high level of worry and concern felt by participants, particularly about patients being stigmatized and not supported by their families. The policy of exclusive breastfeeding is aimed at assisting mothers and babies to begin breastfeeding, but when a mother returns home to her family and the community, she often faces barriers such as cultural norms regarding continuing with exclusive breastfeeding of her infant.

All participants mentioned that the stigma of HIV in the country continues to weigh heavily.

"Exclusive breastfeeding mothers, if they are breastfeeding, they don’t have those fears because now they know that people that are HIV positive are not breastfeeding and now she is confident that with this exclusive breastfeeding nobody knows her status because she has been seen breastfeeding so there is no stigma attached."

The participants stressed the importance of support groups within the community, without which the patients had little chance of breastfeeding their babies exclusively.

"We need support groups and make sure that when we discharge our patients from here they are well taken care of, we need to know about the support groups that are in the community so that we can refer them to the support groups."
“You will find out that when she goes home, she is still having this problem that she must deal with all by herself of HIV, and you will find that most of the time they will come back, she will rather come back and ask for your advice because she can’t talk to anybody else at home.”

Smit (2003:28) states that nurses experienced a sense of stigmatization as a result of being in close and constant contact with people living with HIV/AIDS. It was interesting to note how often the participants mentioned the powerful emotions of worry and concern and raised their tone of voice when mentioning them.

- **Stress** due to work overload. The workplace is seen as an important consideration in health because of peoples’ extensive involvement at work. The work setting and workplace can contribute to physical exhaustion and psychological burnout, for example when demands at work are excessive and incompatible with one another, continued attempts to meet these demands will be emotionally distressful (Moore, 2003:581). Participants verbalized feelings of stress due to work overload and their concern about not giving quality nursing to their patients.

“I feel exhausted and stressed, and the only thing that the management is saying is that they know there is a shortage and they say they are trying to make things right but it is taking a long time. Because it’s been a long time since we have been short and now quality assurance of nursing the patients is not at its best because you can’t do it at its best…you can’t do what needs to be done correctly and in the right space of time with the shortage of people.”

Stress and exhaustion in participants were reported to be increasing with more mothers having to be cared for in the same number of hours with the constantly decreasing numbers of midwives. Most of the participants
expressed a general feeling that they were unable to provide the kind of patient care they wanted to give because of insufficient time and resources.

"More staff can be employed so that we can give the service the way it suppose to be without being stressed out. Now whatever we are doing is under stress".

Research findings support the idea that workload is a significant stressor that is associated with a variety of deleterious psychological reactions, including stress and exhaustion (Lee & Ashforth, 1996: 123). An increase in workload, without support and resources, may result in the perception in workers that the psychological contract with their employer has been eroded, thus leading to feelings of stress (Moore, 2003:582).

3.5 CONCLUSION

Unstructured interviews were used to collect data for this study. During the process of analysis and coding of the data, themes and sub-themes were identified that described the experiences and perceptions of midwives regarding exclusive breastfeeding. A literature review was used to place the themes identified within existing literature.

In the following chapter, recommendations will be formulated to the Department of Health regarding the support and help that can be given to midwives to encourage the implementation of exclusive breastfeeding. The themes and the sub-themes will be used as the basis for the formulation of the recommendations.
CHAPTER 4

FINDINGS, GUIDELINES, RECOMMENDATIONS, AND LIMITATIONS OF THE STUDY

4.1 INTRODUCTION

The previous chapter dealt with the demographic information related to population groups, results of the unstructured interviews, data analysis and findings of the study. In this chapter, the researcher:

- Assesses whether the research objectives were met.
- Develops guidelines to assist midwives to support, protect and promote exclusive breastfeeding in HIV positive first-time mothers.
- Formulates recommendations with regard to future applications of the research findings, including to the Department of Health regarding the support and help that can be given to midwives to encourage their implementation of the exclusive breastfeeding policy.
- Identifies limitations to the study.

4.2 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Explore and describe the experiences and perceptions of midwives related to promoting exclusive breastfeeding in HIV positive first-time mothers.
- Make recommendations to the Department of Health regarding the support and help that can be given to midwives to encourage their implementation of the exclusive breastfeeding policy.
In the researcher’s opinion the first objective was met as the midwives’ experiences and perceptions related to promoting exclusive breastfeeding in HIV positive first-time mothers were explored and described in detail in chapter three. Recommendations will be made in terms of nursing practice, research and education to address the second objective. Recommendations based on the results will be used to formulate guidelines for the implementation of the policy of exclusive breastfeeding.

4.3 FINDINGS OF THE STUDY

During the research process, the midwives who formed the sample population for this study were interviewed about their experiences and perceptions regarding the policy of exclusive breastfeeding in HIV positive first-time mothers. All of the participants were satisfied with the policy and tended to view it in a positive light. They expressed the view that the policy of exclusive breastfeeding is an effective contribution to feeding options of babies born of HIV positive first-time mothers and regarded it as the “best” infant feeding option. The participants regarded the policy as good and right as a guide and also believed it to have educational merit. However, they highlighted several factors as hindrances to the effective implementation of the policy of exclusive breastfeeding in HIV positive first-time mothers:

- Staff shortages make coping with the workload difficult and cause increased work pressure resulting in insufficient time to sit and counsel mothers: Participants expressed major concerns regarding shortages of staff and excessive workloads precipitated by these staff shortages and recommended that more hands be employed to implement the exclusive breastfeeding policy.
- Uncooperative attitudes exist among staff members regarding the promotion of exclusive breastfeeding: Participants complained about the performance of other midwives and the lack of continuity in care and Counseling.
- There is a lack of information regarding the CD4 count of patients on admission to the ward: Participants regarded a record of the CD4 count as
essential when advising the first-time mother about feeding options for her infant, as this provided them with information concerning the state of the mother's immune system.

- Cultural beliefs influence the choice of a mother regarding breastfeeding: Participants were concerned about the cultural beliefs that influence the feeding of infants and mentioned that cultural practices led to a high risk of HIV transmission and infection in the newborn.

- Lack of training among other staff members regarding exclusive breastfeeding hinders the implementation of the policy: Participants were concerned that some of the midwives lacked training regarding the policy of exclusive breastfeeding in HIV positive first-time mothers; participants felt that all staff members needed to be educated so as to understand the reason for recommending such an unusual measure as exclusive breastfeeding.

- Counseling facilities to ensure privacy and confidentiality for mothers are inadequate: Participants expressed concern about the lack of facilities for Counseling of HIV positive first-time mothers as this hampered the implementation of exclusive breastfeeding.

With regard to the emotional experiences, there were positive as well as negative feelings identified. The findings highlight that midwives have particular needs for interventions aimed at preventing further negative feelings. A recent literature review revealed that relatively few studies have focused on midwives’ experiences and perceptions related to promoting exclusive breastfeeding in HIV positive first-time mothers. Furthermore, there have been very few studies on interventions for midwives exposed to exclusive breastfeeding and HIV positive first-time mothers.
4.4 GUIDELINES FOR THE IMPLEMENTATION OF THE POLICY OF EXCLUSIVE BREASTFEEDING

The findings of the study into the experiences and perceptions of midwives regarding exclusive breastfeeding in human immunodeficiency virus (HIV) positive first-time mothers stimulated the following guidelines to help midwives implement the exclusive breastfeeding national policy of the Department of Health.

4.4.1 Implement the policy of exclusive breastfeeding as it is

Problem
It is important that midwives should have thorough knowledge of the policy guideline and recommendation for feeding of infants of HIV positive mothers. The findings of the study revealed that there are deficiencies and gaps in the knowledge regarding infant feeding required by midwives to implement the national policy of exclusive breastfeeding in HIV positive first-time mothers.

Goal
The goal of the above guideline was to help midwives implement the policy of exclusive breastfeeding as it is outlined.

Actions
Midwives should implement the following actions:

- **Ensure knowledge**: Adequate scientific knowledge and a positive attitude towards exclusive breastfeeding are essential. According to Nolte (1998:230) the midwife must be sensitive to the way in which her knowledge is conveyed to the mother.

- **Study the national policy**: They should familiarize themselves with the content of the policy developed by the Department of Health. This will enable them to promote, protect and support exclusive breastfeeding in HIV positive mothers and HIV negative mothers.

- **Prevention of Mother to Child Transmission (PMTCT)**: Participate actively in the PMTCT programme if the increasing new knowledge bestowed on them is going to be an empowering factor in their lives. According to Toomey (1997: 150), power is a relative trait characterized by
more consistent organization of the human and environmental field pattern. The author adds that the person must be knowledgeable in order to participate meaningfully in the recurring process.

- **Study the basic lactating processes:** This will not only better her understanding of the practical management of breastfeeding, but also prove useful during discussions about feeding suggestions with the mother. This knowledge needs to be conveyed to the mother in simple terms in order to motivate her to follow the midwife’s example.

Midwives play an important role in supporting the mother in her decision, assisting with her problems and promoting her self-confidence concerning her ability to breastfeed. There are three roles in particular that the midwife plays, namely: prenatal preparation; commencement of lactation; and maintenance of lactation.

- **Prenatal preparation:** Be involved in motivating pregnant women to breastfeed by means of prenatal classes, one-on-one guidance, or by giving (written) information. Emphasize the advantages of breastfeeding, for example that breastfeeding can contribute to the prevention of diarrhoea and gastro-enteritis.

- **Commencement of lactation:** Help mothers to initiate breastfeeding within half an hour after labour (Nolte, 1998:236). Close contact during the first few hours following birth can strengthen the emotional bond between mother and baby and lead to a significant increase in successful breastfeeding. Inform the mother before the time that some babies are not immediately interested in the breast, especially when the mother has received analgesics or sedatives shortly before giving birth (Nolte, 1998:236). Support, encourage and assure the mother that contact at a later stage is equally important.

- **Maintenance of lactation:** Prepare the mother for the practical changes, which may be brought about by a new baby in the home. Most problems are caused by man-made rules and interventions and by wrong positioning at
the breast. Provide assistance and guidance to the mother that will help her to overcome problems. If there is a problem, an organized approach to managing it is important. The midwife can use the following steps of the nursing process: Establish the nature of the problem with the aid of a thorough assessment based on history, an examination of the breasts and observation of the baby at the breast.

- Make a nursing diagnosis.
- Implement appropriate nursing care.
- Evaluate the situation.

**Outcome**

- The researcher is of the opinion that the above guidelines could ensure that women receive accurate and sufficient information throughout pregnancy to make a fully informed decision about infant feeding.
- Mothers will be able to exclusively breastfeed their infants for six months.

### 4.4.2 Communicate Infant Feeding Policy

**Problem**

It is important to enhance the establishment of a relationship of positive and constructive cooperation amongst maternal and obstetric community. The findings of the study indicated that participants experience uncooperation among staff members regarding the promotion of exclusive breastfeeding.

**Goal**

The goal of the above guideline was to communicate infant feeding policy and to ensure that cooperation among staff members exist.

**Actions**

The following actions should be implemented:

- **Give formal feedback:** After attending the PMTCT programme sessions, they should give formal feedback to their colleagues. Formal feedback presentations are an effective way, achieving a wide dissemination of the information obtained at a course to as many colleagues as possible in a relatively short period of time.
• **Establish effective unit communication channels**: Communication channels need to be well developed. Without effective communications, there is little that can be accomplished.

• **Weekly meetings**: Convene weekly meetings where interactions and discussions regarding infant feeding policy could take place. This will enable clarification of ideas so that midwives understand the content of discussions, instructions from the national policy of exclusive breastfeeding and procedures that facilitate breastfeeding. Develop and maintain effective communication and coordination with other health care workers to ensure full cooperation for optimal breastfeeding education, support and counseling.

• **Informal meetings**: Utilize and institute informal meeting opportunities where maternal and obstetric community can socialize in a relaxed mood in an environment that promotes openness and expression of opinions such as tea and lunch breaks, informal ward rounds. Utilization of ‘slack’ periods during the day for informal discussions, for example visiting hours and quiet periods during night duty.

• **In-service training**: Improve access to in-service training by providing training in the national policy of exclusive breastfeeding as part of orientation programme when new staff are appointed, and make it a requirement that staff must sign that they have read the national policy during the orientation programme.

According to Du Toit, Van Der Walt, Bayat and Cheminals, (1998:202), effective communication exists if there is promotion of maximum accessibility and availability of information through:

• Notes posted on bulletin and notice boards that are accessible, strategically placed and visible to the personnel.

• The use of memos and diaries, which are followed by oral presentations.

• The maintenance of good record keeping.
**Outcome**
With adequate communication and cooperation, a positive attitude will arise amongst midwives and other health care workers, and they will be motivated to promote, support and protect exclusive breastfeeding enthusiastically.

**4.4.3 Infant Feeding Practices Awareness**

**Problem**
South Africans national breastfeeding policy regarding mother to child transmission, recommends either exclusive breastfeeding with rapid weaning at six months, or exclusive bottle-feeding. Cultural practices within the black community favors breastfeeding with the addition of cereals, in effect, mixed feeding. These practices lead to a high risk of transmission and infection in the newborn.

**Goal**
The goal of the above mentioned guideline was to make midwives aware of cultural infant feeding practices.

**Actions**
The midwives should implement the following actions:

- Educate themselves and be aware of the infant feeding practices applicable to the particular community group, as well as unfounded infant feeding beliefs held by that community.

- Take cultural differences into consideration when they decide on recommendations to the pregnant women and mothers. In her recommendations in respect of the prevention or treatment of problems, the midwife should be very careful not to recommend any treatment that is culturally unacceptable to the woman involved.

- Commence the antenatal infant feeding education as early as possible during pregnancy. Nolte (1998:72) states that since child bearing is a process that is influenced by cultural factors, it is important that the midwife understands and is sensitive to the large context in which midwifery care is provided.
• Design an educational programme that involves the mother, her partner (when appropriate) and the family to promote exclusive breastfeeding and to create a support system for the infected mother and her infant. A support system of family members may help the mother to improve compliance with exclusive breastfeeding.

• Encourage dialogue with the community they serve regarding PMTCT. This can be done by maintaining an open communication which is a critical means of changing knowledge and attitudes towards exclusive breastfeeding. Communication is vital in respecting norms that exist in a culture and the possibility of changing them. Midwives in Uganda found that “infant feeding for babies of HIV positive mothers remains a major communication challenge” (Dorhn, 2005:7). They recommend that exposing local cultures to new ideas, such as exclusive breastfeeding and exclusive bottle-feeding, is dependent on excellent communication channels.

**Outcome**

It is important that the mothers make an informed choice and be supported by family and the communities without the possibility of mix feeding the infants.

4.4.4 Ensuring effective Counseling

**Problem**

The counseling setting that does not ensure confidentiality can cause the mother to be uncomfortable and therefore may not wish to disclose or talk about their fears and concern to the midwife. The participants in this study experience the counseling facilities to ensure privacy and confidentiality inadequate.

**Goal**

The goal for the above guideline was to ensure that resources are available to ensure effective Counseling was rendered.

**Actions**

• Provide a physical setting that is conducive to enhancing a therapeutic relationship, preferably a private room. The room needs to be large or lavishly furnished, but it is crucial to minimize noise and distractions such as interruptions from colleagues and telephones. The provision of suitable
environment conveys a message to the mother that they are valued and what they have to say matters. It also reduces the levels of stress for the midwives if they are able to work in reasonable surroundings and give themselves the best chance of being an effective counselor (Freshwater, 2003:82).

- Establish a safe, confidential setting that clearly distinguishes the counseling relationship from social conversation. Arrange the furniture so that you sit facing the mother without any barriers. For example, sit on one side of your desk next to the mother, rather than across from her, or away from the desks and arrange the chairs facing each other in another part of the room.
- Introduce yourself, the process and the context. Don’t assume that the mother knows what counseling entails.
- Be sensitive to how and what you communicate. Convey the message of trust (that is you are trustworthy), acceptance (by being non-judgmental) and structure (that you are skilled).
- Assure the mother that you will maintain absolute confidentiality.

**Outcome**
The researcher is of the opinion that the above guideline could help the mothers to trust and feel safe to disclose information to the midwives and make an informed choice regarding the infant feeding.

### 4.4.5 Stress Management For Midwives

**Problem**
It is important for the self-preservation of midwives and for their emotional survival that they take care of themselves. Much of the stress experienced by midwives is inherent in the nature of the work itself.

**Goal**
The goal of the above guideline was to help midwives manage and cope with the pressure of working with HIV positive mothers.

**Actions**
- **Re-evaluation of expectations and performance goals:** It is important for midwives and counsellors to know themselves. They should take time
to think about what they can realistically expect from themselves and their patients and re-evaluate their performance goals accordingly. If they feel that they are not reaching these goals, they should establish more attainable goals. Midwives should, for example, accept that the emphasis in caring for HIV positive mothers is on caring and not on curing.

- **Development of self-awareness:** Midwives and counsellors need to know themselves and critically evaluate themselves and their motives from time to time. They should ask themselves why they are in a helping profession. Often people enter into the caring role because of their own needs for appreciation and worth. Therefore, they need to explore their own needs in becoming caregivers.

- **Self care:** Van Dyk (2005:328) states that midwives are responsible for their own physical and mental health and that they should look after themselves in the following ways:
  - Develop and maintain a healthy lifestyle in order to build up physical resistance to stress. A balanced diet and sufficient exercise, rest and sleep are important. Also try to change harmful habits such as smoking and heavy drinking.
  - Nurture yourself and take time out to do things that you enjoy, like walking, listening to music or reading.
  - Actively search for ways to cope with stress that work for you, and use these methods of coping. Relaxation exercises, breathing exercises, visualization, imagery and meditation work very well in coping with stress.
  - Set a strict boundary between your professional and your personal life. Force yourself to forget the suffering of your patients when you close the door to home. Spend time with your family and try not to think of your patients at all.
  - Maintain a balance between identification with a patient and over-identification: empathize but do not lose objectivity.
  - Work on your relationships. Learn to be assertive but not aggressive, communicate effectively, resolve conflict and solve problems constructively.
- Learn how to be professional, but also how to be playful, have fun, tell jokes and laugh. This helps to introduce positive emotions into an environment filled with heavy or negative emotion, and it brings emotional balance.

- Learn to set boundaries, create limits and say no to unreasonable helping requests. To really take care of yourself and your patients, you have to learn how to pace yourself so that you can be there at the critical moments. Find your own balance in knowing how much to give. If it is hard for you to say no, explore the reasons for it.

- Keep a stress diary to find out what causes your stress; to gain insight into the level that is optimal for you; to see how you function under pressure; and to test the effectiveness of your stress management strategies.

- Manage your environment in such a way that it does not cause undue stress. If you feel overwhelmed by what has to be done, prioritize items. Amend the list as needed (Van Dyk, 2005:329).

  - **Using a support system:** use professional venting. Venting to a colleague about your frustrating experiences is cathartic and can cleanse or purge your emotions. Ensure that confidentiality is never violated in the process of venting. Group support can be very powerful and allow colleagues to share concerns, problems and fears. Learn to ask for support and assistance when necessary.

**Outcome**

Midwives will be able to cope working with HIV positive first-time mothers. Acknowledge that their work is inherently stressful and that feelings of distress are a legitimate reaction to their experiences rather than signs of personal weakness or lack of professionalism.
4.4.6 Documenting Care

Problem
Patients are frequently transferred within the hospital from one nursing unit to another. Participants in this study experience a lack of information regarding the CD4 count of patients on admission to the ward.

Goal
The goal of the above guideline was to encourage midwives to document the CD4 count of mothers to ensure continuity of care.

Actions
- Determine the CD4 count of the mother after counseling in the clinic and record on the mothers’ prenatal record (mothers’ book).
- Make entries directly onto the mothers record or file, and then transfer information to the baby’s record (baby’s book) after delivery.
- Provide sufficient detailed information including the CD4 count to ensure continuity of care.
- Write in plain and legible script and keep the words basic and simple. This will enable the receiving midwife understand critical points written about the mother and her baby.
- Maintain confidentiality of all records.

Outcome
With effective documentation and transfer of information from the mothers’ record to the child’s record, continuity of care and quality care will be ensured.

4.5 RECOMMENDATIONS

The following recommendations are based on the findings of this study with special reference to nursing education, nursing practice and nursing research.

4.5.1 Nursing Education
The researcher recommends the following with regard to nursing education:
- Workshops and courses on the policy of exclusive breastfeeding should be presented as an ongoing educational process.
• All midwives, doctors, student nurses and other health care professionals must be given the opportunity to attend such workshops and courses to increase their knowledge and enable them to deal more effectively with HIV and exclusive breastfeeding. A roster system would allow all staff an equal opportunity to attend available workshops or courses.

• Opportunities for feedback and communication between staff members must be given so that information obtained at workshops and courses can be disseminated amongst all staff in the maternity department and any queries raised dealt with.

• Staff must be educated on infant feeding options of infants born to HIV positive first-time mothers to make patient education relevant to the particular population group being educated.

• HIV voluntary Counseling and testing should be emphasized in the basic curriculum.

4.5.2 Nursing Practice

The researcher recommends the following with regard to nursing practice:

• The policy on exclusive breastfeeding should be made available in the prenatal clinics and postnatal wards of the maternity departments at the hospitals in the Nelson Mandela Metropole.

• Items related specifically to the provisions of the policy and recommendation of infant feeding options should be included in the in-service training programmes of the hospitals in the Nelson Mandela Metropole.

• Opportunities to provide feedback from meetings and training sessions on all aspects of policy on exclusive breastfeeding should be provided on a regular basis. Staff should also be given the opportunity to raise queries and give feedback on their experiences in dealing with aspects of infant feeding.

• Coordinators and trainers of infant feeding programmes should be developed to act as change facilitators. These nursing professionals
must develop skills that will enable them to accomplish change effectively

4.5.3 Nursing Research
The researcher recommends the following with regard to future nursing research:

- A similar study could be done with midwives working in the outlying clinics and maternity and obstetric units in the Nelson Mandela Metropole as participants.
- A similar study could be conducted comparing the views of gynaecologists, paediatricians and midwives working in the private sectors on the policy of exclusive breastfeeding.
- A follow up study could be done to see if implementation of the policy of exclusive breastfeeding leads to an improvement in infant feeding in hospitals.
- A study to evaluate the possible relationships among the midwives’ experiences regarding the implementation of new policies on infant feeding could be done so that data can be compared and linkages and shortcomings identified.
- The study could be used as a basis for research regarding the experience of HIV positive mothers concerning exclusive breastfeeding at home.

4.6 LIMITATIONS TO THE STUDY
The following limitations to the study were identified:

- Literature to verify themes was limited. It would have been more meaningful if other studies involving implementation of the policy of exclusive breastfeeding had been available.
- The participants had all attended the PMTCT course at least once, which may have influenced their views and experiences
• The participants were all midwives working in the hospital maternity department; further input from midwives working in the clinics could be of value.
• There was no input from midwives employed in the private sector.

4.7 CONCLUSION

From the perceptions and experiences expressed by participants in this study, it is evident that the policy of exclusive breastfeeding has received support, as participants expressed positive views concerning it and were satisfied with the content of the policy of exclusive breastfeeding among HIV positive first-time mothers. Several factors hindering the implementation of the policy of exclusive breastfeeding were identified. These included staff shortage, uncooperative attitudes among staff members and lack of training among staff members. Guidelines to assist the midwives in the implementation of the policy of exclusive breastfeeding were constructed.


CHOPRA, M & SANDERS, D 2000: Research report: Summary of the findings and recommendations from a formative research study from the Khayelitsha MTCT programme, Western Cape, South Africa.


GREINER, T 2001: Research on HIV and breastfeeding: definitions can make all the difference. Paediatrica, 91(6): 615.


INNOCENTI DECLARATION 1990: On the protection, promotion and support of breastfeeding. New York: UNICEF.


RYDER, RW; MANZILA, T & BAENDE, E 1991: Evidence from Zaire that breastfeeding by HIV-1-seropositive mothers is not a major route for perinatal HIV-1 transmission but does decrease morbidity. AIDS.


STATISTICS SOUTH AFRICA 1999: October Household Survey.


TOOMEY, LC 1997: Functional Integration of primary health care within the District Health System. Bisho: MSH.


VAN DER WALT, M 2002: DOTSplus for multidrug-resistant (MDR) tuberculosis in South Africa. Int J Tuberc Lung Dis, 6(10).


INTERNET ARTICLES

CD4 Counts for dummies. 08-12-2005@11:00am
(http://www.aidforaids.co.za/Newsletters/AfA-newsletter.PDF)

CD4 Count: The Test. 2005.11.30@04:00pm
http://www.labtestsonline.org/understanding/analytes/cd4/test.html

LaLeche International breastfeeding and HIV. 07-03-2005@6:40pm.


ANNEXURE A

APPLICATION TO CONDUCT RESEARCH

CLINICAL GOVERNANCE MANAGER
Dear Dr. F Rank,

Application to conduct research

I am currently registered at the Nelson Mandela Metropolitan University (NMMU) studying towards the Magister Curationis (M.Cur) degree in Advanced Midwifery and Neonatal Nursing Science. My research project is entitled: The experiences and perceptions of midwives at provincial hospitals in the Nelson Mandela Metropolitan Municipality regarding exclusive breastfeeding by HIV positive first-time mothers. I hereby request your permission to carry out research on this topic in the maternity department of Dora Ngiza Provincial hospital.

I would need to conduct at least ten interviews with midwives who have counseled HIV positive first-time mothers concerning methods of feeding options for a period of at least six months. The participants will be informed about the purpose of the research and that they may, at any time, withdraw from the interview should it prove to be too distressing to them. The researcher will strive to adhere to all ethical principles of research.

Should permission to do research study be granted, the interview will be conducted during August and September 2005 at a time and place that would suit the participants. A copy of the research proposal and the participant consent form is enclosed for your approval. The research will be conducted under the supervision of Prof J Strumpher and Mrs. L Jantjes of the Department of Nursing Science at the Nelson Mandela Metropolitan University. Should you have any queries please contact my supervisor, Mrs. L Jantjes at (041) 504 2122.

Thank you for considering my request

Yours faithfully,

EK Moobi (Research Student) © 0733080624
ANNEXURE B

APPLICATION TO CONDUCT RESEARCH

MEDICAL SUPERINTENDENT
Dr A Vehbi  
Medical Superintendent  
Private Bag X11951  
Algoa Park 6005  
Port Elizabeth

Dear Dr. A Vehbi

Application to conduct research

I am currently registered at the Nelson Mandela Metropolitan University (NMMU) studying towards the Magister Curationis (M.Cur) degree in Advanced Midwifery and Neonatal Nursing Science. My research project is entitled: The experiences and perceptions of midwives at provincial hospitals in the Nelson Mandela Metropolitan Municipality regarding exclusive breastfeeding by HIV positive first-time mothers. I hereby request your permission to carry out research on this topic in the maternity department of Dora Ngiza Provincial hospital.

I would need to conduct at least ten interviews with midwives who have counseled HIV positive first-time mothers concerning methods of feeding options for a period of at least six months. The participants will be informed about the purpose of the research and that they may, at any time, withdraw from the interview should it prove to be too distressing to them. The researcher will strive to adhere to all ethical principles of research.

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Thank you for considering my request

Yours faithfully

EK Moobi(Research Student) © 0733080624
ANNEXURE C

LETTERS OF PERMISSION TO CONDUCT RESEARCH STUDY
Ref: 204063978

Contact person: Ms G Ehebel

Date: 31 August 2005

Address:

Ms EK Mocbi
8 Glenairlie
69 Cape Road
Mount Croix
PORT ELIZABETH
6001

Dear Ms Mocbi

FINAL RESEARCH PROPOSAL

Congratulations on a well-prepared final research proposal.

Please be advised that your final research proposal was approved by Faculty Management subject to the following amendments/suggestions/recommendations being made to the satisfaction of your Supervisor:

(i) that the following suggestion for a title amendment was made:
THE EXPERIENCES AND PERCEPTIONS OF MIDWIVES AT PROVINCIAL HOSPITALS IN THE NELSON MANDELA METROPOLITAN MUNICIPALITY REGARDING EXCLUSIVE BREASTFEEDING BY HIV POSITIVE FIRST-TIME MOTHERS

(ii) that there were minor editorial and referencing amendments to be made. Also the method of internet referencing was to be revised;

(iii) that the Sampling Criteria be revised on page 15. The sentence stating the criteria needed to be more clearly formulated.

Yours sincerely

[Signature]

OFFICE OF THE DEAN
FACULTY OF HEALTH SCIENCES
To:  Ms F K Moodi
     Registered Nurse
     8 Glenarrie
     69 Cape Road
     Mount Croix
     Port Elizabeth, 6000

RE:  RESEARCH – APPLICATION

Your unsigned letter of 02/08/2005 refers.

You are hereby authorised to conduct research at the Maternity Department on condition that:

1) Patient confidentiality is maintained at all times.
2) Information obtained is used positively and
3) You make a copy of your findings available to us

DR. F.L. RANK
HEAD: CLINICAL GOVERNANCE MANAGER
FLR/mn
AUTHORISATION TO DO ACADEMIC RESEARCH/PROJECTS AT DORA NGINZA HOSPITAL.

This is to certify that—Miss Moobi— (Identity/ student no., 204053978–), has been given permission to do academic research / project of a non-clinical nature at Dora Nginza hospital.

The duration that the above mentioned will be present in the hospital is from –August 2005– to –October 2005– and during such time, he/she will be in the accompaniment of an official employee of Dora Nginza hospital at all times and agrees to abide by all hospital rules and regulations regarding conduct, patient privacy and confidentiality and access to sensitive information. Further, he/she agrees to present the completed academic work to the superintendent of Dora Nginza hospital before submitting it for evaluation and gives assurances that this information will not be given to the media or used in any way to negatively impact on this hospital.

The above mentioned person also fully indemnifies the hospital from any responsibility should any untoward event or accident befall him/her while on the premises of Dora Nginza hospital.

Signed this---------day of----------------2005.

Signed (Researcher):___________________________

Signed (Medical Superintendent):___________________________
ANNEXURE D

PARTICIPANT CONSENT FORM
1 NELSON MANDELA METROPOLITAN UNIVERSITY

1.1 INFORMATION AND INFORMED CONSENT FORM
(Please delete any information not applicable to your project and complete/expand as deemed appropriate)

<table>
<thead>
<tr>
<th>Title of the research project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference number</td>
</tr>
</tbody>
</table>

| 1.1.1.1 Principal investigator |
| Address |
| Postal Code |
| Contact telephone number |
| (private numbers not advisable) |

### A. DECLARATION BY OR ON BEHALF OF PARTICIPANT
(Person legally competent to give consent on behalf of the participant)

| I, the participant and the undersigned |
| I.D. number |

1.1.3.1.1 OR

| I, in my capacity as |
| of the participant |
| I.D. number |

| Address (of participant) |

#### A.1 I HEREBY CONFIRM AS FOLLOWS:

1. I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by
   of the Department of
   in the Faculty of
   of the Nelson Mandela Metropolitan University.

2. The following aspects have been explained to me, the participant:
### 2.1 Aim: The investigators are studying:

The information will be used to/for:

### 2.2 Procedures: I understand that

### 2.3 Risks:

### 2.4 Possible benefits: As a result of my participation in this study

### 2.5 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators.

### 2.6 Access to findings: Any new information/or benefit that develops during the course of the study will be shared as follows:

### 2.7 Voluntary participation/refusal/discontinuation:

My participation is voluntary

- [ ] YES
- [ ] NO

My decision whether or not to participate will in no way affect my present or future care/employment/lifestyle

- [ ] TRUE
- [ ] FALSE

### 3. The information above was explained to me/the participant by

(name of relevant person)

in

- [ ] Afrikaans
- [ ] English
- [ ] Xhosa
- [ ] Other

and I am in command of this language/it was satisfactorily translated to me by

(name of translator)

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

### 4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

### 5. Participation in this study will not result in any additional cost to myself.

### A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT
Signed/confirmed at [ ] on [ ] 20

Signature or right thumb print of participant [ ] Full name of witness [ ]

B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

I,……………………………………………………………………………………………………………….…………declare that

- I have explained the information given in this document to
  (name of patient/participant)

  and/or his/her representative
  (name of representative)

- He/she was encouraged and given ample time to ask me any questions;

- This conversation was conducted in [ ] Afrikaans [ ] English [ ] Xhosa [ ] Other [ ]

  and no translator was used / this conversation was translated into

  (language) by [ ]

- I have detached Section D and handed it to the participant YES [ ] NO [ ]

Signed/confirmed at [ ] on [ ] 20

Signature of interviewer [ ] Full name of witness [ ]

C. DECLARATION BY TRANSLATOR
I,
I.D. number
Qualifications and/or
Current employment

confirm that I
- translated the contents of this document from English into (indicate the relevant language) to the participant/the participant’s representative;
- also translated the questions posed by (name) as well as the answers given by the investigator/representative; and
- conveyed a factually correct version of what was related to me.

Signed/confirmed at on 20

I hereby declare that all information acquired by me for the purposes of this study will be kept confidential

<table>
<thead>
<tr>
<th>Signature or right thumb print of translator</th>
<th>Signature of witness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full name of witness</td>
</tr>
</tbody>
</table>

D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant/representative of the participant

Thank you for your/the participant’s participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(indicate any circumstances which should be reported to the investigator)

Kindly contact at telephone number
(it must be a number where help will be available on a 24 hour basis, if the research project warrants it)
ANNEXURE E

PROTOCOL FOR DATA ANALYSIS
Dear Colleague

**RE-STEPS TO FOLLOW FOR INDEPENDENT CODING OF TRANSCRIBED RESEARCH INTERVIEWS**

Analysis of data should be according to Tesch in Creswell (1994: 153). Kindly follow the eight steps for data analysis as follows:

1.1 Get a sense of the whole. Read through all the transcriptions carefully and make short notes as you read through
1.2 Pick one document at a time, read through it, extract the essence and write notes in the margin of the document as you go through it.
1.3 Make a list of all the topics. Cluster similar topics together and place them into columns that can be arranged as major topics, unique topics and leftovers.
1.4 Abbreviate the topics as codes and write the codes next to the appropriate segments of the text to see whether new categories and codes emerge
1.5 Find the most descriptive wording for your topics, turn them into categories and group related topics together
1.6 Arrange categories alphabetically
1.7 Assemble the data material belonging to each category in one place and perform a preliminary analysis and
1.8 If necessary, re-code your existing data.

Thank you for your valued assistance.
Yours sincerely;

Ms. E Moobi
(Research student)
ANNEXURE F

TRANSCRIPT OF AN INTERVIEW
Name: Sister G
Area of Work: Antenatal Clinic
Date: 24.09.2005

2 INDICATORS

I: INTERVIEWER
P: PARTICIPANT
[...]: PAUSE
(Ok), (mhm), (yes)

I: Tell me your view regarding exclusive breastfeeding and HIV
P: Breastfeeding as it is, is very good, and is healthy for the baby (mhm). I feel like for the first three months the mother should breastfeed, because they say the...the infasoy or whatever milk that they are giving to the mothers, is free of charge but there has been times that...there has not been milk in the clinic (mhm), and what happen now, the mother will start buying cheap milk and then is not good for the baby. I also feel that there is a chance that the virus can be introduced to the baby, but is about a very small amount of virus in the breast milk. So it is unlikely that by breastfeeding the baby exclusively...that the virus will be transferred to the baby from breast milk (mhm), because the breast milk forms a lining, especially the colostrum, that is given to the baby, it forms a lining on the stomach and that prevents the penetration of the virus into the baby’s system (yes). That is why if the mother is only breastfeeding there is no chance that the virus will be transferred to the baby. People may say that they will have money but people are not so diligent with washing hands, especially as the baby grows, you know. And the baby is small and we are not always close to water so breastfeeding...exclusive breastfeeding for the first three months is very important and also the baby grows much quicker (mhm). And it also keeps the bond between the mother and the baby, just that the mother needs to be taught how to breastfeeding correct (ok).
I: Can you elaborate?
P: I said when the mother exclusively breastfeed there is little chance that the virus can be transferred. There is little virus in the breast milk, small amount. So mhm...it is very seldom that it will be transferred to the baby.
I: What advice do you give to the HIV positive first-time mothers regarding feeding options?
P: We do tell them about...we give them feeding options (yes). We do tell them that breastfeeding is far the best, because it is the same temperature all along when you breastfeed the baby (mhm). Whereas, if you are bottle-feeding the baby the temperature is warm in the beginning and it cools off. And in the first months of the baby’s life, maybe the woman is warming the bottle, but as times go on...in the second month now she is lazy, and now she is giving the baby a chance to get diarrhoea, whereas with breast milk is the same temperature from the time the baby starts until the baby ends (yes). Therefore there is no change in the temperature and no irritation in the lining of the stomach. That is why the babies wont have diarrhoea and apart from the HIV virus that is contained in the breast milk there is no other virus, and there is no other infection. Milk is sealed in the breast and it is clean, but when you prepare the bottle there is a chance of other infections, germs or viruses, bacteria to get into the bottle. Not everybody has got facilities for cleaning of the bottle, there are those that diligently washing hands, but there are the once that are not having the facility to clean the bottles properly (mhm) then the baby that erh...is easy for the infection to get to the baby.
I: Tell me more about the motivations you render to HIV positive first-time mothers
P: Everyday we are having...whenever you are meeting somebody who is HIV positive, you tell them about breastfeeding exclusively, telling them about the importance of breastfeeding you know. If you tell them about the benefits of breastfeeding then they do opt for (yes) for breastfeeding rather than for bottle-feeding. There are those who opt for bottle feeding and it is because they are not motivated enough, but in any case mothers they don’t want...young girls if they are not motivated enough regarding breastfeeding, they would want to bottle feed, because they have got that cosmetic thing, think that the breast is
going to be flabby and then that is the reason. But I have got three children and I still got firm breast, so I show them mine, and after showing them mine they turn to be enthusiastic really. And some of them have been to the private doctors, and private doctors seems to discourage breastfeeding, because some of the people come and say the private doctor said their milk is salty without knowing their status. Those that have been attending antenatal at the private doctor that is the challenge. The challenge is that the private doctors should be informed of the benefits of breastfeeding so that they can also start encouraging people about breastfeeding and not giving people wrong information about breastfeeding.

I: Tell me how in your unit you implement the policy of exclusive breastfeeding.

P: In my unit exclusive breastfeeding is not maintained, because most of the time we accept babies that are delivered by caesarean section (ok), and then they are done under general anaesthesia of which it is very difficult to implement breastfeeding immediately.

I: You mentioned that you are unable to maintain exclusive breastfeeding. Can you elaborate?

P: I will say that because of the pressure...I will say now the shortage of Staff, you understand, sometimes you are alone in the ward then even if you wish to take the baby to the mother you cannot leave the ward alone and go and commence breastfeeding, those are the things that are really making it impossible for exclusive breastfeeding. And ...it’s very difficult with this exclusive breastfeeding with HIV positive mothers. Firstly as you know that this thing is suppose to be started in the clinic when the patient now comes to us, you will find that the patient, they don’t know anything about this exclusive breastfeeding (ok) in spite of being told that they are HIV positive. The Sisters in the clinic as if they are not promoting exclusive breastfeeding. Mothers who are HIV positive neh...they have to choose neh...between breastfeeding and not breastfeeding ok. If she chooses to breastfeed now she will be educated that she can breastfeed for three months neh...exclusively nothing else but that will depend now for her to breastfeed on the CD4 count, if it is less than two hundred the mother even if she wants to breastfeed she wont be able to breastfeed, and if the mother chooses formula at Antenatal clinic and she
chooses again at Labour ward and she chooses again at Postnatal the formula she will have to give formula exclusively, no breast and formula (ok), it is exclusive formula or exclusive breastfeeding

I: Tell me how you overcome the problem of shortage

P: Yhoo...we are killing ourselves, there is no overcoming of shortage. If you are one you are one, if you are two you are two you just do whatever you can do to your best possibility. And I feel exhausted and angry, and the only thing that the management is saying is that they know there is a shortage and they say they are trying to make things right but it is taking a long time because its been a long time since we have been short and now quality assurance of nursing the patients is not at its best (mhm) because you cant do it at its best...you cant do what needs to be done correctly and in the right space of time with the shortage of people, this is a thirty bedded ward and at the moment there are two nurses nursing the thirty bedded. The other thing that is a problem is that the mothers are not disclosing their status to their families and even their partners. Maybe they need...they need support groups because we also need hands here. I think it is important that we have support groups, I think it is important that she has someone she tells even before delivery, so that even when these people come maybe they are two then the three of us we talk and they get educated about breastfeeding so that when she goes home they might support her, even when she is home she will encourage her to continue breastfeeding, we educate we counsel because here we do post Counseling.

I: Is there anything else you would like to tell me?

P: What I think needs to be done to implement the policy. Mostly neh...I think we need to have...when the mothers come in neh...the HIV positive first-time mothers we ought to have the mothers visitors that is the father of the baby, the mother in law, the sisters to come and make use of them. I want them to form a support group neh...a support group (ok) to this mother, but the only problem is when this mother hasn’t divulge any thing to them so they don’t know but if this mother has spoken out to them neh...it was going to be easy for her to be supported for her to be loved you know to be cared for and to be guided (mhm) because most of them they are young mothers. I think the Department of Health is on the right track but now like right now we are short staffers and it is not only
nurses who can teach and help mothers with breastfeeding, if they can train and educate people or whatever who can be available everyday and teach mothers breastfeeding and teach mothers from Antenatal clinic, labour ward and Postnatal about breastfeeding and its so difficult for us to form this support groups.

I: Its there anything else you would like to tell me?

P: What I think needs to be done to implement the policy. Mostly neh...I think we need to have...when the mothers come in neh...the HIV positive first-time mothers we ought to have the mothers visitors that is the father of the baby, the mother in law, the sisters to come and make use of them. I want them to form a support group neh...a support group (ok) to this mother, but the only problem is when this mother hasn’t divulge any thing to them so they don’t know but if this mother has spoken out to them neh...it was going to be easy for her to be supported for her to be loved you know to be cared for and to be guided (mhm) because most of them they are young mothers. I think the Department of Health is on the right track but now like right now we are short staffed and it is not only nurses who can teach and help mothers with breastfeeding, if they can train and educate people or whatever who can be available everyday and teach mothers breastfeeding and teach mothers from Antenatal clinic, labour ward and Postnatal about breastfeeding and its so difficult for us to form this support groups neh

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educate people or whatever who can be available everyday and teach mothers breastfeeding and teach mothers from Antenatal clinic, labour ward and Postnatal about breastfeeding and its so difficult for us to form this support groups.

I: Thank you for your time and the information you have shared with me