EVALUATION OF THE BABY FRIENDLY HOSPITAL INITIATIVE AND THE BREASTFEEDING PROGRAMME

1.0 INTRODUCTION

In the decade of the nineties international efforts were intensified to promote exclusive breastfeeding for 4-6 months by lactating mothers. This major initiative spearheaded by United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO) was taken in light of the recognition that globally "breastfeeding is an endangered practice" and the impact of the significant benefits on the development and health of infants and mothers were not being fully realized. It is to be noted that in October 1979 the WHO/UNICEF meeting on Infant and Child Feeding issued a statement, which addressed the issues of poor infant feeding practices and their consequences, weaning practices, breastfeeding as an integral part of the reproductive process and the relationship between infant and child malnutrition and malnutrition and poor health in mothers. There has been a longstanding concern with infant feeding, its practices and health outcomes for mother and child and the wider society.

In 1990 the international framework for the promotion of breastfeeding saw a number of bold initiatives to stimulate and enable nation states to implement programmes to facilitate breastfeeding. The 1990 Convention on the Rights of the Child included in its provisions, the legal obligation of States to provide mothers with the knowledge and support needed for breastfeeding. This position was further strengthened in the same year when 32 Governments and 10 United Nation Agencies developed and signed the unanimous agreement, the Innocenti Declaration, which declared the need for and the process to enlist global support for breastfeeding. This Declaration fully endorsed the position of health experts that children should be exclusively breastfed for the first four to six months and thereafter breastmilk complemented by other foods should be continued beyond the second year of life.

The declaration outlined 4 specific actions to be implemented at the national level by 1995. The actions to be undertaken by the States indicating their commitment to the promotion of exclusive breastfeeding were as follows:

The appointment of a breastfeeding co-ordinator of appropriate authority and the establishment of a national breastfeeding committee comprised of representatives from relevant government departments, non-governmental organizations and health professional associations

Ensure that every facility providing maternity services fully practices all of the Ten Steps to Successful Breastfeeding set out in the joint WHO/UNICEF statement, "Protecting, Promoting and Supporting Breastfeeding: Special Role of Maternity Services."

Take action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health
Resolutions in their entirety and;

Enact imaginative legislation protecting the breastfeeding rights of working women
and established means for its enforcement.

Also in September of 1990, 71 Heads of State and Government agreed at the World Summit for Children on a set of goals for children and development. Emerging from these goals was the World Declaration and Plan of Action that placed high priority on the re-creation of an environment that is conducive to and for all women to breastfeed.

There were three principal areas of concern selected from among several others that were recognized as having direct impact on the status and practice of infant and young child feeding. The concerns were the obstacles faced by women for the initiation and continuation of breastfeeding influenced by inappropriate

practices in hospitals and other maternity facilities; inadequacies in the skill and knowledge of health workers to support and sustain breastfeeding and the donation of infant formula to maternity institutions. These concerns dictated the directives for the Baby Friendly Hospital Initiative (BFHI) and the development of the International Code of Marketing of Breastmilk Substitutes.

In relation to the three concerns there were definitive programme objectives that were in mutual support of each other. The BFHI essentially sought to "transform maternal and child care practices at the health care facility level by fully implementing the "Ten steps to Successful Breastfeeding", to promote breastfeeding there was the elimination of the distribution of free and or low cost infant formula in hospitals and maternity facilities and the implementation of training programmes in lactation management inclusive of in-service courses in health care facilities, national training of trainers and advanced regional and international courses and advocacy.

The benefits of breastfeeding are extensive as they reach beyond the infant and child to the community and the nation. Direct benefits to the infant are the provision of their total nutritional requirements protecting them against malnutrition, protection against bacterial infection and viral pathogens, prevention of diarrhoea and the reduction of the risks for morbidity and mortality. For the mother, it contributes to birth spacing, helps the expulsion of the placenta and saves money as breastmilk is provided from the available resources of the mother and her family. At the national level there is reduced use of scarce foreign exchange to purchase infant formula and hospital resources to treat the resulting diseases and infections thereby making them available for other uses.

It is in the context of the foregoing that the Government of Jamaica, as a signatory to the Innocenti Declaration and the International Code of Marketing of Breastmilk Substitutes has through the Ministry of Health (MOH) sought to recommit its efforts to the promotion of full breastfeeding for 4-6 months by the adoption of the BFHI, training of health professionals in lactation management and the continued promotion of breastfeeding in health centers. In fulfillment of the required obligations of these agreements the major activities undertaken by the Ministry of Health are as follows:
The establishment of a national Intersectoral Lactation Management Committee

Delivery of lactation management training to strengthen the knowledge and skills of public and private sector health personnel

Placement of breastfeeding promoters in selected hospitals

Removal of feeding bottles from public hospitals and their replacement with cups

Establishment of breastfeeding support groups in some communities

Institution of social mobilisation programmes including the annual celebration of National Br eastfeeding Week

Award of baby friendly status to ten hospitals who have met the criteria by fully implementing the "Ten Steps to Successful Breastfeeding".

These efforts have had limited outcome as there has been no significant increase in the national breastfeeding rate. In 1998 exclusive breastfeeding rate at six weeks was 54 percent (Monthly Clinic Summary Report, Ministry of Health, 1998). The findings of national surveys of the prevalence of breastfeeding show that breastfeeding is initiated by more than 90 percent of mothers. This level is however not sustained for the recommended period and there is wide variation in duration. The ongoing challenge faced by the Ministry is to determine the most successful means to support and sustain the initiation level of breastfeeding so that the optimum benefits will accrue to infants and their mothers in the first instance.

2.0 TERMS OF REFERENCE

The terms of reference outlined by the Ministry of Health for the evaluation of its Breastfeeding Programme and Baby Friendly Hospital Initiative are stated below:

Review all background information relating to the Ministry of Health's Lactation Management Programme

International /national policies and other policy documents
Training of health care staff
Implementation of Baby Friendly Hospital Initiative (BFHI)
Monthly Clinic Summary Report (MCSR) data (1990 –1999)

2. Prepare a project proposal for evaluation of the National Lactation Management Programme (Jamaica)

Prepare evaluation/assessment tool

Identify and train interviewers

Evaluate components of Ministry of Health's Management Programme
Training of Health Care workers
Baby Friendly Hospital Initiative
Advocacy
Political Commitment
Degree of standardization of breastfeeding data collection and recording by parish
Analyse data
Submit report to Ministry of Health

The evaluation should include focus group discussions and interviews with:
Adolescents
Men
Pregnant Women
Breastfeeding mothers
Health care workers
Influential persons eg. Grandmother

4.0 AIM AND OBJECTIVES

The evaluation has as its major aim the assessment of the impact of the Baby Friendly Hospital Initiative and the lactation management programme to identify its strengths and weaknesses.

The specific objectives are to:

Assess the process and impact of the National Intersectoral Lactation Management Commitment in relation to its stated roles and functions

Evaluate staff training in lactation management

Assess the implementation and status of the baby friendly initiative in selected accredited baby friendly hospitals

Ascertain the degree of standardization of breastfeeding data collection and recording in health care facilities

Investigate among selected target groups, adolescents, men, pregnant women (antenatal), breastfeeding mothers (postnatal), health care workers and influential persons their knowledge, opinion, beliefs, support for breastfeeding, breastfeeding practices and experience.

5.0 STUDY METHODOLOGY

The study utilized several approaches, which included documentary, quantitative and qualitative approaches. Documentary research was undertaken in relation to international and national policy documents, lactation management curriculum, training materials and the Monthly Clinic Summary Reports 1990 – 1999.

The quantitative component of the study utilized three questionnaires developed for the target groups of antenatal and postnatal clients and health care service providers. A wide range of health care providers were targeted which included medical doctors; matrons staff nurses, public health nurses, enrolled assistant nurses, breastfeeding promoters and community health aides.

The survey sites were selected in collaboration with the Ministry of Health and a rural urban distinction was maintained. A quota sampling approach was utilized which entails the selection of a specific number of individuals by category. All respondents were selected in the health facility during antenatal and postnatal clinic sessions.

The sample of antenatal and postnatal clients and health service providers was drawn from 14 health care facilities, which included 3 hospitals and 11 health centers in the parishes of Kingston and St. Andrew, St. Catherine, Clarendon and Trelawny (Table 1). A total of 674 persons comprised of 262 antenatal clients, 260 postnatal and 152 health care providers were interviewed.

Table 1 Respondents Distributed by Selected Parishes and Health Facilities

Selected Parishes	Institutions	Antenatal Clients	Postnatal Clients	Health Care Providers	Total
Kingston	Victoria Jubilee Hospital	49	50	21	120
	Comprehensive H/C	-	-	6	6
St. Andrew	Duhaney Park H/C	29	6	14	49
	Glen Vincent H/C	1	9	11	21
St. Catherine	Spanish Town Hospital	41	1	-	42
	St. Jago de la Vega H/C	20	59	20	99
Clarendon	May Pen H/C	27	17	20	64
	Denbigh H/C	18	25	21	64
	Chapelton H/C	15	18	9	42
	Chapelton Hospital	-	14	-	14
Trelawny	Clark's Town H/C	10	24	1	35
	Jackson Town H/C	-	2	5	7
	Falmouth H/C	52	34	23	109
	Duncan's H/C	1	-	1	2
Total		**262**	**260**	**152**	**674**

The proportions of respondents contributed to the sample were Kingston and St. Andrew (29.1%), St. Catherine (21%) Clarendon (27.3%) and Trelawny (22.4%).

The qualitative component of the study utilized focus group discussions (FGDs) among the selected target groups of adolescents, men, pregnant women (antenatal), breastfeeding mothers (postnatal), men and influential persons to obtain information on their knowledge, opinion, beliefs, support for breastfeeding, breastfeeding practices and experience. A total of 20 FGDs were conducted, 5 in each of the study parishes (Table 2). Focus group discussions were recorded for content analysis.

Table 2 Distribution of Focus Group Discussions by Parish and Type

Parish	**Type of Focus Group Discussions**				
	Antenatal	**Postnatal**	**Adolescents**	**Men**	**Influential Persons**
Kingston and St. Andrew	1	1	1	1	1
St. Catherine	1	1	1	1	1
Clarendon	1	1	1	1	1
Trelawny	1	1	1	1	1
Total	**4**	**4**	**4**	**4**	**4**

Health professionals in the health care facilities mainly the nurse in charge and the record clerk were individually interviewed, the former, on the implementation of the breastfeeding programme, data collection and reporting and their opinions and suggestions for improvements, while the latter focused on the recording and transmission of breastfeeding data. An inventory was also undertaken of the breastfeeding materials seen in the health facility.

Adjustments had to be made during the fieldwork to increase the number of study sites, as the pre-determined number and type of respondents specified were not available at some sites. Additionally, unfavourable weather conditions also contributed to the adjustments.

Organisation of the Study Findings

The major study findings are organized in sections 6 -14. Sections 6 - 8 deal with the findings in antenatal and postnatal clients and service providers respectively. In each of the sections both the quantitative and qualitative findings among the respondents are included. In sections 9 - 11 the qualitative findings among the other target groups namely, men, significant others and adolescents are presented. Section 12 addresses the National Co-ordinating Committee and issues of policy and institutional support. In Section 13 the monthly clinic summary report (MCSR) data are analyzed and the findings are concluded in Section 14 with observations relevant to breastfeeding in the health facilities. The conclusion and recommendations based on the findings are presented in Section 15.

6.0 MAJOR FINDINGS

6.1 ANTENATAL CLIENTS

6.2 Profile of the Antenatal Clients

A total of 262 antenatal clients were interviewed at eleven survey sites. The average age was 25.1 years and the majority (56%) was in the 14 – 24 year age group (Table 3). Eighty three percent belonged to a church or religion and the major churches of affiliation were Church of God (30%), Seventh Day Adventist (16%) and Pentecostal (11%).

Table 3 Distribution of Antenatal Clients by Age Groups

Age	Frequency	Percentage
14 – 19	72	27.5
20 – 24	75	28.6
25 – 29	41	15.6
30 – 34	44	16.8
35 – 39	19	7.2
40 – 44	10	3.8
45 and over	1	0.4
Total	**262**	**100.0**

Approximately equal proportions of the respondents reported that they were living with their parents (26%) or with their partner and children (25%). Fifteen percent were living with partner only, 10 percent with children and 8 percent with other adult relative (Table 4). The average household size was 4 and most households (25%) had three persons. Eighty five percent of the households had a range of 1-6 persons.

Table 4 Persons with Whom Antenatal Clients Live

Persons Lived With	Frequency	Percentage
Parents	77	26.3
Partner and children	74	25.3
Partner only	45	15.4
Children	30	10.2
Other relative (uncle, aunt etc.)	23	7.8
Siblings	20	6.8
Live alone	12	4.1
Grandparents	7	2.4
Friends	4	1.4
Other	1	0.3
Total	**293**	**100.0**

The most predominant union status among the respondents was common-law union (45%). Twenty nine percent were in visiting unions, 13 percent married and 11 percent said they had no current relationship.

The 30 –34 year old group had the highest proportion (34.3%) of married unions, while the highest proportions of visiting unions (43.4%) and common-law unions (30.3%) were in the 14 – 19 and age group and 20 – 24 age groups respectively. This union pattern is in conformity with the known movement in consensual relationships from visiting at the younger ages through common-law to marriage at the older ages. Among those reporting "no relationship", the largest group was 14-19 years (43.3%) followed by the age group 20-24 years (Table 4a).

Table 4a Respondents' Union Status by Age Group

Age Group

Union Status	14-19	20-24	25-29	30-34	35-39	40-44	45 and over	Total
Married	1	6	7	12	5	4		35
	2.9	17.1	20.0	34.3	14.3	11.4	0.0	100.0
Visiting	33	22	7	9	4	1		76
	43.4	28.9	9.2	11.8	5.3	1.3	0.0	100.0
Common-law	25	36	24	20	9	5		119
	21.0	30.3	20.2	16.8	7.6	4.2	0.0	100.0
No relationship	13	11	3	1	1		1	30
	43.3	36.7	10.0	3.3	3.3	0.0	3.3	100.0
Not stated				2				2
				100.0				100.0

Among the respondents, the highest level of education reported saw almost half (48%) with high school education, 25 percent new secondary, 13 percent post secondary and 8 percent primary education (Table 5). Twenty eight percent of the respondents were housewives, not looking for work, 24 percent were unemployed and looking for work, 21 percent were in someone's employ and 13 percent were self-employed. Thirteen percent were students. Respondents were engaged in a wide range of economic activities including informal commercial importation, cosmetology, domestic services, catering, clerical, sales, dressmaking etc.

The majority of respondents including those employed received assistance from some other source. Sources of financial support came mainly from their partners, 63 percent, 14 percent mothers, 11 percent other relatives, 4 percent overseas remittances and 3 percent friends. Three percent said that other than themselves they had no other financial source. Forty three percent are either in receipt of or plan to seek assistance. Approximately 45 percent of the respondents receive or plan to seek assistance from the food stamp programme.

Table 5 Highest Level of Educational Attainment by Respondents

Level of Education	Frequency	Percentage
Primary	23	8.8
New Secondary	65	24.8
High School	125	47.7
Post secondary/college	33	12.6
University	2	0.8
Not stated	13	5.0
Total	**262**	**100.0**

Forty one percent (108) of the respondents were pregnant for the first time and 58 percent (153) had had previous pregnancies. The majority of the respondents (49%) were in the last trimester (6-9 months) of their pregnancy, 41 percent in the second trimester and 9 percent in the first trimester. The mean age of the pregnancies was 7 months (Table 6). One hundred and forty seven respondents had an average of 2 children.

Table 6 Pregnancy Status of the Respondents

Pregnancy Status	Frequency	Percentage
One month	3	1.1

Two months	3	1.1
Three months	18	6.9
Four months	29	11.1
Five months	33	12.6
Six months	44	16.8
Seven months	34	13.0
Eight months	45	17.2
Nine months	50	19.1
Not stated	3	1.2
Total	**262**	**100.0**

Seventy seven percent of those with children had 1-3 children (Table 7). The children's ages ranged from 1 – 26 years. More than three-quarters of the children were under 15 years of age and just less than one quarter were under 5 years.

Table 7 Number of Children Reported by Respondents

Number of Children	Frequency	Percentage
0	6	3.9
1	56	36.4
2	42	27.3
3	21	13.6
4	12	7.8
5	9	5.8
6	5	3.2
7	1	0.6
8	1	0.6
9	1	0.6
Total	**154**	**100.0**

6.3 Breastfeeding Experience with Last Child

Eighty five percent of mothers reported that they had breastfed their last child. The reported feeding pattern showed that 47 percent breastfed on demand, 37 percent when they felt that the baby was hungry and only 7 percent breastfed on a schedule. There was wide variation in the number of times that the babies were breastfed per day. Breast milk only was fed to the babies with varying periods between a month and more than six months. Breastmilk only was given by 31 percent for six or more months (Table 8).

Breastfeeding was overwhelmingly supported by the majority of the focus group discussants as indicated in the following quotes:

"I like breastfeeding and it good for baby. It more healthier when you breastfeed, it easier."

"It heals inside and you don't have to wake up at nights to mix feed."

"I breastfeed my first child until he was 1 year and 7 months and it was good so I would do this for this other child."

Less favourable minority comments that were noted are as follows:

"It depends on how the breast feel, it feel hot at birth when the nurse say put the baby on the breast."

"I usually don't have enough milk for the baby so I have to buy milk and sometimes when I finish breastfeed I have to stretch out."

"Sometimes breast alone cannot hold baby belly, it not sufficient."
"It depends, I don't like boy children to breastfeed, can't feed them, the first boy suck till 1 year five months, could not stop him. Boys take too much milk, do not like them."
"I had difficulty with two first children and with what I went through with them, I will not breastfeed although it is best for the baby."

"Sore nipples, breast split and pain you bad."

"When baby belches it hurt, they say to box the baby with the titty that it no pain you."

Many participants reported that older persons were more inclined to encourage breastfeeding than younger persons. Some of the younger ones say things like "stay there yu breast going to get long."

Table 8 Percentage Distribution of Mothers Attending Antenatal Clinic According to the Age at which Exclusive Breastfeeding of the Last Child was Discontinued (n=127)

Age at which Exclusive Breastfeeding Discontinued	%	Cumulative %
1 month	3	3
1 - 2 months	17	20
3 months	17	37
4 months	11	48
5 months	5	53
6 months	16	69
More than 6 months	31	100

Sixty one percent of the mothers fed their babies breastmilk before giving other foods. The most popular food items given to the babies by at least half of the respondents by rank were porridge/cereal (66%), mashed potatoes (55%), fruit juices (51%), skim powered milk (51%) and tinned feeds/formula (49%), Table 9.

Table 9 The Most Popular Food Items Fed to Babies by the Respondents

Food Items	Frequency	Percentage
Porridge/cereal	87	65.9
Mashed potatoes	73	55.3
Fruit juices	68	51.5
Skim powered milk	68	51.5
Tinned feed/formula	65	49.2
Food from the family pot	41	31.1
Mashed pumpkin	39	29.5
Fruits	33	25.0
Glucose water	18	13.6
Egg	16	12.1
Gerber foods	16	12.1
Bush tea with sugar	15	11.4

The major reasons for giving the baby these other foods were that the baby was at the "right age for food" (33%), "needs more than breastmilk" (24%) and "breastmilk insufficient" (17%). Other reasons such as the child was hungry, mother had to go to work and child wanted the food were each endorsed by less than 8 percent of the mothers.

Mothers used a variety of utensils to feed their babies. Most mothers (38%) used the bottle and cup and spoon, 36 percent used cup and spoon, 23 percent bottle and 14 percent plate or saucer with spoon. In general, there was very little response (18%) as to the reasons for the non-use of the cup and spoon. Among the main reasons mentioned were the "bottle is easier to use", "baby comfortable with bottle" and "it (cup and spoon) takes too long" and "the baby cannot feed well with cup and spoon".

With respect to reasons why breastfeeding was terminated, 25 percent reported that the baby stopped or weaned him or herself, 24 percent felt that the baby was hungry when given only breastmilk and 16 percent either had no breastmilk or it was insufficient (Table 10).

Table 10 Major Reasons Why Respondents Stopped Giving Babies Only Breastmilk

Reasons	Frequency	Percentage
Child stopped/weaned self	36	24.5
Child hungry with only breastmilk	35	23.8
None/insufficient breastmilk	23	15.6
Had to work /separated from baby	15	10.2
Mother sick/weak/not eating Properly	10	6.8
Other person advised	4	2.7
Child sick/not nursing	3	2.0
Nurse/doctor advised	3	2.0
Not stated /not sure/don't remember	15	10.2
Total	**147**	**100.0**

From Focus Group Discussions among the antenatal clients some of the reasons expressed for terminating exclusive breastfeeding were varied and are reflected in the following quotes:

"Baby should get food from other sources like formula, help baby more than just mainly breastfeeding."

"When babies born too small, and you give them feeding with breastmilk it build up dem body."

"Because of work, I can't breastfeed for long, would consider expressing milk, but I have not done it before."

"Nipples get sore and bust up round it"
"It make your breasts long"

In reporting on the weaning process, 38 percent of the mothers indicated that their babies were gradually weaned, 33 percent abruptly weaned and 15 percent said that the babies weaned themselves. With respect to the complete cessation of breastfeeding just over two thirds (68%) reported that they ceased after six months (Table 11).

Table 11 Percentage Distribution of Mothers Attending Antenatal Clinic According to the Age at which Breastfeeding of the Last Child was Completely Stopped (n=127)

Age at which Breastfeeding Stopped	Percentage	Cumulative %
1 month	3.0	3.0
1 - 2 months	13.0	16.0
3 months	21.0	37.0
4 months	10.0	47.0
5 months	5.0	52.0

6 months	16.0	68.0
more than 6 months	32.0	100.0

6.4 Projected Feeding Plans for the New Baby

Feeding plans for the new baby for the first six months saw 53 percent of the sample planning to breastfeed only for six months and 38 percent planned to feed using both the breast and the bottle. Altogether more than 91 percent of the antenatal clients plan to breastfeed their babies, though not exclusively in the first six months. Only 2 percent indicated that they would only feed their babies with infant formula, 4 percent plan to combine breastmilk, formula and to use cup and spoon. One percent was unsure or did not have specific feeding plans.

The major reason given for planning to breastfeed only (44%) is based on the knowledge that breastmilk is the best and most suitable food for the baby while the administration of formula and the use of the bottle are related to the need to return to work (11%), the baby needs more than breastmilk (7%) and insufficient breastmilk (5%).

In relation to the length of time that respondents plan to feed their babies only breastmilk just over half (51%) indicated that they will do so for six months or more (Tab le 12).

Table 12 Length of Time the Respondents' Plan to Only Breastfeed their Babies

Time Period	**Frequency**	**Percent**
Under 4 weeks	7	4.6
Four weeks	4	2.6
Six weeks	2	1.3
Seven weeks	1	0.7
Eight weeks	9	5.9
Two and a half months	1	0.7
Three months	25	16.3
Three and a half months	1	0.7
Four months	14	9.2
Four and a half months	1	0.7
Five months	2	1.3
Six months	35	22.9
More than six months	43	28.1
Total	**153**	**100.0**

The three principal reasons given by respondents as to why they plan to breastfeed their new baby are that it is the best source of nutrition (36%), it promotes growth and development (25%) and protects against disease (18%). Other reasons such as the economy of breastfeeding, "saving money" and "child spacing" received endorsements of 9 percent and one percent respectively.

From the FGD it is apparent that the range for exclusive breastfeeding spanned from 3-6 months. This intention is noted in the following quotes:

"I would give the breast until up to 3 – 4 months and after that start mixing"

"I would give breast alone to up to 5 months then after mix with other foods like porridge."

But there were others who were not too sure of their plans.

"I don't know for how long."

"I cannot say now, but I intend to breastfeed as long as possible."

Table 12a Baby Feeding Plans for 4-6 Months by Age Group

Age Group

Feeding Plan	**14-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45+**	
Breastfeed Only	29	35	23	24	10	6		
		40.3	46.7	56.1	54.5	52.6	60.0	0.0
Give both breast & bottle	40	32	16	7	4	1		
		55.6	42.7	34.1	36.4	36.8	40.0	100.0
Bottlefeed Only	0.0	1	1	1	0.0	0.0	0.0	
			1.3	2.4	2.3	0.0	0.0	0.0
Bottle, cup and spoon	0.0	0.0	1	0.0	1	0.0	0.0	
		0.0	0.0	2.4	0.0	5.3	0.0	0.0
Breast, bottle, cup & spoon	1	1	2	3	1	0.0	0.0	
		1.4	1.3	4.9	6.8	5.3	0.0	0.0
Breast & tea	0.0	1	0.0	0.0	0.0	0.0	0.0	
			1.3					
Not stated		1	1	0.0	0.0	0.0	0.0	0.0
1.3								
Don't know/not sure	1	4	0.0	0.0	0.0	0.0	0.0	
5.3								
Total		**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Respondents' plans for feeding their baby varied somewhat by their age. With respect to the age group 14-19 years, the majority (55.6%) has plans to both breastfeed and give their babies other foods. Conversely a larger percentage of respondents in the other age groups had plans to breastfeed exclusively. The majority of with this response were in the 25 – 45 and over age groups (Table 12a).

With respect to those who stated that nothing will convince them to breastfeed, 30 percent were in the age group 14-19 years, followed by the age group 20-24 years (28.3%). The older groups ranging from 25 years

to 45+ years were less inclined to feel this way. Seventy one percent of those who said nothing would convince them to breastfeed exclusively for 4-6 months had achieved post primary education, (New Secondary Education 33.3% and High School Education 37.8%).

6.5 Reasons for the Projected Feeding Plans for the New Baby

Fifty five percent reported that they plan to give their babies breastmilk only for 4-6 months for reasons of good nutrition (27%), growth and development (27%), disease protection (21%) and saving money (9%). The important things identified by the respondents to be done to facilitate breastfeeding for 4 – 6 months are eating right (64%), keeping the breast clean and drinking a lot, each 11 percent. Six percent reported that they were either not sure or did not know what to do.

Forty one percent said that there were no problems as they saw it with giving only breastmilk for 4 to 6 months. Others identified problems as, time constraint and stress (9%), sore and painful/sore nipples (9%), having to work (8%), insufficient milk (4%), breast out of shape (3%) and baby not satisfied and breastmilk not nutritious enough (3%). Twelve percent said they were unsure as to what problems could arise. Problems identified by 1 percent or less of the respondents were related to weight, breast rejection by the baby and medical conditions.

When asked what could be done to convince respondents to breastfeed only for 4 to 6 months, 52 percent reported that they were already convinced. Seventeen percent said that nothing would convince them, while the main request from 12 percent was they wanted proof about the nutritional value of breastmilk.

6.6 Sources of Breastfeeding Information

Seventy three percent of the respondents had someone explain to them about breastfeeding. The nurse received the highest ranking (45%) as the person from whom information was received, next was their mother (18%). All other sources received 10 percent or less endorsement (Table 13).

Table 13 Source of Breastfeeding Information by Rank

n = 332

Source	Frequency	Percent
Nurse	151	45.5
Mother	60	18.1
Friend	34	10.2
Doctor	32	9.6
Other relative	17	5.1
Community Health Aide	11	3.3
Grandmother	13	3.9
School Teacher	5	1.5
Health Worker	4	1.2
Partner	4	1.2
Self	1	0.3
Total	**332**	**100.0**

In terms of the main person providing the information, the first two sources had a ranking similar to the sources identified for breastfeeding information, nurses 45 percent, mothers 14 percent. Doctors (5%) were ranked as the third main source.

Thirty six percent reported that they got reading material on breastfeeding to take home, and again the nurse (77%) was the major person and the place was the health center (78%) from which it was obtained.

This is a clear statement that the nurse and the health centre are the most important avenues through which breastfeeding information is disseminated to antenatal clients. All other persons and sources each received an endorsement of fewer than 10 percent.

The FGD revealed similar sources of breastfeeding information with the most dominant source being nurse and to a lesser extent relatives and friends. Information about breastfeeding with respect to the main source revolved around the following quotations.

"At the clinic they tell you how to take care of the breast, stretch nipples so baby can hold on"

"Information from clinic was very helpful and useful, the babies get germ from the bottle not the breast unless dirty."

"Information from the clinic was useful, - cleaning of the breast, care of the breast and how to position the baby when breastfeeding, things to eat such as milk, cheese and sardines."

Other sources of breastfeeding information relating to audiovisual and print sources were identified as television (15%), pamphlets (10%), radio (9%), magazines (6%), and newspaper (1%). The doctor and books were reported by 10 percent each of the respondents as sources, all other sources including pharmacies (4%) were fewer than 5 percent.

6.7 Discussions Held on Breastfeeding Management

The discussion of issues related to breastfeeding management both before and after delivery are of key importance for the successful implementation of breastfeeding. The main source providing information on breast preparation stressed three aspects, washing the breast properly (38%), pulling out the nipples daily (15%) and drying the breast properly (13%). Information was also given on how to position the baby properly for breastfeeding (6%) and providing proper support for the breasts by wearing a good supporting brassiere (5%). Only 5 percent reported not remembering what they were told.

Thirty two percent of the respondents reported that they received no information as to what should be done with their breasts 6 weeks before delivery. Twenty percent each said they were told to squeeze fluid from the breast to assist the flow of milk and 11 percent to take note of the flow of colostrum.

The important benefits told to respondents about breastfeeding were that it is the best nutrition for the baby (28%), it promotes growth and development (24%) and protects against disease (20%). Only 6 percent reported that they were told that breastfeeding saves money and less than 1 percent (0.4%) that it assists in child spacing.

The FGDs demonstrated similar findings

"The baby get germ from the bottle, not the breast unless dirty."

"Nurse tell us to eat cheese, vegetables, peas, beans… take iron."

However most of the mothers reported that they did not receive pamphlets and other written material from the clinic. However, they all agreed that the information they received from clinic personnel was useful, especially regarding the care of the breast, how to position the baby when breastfeeding the nutritional value of breastmilk and nutritional things to eat such as cheese and sardines.

The information provided to respondents on the benefits of full breastfeeding had approximately similar endorsements as the benefits of breastfeeding. The opinions of the respondents on full breastfeeding saw 34 percent endorsing that it was the best nutrition for the baby, 28 percent that it promoted growth and

development and 21 percent that it protected against disease and death. Seven percent were also of the opinion that it saved money and less than one percent (0.2) that it aided child spacing.

Discussions on how to return to work and breastfeed were reported by 18 percent of the respondents and among them the nurse (43%), their mother (15%) and friends (17%) were the main persons with whom these discussions were held. The majority (82%) did not have any discussion about how to return to work and continue breastfeeding. Among those who did 4 percent was before the pregnancy and 14 percent during the pregnancy.

Twenty nine percent of the respondents had discussions about the expression and storage of breastmilk and the nurse (51%) was the principal person with whom it was discussed, followed by mothers (19%) and friends (16%). Sixty nine percent of the sample reported that they had had no discussions on how to express and store breastmilk. Discussions before pregnancy took place among 12 percent of those reporting such discussions (29% of the sample) and 85 percent since the pregnancy.

Only 13 percent of the sample reported that they had discussions on breastfeeding as a contraceptive. Among this 13 percent, the nurse (66%) was the main discussant, followed by mother (12%) and friend (6%). Eighty four percent discussed it since the pregnancy and 16 percent before.

Forty one percent of the respondents had discussed about the right time to give the baby other foods and again the nurse (50%), mother (26%) and friends were the principal persons with whom these discussions were held. Thirteen percent had discussions prior to the pregnancy and 86 percent since the pregnancy.

Proper positioning of the baby for breastfeeding was discussed by 40 percent of the sample with the nurse (63%), mother (19%), other relatives (6%) and friend (4%).
The proportions discussing before (13%) and since pregnancy (84%) are similar to those discussing the right time to give other foods to the baby.

Some of the things that respondents reported that they were currently doing based on the information received were keeping their breasts clean (21%) eating properly (18%), massaging and oiling the breast (7%) and pulling the nipples (7%). All other actions including drinking milk, water, taking calcium tablets were endorsed by less than 5 percent of the respondents. Sixteen percent reported that they were doing nothing of what they were told.

6.8 Information Obtained on Infant Formula

Only 13 percent had heard a manufacturer or distributor of infant formula speak about the product and the information received was that it provided calcium and nutrition (6%) and is a substitute for breastmilk (3%).

Less than 1 percent reported the receipt of free baby formula. The information was heard mainly on television (6%) and radio (6%). Less than 1 percent had heard such information in the clinic.

There was a high level of non-response (87%) to the issue of what is the best time to introduce other foods to the baby by those sources giving information on formula feeding. Among the 13 percent who responded 3 percent indicated that 6 months was the best time. All other times indicated from 1 to 12 months had less than 1 percent endorsement. Information on formula feeding was received by 4 percent of the respondents since their pregnancy.

Based on what respondents have heard about formula feeding the plans for their new baby are outlined as follows:

19 percent will introduce formula after a certain age
16 percent plan either not to use or do nothing about formula feeding
16 percent plan to give their babies' formula

5 percent will give both breastmilk and formula
3 percent said it depends on the baby's acceptance or rejection of formula
3 percent will give formula if they are working or away from baby

Twelve percent of the respondents are of the opinion that formula is not nutritious or good for the baby and 10 percent feel that the breast is better. Fifteen percent ind icated that infant formula is good for the baby and 32 percent feel that it is a good substitute for breastmilk. Seven percent have never used infant formula. Two percent or less each feel that formula feeding reduces the pressure on mothers, is convenient when mothers have to work or be away from the baby and if breastmilk is insufficient.

The FGD information showed that information about formula feeding was sourced from advertisements and the displays in the supermarket. Views were mixed about the benefits of formula feeding but the general consensus was that it was a suitable substitute for breastmilk but after the baby has reached 3-4 months. The following comments were made:

"After 3 - 4 months, baby can manage it, but not just any tin feed though."

"Some mothers afraid if they have HIV positive they will pass on this to the baby so they use tin feed."

Some partners also deemed infant formula suitable when breastfeeding mothers were experiencing pain as indicated in the following quotes:

"If I am feeling pain he buys formula for me."

"He does not like pain, he is uncomfortable when I am in pain, if he hears me complaining he will tell me to stop and buy feeding for the baby."

However, it was reported several times over that in general their partners encouraged breastfeeding and were aware of the nutritional value of breastmilk.

6.9 Plans for Maternity Leave and Access to Financial Support

In relation to this current pregnancy the majority, (70%) had no definitive plans for maternity leave. Among those who were employed, 43 percent planned 3 months maternity leave. In the total sample 13 percent planned to take 3 months maternity leave, 4 percent each planned to take two, four or six months.

7.0 POSTNATAL CLIENTS

7.1 Profile of Postnatal Clients

Postnatal clients had a mean age of 25.6 years with the largest group being in the age range 20-24 years (32.3 %) followed by the age group 25-29 years (23.1 %) (Table 14).

Table 14 Distribution of Postnatal Clients by Age Group

Age Group	Frequency	Percentage
15 – 19	50	19.2
20 – 24	84	32.3
25 – 29	60	23.1
30 – 34	34	13.1
35 – 39	23	8.8
40 – 44	8	3.1
Not Stated	1	0.4
Total	**260**	**100.0**

The large majority belonged to a church/religion and the main affiliations were the Church of God and Seventh Day Adventist (Table 15).

Table 15 Respondents' Church Affiliation

Denomination	Percentage
Church of God	40.8
Baptist	12.1
Anglican	4.0
Seventh Day Adventist	17.8
Mormon	0.6
Pentecostal	10.3
Roman Catholic	2.3
Methodist	2.9
Rastafari	0.6
United/Presbyterian	2.3
Revival/Zion	1.1
Salvation Army	0.6
Jehovah Witness	4.0
Bretheren	0.6
Total	**100.0**

Living arrangements saw the largest group (34.6%) of respondents living with their partners and children, followed by parents (25.2%), (Table 16).

Table 16 Respondents' Distributed by Persons with whom they Live

Persons Lived With	Percentage
Partner only	8.0
Partner and Children	34.6
Children	11.5
Sister/brother	6.3
Parent/s	25.2
Other adult relative	2.8
I live alone	4.9
Friends	5.6
	1.0
Total	**100.0**

The mean household size was 4 persons with three persons per household being the most dominant size (23.1 percent) followed by five with 21.2 percent (Table 17).

Table 17 Respondents' Reported Household Size

Household Size	Frequency	Percentage
2 persons	19	7.3
3 persons	60	23.1
4 persons	52	20.0
5 persons	55	21.2
6 persons	30	11.5
7 persons	18	6.9
8 persons	13	5.0
9 persons	5	1.9
10 persons	6	2.3
11 persons	2	0.8
260	**100.0**	

A marginal majority of the mothers (53.3 percent) have other children whereas 46.7 percent gave birth to their first child. Of those with children the largest group (37.0 percent) have two children followed by 30.4 percent with three children (Table 18). The mean number of children was 3.

Table 18 The Distribution of Number of Children Had by Respondents Excluding The New Baby

Frequency	Percentage
One	0.7
Two	37.0
Three	30.4
Four	15.6
Five	8.9
Six	5.9
Seven	1.5
Total	**100.0**

The age of the new baby varied widely, ranging from one week to ninety-six weeks (Table 19). The largest group (35%) of the babies brought to the postnatal clinic was six weeks old, which is the recommended age for the postnatal visit. More than half (55%) was between 6- 8 weeks old.

Table 19 Distribution by Age of the Respondents' New Baby

Age of Child	Frequency	Percentage
4 weeks	19	7.5
4-5 weeks		
6 weeks	92	35.4
7 – 8 weeks	53	20.3
9 – 10 weeks	5	2.0
11 – 12 weeks	16	6.2
14 – 15 weeks	6	2.3
16 weeks	11	4.2

20 – 21 weeks	10	3.9
24 –26 weeks	12	4.6
28 weeks		
32 weeks	6	2.3
36 weeks	2	0.8
40 weeks and more	6	2.4
Total	**260**	**100.0**

The majority (78.8 %) reported normal delivery but interestingly, a little over twenty-one percent (21.2%) had caesarean births. Less than fifty percent of the postnatal clients (45%) were offered help to initiate breastfeeding. For the majority (54%) this help came within hours (1-12 hours) of delivery, whereas 17.4 percent received assistance the next day (Table 20).

Reports from the FGD participants were similar to that of those surveyed in that the majority had received no help to initiate breastfeeding. The lack of follow-up assistance after delivery is poignantly reflected in the quote of an FGD participant:

"As you give birth, they finish with you."

Table 20 Period of Time After Delivery in Which Help was Offered with Breastfeeding (n=121)

Period of Time	**% of Respondents Offered Help**
1 hour	30.6
2 hours	9.9
3 hours	5.0
4 hours	3.3
5 hours	0.8
6 hours	2.5
10 hours	
12 hours	0.8
Next day	17.4
Some hours	9.9
Two days	4.1
3-4 days	2.5
4 days – 1 week	2.5
More than 1 week	4.1
Before birth	4.1
Don't remember	1.7
	100.0

The highest level of educational attainment by the largest group (46.2%) of the respondents was high school education, which was followed by the new secondary level (25.4 percent), (Table 21).

Table 21 Highest level of Education Attained by Respondents

Type of School	**Frequency**	**Percentage**
Primary	21	8.1
New Secondary	66	25.4
High School	120	46.2
Post Sec/College	42	16.2
University	3	1.2
Not stated	8	3.1
Total	**260**	**100.0**

Over thirty percent (31.2%) are unemployed and looking for work whereas, 28.5 percent are working for someone else (Table 22). The span of the occupations was wide and the largest categories were housewives (18%), hairdressers (11%) and higglers (9%), helpers (8%), teachers (7%) and clerical (5%). All other categories were represented by fewer than five percent.

Table 22 Respondents' Employment Status

Status	**Frequency**	**Percentage**
Work for self	36	13.8
Work for someone else/co.	74	28.5
Unemployed-looking for work	81	31.2
Housewife – not looking for work	49	18.8
Student	20	7.7
Total	**260**	**100.0**

With respect to union status, common-law was the most dominant relationship (47.7%) percent), followed by visiting (23.8%). More than one-tenth (15.8 %) of the mothers indicated that they had no current relationship (Table 23).

Table 23 The Union/Relationship Status of the Respondents

Union Status	**Frequency**	**Percentage**
Married	32	12.3
Visiting	62	23.8
Common-Law	124	47.7
No relationship	41	15.8
Not stated	1	0.4
Total		

Of those in visiting relationships the majority (58.1%) were in the youngest age group of 14-24 years. Among those not in a relationship the majority (70.7%) were also in the same age group (14-24 years), (Table 23a).

Table 23a Respondents' Union /Relationship Status by Age Group

	Age Group						
Union Status	**14-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**Total**
Married	7 0.0	11 22.6	6 35.5	5 19.4	2 16.1	31 6.5	100.0
Visiting	16 25.8	20 32.3	11 17.7	8 12.9	7 11.3	62 0.0	100.0

Common-law	19	43	35	15	8	4	124	
	15.3	34.7	28.2		12.1	6.5	3.2	100.0
	15	14	2		5	3	2	41.0
No Relation ship	36.6	34.1	4.9		12.2	7.3	4.9	100.0

7.2 Infant Breastfeeding Patterns

The overwhelming majority of mothers (88%) reported that they had breastfed their second to last child. Of the small percentage who did not breastfeed, the reasons
centred on the mother's health and baby's rejection of the breastmilk.

The most dominant period when foods other than breastmilk were introduced to the second to last child was six months (24.4%).

Like with the previous child over eighty percent of the mothers (86.5 %) reported that they are currently breastfeeding their new baby. However, the largest group (45.0%) is breastfeeding the baby and giving other foods and 42.7 percent is giving the baby only breastmilk (Table 24).

In one FGD, in an urban area only one mother was breastfeeding exclusively. Others reported that their babies were in good health on the 'mixed' regime of breastmilk and other foods. One mother underscored the need for the mixed regime in her comment that "the baby get breast alone for six months and the baby malnourish."

Table 24 Current Feeding Patterns of New Baby

Breastfeeding Pattern	**Frequency**	**Percentage**
Breastfeeding only	111	42.7
Breastfeeding and giving other foods	117	45.0
Stopped breastfeeding	22	8.5
Never breastfed	10	3.8
Total	**260**	**100.0**

The majority of mothers breastfed their baby on demand (52%), 39 percent breastfed when they felt that the baby was hungry and 7 percent breastfed on a schedule. Ninety percent gave negative responses to the question of feeding babies with expressed breastmilk. Less than 8 percent indicated that they had fed their babies with expressed breastmilk.

Table 24a Giving Baby other Foods by Age Group

	Age Group						
	14-19	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**Total**
Breastmilk Only	17	33	32	10	10	4	106
	16.0	31.1	30.2	9.4	9.4	3.8	100
Gave other food in the past now breastfeeding	1	1	2				4
	25.0	25.0	50.0	0.0	0.0	0.0	100
Giving other foods and breastmilk	21	40	22	19	11	4	117
	7.9	34.2	18.8	16.2	9.4	3.4	100

Stopped breastfeeding	7	31.8	6	27.3	3	13.6	4	18.2	2	9.1	22	100
Never Breastfed	4	40.0	4	40.0	1	10.0	1	10.0	10	0.0	0.0	100

Respondents in the age groups 20-24 and 25-29 were practicing exclusive breastfeeding more than the other age groups. Conversely, almost one third (31.8%) of the 14 – 19 age group had ceased breastfeeding (Table 24a).

7.3 Exclusive Breastfeeding

Tables 25 – 27 focus on mothers who are breastfeeding exclusively. The length of time mothers intend to breastfeed exclusively is reflected in Table 25. Interestingly, the dominant cut off periods for exclusive breastfeeding were three months (17.9 %), six months (17.9 %) and "as long as the baby wants the breast" (17.9%).

Exclusive breastfeeding was also supported by the focus group participants and is underscored by the following quotes:

"The breastmilk is the safest, it prevents the baby from getting germ, I plan to give breast alone for six months."

"I plan to give breast alone for six months," says a 26 year old mother of 2 children and a six weeks old baby."

"I am nineteen years old and this is my first baby who is one week old and "I plan to breastfeed alone for six months."

"It cut down on the cost of feed."

Table 25 The Projected Time that Mothers Plan to Give their Babies Only Breastmilk

Length of Time	**Percentage**
2 months	5.7
3 months	17.9
4 months	8.5
5 months	2.8
6 months	17.9
7 months	2.8
8 months	2.8
9 months	2.8
10 months	0.9
12 months	11.3
18 months	0.9
36 months	0.9
Under 1 month	1.9
As long as the baby wants	17.9
Don't know/not sure	4.7
Total	100.0

Of those who reported that they planned to breastfeed for 4-6 months, more than one third (35.3%) were in the age group 25-29 years (Table 25a). Twelve respondents who said nothing would convince them to breastfeed exclusively for 4-6 months were almost usually distributed among all the age groups.

Table 25a Respondents' Plan to Give Only Breastmilk for 4-6 Months by Age Group

Plan Status	**Age Group**						
Plan Status	**14-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**Total**
Yes	11	18	24	5	8	2	68
	16.2	26.5	35.3	7.4	11.8	2.9	100.0
No	8	14	6	5	2	2	37
	21.6	37.8	16.2	13.5	5.4	5.4	100.0

The main reasons given by respondents for their feeding plans were focused on nutrition (33.7%) growth and development (27.4 %) and protection from disease and death (19.7 %), (Table 26). The opportunity to save money by giving only breastmilk to their babies was not widely ascribed to, as only approximately 11 percent offered this as a reason.

Table 26 Respondents' Reasons for Giving their Babies Only Breastmilk

Reason	**Percentage**
Breastfeeding provides the best nutrition	33.7
Breastfeeding promotes the baby's growth and development	27.4
Breastfeeding protects the baby against disease and death	19.7
Breastfeeding saves money	10.6
Breastfeeding protects the baby from contaminated food through e.g. substitutes, bottles, nipples etc.	2.9
Breastfeeding promotes child spacing e.g. a form of family planning	0.5
Have to work soon	1.9
Recommended by nurse	1.0
Don't know/Not sure	2.4
Total	**100.0**

Although approximately 30 percent of the respondents (Table 25) projected that they would breastfeed only for 4-6 months when asked directly "will you breastfeed only for 4-6 months", more than double (64%) replied in the affirmative. This points to some inconsistency in what they really intend to do about exclusive breastfeeding. The majority (54.3%) also reported that eating and drinking healthy foods are important to ensure that they are able to continue breastfeeding for that period. The drinking of juice was also seen as important (30.2%).

In the FDGs, nutrition and mental well-being were also projected as a major variable for exclusive breastfeeding. The comments made were as follows:

"Eat right like lots of green vegetables, rest well, and drink lots of water, fruit juice, things that are nutritious for the body."

"Drink a lot of porridge, be happy and relax because when you stress out you cannot breastfeed baby."

Encouragement and support from partner and other relatives have added to mothers' will to breastfeed. This is evident in the FGDs, some of which are highlighted below.

"When I am going to breastfeed he gives me a pillow to be comfortable and make sure I have a lot of water. He cook, wash and clean for me."

"My baby father say give the baby the breast and dash way de bottle."

"My mother told me about breastfeeding, all good things, nothing to discourage me, she told me the baby won't need water as long as I am breastfeeding him."

"My grandmother encourages me to give both breast to the baby, not only one side."
On the other hand younger relatives and friends were more inclined to discourage breastfeeding.

"They encourage us to give the baby bottle…they say baby suck you down and give you long breast."

But there were some without spousal and other support as indicated in this quote.

"Me have no spouse, I am alone, when he visits me baby sleeping. I get my work done when the baby is sleeping and I do what I want. I was not getting any financial help so I jump around and help me self now."

With respect to the level of fertility and breastfeeding the majority of the respondents with three or four children reported that they did not plan to breastfeed exclusively for 4-6 months (Table 26a).

Table 26a Respondents' Plan to Breastfeed Exclusively for 4-6 Months by Number of Children

	Number of Children								
Breastfeeding Only 4-6 Months		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**9**
Yes		1	25	16	7	6	4	1	-
		100	48.1	39.0	33.3	50.0	50.0	50.0	-
No	-	27	25	14	6	4	1	1	
			51.9	61.0	66.7	50.0	50.0	50.0	100
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

More than a third (34.6%), do not intend to breastfeed for the recommended period of 4 – 6 months and the main reasons given were work (34.1%) insufficient milk (17.1%) and "baby hungry only with breastmilk" (17.1%), Table 27.

The reasons given for not planning to give breastmilk alone for 4-6 months were also given in the Focus Group Discussions. One mother in underscoring the need for supplementing the breastmilk said:

"The first baby I gave breast alone for six months and the baby get malnourish, the baby look weak in the eye and nurse said baby was malnourish"

Table 27 Reasons Given for not Planning to Give Breastmilk Alone for 4-6 Months

Reason	**Percentage**
Baby might wean itself	7.3
No milk/insufficient milk	17.1
I am uncomfortable with breastfeeding	4.9
Mother weak/not eating	4.9

Mother sick	2.4
Have to work	34.1
Have to separate from baby	7.3
Other person advised	2.4
Hungry only with breastmilk	17.1
Don't know/not sure	2.4
	100.0

The large majority (81.3%) of the mothers currently practising exclusive breastfeeding have received no follow up help with breastfeeding. Among the 18% who got some assistance the majority 45 percent received it four or more weeks after delivery.

7.4 Mothers who are Breastfeeding and Giving Other Foods

The majority (59.0%) of these mothers who were mixing breastmilk and other foods stopped exclusive b reastfeeding in the first five weeks after the birth of their baby (Table 28).

Table 28 Time Period when Respondents' Ceased Exclusive Breastfeeding (n=117)

Time Period	Percentage
Less than 1 week	16.2
1 week	5.1
2 weeks	15.4
3 weeks	10.3
4 weeks	12.0
5 weeks	3.4
6 weeks	3.4
7 weeks	1.7
8 weeks	1.7
2 months	5.1
2 ½ months	2.6
3 months	11.1
3 ½ months	3.4
4 months	1.7
4 ½ months	0.9
6 months	6.0
	100.0

The main food items that were introduced were powdered milk/tinned feed (22.4 %), water (18.5%) and orange/fruit juice (10%). The dominant reasons for introducing these foods were 'insufficient breastmilk' (27.3 %) followed by "the baby needing more than breastmilk" (18.8%) and that " the baby was hungry" (12.1%). Only a little over one tenth (10.9 %) gave 'work' as a reason for introducing foods other than breastmilk, (T able 29).

Table 29 Reasons for Introducing Food Other than Breastmilk (n=117)

Reason	Percentage
Insufficient breastmilk	27.3
Needs more than breast	18.8
Child was hungry	12.1
Mother to go to work	10.9
Separated from baby	4.8
Right age for introduction	4.2
Medicinal reasons	3.6
Child stopped breastfeed	3.6
Mother sick	3.0

Advice from others		2.4
Good/nutritious for child	1.8	
So baby/I could sleep		1.8
Child wanted food		1.2
Other reasons		1.2
Advice from nurse/doctor	0.6	
Don't know/not sure		0.6
		100

Likewise in the FGDs reasons for mixing stemmed mainly from the perception that the baby was not satisfied with only breastmilk.

"The baby not satisfied with only the breast so I give the baby a little formula."

"My breast is full of milk but it is still not enough for the baby."

"Some babies born craven so it is impossible to feed them on breast milk only."

"I really don't have no patience sometime I want to sleep at night and can 't get any sleep."

"Babies should be given mixed foods because the bigger dem get the more dem want, cause the breast can't hold dem."

"Some a de baby dem no want the breast so what are you suppose to do."

"I was told by mother to gi him tin feed cause him too craven"
It should be noted that some babies were introduced to formula at the hospital
Other for reasons for supplementing or introducing formula feed related to the constraints of time and other duties/functions that had to be performed by the mothers

"Sometimes I want to go and do something as the other children in school, so I decide to mix."

With regard to giving breastmilk in relation to other foods, the majority (37.6%) gave breastmilk before other foods and 22 percent after (Table 30).

Table 30 Breastfeeding Patterns in Relation to Other Foods (n= 117)

Time at which Breastmilk is Given	**Percentage**
Before formula	37.6
After formula	6.8
Before and after	22.2
Between formula	11.1
No pattern	16.2
Other	6.1
Total	**100**

The majority (67.7%) used the bottle to feed the baby, cup and spoon were used by 8.9%, plate/saucer and spoon (4%) and the combination of bottle, cup and spoon by 19.4%. The main reasons given for not using a cup were 'baby is too young' (27.4%) 'it takes too long' (17.0%) and 'bottle easier to use' (16.0%). With respect to follow up 71 percent reported that they have not received follow up help with breastfeeding.

7.5 Mothers Who Have Stopped Breastfeeding

Among the small number of mothers who have stopped breastfeeding (22), 77.3 percent reported that the child stopped/weaned himself, 9% that they had to work and 4% each that it leaves the child hungry, no/insufficient milk and that it takes too long. Of the majority of these mothers, more than one half (54%) had stopped breastfeeding within a week to two months. The largest group of women (43.5 percent) weaned their baby abruptly and 39.1 percent reported that the baby weaned himself/herself. With respect to other foods, those introduced were mainly powdered milk including tinned formula (10.7%), water and orange/fruit juice each 9.5 percent and porridge 7.1 percent. The most noted reason was that 'the child stopped breastfeeding (45.2%).

With respect to how food was given the same proportion (43.5) used or the combination of the bottle, cup and spoon. Only 13.0 percent were using the cup alone. The main reason that the cup was not used was that "the baby is too young" (45.5%). Eighteen percent each said that the baby is comfortable with the bottle and the baby cannot feed well with the cup and spoon.
Reasons given for introducing other foods were that the child needed more than breastmilk (13%), whereas 10 percent each reported that the child wanted the food and that it was the right age for the introduction of other foods. Follow up help with breastfeeding has been limited with 90.9 percent responding negatively.

7.6 Mothers Who Never Breastfed

Ten mothers reported that they have never breastfed. The rejection of the breast by the baby (40.0 percent) was the main reason given. Additional reasons included no/insufficient milk (20%), work (20%) and mother sick and weak (20%). Like the other groups of mothers, powdered milk including formula (12.1%) and water (12.1%) were the main foods given. The decision to give other foods was influenced by the rejection of the breast.

The bottle (60%) is the most used followed by bottle, cup and spoon (40%). Fifty percent reported the main reason for not using the cup was that the baby was too young, and 10 percent each referred to the inability of the baby to feed properly with the cup and spoon, that it was messy, and in relation to the bottle, the ease, relaxation and comfort it provided.

7.7 Breastfeeding Knowledge and Attitude

This section addresses the mothers' knowledge and attitude about breastfeeding. The vast majority of mothers (84.6%) were exposed to information about breastfeeding.
Persons identified as sources were many and varied but the largest group (43.9%) reported that nurse was the main source followed by mother (19.7%), Table 31.

Table 31 Persons Identified as Explaining about Breastfeeding (n = 220)

Persons	Percentage	
Nurse/Public Health Nurse	43.9	
Midwife	4.0	
Doctor		6.8
Matron		0.5
Breed Promoter	0.8	
Health worker		1.3
Community Health Aide	3.5	
Mother		19.7
Grandmother		2.8
School teacher		1.3
Friend		9.1
Neighbor		0.8
Partner		1.8

Other relative	3.8
Total	100.0

The main things the mothers have been told about preparing the breast for breastfeeding are to wash breast properly (44.2%) pull out nipples (17.1 %), dry the breast properly (16.5%) and to support the breast with a well fitting brassiere (8.%). They also reported being advised about the benefits of breastfeeding for growth and development of the baby, protecting the baby from disease and death and the nutritional value of breastmilk.

The largest group of mothers (36.3%) reported that they were advised that they should give their baby only breastmilk for six months and approximately 14 percent reported that they were advised to breastfeed exclusively for 4-6 months. Interestingly, more than one-tenth of the mothers (14.6 percent) reported being told to breastfeed for as long as needed. Additional information about breastfeeding came mostly from television (18.6%) and nurse (19.2 %). The nurse was identified as the main source of information on breastfeeding by 47 percent of the respondents.

The FGDs also highlighted the nurse as the main conveyer of breastfeeding information even to the level of 'preferred breast.' According to some of the mothers, babies have a preferred breast.

"My baby will tek the left breast all the time and nurse say one breast is sweeter than the other so the baby will tek the sweeter breast."

In general, the information received by FGD participants were similar to the quantitative findings. The following quotes demonstrate the information provided about the physical, emotional and nutritional breastfeeding aspects of breastfeeding.

"The clinic told us to breastfeed up to 3 months… no bottle for baby as each time baby sucks it draw up the womb and help with healing."

"The breast is comforting."

"Clean black thing around the nipple, massage the nipple and the milk will come down."

"Nurse say whether it is sore or paining you or not, you must still give the breastmilk because it is nutritious… nurse say when it is sore squeeze it out and rub it… they say baby heal the breast."

"I was told at the hospital that if mi no have enough milk I should still continue to feed the baby and the milk will eventually cum down."

FGD participants also reported advice, which contained questionable information. The comments are as follows:

"Mi mummy and nurse tell mi to use the comb to comb the breast, yu must massage so di milk can flow."

"My mother told me that if yu feeding the baby and the baby burp pon the breast yuh should use the breast to hit the baby pon the mouth cause this will prevent yuh breast from swelling up."

The majority (64.5%) did not receive any reading material to take home and for those who had received, the nurse (70.7%) was the principal provider. The main places from which materials were obtained were the clinic (72.3%), doctors' office (11.7%), hospitals (7.4%) and pharmacies (4.3%), Table 32.

The Focus Group Discussions also revealed similar sources of breastfeeding information, the most dominant being the nurses followed by relatives and friends.

Table 32 Source of Material on Breastfeeding
(n=87)

Source	Percentage
Nurse	70.7
Doctor	12.0
Pharmacist	3.3
Community Health Aide	4.3
Midwife	1.1
Public Health Nurse	4.3
Friend	2.2
Promoter	1.1
Teacher	1.1
Total	**100.0**

Table 33 shows that the majority discussed by rank, the right time to introduce other foods (62.2 %), how to position the baby during breastfeeding (60.8%) and expressing and storing of breastmilk (58.9%). It is of note that the other important and useful items related to breastfeeding to help mothers to cope with two critical aspects of their lives, working and their fertility were discussed by less than one third of the respondents. The main discussant identified for all areas was the nurse.

Table 33 Percentage of Mothers Responding 'Yes' to Having had Discussions About Breastfeeding Since their Pregnancy

Statement	Percentage
The right time in the baby's life to give other foods	62.2
How to position the baby during breastfeeding	60.8
How to express and store breastmilk	58.9
How to return to work and still breastfeed	31.3
Breastfeeding as a contraceptive	20.2

When asked what are some of the things being practiced from the knowledge gained, the dominant practices were "eating right, washing and cleaning breasts" and "drinking a lot of water."

Approximately 90 percent have had no discussions with representatives from the makers/sellers of baby formula. Of the small number exposed, they were advised mainly that formula is the best substitute for breastmilk, that it is nutritious, and that the best time to introduce foods other than breastmilk is six months. The information came mainly from television (36.0%) and radio (28.0%).

Almost 30 percent (28.7%) are of the view that infant formula is a good food substitute. Over fifty percent of the mothers have started to use the formula, (Table 34).

Table 34 What Respondents are Currently Doing About Infant Formula (n = 117)

Current Action	Percentage
Not sure as yet	1.7
Will introduce formula after a while	14.3
Nothing	16.0
Will not use formula	12.6
Already introduced formula	31.9
Introduced formula and other foods	5.9
Supplementing formula with breastmilk	7.6
Will introduce when return to work	10.2
Other reasons for introducing formula	
Total	**100.0**

Most mothers (60.8%) do not intend to breastfeed exclusively for 4-6 months, but those who intend to do so disclosed reasons linked to nutritional benefits, growth and wellness of the child. Those who do not intend to breastfeed exclusively have placed some value on infant formula, which is often termed the " breastmilk substitute." The following quotes from the FGDs demonstrate the varied views and motivation for formula feeding.

"The first baby got breast alone for six months and the baby malnourish"

"The baby look weak in the eye and nurse said the baby was malnourish. Of course I saw it on health watch that breast alone can keep baby but to me when three months come they need soup and juice and dem strong same way."

"I bought a baby bag and formula feed pamphlet book was in the bag. It tell you how to mix feed and they say it come like breastmilk."

"My aunt encourage me to buy tin feed for the baby, so that if I want to go somewhere I can leave that feed."

"My friend say to have a "back up."
The saving of money was not a strong motivator to breastfeed for the recommended 4 –6 month period. Eating healthy foods (54.7%) and the intake of lots of fluids (24.3%) were viewed as important to sustain breastfeeding. The problems with exclusive breastfeeding are many and varied as outlined in Table 35.

Table 35 Problems Faced with Exclusive Breastfeeding for 4-6 months

Problems	Percent
Have to work	12.9
Insufficient milk	13.3
Breastmilk not satisfy baby	5.5
Have to go to school	1.5
Breast lose shape/long	2.2
Nipples sore/painful	7.7
Baby rejects breast	2.2
Baby dependent on breast	2.2
Medical condition	0.7
Accustom to bottle	1.1
Have to restrict diet	1.8
Too tied down/couldn't go out	7.7
Can spoil baby	1.1
Tired/exhaustion	2.6
Chest pains	2.2
No problems	1.8
Don't know/not sure	31.0
Total	**100.0**

Despite the variety of issues with breastfeeding, 31 percent almost one third of the mothers have not experienced any problems with it. However, the problem areas were specified in great depth during the FGDs. Some of the quotes are as follows:

"I'm having it bad as I cannot sleep at nights as the baby want the breast."

Sometimes the breast swell and it is embarrassing on the road, every minute it get bigger and sore."

"Baby draw the breast and it feel sore."

"I'm uncomfortable with breastfeeding because mi not used to it."

Only 36 percent of the sample indicated that they were on maternity leave. Among these persons, 52 percent have taken three months and 21 percent two months maternity leave.
In the sample, the reported sources of funds were obtained mainly from partner (63.2%) and to a lesser extent parents (14.3%). Forty percent have received formal assistance and of this group, almost all (92.7%) received food stamps.
A perspective, on the use of infant formula gleaned from both the antenatal and postnatal mothers, is that a major part of child support as interpreted by their partners is the provision of money to purchase food for the child. This food refers in the main to infant formula. Exclusive breastfeeding by the mother suggests that support is not needed for food and could result in reduced or very limited financial support. So oftentimes, it is not that they would not breastfeed but it is the threat that it poses in that it could prevent the receipt of adequate financial support for the child. The purchase of infant formula represents tangible evidence of the use of the partner's support funds on the child.

Table 35a Problems with Breastfeeding Exclusively for 4-6 Months by Union Status

	Union Status			
Response	**Married**	**Visiting**	**Common-law**	**No relationship**
No problems	43.8	29.2	34.1	17.0
Problems	56.2	70.8	65.9	83.0
Total	100.0	100.0	100.0	100.0

Although the majority of the respondents regardless of their union status reported that they would expect problems if they breastfeed for 4-6 months, married respondents were inclined to be more optimistic than the other groups, (Table 35a). Over forty percent (43.8%) of the married group expected no problems, followed by those in the common-law union (34.1%) and visiting union (29.2%). Interestingly, those in no relationship expected to have the most problems (83%).

8.0 HEALTH CARE PROVIDERS

8.1 Profile of Health Care Providers

One hundred and fifty two health care providers were surveyed in 12 health facilities in the parishes of Kingston and St. Andrew, St. Catherine, Clarendon and Trelawny (Table 36).

Table 36 Health Care Providers Distributed by Parish

Parish of Provider	Frequency	Percent
Trelawny		
Kingston and St. Andrew	52	34.3
St. Catherine	40	26.3
Clarendon	30	19.7
	152	**100.0**

The age group of the providers ranged from 20 – 50 years with the two most dominant age groups being 30-34 years (18.4%) and 50 and over years (18.4%), (Table 37).

Table 37 Health Care Providers Distributed by Age

Age Group	Frequency	Percent
15 – 19	1	0.7
20 – 24	9	5.9
25 – 29	17	11.2
30 – 34	28	18.4
35 – 39	25	16.4
40 – 44	24	15.8
45 – 49	20	13.2
50+	28	18.4
Total number	**152**	**100.0**

Table 38 details the range of health care providers that were interviewed of which the nurse/midwife was the largest group (21.1%). The large majority of the providers have held their position for 6 to 10 years and more.

Table 38 Health Care Providers' Position in Clinics and Hospitals

Position of Provider	Frequency	Percentage
Doctor	12	7.9
Public Health Nurse	12	7.9
Matron	1	0.7
Nurse/Midwife	32	21.1
Registered Nurse	21	13.8
Enrolled Asst. Nurse	13	8.6
Breastfeeding Promoter	20	13.2
Community Health Aide	23	15.1
Nurse Practitioner	6	3.8
Orderly	4	2.6
Porter	8	5.3
	152	**100.0**

8.2 Availability and Implementation Instructions for the Ministry of Health's Breastfeeding Policy in the Health Facilities

Respondents reported that most of the health facilities (61.8%) have a copy of the Ministry of Health's Breastfeeding Policy and 28.9% did not know if there was a copy available. The policy was displayed by 48.6% of the facilities and 31% did not know if it was in fact displayed in the health facility. Among those facilities displaying the policy, the most popular areas were reception and general and maternity ward areas (Table 39).

Table 39 Areas in Which the Ministry of Health's Breastfeeding Policy is Displayed (n=132)

Response	Percent
Child Health Section	3.0
Reception Area	18.9
Nurses Station	6.1
Antenatal clinic	7.6
On general wards	14.4
Maternity ward	13.6
Child Health Centre	0.8
Not sure	35.6
	100.0

Some providers were more knowledgeable about the measures to implement the breastfeeding policy than others, (Table 39a). For instance, only half of the doctors and orderlies were instructed, approximately sixty percent of the enrolled nurse, breastfeeding promoters whereas the majority of the nurse practitioners and the porters have not been instructed.

Table 39a Health Care Providers by Knowledge of Measures to Implement Breastfeeding Policy

	Yes	No	Don't Know	Total
Doctor	6	2	4	12
	50.0	16.7	33.3	100.0
Public Health Nurse	12	0.0	0.0	12
	100.0	0.0	0.0	100.0
Matron	1		1	
	100.0	0.0	0.0	100.0
Nurse Practitioner	1	1	4	6
	16.7	16.7	66.7	100.0
Nurse/Midwife	24	5	3	32
	75.0	15.6	9.4	100.0
Registered Nurse	15	2	4	21
	71.4	9.5	19.0	100.0
Enrolled Assistant Nurse	8	1	4	13
	61.5	7.7	30.8	100.0
Breastfeed Promotion	12	4	4	20
	60.0	20.0	20.0	100.0

Community Health Aide	16	1	6	23	
	69.6	4.3	26.1	100.0	
Orderly	2	2	4		
	50.0	50.0	100.0		
Porter	1	1	6	8	
	12.5	12.5	75.0	100.0	

A number of elements were identified by respondents as being part of the content of the Ministry of Health Breastfeeding policy. The major aspect highlighted by the respondents was that breastmilk is best food for infants. All other aspects referred to received endorsements of less than 20 percent, (Table 40).

Table 40 Respondents Identification of the Content of the Ministry of Health's Breastfeeding Policy (n=123)

Response	**Percentage**
Breastmilk is best	28.5
Breastmilk is healthy	2.4
How to store breastmilk	5.7
Breastmilk is cheapest	6.5
Bottle hazards	17.1
Life span to store breastmilk	1.6
10 steps to successful breastfeeding	17.9
Promote breastmilk birth – 6 months	10.6
All clinics must know	1.6
Promote bonding	3.3
Not sure	4.8
	100.0

Almost two thirds (64.5%) of the respondents indicated that all staff members are given instructions on how to implement the Ministry 's breastfeeding policy with ante and postnatal clients. Almost a quarter (24.3%) replied negatively and 11 percent did not know. These two latter responses taken together reveal that 35 percent are unaware of the steps to implement the policy.

A variety of instructions as detailed in Table 41 were given to mothers on how to manage and prepare their breasts before delivery. The most commonly given instructions were to 'clean and prepare breasts' (21.8%) and to take 'notice of colostrum' (17.8 %). Sixteen percent reported that no instructions were given. Those who reported that no instructions were given mainly held positions in all the categories listed with the exception of matron and nurse practitioners. However the response 'nothing' was more pronounced among the orderly, porter, and to a lesser extent doctor.

Table 41 Information Given by Health Care Providers to Mothers on What to do with their breasts Six Weeks Prior to Delivery (n=225)

Response	Percent
Notice colostrum	17.8
Squeeze fluid everyday	8.4
Squeeze to help flow	5.3
Stretch nipple	12.2
Care for inverted nipple	0.9
Massage nipples	4.0
Wear proper fitting bra	4.9
Clean/prepare breast	21.8
Eat properly	0.9
Express milk	0.4
Keep breast moist/oil	5.3
No oil/soap on breast	0.9
Nothing	16.4
Don't deal with mothers directly	0.4
Don't know/not sure	0.4
	100.0

8.3 Health Care Providers Promotion of Breastfeeding

Health care providers as the repository of information and with the responsibility to promote breastfeeding were asked to provide information on specific and important pieces of information given to mothers and at what time during the pregnancy. Tables 42 – 47 detail their responses in relation to the following issues:

Initiation of breastfeeding
Breast stimulation to establish milk supply
Breast stimulation to aid uterine contraction
Breastmilk as an excellent food source
Exclusive breastfeeding for 6 months
Breastmilk as a protective agent against disease

In general the level of positive responses to giving information on, and promoting the above 6 issues with clients were in the range of 32 to 51 percent of the total sample. Only two items received at least a 50 percent positive endorsement. They were, breastmilk provides protection against disease and exclusive breastfeeding for six months. The other four items were each less than 50 percent, with breast stimulation to aid uterine contraction receiving the lowest (32%).

Among those providing responses, at least 62 percent or more did not identify any specific time during pregnancy to promote and inform mothers on any of the above six issues. Beyond this observation, the most endorsed time for providing and or promoting the issues was either at birth or after delivery. The range of responses for this time period was between 9 and 13 percent.

It is of note that only 45 percent (69) health care workers responded to this issue of their promotional efforts on breastfeeding. Among these respondents (69.6%) did not identify any specific time during and after pregnancy to begin to advise clients to start breastfeeding as soon as possible, particularly

immediately after delivery. In terms of a specific time to promote breastfeeding, only 11.6% did so either at birth or after delivery, (Table 42).

Table 42 Stage of Pregnancy at Which Health Care Providers Promote Breastfeeding Among Mothers (n = 69)

Stage of Pregnancy		Percent
After delivery/at birth		11.6
1st Trimester		2.9
2nd Trimester		7.2
3rd Trimester		5.8
No specific stage	69.6	
Not stated		2.9
Total		**100.0**

Table 43 Stage of Pregnancy at Which Health Care Providers Promote Early and Frequent Stimulation of the Breast for Establishment of an Adequate Milk Supply (n= 61)

Stage of Pregnancy		Percent
After delivery/at birth		13.1
1st Trimester		1.6
2nd Trimester		8.2
3rd Trimester		9.9
No specific stage/anytime	67.2	
		100.0

Table 44 Stage of Pregnancy at Which Health Care Providers Promote Early and Frequent Stimulation of the Breast to Aid in Uterine Contraction (n=460)

Stage of pregnancy		Percentage
After delivery/at birth		6.5
1st Trimester		-
2nd Trimester		8.7
3rd Trimester		6.5
No specific stage/anytime	78.3	
		100.0

Table 45 Stage of Pregnancy at Which Health Care Providers Promote Milk as an Excellent Source of Both Calories and Protein

(n=64)

Stage of pregnancy	Percentage
After delivery/at birth	9.4
1st Trimester	4.7
2nd Trimester	7.8
3rd Trimester	10.9
No specific stage/anytime	67.2
	100.0

Table 46 Stage of Pregnancy at Which Health Care Providers Promote Exclusive Breastfeeding for the first 4 to six months
(n=73)

Stage of pregnancy	Percentage
After delivery/at birth	8.2
1st Trimester	-
2nd Trimester	6.9
3rd Trimester	6.8
No specific stage/anytime	78.1
	100.0

Table 47 Stage of Pregnancy at Which Health Care Providers Promote Breastfeeding as Protecting Baby from Disease
(n = 71)

Stage of pregnancy	Percentage
After delivery/at birth	11.3
1st Trimester	-
2nd Trimester	5.6
3rd Trimester	7.0
No specific stage/any time	71.8
Not stated	4.3
	100.0

Mothers are provided with information by the majority of health care providers (74%)on the protective and nutritious properties of colostrum, which is present in the breast after delivery (Table 48).

Table 48 What Health Care Providers Tell Mothers about Colostrum, the Early Milk Present in the Breast During the First Few Days Following Birth
(n=177)

Response	Percentage

For nutrient/protect		74.0
Is useless		4.0
Nothing discussed		7.3
First Immunization for baby		8.5
Help milk flow	2.3	
Aid digestion		2.3
Most valuable part of breastmilk	0.6	
Don't deal with mothers directly	0.6	
Other		0.6
		100.0

The importance of proper breast preparation for breastfeeding was underscored with the range of advice give to mothers, the main ones being to wash the breast properly (36.5%) and to give it proper support (21.6%) among other advice, Table 49.

Table 49 What Health Care Providers tell Mothers about Preparing the Breast for Breastfeeding

Response		**Percent**
Support/well fitting bra	21.6	
Wash breast properly		36.5
Dry breast properly		10.3
Pull out nipples daily		18.5
Nothing	4.3	
Drink so milk flow		1.5
Don't squeeze		0.3
Search for lumps	0.6	
Keep moist		0.9
Positioning baby	2.4	
Don't use oil		1.5
Squeeze milk when not breastfeeding		0.6
Nutritious diet		0.3
Don't deal with mothers directly	0.6	

As with the advice on how to care for the breasts, mothers were told a wide range of benefits that can be accessed by breastfeeding for both the baby and herself (Table 50).

The benefits that were most emphasized were those for the baby represented by good nutrition (22%), growth and development (19%) and protection from disease and death (19%). Benefits to the mothers are less emphasized and moreso in relation to their own wellness as saving money was approximately 17 percent compared to healing mother (1.9%) and getting back in shape (0.4%). There is a distinct unevenness in the information provided on the benefits of breastfeeding to infant and mother.

Table 50 What Health Care Providers tell Mothers about the Benefits of Breastfeeding
(n= 523)

Response

For growth/development	19.5	
Protect/disease/death		19.3
Provide best nutrition		22.2
Saves money		16.6
Protect/contamin. food	7.3	
Promote child spacing		2.7
Bonding		
Healing mother	1.9	
Get back in shape	0.4	
Nothing	1.5	
Convenient		1.7
Right temperature		1.9
Don't deal with mothers directly	0.6	
Total		

More than 84 percent of the health care providers indicated that they were actively involved in showing mothers the important techniques that they must acquire to successfully breastfeed (Table 51). The provision of opportunities however for the mothers themselves to demonstrate how to express breastmilk was significantly lower at 51 percent.

Table 51 Health Care Workers Teaching/Demonstration of Breastfeeding Techniques to Mothers (n =152)

	Yes percent	No percent
Show/teach mothers to position babies for breastfeeding	84.1	15.9
Show/teach mothers how to get babies to suck	82.8	17.2
Instruct mothers how often they should breastfeed	87.4	12.6
Show/teach mothers how to express breastmilk by hand	84.1	15.9
Opportunities for mothers to demonstrate how to express breastmilk by hand	51.0	49.0

With special reference to teaching mothers to position babies for breastfeeding, two thirds of the doctors (66.7%) and all the porters did not participate. (Table 51a).

Table 51a Health Care Provider by Instruction to Mothers on How to Position Baby

	Yes	No	Total
Doctor	4	8	12
	33.3	66.7	100.0
Public Health Nurse	12	0.0	12
	100.0	0.0	100.0
Matron	1	1	
	100.0	0.0	100.0
Nurse Practitioner	6	0.0	6
100.0			
Nurse/Midwife	32	32	
	100.0	0.0	100.0
Registered Nurse	19	2	21
	90.5	9.5	100.0
Enrolled Assistant Nurse	9	4	13
	69.2	30.8	100.0
Breastfeeding Promoter	20	0.0	20
	100.0		100.0
Community Health Aide	22	1	23
	95.7	4.3	100.0
Orderly	2	2	4

	50.0	50.0	100.0
Porter	0.0	7	7
100.0			

In teaching mothers about breastfeeding, a variety of tools and methods are utilized (Table 52). Charts are the most commonly used support material (20%). Other measures are individual and group counseling (31%) and lectures (16%). It is apparent that there is a lack of audio-visual technology and materials to support the teaching and that there is heavy reliance on traditional oral teaching methods.

Table 52 Teaching Tools and Methods Utilized by Health Care Professionals

Charts	20.1
Individual counselling	16.7
Group counselling	14.5
Demonstration	16.2
Tapes	4.4
Lecture/talk	16.4
Role play	5.6
Pamphlets/brochure	2.9
Don't teach	2.2
Don't deal with mothers directly	0.7
Don't know	0.2
Total	**100.0**

Advice to mothers on how to breastfeed saw most health care providers (43%) instructing them to breastfeed their babies when they are hungry, 10 percent any time day or night, 10 percent every 1-2 hours, 8 percent every 3-4 hours and 6 percent on demand. The principal directions to express breastmilk were to press thumb and two first fingers inward toward the chest wall and firmly press on the areola between thumb and finger, 16 percent each and to rotate thumb and fingers around the areola to remove milk and press and release the thumb and forefinger several times until the milk flows, 12 percent each.

Sixty one percent reported that they promote exclusive breastfeeding for the first six months and the major reason is that it helps child spacing (47%). Approximately 12 percent reported that they do not always promote exclusive breastfeeding and the reason offered is that it is not 100 percent safe. There are concerns for the transmission of HIV.

Nineteen percent of the health care providers recommend food supplementation at 4 months, 44 percent at six months and 23 percent between 4–6 months. All together almost all agree that food supplementation should not take place before 4 months.

Seventy percent reported giving breastfeeding support to mothers after they leave the hospital or birth facility. This level of assistance is not substantiated by the reports from mothers.

The forms of the reported support include home visits (61%), clinic visits (23%) and counseling (11%). Less than 2 percent each do demonstrations, give printed material or explore the existence of any problems being experienced by the mothers.

In relation to problems with the breast that affect the quality of the breastfeeding exercise for mothers and their babies, poor attachment of the baby to the breast (51%) and the use of wrong breastfeeding techniques (18%) were the reasons supplied as the major causes of painful nipples. Breast engorgement was reportedly caused by four main and inter-related reasons, not breastfeeding early enough (39%), presumably immediately after delivery, too much milk (16%) which is related to the previous reason, failure to breastfeed regularly (15%) and poor technique (11%).

The information shared by mothers with health care providers illustrate both the rewards

and challenges of breastfeeding (Table 53). The major issues of inadequate breastmilk (17%) and the lack of time to breastfeed (11%) point to the physical constraints faced by mothers in caring for a new baby.

Table 53 Feedback from Mothers about Breastfeeding

Categories	Percentage
No feedback	2.6
Rewarding to mothers	7.3
Bonding reported	1.6
Most breastfeed	11.5
Breastmilk is inadequate	17.5
Fear breast elongate	8.4
Majority co-operate	8.4
Other food, so can go to work	2.6
Breast is best	1.6
Lack time to breastfeed	11.0
Don't continue to breastfeed	4.2
Can't bother express milk	1.6
Lack information/care breast	0.5
Agree with breastfeed	7.3
Save money	
Lactose intolerant	2.6
Mothers' poor diet	1.6
Pain in breast	0.5
Negative old wives tale	0.5
Uncomfortable with breastfeed	0.5
Don't deal with mothers directly	5.7

Major issues faced by health care providers about breastfeeding are their clients'concern with the aesthetics of their breast (19%) captured by the comment " breast too long", unwillingness to breastfeed (14%), insufficient milk (12%), takes too long to breastfeed (9%) and breastmilk not enough to satisfy the baby (6%).

Seventy two percent indicated that postnatal clients are given reading material in the form of pamphlets to take home. However, clients in their report of this matter of receiving reading materials to take home and also with assistance with breastfeeding after leaving the maternity facility are significantly less than that reported by the health care providers. There is a considerable gap in the reported delivery of these services and their receipt and acknowledgement by the clients.

8.4 Training Received by Health Care Providers in Breastfeeding and Lactation Management

Twenty percent of the survey respondents indicated that they have received in-service training in breastfeeding and lactation management. Of the 152 health care providers surveyed at least 120 (79%) have not participated in any of the 6 training modules on Lactation Management offered by the Ministry of Health to improve breastfeeding information and skills. At most, approximately one fifth (30) of the respondents were in attendance at any one of the training modules. Among those who participated in all cases, at least 60 percent or more gave positive endorsements of the 4 elements investigated re the relevance of the instructions for their work, presentation of the material in an understanding and useful way, adequacy of the training time and the on the job practice of what was learnt.

In Module 1 the range of participants was between 20 – 24 for the 3 components namely; National and International Policies, International Code of Marketing and Jamaica's National Code of Marketing of Breastmilk Substitutes Implementation and Monitoring of Code. At least 62 percent gave positive

endorsements to all aspects of the module delivery with respect to relevance to work, useful and clear presentation of the material, adequacy of the time and application at work, (Figure 1).

Figure 1 Evaluation of Topics Covered in Module 1 of Training Courses in Breastfeeding and Lactation Management

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There are 12 components in Module 2 which cover the details of breastfeeding including the fundamentals of breastfeeding, how it works, suckling position, colostrum and breastmilk, contents of different types of milk, benefits to mother and child, psychological benefits, benefits and dangers of partial breastfeeding, dangers of artificial breastfeeding, expressing breastmilk and feeding with cup. At least 80 percent or more, except in one case, gave positive ratings on all the elements related to delivery, (Figures 2a & 2b). The one item, which received a 77 percent endorsement, had to do with the understanding and usefulness of the material presented on what different milks contain. Attendance was in the range of 23 to 30 persons.

Figure 2a Evaluation of Topics Covered in Module 2 of Training Courses in Breastfeeding and Lactation Management

Figure 2b Evaluation of Topics Covered in Module 2 of Training Courses in Breastfeeding and Lactation Management (Cont'd.)

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Figure 2b Evaluation of Topics Covered in Module 2 of Training Courses in Breastfeeding and Lactation Management (cont'd.)

The focus of Module 3, which has 5 components was on growth and development, special needs of mother and baby, early and prolonged jaundice and breastfeeding under special circumstances. At least 70 percent or more of the participants responded positively to all aspects of delivery except in relation to prolonged jaundice, which had ratings in the mid sixties, (Figures 3a & 3b).

Figure 3a Evaluation of Topics Covered in Module 3 of Training Courses in Breastfeeding and Lactation Management

Figure 3b Evaluation of Topics Covered in Module 3 of Training Courses in Breastfeeding and Lactation Management (cont'd.)

Figure 3b Evaluation of Topics Covered in Module 3 of Training Courses in Breastfeeding and Lactation Management (cont'd.)

The challenges of breastfeeding were addressed in 4 components in Module 4, breastfeeding challenges, physiological, psychological and environmental challenges. Fifteen to twenty persons participated and the majority gave positive endorsements of 61 percent or more for all items. This module unlike the others did not have more than 80 percent of the participants giving positive endorsements on any of the items, (Figure 4).

Figure 4 Evaluation of Topics Covered in Module 4 of Training Courses in Breastfeeding and Lactation Management

The emphasis of Module 5 was on breastfeeding practices, which encompassed
health care practices, preparation of mothers, initiating and sustaining breastfeeding and drugs and breastfeeding. Continuing the trend, high proportions approximately 79 percent or more gave positive affirmations of all the specific delivery elements, (Figure 5).

Figure 5 Evaluation of Topics Covered in Module 5 of Training Courses in Breastfeeding and Lactation Management

Included in the Module 6 were 10 components addressing women's health and fertility, adolescent mothers, medical conditions and breastfeeding, sex and breastfeeding, breast examination, breastfeeding and the working mother, breastfeeding and fertility, Included in Module 6 were 10 components addressing

women's health and fertility, adolescent mothers, medical conditions and breastfeeding, sex and breastfeeding, breast examination, breastfeeding and the working mother, breastfeeding and fertility. Participation in this Module ranged between 15- 22 persons. Components with between 15 –17 persons participating were the ones on medical conditions and breastfeeding, sex and breastfeeding, HIV transmission and breastfeeding and breastfeeding and fertility. These components also had the lowest positive rating in the sixties compared to seventies and above for the other components, (Figures 6a and 6b).

Figure 6a Evaluation of Topics Covered in Module 6 of Training Courses in Breastfeeding and Lactation Management

Figure 6b Evaluation of Topics Covered in Module 6 of Training Courses in Breastfeeding and Lactation Management (cont' d.)

Figure 6b Evaluation of Topics Covered in Module 6 of Training Courses in Breastfeeding and Lactation Management (cont'd)

Thirty seven respondents identified areas of the training programme that were comprehensive and well presented. Just less than a quarter (24%) reported that all areas were comprehensive and well presented, 13 percent identified the advantages of breastfeeding, 8 percent each for fundamentals of breastfeeding and expressing breastmilk. All others areas had endorsements of 5 percent or less. More than half (52%) of the 25 persons who reported weaknesses in the training did not specify which areas were weak. Eight percent each indicated contraception during lactation and Module 4, which is breastfeeding challenges. Identification of additional areas of training did not yield any new ones. Approximately 13 persons wanted to exclude contraception during lactation. The principal suggestion to improve breastfeeding was to provide more breastfeeding information and media promotion (Table 54).

Table 54 Health Care Providers' Suggestions on How to Improve Breastfeeding in their Health Facility

Suggestion	Frequency	Percentage
More Breastfeeding Education	43	30.3
Increased Media Promotion	39	27.5
Promotion at Antenatal Clinics	13	9.2
Promotion at Hospitals	11	7.7
More Billboard and Brochures	10	7.0
More Involvement by Health Care Providers	8	5.6
Structured Classes for Mothers	6	4.2
Give Mother Incentive	4	2.8
Highlight Economic Benefits	3	2.1
Restrict Formula Importation	3	2.1

More Information on Mothers' Nutrition	2	1.4
Total	**142**	**100.0**

Approximately 70 percent of the respondents made recommendations to improve the breastfeeding programmes in their health facilities (Table 55).

Table 55 Recommendations by Health Providers to Improve the Breastfeeding Programme in their Health Facility

Recommendations	**Frequency**	**Percentage**
Visual Aids	29	20.0
Baby friendly environment/privacy to breastfeed	26	17.9
Educational materials on breastfeeding	24	16.6
Train more health professionals –nurses and doctors in breastfeeding	19	13.1
Implement Health Seminars on breastfeeding	13	9.0
Use successful breastfeeding mothers to impart their knowledge to others	6	4.1
No Bottles in Health Centres	5	3.4
Emphasize breastfeeding during pregnancy	5	3.4
More community involvement	5	3.4
Improve sanitation	3	2.1
Use peer educators to visit mothers	2	1.4
Provide transportation for nurses to do follow-up visits	2	1.4
Incentives needed for mothers	1	0.7
Display the Breastfeeding Policy	1	0.7
Total	**145**	**100.0**

Interviews held with the nurse in charge of the facilities visited confirmed that they are very interested in seeing to it that the breastfeeding initiative is promoted, maintained and sustained among the mothers. There are however several limitations which affect the efficacy of the programme. Limitations include staff constraints; lack of ongoing training in lactation management to reinforce and update training received and to integrate new staff members, limited print and audio-visual materials, and a reduction in programme thrust from the central administrative office of the Ministry of Health.

Clinic staff is committed to serving their clients by providing information and education on breastfeeding, promoting exclusive breastfeeding and dispelling their myths and or fears. In the estimation of the clinic staff at least 80 percent of the mothers are willing to breastfeed exclusively, but much less are able to achieve this for a variety of reasons. Feeding bottles are taboo in the clinics and are in some instances taken from the mothers. It is well known among the clientele that clinic staff is not in support of the use of feeding bottles. Health care providers feel very strongly that with greater support especially through early and regular home visits significantly higher levels of exclusive breastfeeding could be achieved. Midwives and community health aides undertake visits to mothers at home but there is need for expanded coverage.

The issue of exclusively breastfed babies being overweight for their age and height was mentioned. There is the need for information and training on how to deal with this concern by health care providers. Men were marginally involved in the breastfeeding promotion, but were included in educational sessions if they visited the clinics with their partners. Nursing personnel felt that special national effort should be made to target men to increase their support for breastfeeding and to increase their knowledge.

8.5 Health Providers' Experience with Breastfeeding

Almost 100 percent (97.2%) of the health providers interviewed reported that their last child was breastfed. Other foods were introduced at various stages but the main ages at which this was done were, 30 percent at

4 months, 25 percent at six months, 19 percent at 3 months, 9 percent at five months and 3 percent at 7 months. At all other periods during the first year of the infants' life the rate of introducing other foods was less than 3 percent.

Approximately all respondents (97.4%) reported that their last child was breastfed. By sex, 97.2 percent of the females reported that they breastfed their last child while all the males reported that their last child was breastfed.

Thirty percent of the providers reported that the major reason given by the mothers not to breastfeed included having to work, none or insufficient milk, baby stopped or weaned self, mother sick, mother weak and not eating each 5 percent. Less than 5 percent identified stress, nipple problems, lack of education and myths, sick baby and can't be bothered.

Early introduction to the breast after birth was endorsed by a third of the providers as the best way to promote breastfeeding. Community education and helping to attach the baby to the breast were each endorsed by approximately 12 percent of the respondents. Ten percent reported the non-use of bottles and 7 percent rooming of mother and baby during the first 24 hours after delivery.

9.0 QUALITATIVE FINDINGS AMONG MEN, SIGNIFICANT OTHERS AND ADOLESCENTS

The focus group discussions (FGDs) were held with groups of men, significant others and adolescents to get a more in-depth understanding of the important issues related to breastfeeding patterns in Jamaica. The findings have been analyzed within the specific target groups and are presented accordingly. The findings from the target groups of men, significant others and adolescents are presented in this section.

9.1 MEN

9.2 Knowledge/Views about Breastfeeding

"Breast milk is the best thing, best nutrient."

This quote echoed the views of all the men who participated in the sessions. They had strong feelings about the benefits of breastmilk for a baby's growth and development. Most recounted stories about their children who were breastfed and these experiences were mainly positive as indicated in the comment "my child that have the breast for two years is very strong and very frisky." They also reflected on their own childhood regarding breastfeeding to the point of sometimes 'boasting' about the positive effects breastmilk had on their strength and general immune system. One participant said that he was told that he would have been stronger if he was consistently breastfed as a baby, "The story my grandmother told me is that I did not get enough milk, if I had, I would be stronger and better," while another boasted, "mi suck breast until mi 2 years old."

The fathers received most of their information about breast care and how to position baby during breastfeeding from five sources, namely:

hospital after delivery
antenatal clinic visit with partner
posters at clinic
mother, grandmother and other relatives
radio and TV programmes.

Overall the fathers strongly approved extending breastfeeding for as long as one year. However, this approval was tied to the practice of introducing foods other than breastmilk. The comment was made that

"four months not enough to give breast, child still tender so one year to two years and the least should be six months before stopping breastfeeding."

Foods like porridge, soup, cows milk, tinned formula, crushed potatoes, pumpkin and carrots were viewed as necessary supplementation for the child from the age of 5 months.

Specifically, formula feeding was viewed as a good substitute for breastmilk. They learnt about tinned feeding from friends, relatives and the written instructions on the tin.

Some skepticism about infant formulas was noted. The main views were that information about the formula feeding should be thoroughly read or "try the formula and see if it agree with the baby,…there are differences in the formula so yuh have to test dem out."

9.3 Perceived Motivations for Practising Mixed Feeding

Various postulations were put forward regarding why some mothers were motivated to introduce foods other than breastmilk prematurely (before 4-6 months). They include:

Child's rejection of the breast.
"my little girl drank suppligen from she was two months,…she did not want breastmilk and milk was flowing from the mother, but no breast or tin feed she wants".
Insufficient Milk
The consensus was that some mothers have not maintained a proper diet, sometimes linked to their poor economic circumstances.

"With the economic crisis, some mothers can't buy right food, so they don't have proper diet, they not eating properly and mothers must have correct substance for breastfeeding baby cause the breastmilk would dry up because of wrong diet."

Preoccupation with physical appearance/attracting the opposite sex**.**
The firmness of the breast has been identified as a main factor impinging on exclusive breastfeeding. "They don't want the breast flop, and not sexy for the man". It was their view therefore that some mothers would breastfeed exclusively, but not for an extended period because of being overly conscious of their breast and they have the belief that too much breastfeeding would affect the firmness of the breasts. They perceived some women as mimicking models, "they dress up with hairstyle and go modeling on the street and the youth stay home and don't get proper care and end up with disease," or looking for a partner." Mothers looking men to support them and the child…after three weeks of having baby, they on the road again looking".

Working away from home
The fathers linked the need for some mothers to seek employment as a major motivator for mixing breastfeeding with other foods. The hours of work have resulted in mothers being away from their child for extended periods of time. Substitution is therefore seen as an imperative because 'mother can't be at work and at home at the same time breastfeeding." The logical response would be to have a caregiver to feed the baby. "The economic situation is hard, mothers looking a penny for themselves, everybody looking something for their child." Most of the fathers felt that employers should give working mothers more time to be with their babies.

One father with full agreement from the other participants had this to say, "I lost my job and I got a job for my baby mother, so after three months she had to work and leave me to look after the child and her employer let her off to come home early to feed the baby." Mothers' working to the fathers, meant introducing other foods, and expressed milk was not really seen as a way to continue to breastfeed exclusively.

Problems with breastfeeding
They identified the following as problems hindering breastfeeding:

Pain and sore nipples have encouraged some mothers to introduce other foods.

"Breast nipple tender so they afraid to breastfeed."

"When the baby hungry and you give the baby breastmilk the baby bite the breast"

"sometimes the baby prefer one breast than the other"

Poor dietary intake

The consensus was that some mothers cannot sustain breastfeeding exclusively because, "It pull down mother…the man must ensure partner gets proper diet to feed baby because without that she cannot breastfeed."

Mothers are overwhelmed, have too much to do with limited or no help, "it kinda break down the nerves."

Lazy and idle mothers

Fathers also proposed that some mothers are not good mothers and spend little or no time with their babies. "some mothers are lazy and quite prepared to offer other foods." "They are idle and only want to move around."

9.4 Knowledge Deficiencies, Myths and Misunderstandings

From the discussions many distorted perceptions about breastmilk surfaced. They included:

Poor breastmilk quality.

This issue, about good quality versus poor quality milk was linked to whether breastfeeding was beneficial to the baby. Poor quality breastmilk was associated with mothers who were not well nourished with appropriate foods, juices and vitamins. Some were adamant that they have seen babies who were breastfed; lose weight and showing signs of malnutrition. Therefore, although they promoted breastfeeding they were convinced that poorly nourished mothers produced breastmilk of poor quality.

The notion that a male baby would benefit more from breastmilk than a female baby also surfaced among few of the fathers as reflected in this quote.

"Boy baby should suck milk from mother, as it help them build back… that is the difference with boy and girl baby."

Another myth centred on the action of hitting the baby with the breast in order to avoid swelling.

"When the baby bite on the breast it swell up and pain up, but if the breast is used to bounce baby on the mouth, then it will not swell."

9.5 Forms of Support to Encourage Exclusive Breastfeeding

Partners reported that they are convinced of the importance and benefits of breastfeeding and so they encourage their partners to breastfeed. Moreover, adverse feelings towards breastfeeding were non-existent. This encouragement however became less around the period when the baby was around 3-6 months.

"After a while I did not encourage breastfeeding only as I bought tin food."

During the first three months after the birth of the baby, partners were encouraged to:

Eat nutritious foods:

Continue breastfeeding even when other foods were introduced

Breastfeed as long as the baby wants the breast

Breastfeed even when the nipples were sore and encourage her to use the other breast

Wash and keep the breast clean

Rest and sleep when tired.

Some fathers reported caring for the baby at nights in order for the mothers to get a 'good rest'. Some positioned the child for feeding while mother was resting and supervised this activity in addition to helping with the housework. Most fathers said that they helped to care for their babies as supported by the comment that, " I wash nappy and do house work and carry her to clinic." One father who reported that he was in a visiting relationship commented, "I found the time to help out with the baby."

Most fathers said that they gave not only financial support but also emotional and tangible support. They reported that soups and other healthy drinks were provided because "the more liquid the mother get, the more milk she produce".

Other fathers support their partners by "rubbing her feet when it is swollen, rub down the belly with lotion."

In summary, the men were generally in support of the view expressed that:

> "It is tradition in Jamaica that mothers give baby breastmilk."
> "It is the will of God that women should breastfeed, they should know directly that it is right. It is a born thing, you born to suck the breast, so it is the right thing to do. Instinct born in you to do it, it not a telling thing, woman have sense, they must know that."
>
> The men had very positive views about breastfeeding and its overall nutritional and health value to a child. However, it was apparent that this value was not determined by exclusive or non-exclusive breastfeeding. They cited examples of children who had benefited from breastmilk up to two years when other foods were introduced. Their overall assessment of the value of breastmilk was not determined by the benefits of exclusive as against mixed feeding. On the average, the accepted period for exclusive breastfeeding was three months. There is a high level of consciousness and sensitivity among men to the needs of pregnant and postnatal women and they do provide some support to alleviate the additional burden caused by these conditions.

10. 0 SIGNIFICANT OTHERS

10. 1 Knowledge/Views about Breastfeeding

The information from the FGDs showed that breastfeeding is viewed as valuable. The consensus among both males and females is that breastmilk enhances the child's growth and development, helps in the contraction of the uterus and protects the infant from diseases, as "the majority of the diseases that affect children will stay away" and that it reinforces bonding between mother and child. Breastfeeding was seen as relaxing the baby and "put dem to sleep", in addition to making them more loving as expressed by "If dem nuh get breast dem no grow loving."

The participants reflected on their own experiences with breastfeeding and overall their accounts were positive. "I have three children and dem grow better on the breastmilk. Dem stay on it for about six months".

Alertness and academic development were strongly associated with breastfeeding. A strong view proposed was that children's mental underdevelopment was related to inadequate breastfeeding during their early life. As one participant noted: "The children dem have too much sugar and water as food; while others added "and bag juice and tinned food."

Most of the information about breastfeeding came mainly through clinic sources, in addition to information from family members, observing relatives and friends' breastfeed and their own personal experiences with breastfeeding.

10. 2 Perceived Motivations for Practicing Mixed Feeding

Reasons proposed for mothers practising mixed feeding and not breastfeeding exclusively included:

Not convinced about the value of exclusive breastfeeding versus mixed feeding.

> The view was that breastfeeding was well known and valued whether or not it was being practised exclusively. According to the participants, some mothers were not convinced that breastmilk had more benefits than tinned formula, and in addition some mothers who believed that breastmilk combined with formula enhanced the baby's growth and development.

Partner's objection

Partner objection was viewed as a possible motivating force with respect to mothers introducing other foods. Despite being an important factor it appeared not to be
widespread. It was however proposed that some men were preoccupied with the physical appearance of women.

"Some men might discourage their partners to a point, they might be concerned by how the women look, want the shape to be kept and so but most men do not feel that way." The consensus however was that women were more preoccupied with their physical appearance than their partners. "It is more on the minds of women, they get these thoughts from themselves possibly from TV showing sexy shapes."

The men were adamant that men have always been supportive of breastfeeding but cautioned that adolescents and young adult males might be influenced by the so called 'sexy body', which to them is linked to a new way of thinking.

The demands of formal work, limited or no support from fathers and maternity leave.

"Woman have to work cause the baby father dem not there, because me have 3 children and bwoy is like sey is only me. Two of dem mi no know weh dem deh, mi na get nuttin from dem and is 3 of dem. So me couldn't have one baby fi suckle me 3 straight months, how dat would a go."

The demand of work on a breastfeeding mother was viewed as an important reason for discontinuing full breastfeeding, even with the option to express milk. The practice of expressing milk was viewed as unfavourable as most mothers were perceived as not having the facilities for storing breastmilk. Additionally, the milk was labeled as 'raw'. Mixing feeds was therefore ideal for working mothers as they could comfortably breastfeed before and after working hours and arrange for the child to be fed with formula during working hours.

The length of time given for maternity leave was assessed as inadequate for the majority of mothers whose maximum leave period was one month.

Poor nutrition of mothers

Poor nutrition of some mothers was also linked to the introduction of mixed feeding. "Mothers have to be eating properly to breastfeed…they don't have the means to buy the nutritious foods."

Insufficient milk/child not satisfied

"The breast alone can't hold dem." This quote reflected a strong reason for introducing other foods. The opinion was that some mothers did not have enough milk to satisfy the child and that even when some mothers had enough milk, some babies were "greedy" and needed more than breastmilk. They recounted some of their own experiences when the baby was not satisfied and cried a lot until other foods like formula were given.

Some participants were adamant that some babies refused the breast regardless of the methods, which the mothers used. "If you give him 1,2,3 times and him nuh tek it then yuh can't do anything about it".

Premature motherhood
According to the participants, some mothers are unprepared for motherhood and the associated responsibilities. Some proposed that some unemployed mothers shied away from exclusive breastfeeding mainly because they were unprepared for motherhood and felt tied down, "they want to be up and down." As a result they have not committed themselves to consistent breastfeeding.

The role of formula
Mothers do place some value on infant formula. Interestingly, the group consensus was that infant formula had some positive value, in that some mothers genuinely could not breastfeed for reasons related to the health of mother or baby and other circumstances such as death of mother. The agreement was that although the "breast is best", the constituents of baby formula must be "close enough" to breastmilk. The example cited targeted babies who have rejected the breast and therefore require alternative nutrition.

Infant formula was also identified as practical and convenient for working mothers since expressed milk was a limited option. So, although the participants will promote and encourage breastfeeding to relatives and friends, there were some who strongly believed that breastmilk should be substituted by formula between 4-6 months or earlier. This position is reflected in the following quote: "Nowadays child dat a born is different from first time because they are very sensible and only want formula. Dem don't want any tete."

Problems with breastfeeding.
The initial painful experience some mothers faced with breastfeeding 'turns them off' and motivate them to introduce other foods. It was felt that if they had continued to breastfeed consistently the pain would have subsided. However they recognized "sore nipples" as a real problem for mothers. "Sometimes baby hold on to the breast and it is so painful that yuh have to clap them to let go."

Emotional and physical ill-health
The view was that some mothers were either stressed out emotionally or were physically ill and were not in a position to breastfeed adequately. Some concluded that in these circumstances the breastmilk was not healthy for the child. "Some a the mother dem under stress, mi nuh tink the stress milk is good either… and if the mother is sick then the breastmilk can't be good."

10.3 Knowledge Deficiencies, Myths and Misunderstandings

Knowledge deficiencies about breastfeeding were most obvious with respect to expressing milk, which has resulted in a high degree of non-acceptance of the practice. Negative comments like, "the milk would get stale" and the need for "instant" refrigeration were reported. Also the practice of expressing milk was viewed as an activator of breastmilk flow to uncontrolled levels. "After expressing even with breast pads the milk comes flowing." "The milk come down and smell bad too."

Some participants held the view that the child who was receiving breastmilk from an under nourished mother would be "better off" on a tinned formula as the breastmilk would be of "poor quality". Other similar quotes about poor quality of breastmilk included the following:

"Some breastmilk not up to standard, it just like when blood is not up to standard."

"If there is nothing much there (nutrition of the mother) there is nothing to come out."

"The constitution of the body affects the constitution of the milk."

The size of the breast and the texture of the nipples were also identified as deterrents to breastfeeding. The following story was related about a mother and baby received some support from other participants. "Some of the babies don't want the breast, I don't know if it is how it feel because this girl have two different set of nipples, the white one and the brown one, but yuh know the white one kinda soft and the brown one kinda stiff and the baby don't want the white one, him only want the stiff one in his mouth."

Some participants were also convinced that certain illnesses which babies suffered from, for example, diarrhoea, were because of breastmilk. "Mothers are not eating on time and they pass on 'gas' to the baby."

The issue of male versus female babies was also raised. Respondents reported that boy babies were more resilient than girls where breastfeeding was concerned. Some participants were convinced that boys tend to desire the breastmilk more than girls. One participant had this to say:

"Boys suckle for long time and mek di mothers dem very slim. When the boy baby dem suckle yu can see it in the collar bone… yu collar bone sink in a hole because the baby is sucking yu dry."

10.4 Forms of Support to Encourage Exclusive Breastfeeding

Positive support to spouses, relatives and friends was noted. Men detailed the ways in which they supported their spouses with chores and "night duty." Their efforts are reflected in the following quotes: "I got up 5-6 times a night, sometimes I stayed up, even put the baby to the breast for her. She never wake up one night" and "I was on night shift." Females gave accounts of their forms of support and encouragement to family members. These included allowing their daughters or granddaughters to rest or sleep for longer hours as often as required.

Suggestions for formal support to encourage exclusive breastfeeding were as follows:

Most of the participants felt that specific campaigns should be designed to target groups based on their educational, social and economic profiles. Other than posters and brochures, creative methods such as skits, role-play in addition to other visual stimulation for radio and television should be developed and used.

Introduce competitions among breastfeeding mothers. For instance attractive prizes for mothers who brea stfeed exclusively for 4-6 months.

The allocation of food packages for financially marginal lactating mothers on a weekly basis to improve their nutrition and breastfeeding capacity.

Regular home visits by CHA's to guide, encourage and address problems faced by breastfeeding mothers.

In summary, breastfeeding was viewed in a positive light and tied to many benefits for the child's growth and development. However, the consensus regardless of gender and residence was that 4-6 months for exclusive breastfeeding was problematic and for all practical purposes breastmilk in addition to appropriate foods should be used. They were also accepting of some of the tinned formulas and felt that some of these substitutes were "good for the baby"
Some babies were perceived as "greedy" and required more than breastmilk. Mixed feeding was therefore tolerated and to a point, supported. Overall they did not think that mixing breastmilk with other foods was detrimental to the babies.

A large amount of information on breastfeeding was sourced from the clinics although relatives and the media were other significant information sources. They all agreed that they would endorse breastfeeding to both relatives and friends.

Participants constantly referred to and emphasized the linkage between mothers who were ill equipped financially, emotionally and physically with the production of 'substandard' breastmilk. This view was strongly held by both males and females across urban and rural areas. The emerging theme for successful breastfeeding incorporated good nutrition, emotional and physical health with meaningful support and encouragement mainly from fathers.

11.0 ADOLESCENTS

11.1 Knowledge/Views about Breastfeeding

In the FGDs, adolescents, both males and females indicated their receipt of some positive messages about breastfeeding. Girls, gave more examples about the positive messages received but the consensus, regardless of gender was that "breastfeeding is very healthy for baby and good for mother." They also frequently mentioned bonding, the nutritional and health value in addition to its aid in 'healing the womb'.

Many more adolescent females than males expressed their views about the value of colostrum. Their expressions included "First milk is healthy for baby so when you give birth at hospital you don't have to carry bottles as it makes baby strong".

"When baby drinks first milk, it has colostrum and gets him/her ready for digesting the breastmilk."

Sources of knowledge were varied and information came mainly from media, health care providers and family members. In general, the messages were positive towards breastfeeding.

Overall, negative views about breastfeeding were limited and were related to problems and concerns about breastfeeding. Most of the adolescents gave accounts of mothers who experienced problems related to:

Sore breast

Additional pain when the breast is too full, and the toll breastfeeding took on the well being of breastfeeding mothers.
"Baby draw down the mother"

"Sometimes the breast pain them and it get tender when they breastfeed"

Perceived Motivations for Practising Mixed Feeding

Adolescents offered the following reasons for the practice of mixed feeding:

Work and expressing milk for exclusive breastfeeding
Opinions regarding expressing and storing of milk were varied and spanned from minority acceptance to total unacceptability with a larger swing to the latter. The consensus was that it was an impractical and cumbersome exercise.

Some felt that many mothers did not have the cooling facility like a fridge or icebox, whereas others felt that expressing encouraged increased milk flow, which could cause embarrassment outside of the home environment at school and the work place.

The need for most mothers to work was a major reason given for non-compliance to exclusive breastfeeding for 4-6 months.

" Sometimes mother has to work because the man not giving any money."

The value of formula feeding

With few exceptions, both sexes stated their approval of formula feeding for babies at three months of age. They were apparently convinced that tinned formula is the closest substitute to breastmilk and therefore also beneficial to the child's well being at a certain age.

Both male and female adolescents gave similar reasons about the value of formula feeding when baby is a certain age because the baby need more than breastmilk. At this stage of the babies life infant formula was positively assessed as an appropriate feeding measure. The following comments were in support of its use:

> "It is almost nearly like breastmilk".
>
> "It is just as good as breastmilk".

Additionally, non-compliance was linked to the high regard placed on formula feeding over breastmilk. Although not a consensus view it was clearly indicated that some mothers have no recourse but to breastfeed for 4-6 months because they were unable to purchase infant formula to feed their babies. As a consequence, in the face of dire economic constraints breastfeeding was the only realistic way to provide food and nutrition for their babies.

Porridge and the need to introduce this food was linked as 'very important for the baby's growth and development.'

Preserving 'youthful' breast.

Adolescent females more than the males were somewhat convinced that 'too much breastfeeding could cause the breasts to be out of shape (ill-shaped). 'They come like slippers." was a popular quote among the young people. A minority felt that ongoing breastfeeding helped the mother's shape overall but this was not the consensus.

Adolescent females also cautioned that this obsession about the breast came more from the females themselves instigated by media advertising with "sexy girls". They emulated these models and also wanted "the firm look". One male adolescent also reported that he has heard many women say that once they have a child, their breast will go flat. He added 'when she go a dance she don't want the selector to look pon her and say her breast drop and favour slippers.'

Refusal to be 'tied down'

Derogatory statements were made about some mothers who did not breastfeed exclusively. The view proposed was that some mothers 'love to walk up and down' instead of nurturing their babies and that 'careless mothers don't want to spend time with their babies'.

11.3 Knowledge Deficiencies, Myths and Misunderstanding

While both males and females were adequately versed about some aspects of breastfeeding there was indication of some misunderstanding, inaccuracies, incomplete knowledge and myths about the topic. For instance, in one of the rural groups, an issue was raised concerning the detrimental effects of breastmilk to baby if mother was sexually involved with someone who was not the baby's father. Although spurned by some group members, others gave credence to the view that the breastmilk would no longer be suitable for the baby, resulting in some mothers being deterred from breastfeeding.

Some participants as reflected in the following statements also reported problems with breastmilk:

> "When baby is young the milk can cause rash on baby's tongue, and the milk can also burn baby tongue" (Female 15 years).

"Breastmilk can also burn baby face" (Female 16 years).

"Mothers have to watch what she eat so things don't run baby belly" (Male 15 years)

"If mother is not eating right, the baby will get 'gas' from her breastmilk".

"If the mother is sick, it can pass to baby through the milk".

11.4 Forms of Support to Encourage Exclusive Breastfeeding

Many suggestions were made to encourage breastfeeding for 4-6 months. They included:

Mothers having a balanced and nutritious diet.
Mothers must eat healthy foods like yam and liver in the mornings and drink a lot of cornmeal porridge.

Supplementary vitamins and iron tablets should be taken.

More information on breastfeeding should be provided

"Most teenagers need more information on breastfeeding" (16 year old female), other than information from clinic sources, books and information highlighted on television and radio were also seen as useful sources. In addition to the exposure to information and good nutrition, most of the young people felt that in practice, mothers should attend clinic promptly when problems with breastfeeding and illnesses arise. The comment was made that "mothers with some infection must come to clinic so a nurse or doctor can treat them".

In general, the views expressed by the adolescents, both males and females were that breastfeeding had many nutritional, health and emotional benefits for the child in addition to enhancing a mother's health. The consensus in all the groups was that they would encourage breastfeeding exclusively up to 3-4 months.

Problems were seen mainly with painful nipples and the ability for some mothers to maintain a well balanced diet in ord er to sustain breastfeeding as the baby 'draw down mothers". Also, the belief that the breastmilk could harm the baby was persistent.

The adolescents obtained their information about breastfeeding from numerous sources. These included books on how to breastfeed, eat and care for baby, family life sessions at school, clinic and relatives. More information in the form of pamphlets at clinics, stores, schools and other public places was suggested.

Reasons for practising mixed feeding were varied and many but the issue of time, patience, insufficient milk, painful breasts and the need for mothers to work were consistently mentioned. The maintenance of physical attractiveness was important as shown by the strong concerns about the physical appearance of the breast with breastfeeding.

There was overall acceptance of formula feeding for babies 3-4 months old and it was viewed as the closest supplement to breastmilk. Exposure about the various tinned formula was through the media and the displays on the supermarket shelves.

12.0 ANALYSIS OF BREASTFEEDING TRENDS AMONG INFANTS ATTENDING POSTNATAL AND CHILD HEALTH CLINICS

The Monthly Clinic Summary Report (MCSR) records information on the breastfeeding status of infants brought to postnatal clinics at 6 weeks and since 2001, on the status of those visiting child health clinics at 3 months. Over the last 12 years (1990-2001), the percentage of babies who were exclusively breastfed at 6 weeks has remained almost constant and has never approached the national programme target of 70 percent. National breastfeeding rates ranged from 47 percent to 54 percent and averaged 51 percent in a typical year.

Since 1996 there has been a slight though steady decline in most parishes, culminating in a rate of 47 percent in 2001, which was the level attained in 1990. The parishes of Kingston and St. Andrew reported the lowest rates of exclusive breastfeeding throughout the period. Percentages for Kingston and St. Andrew ranged from 35 percent to 44 percent and averaged 39 percent. Trelawny, on the other hand, was the only parish where more than one-half of the babies were reported to be exclusively breastfed at 6 weeks. Percentages ranged from 54 percent to 78 percent, with an average of 69 percent (Figure 7).

Figure 7 Rate of Exclusive Breastfeeding Reported at the Six-week Postnatal Clinic: National Rates and Parishes Reporting the Lowest and Highest Rates, 1990-2001

Further analysis reveals that in 2001, only 3 percent of babies were not being breastfed at 6 weeks. The proportion doubled by the time the baby had reached 3 months. At 6 weeks an almost equal number of babies were being partially breastfed (50%) as were being exclusively breastfed (47%). By the age of three months the rate of exclusive breastfeeding declined to 35 percent. However, most mothers continued to partially breastfeed as the percentage of babies in this category increased from 50 percent at 6 weeks old to 59 percent at three months old (Figure 8).

Figure 8 Breastfeeding Status of Babies Attending Postnatal and Child Health Clinics in 2001

14.0 THE NATIONAL BREASTFEEDING COMMITTEE

The administration and management of the Breastfeeding programme and the Baby Friendly Hospital Initiative is the responsibility of the Ministry of Health. In essence, it is responsible for the direction, control and execution of a number of diverse activities that will be performed to achieve the stated objectives. This programme falls within the portfolio of the Family Health Services and the Nutrition Unit in the Ministry of Health.

The National Breastfeeding Committee was established in the Ministry of Health with the specific responsibility to oversee the implementation of the national breastfeeding programme and the baby friendly hospital initiative. The creation of this committee would serve to augment in-house resources of the Ministry for programme support and to garner ideas from a wide cross section of stakeholders and interest groups.

The Government of Jamaica has declared by its signatory to the various international agreements, its philosophical and policy support for breastfeeding. The establishment of the National Breastfeeding Committee within the Ministry of Health, the relevant policy implementing agency, is a further step towards institutionalizing the signed agreements. With the fundamental and basic components in place, the allocation of the necessary resources for programme implementation becomes one of the most critical aspects on which to verify the fulfillment of the agreements coupled with the achievement of the pre-determined targets or objectives.

With the advent of health reform and the strong emphasis on health regions it is expected that each region will establish a regional breastfeeding committee and that there will be representation on the national committee. It has been reported that this is taking place, but at a very slow pace.

The major strategies to achieve the principal objectives of attaining the target of a 70 percent rate of exclusive breastfeeding and having all health facilities in Jamaica meeting the requirements to be certified as baby friendly institutions were training, advocacy, social mobilization and public education. These strategies are in keeping with international guidelines set by UNICEF and WHO. Institutionally, the major focus thus far has been on hospitals, and to date 10 hospitals have been certified and it is anticipated that 3 -

4 others will be certified in 2002. It is also projected that the health clinics, which provide the greater portion of antenatal and postnatal services islandwide will eventually be incorporated into the baby friendly initiative certification process.

There are outstanding issues and limitations that are faced by the National Co-ordinating Committee. These include:

The non-enactment of the International code of marketing of breastmilk substitutes for Jamaica. This is an important piece of legislation that will set the legal framework for the marketing of infant formula. Efforts to get this code enacted include sending the Ministry of Health's Legal representative to access training in this area to assist with the drafting of the legislation.
Insufficient media promotion on breastfeeding due to limited financial resource. Promotion is mainly done during the annual breastfeeding week in September.

Insufficient budgetary support for the programme outside of that provided by PAHO and or UNICEF. UNICEF provided funding for the period 1992-1997. There is no specifically designated programme budget in the Ministry of Health for breastfeeding significant.

The programme focus is diffused, as there is no staff with the sole responsibility for breastfeeding promotion to anchor, monitor, develop and push the programme forward. The Ministry of Health has not appointed a breastfeeding co-ordinator to manage and administer the programme.

Training in lactation management needs to be expanded, and continuously maintained to ensure that the staff is adequately prepared to implement and sustain the programme. The target of at least 80 percent of the staff to be trained in lactation management has not been achieved.

The physical facilities in the health institutions need to be improved to facilitate and encourage breastfeeding among mothers.

Social mobilization to support breastfeeding is very weak; very few parishes have established support groups at the community level.

The monitoring and evaluation system to ensure sustainability of those institutions that have achieved baby friendly initiative needs to be consistently applied at the designated time period of six months to ensure that there is no lapse in quality. The global criteria for monitoring and evaluation of the breastfeeding baby friendly initiative are available and have been utilized in the process.

There are indications that there have been gaps and periods of slow-down in the implementation of the national breastfeeding programme particularly in the second half of the nineties, which have resulted in the programme losing momentum. The rate and pace of the training of health providers declined, reduction in volume and distribution of educational materials, reduced support from Ministry of Health Head Office and the cessation of the breastfeeding helpline. The helpline, a public information service on breastfeeding, was seen to address many of the practical problems and issues faced by mothers with breastfeeding.

Throughout the interviews with health providers they continuously stressed the importance of being able to provide immediate and practical assistance to mothers to encourage breastfeeding. Many instances were related in which health providers assisted and encouraged many mothers frustrated with their best efforts to breastfeed to do so successfully. It is evident that mothers are in need of extra support outside of the clinic to sustain breastfeeding. As such, social mobilization must be an important pillar of the programme.
The breastfeeding policy is clearly stated and there are specific institutional guidelines to promote exclusive breastfeeding. The area of concern is in relation to the implementation, development and maintenance of the activities.

14.0 OBSERVATIONS OF BREASTFEEDING RESOURCES IN ELEVEN

HEALTH FACILITIES

At the eleven health facilities surveyed, the investigators were required to observe the availability of specified resources used in the promotion of breastfeeding. They also interviewed the officer responsible for recording breastfeeding data with a view to identifying issues that could impact on its reliability.

14.1 Availability and use of the MCH Manual

The investigators in only 5 of the 11 health facilities surveyed observed the MCH manual. However, at 8 facilities the Record Clerk/Officer responsible for recording breastfeeding data reported that there was a MCH manual, 1 officer did not know if there was a manual and 2 reported that there was none. Where it was available, most persons interviewed (7) affirmed their use of the manual. It was used most frequently to look up information/seek clarification on breastfeeding issues. Respondents also mentioned using the manual to find out how to record pregnant women, children etc., for reference in-patient care, as a guide for talks and training and for breastfeeding promotion.

14.2 Availability of Resource Materials

A total of seven facilities had television sets; one had a VCR and one had a projector and screen. Other types of audio/visual equipment were also observed at four locations.

Pamphlets and brochures on breastfeeding were observed in 7 of the 11 health facilities visited. There was a wide variation in the titles of the educational material seen. A total of 29 different publications were observed on display, but only a few bearing the same titles were found in more than 1 facility. These included:

How to express breastmilk by hand
Breastfeeding in the information age
Advantages of breastfeeding
Storage of breastmilk

A list of the 29 titles found is included at Annex 1.

The Ministry of Health's breastfeeding policy was observed at 4 of the 11 locations visited. They were prominently displayed in a waiting area, on the wall of a clinic and at the entrance to a ward/clinic.

14.3 Recording of Breastfeeding Data

Inasmuch as most of the Record Clerks interviewed (9 of the 11) were identified as the persons responsible for recording and collating data on breastfeeding only 2 are reported to have received training (apparently organized by the Ministry of Health) on how to perform this task. They considered the training to be adequate. When questioned as to whether they could define breastfeeding, 9 of the 11 persons interviewed responded in the affirmative. The most frequent definition given was that the baby is fed breastmilk only, and neither water nor formula is allowed. Persons providing this definition did not identify any duration for exclusive breastfeeding. One person qualified this definition to include 4 to 6 month duration. Two persons defined exclusive breastfeeding as giving the baby breastmilk and a little water for at least 6 months.

Respondents were asked to specifically identify the items of data recorded on breastfeeding. There appears to be a lack of standardization in relation to the data items collected and recorded. The items recorded in most instances are:

whether the mother is breastfeeding fully; and
whether the mother is giving the baby breastmilk and other foods

Other items less frequently recorded include:

counseling/educational information given on breastfeeding;
clients concerns/problems having to do with breastfeeding;
follow-up information regarding the client's breastfeeding practices after the first postnatal visit.

In most instances breastfeeding information was recorded on postnatal clinic days. There were only in a few instances in which it was reported as recorded on child health clinic days, follow-up home visits or on other occasions.

Various opinions were offered as to what can be done individually and by the health facility to improve the data collection/information on breastfeeding. As far as personal efforts were concerned a substantial number of respondents (5 out of 11) seemed to feel that they were already doing their best and could do nothing further. Three persons felt that they could continue/ increase efforts to teach and encourage mothers to breastfeed and avoid the bottle. Two persons had no opinions on the matter. With regards to the health centers and hospitals, respondents emphasized the need for calculators and computers, educational material and report forms. It was also felt that community health aides needed to visit mothers more to encourage new mothers to breastfeed as promoted at the clinic.

15.0 CONCLUSIONS AND RECOMMENDATIONS

The findings indicate that the Ministry of Health, Jamaica has directed its health delivery system to promote and deliver services to ante and postnatal women to encourage them to breastfeed their infants exclusively for 4- 6 months. A variety of approaches have been used at different levels to institutionalize exclusive breastfeeding as a norm. Efforts include the development of a breastfeeding policy, training of health professionals, production and distribution of educational materials, public promotion of breastfeeding, advocacy and community mobilization.

These efforts have had some impact, in that mothers are more aware and believe in the benefits of breastfeeding to their infants. The support services however, to sustain the initial interest and willingness among mothers to continue breastfeeding are not at the required strength and comprehensiveness to support and maintain the initial high level of breastfeeding. It is a small proportion of mothers who report getting help with breastfeeding after leaving the maternity institutions. This period is the most vulnerable in which the mother makes an almost irrevocable decision to suspend breastfeeding and to introduce formula. The mothers' experience with breastfeeding coupled with the professional help received will help to determine whether or not they will make the effort and adopt in earnest good breastfeeding practices. The assistance and support of the trained and experienced health care providers are critical facilitators for breastfeeding.

The level of coverage and intensity of the lactation management training appear to be inadequate to keep staff motivated and continuously updated on how to address breastfeeding as an integral, critical and fundamental aspect of ante and postnatal care. There is some measure of unevenness in the delivery of the breastfeeding information and services and this points to the need for greater standardization among health care providers.

More information is needed about breastfeeding among high-risk mothers, including those who are HIV positive. Mothers and health professional have expressed their concern about the risks of breastfeeding particularly by HIV positive mothers. More in-depth training of health providers is needed on how to counsel and advise mothers who are high risk for all the various reasons.

Among all target groups in the study it is unanimous that breastfeeding is best feed for infants. It is also very clear that men are willing supporters of breastfeeding and want their partners to breastfeed. Irresponsibility and poor preparation for motherhood among mothers were often noted as reasons for limited or inadequate breastfeeding. More intense preparation is obviously required to prepare mothers for

breastfeeding and to inform their partners on how they can improve their support for breastfeeding. This support is underscored by the nagging problem of sore nipples and pain experienced by most breastfeeding mothers.

The main issue with breastfeeding among the respondents (excluding health care providers) is that despite its wide acceptance, is whether breastfeeding should be done exclusively or combined with other foods, at what age and for how long. Related to this issue is the question as to how well does breastmilk meet the nutritional needs of a growing child without supplementation. This issue of exclusive breastfeeding needs to be consistently explained and promoted with evidence that addresses each of the benefits to infants and mothers in a convincing and culturally sensitive way. Women are already convinced of the benefits of breastfeeding to their infants, which must be reinforced, but the specific benefits to them, as women need to be more highlighted.

Among the women there is also the valid concern for their physical appearance and how it is impacted by breastfeeding particularly with respect to the condition of their breasts and weight loss. These issues are real and need attention. Information is required on as to how lactating women can maintain and or enhance their physical appearance while breastfeeding. This information should be developed and provided by health providers to their clients.

As reflected in the surveys and the Focus Group Discussions (FGDs) the overwhelming majority of post-natal mothers initiated breastfeeding but less than half (42.7 percent) were breastfeeding exclusively. As seen from the data there have been various strains of resistance regarding exclusive breastfeeding for more than 3-4 months. This must be noted in the context of insufficient professional support to maintain breastfeeding and limited promotion of the expression and storage of breastmilk.

These resistant areas, as noted in the text, included issues like working mothers, time constraints, physical attributes and the perception about what the nutritional contribution for the baby. These positions have support among partners and other relatives. The constraints, both personal and institutional that are faced by women to breastfeed exclusively for 4-6 months need to be considered and strategies developed to address them. Beyond the individual woman there are some practical and institutional issues involved in relation to physical facilities and working conditions to facilitate exclusive breastfeeding that are outside the direct control of the women. These will require the both the development and implementation of public policy measures.

A major area of resistance has been the expressing of breastmilk to ensure exclusive breastfeeding. This resistance has often been based on previous experiences with this practice and or negative information about the procedure from other sources. Possibly more education and skill development will increase exposure to and heightened awareness about breastmilk expression. Demonstrations are needed with respect to storage and the length of time that the milk remains “fresh” without refrigeration to increase the acceptance of expressing and storing breastmilk.

Moreover respondents’ view that intentions to breastfeed are hampered by the poor nutritional status of some mothers needs to be addressed. Possibly a broadened food assistance programme for “needy” pregnant and lactating mothers to enhance their nutritional status could be considered. As reflected in the data, breastfeeding is linked to “drawing down mother,” therefore the expansion of the food stamp programme should be an encouragement for some mothers to practice exclusive breastfeeding.

Reports from health care providers and Ministry officials identify diminishing resources being available for the maintenance of the breastfeeding initiative and as a consequence there has been a lapse in the programme. The Ministry needs to refocus its efforts to regain the lost ground and to push forward to achieve increased levels of exclusive breastfeeding.

The strategies for the implementation of the breastfeeding programme are already detailed in various international and local documents, which are available in the Ministry of Health. What is therefore required is for resources to be allocated to facilitate their full implementation.

It appears that for the breastfeeding initiative to achieve its intended goals, a certain level of synergy is needed between health care providers, the clients and the community, so that each supports and reinforces the other. In order to do this there must be a strong focal point in the main stakeholders domain, which is the Ministry of Health to energise and drive the process.

Recommendations

The overall recommendation to the Ministry of Health is that the 4 specific actions outlined in the Innocenti Declaration of 1995 with respect to the following should be fully implemented:

Appointment of a breastfeeding co-ordinator
Ensure that every facility providing maternity services fully practices all Ten Steps to Successful Breastfeeding
Give effect to the principles and aims of all Articles of the International Code of Marketing, and
Enact legislation to protect the breastfeeding rights of working women and establish the means for its enforcement

Additionally it is further recommended that the following steps be taken to revitalize the breastfeeding programme:

1. Training

The Ministry of Health's training in lactation management should be reviewed to address the concerns raised in this study and to update the information where necessary.

Training in lactation management needs to be intensified on a planned basis to ensure that
in the short run at least 50 percent of the health care providers in health facilities providing maternal services have accessed such training.

Institutionalise further the standard interpretation of exclusive breastfeeding among health workers so that a single definition will be consistently used to record the data thereby improving its quality and reliability.

2. Budgetary Allocation

Specific budgetary allocation is required to effectively implement the breastfeeding programme to facilitate proper planning including targeting, implementation, monitoring and evaluation of programme objectives and outcomes.

3. Monitoring and Evaluation

Establish sentinel stations to track changes in exclusive breastfeeding.

Use consistently the evaluation tools developed by UNICEF at the recommended time periods to assess progress and maintenance of BHFI in maternity facilities.

4. Breastfeeding Support Services

Re-establish the breastfeeding helpline to provide a ready relatively cheap and efficient source of information and advice to mothers.

Improve the physical facilities in the health centers and extend the availability of overnight rooming facilities in maternity facilities and hospitals to encourage breastfeeding.

Increase significantly, community mobilization to establish breastfeeding support groups to promote and advocate for breastfeeding. Collaboration with community agencies and organizations will be required to effect this mobilization.

Increase the availability of breastfeeding promoters, community health aides and midwives to provide post delivery advice and support at home, in the first instance to mothers who are having problems with breastfeeding and secondly, to encourage its maintenance among other mothers.

5. Policy and Institutional Development

Identify and develop public policy measures that will govern working and related conditions to facilitate exclusive breastfeeding for the recommended period.

Develop the criteria and establish baby friendly health centers as a counterpart to the BFHI to demonstrate and strengthen the linkage between primary and secondary care and to provide continuity in the breastfeeding service.

Increase the integration of the breastfeeding programme with other child health programmes such as oral rehydration, reproductive health, nutrition, health promotion and education to achieve a greater reach of the target group and to maximize the benefits.

6. Promotion, Information and Education

Promote 3-4 months exclusive breastfeeding

Improve and expand breastfeeding information provided to ante and post natal clients to emphasize the following; more balanced information on the benefits of breastfeeding to both mother and child, how to enhance the physical appearance of breastfeeding mothers, how to express and store breastmilk and the nutritional benefits of exclusive breastfeeding.

Develop and produce more educational materials using print and audiovisual media to respond to the major issues in breastfeeding and appropriate for the range of literacy levels of the clientele.

Develop and implement programmes for men, in particular to educate and inform them about breastfeeding, infant formula and the actions that they can take to support good breastfeeding practices thereby protecting the health of their partners and children.

7. Research

Given the demand for evidence of the value and benefits of exclusive breastfeeding research needs to be undertaken in the Jamaican context on some of the concern and issues around breastfeeding. Research should be undertaken to determine:

The cost-effectiveness of exclusive breastfeeding for the recommended period of 4-6 months as against formula feeding and mixed feeding

The health, nutritional, growth and developmental benefits of exclusive breastfeeding and non-exclusively breastfed infants.

The Ministry of Health has in place many of the critical elements that are required to carry forward the breastfeeding programme. The policy framework while it needs further strengthening is in place, the National Breastfeeding Committee, institutional infrastructure of maternity facilities with islandwide coverage and health providers, even though limited are in place. There is high interest and commitment among health care providers to promote and deliver breastfeeding services.

The health system therefore needs to be energized through the allocation of funding, provision of key personnel to oversee and direct the programme, revitalized training of healthcare providers and public education and information. The contribution of breastfeeding to the health of infants and their mothers if not increased through direct and programmed activity will continue to show its effect in the incidence of preventable childhood diseases such as diarrhoea and other illnesses.

Exclusive breastfeeding is an economic and healthy strategy to be pursued in the protection of the health of mothers and children by all governments, moreso in developing countries such as Jamaica where resources are in limited supply.