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Exploring low income working mother's perceptions of community support for exclusive breastfeeding after returning to work

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Abstract

This qualitative study sought to explore low income working mother's perceptions of community support for exclusive breastfeeding after returning to work. The results from 12 in-depth semi-structured interviews conducted with low income mothers, working full-time in a clothing factory located in the Cape Flats area, were analysed using thematic analysis. Three key themes emerged. The mothers generally expressed that they received informational support for breastfeeding from various members of their community, however there was a lack of emotional, instrumental, and appraisal support for these working mothers to continue to exclusively breastfeed after returning to work. Furthermore, the mothers come from communities in which there is a shared responsibility for raising babies. They are often given instructions and advice on how to feed their babies by different people and this advice often contradicts the World Health Organization's breastfeeding recommendations. Lastly, the mothers expressed that breastfeeding is an act that is usually reserved for stay at home mothers. Working mothers' breastfeeding intentions are generally not supported within their communities and working mothers are often encouraged to give their babies formula and other feeds as early as possible. It is important for organisations employing low-income mothers to understand the community context when designing workplace policies and interventions aimed at promoting exclusive breastfeeding. This will allow organizations to address their employees breastfeeding challenges in a culturally sensitive ways.

Keywords: *breastfeeding at work , community support, working mothers, low income, South Africa,*

Definitions

Breastfeeding

When reviewing the topic of breastfeeding in the workplace, it is important to have an understanding of the definitions of breastfeeding. It is widely recognized that the accurate and consistent use of standardised breastfeeding indicators and definitions is important in understanding women's breastfeeding behaviours. The World Health Organisation (WHO) has established a common set of breastfeeding definitions as outlined in table 1. Scholars have suggested that the definition of exclusive breastfeeding (EBF) must be used in strict accordance with the WHO definition (World Health Organization, 2003).

Table 1

Key terms

Terms	Definition
Exclusive breastfeeding	Feeding an infant breast milk only and any vitamins, minerals and prescribed medicines (if they are required), for the first six months of an infants' life.
Mixed feeding	Feeding an infant breast milk as well as other solids and fluids.
Supplementary feeding	The transition from EBF to supplementing breastmilk with solids and fluids, usually between the ages 6 and 18 −24 months.
Breastfeeding at work	The continuation of EBF after returning to work from maternity leave i.e. combining breastfeeding and work by taking lactation breaks during working time to express breastmilk.
Low-Income Worker	Low-income workers can be defined as weekly wage earners earning less than R4500 per month (Republic of South Africa, 2017).
Community Support	Support that can be organized through informal social network members (such as the mother's partner/husband, extended and immediate family members, close friends and individuals in their community) and formal social network members (such as support groups, members of religious institutions, stokvel (a rotating investment or savings society in South African where members regularly contribute a fixed amounts of money from which they are entitled to receive a lump sum payment) members and community health workers).

Chapter 1: Introduction

Maternal employment is a great barrier to breastfeeding across many countries and cultures (du Plessis, Peer, Honikman & English, 2016). In South Africa, the legislated maternity leave is four months. Maternity leave needs to begin a month prior to the anticipated date of birth of the child, and it is the responsibility of the employee to give their employer one month's notice before the start of their maternity leave. Employers are not required to pay employees for maternity leave, and the employee needs to claim for maternity benefits from the Unemployment Insurance Fund (UIF) at the Labour Office. An employee contributing to UIF, is eligible for a maternity benefit of 38% to 60% of their average remunerations in the last six months (this amount is contingent on their level of income) (Republic of South Africa, 1997). Low-income, low-skilled women in South Africa tend to return to work even earlier than the legislated four months for economic necessity (Siziba, Jerling & Hanekom, 2016)**.** This makes it difficult to reach six months of EBF as recommended by the WHO. Guttman and Zimmerman (2000) argued that a working mother's breastfeeding decisions are often based on the degree to which there are conflicting demands between their role as a mother and as an employee. Adding to this challenge, most South African workplaces remain largely uncooperative environments to continue breastfeeding upon return to work (du Plessis et al., 2016) despite legislation that protects mothers to do so such as the stipulated guideline that should be upheld in the Code of Good Practice on the Protection of Employees during Pregnancy and After the Birth of a Child in the Basic Conditions of Employment Act. This Code states that mothers returning to work are allowed to take two 30 minutes breaks, over and above their tea and lunch breaks, for milk expression or breastfeeding each working day for the first six months of their child's life. Beyond six months, it is the duty of the employee to engage with their employer in order to make the necessary arrangements to support their breastfeeding needs (*Basic Conditions of Employment Act,* 1997). South African workplaces, at large, do not provide women with the opportunities and resources that will allow them to express breastmilk during their work schedule for feeding their babies breastmilk at a later time (du Plessis et al., 2016).

The WHO recommends that breastfeeding needs to begin within an hour of birth. The baby should then be exclusively breastfed for the first six months of its life, with the timely introduction of supplementary foods thereafter so as to meet the infant's evolving nutritional requirements, and continued supplementary breastfeeding for up to two years and beyond (World Health Organization, 2003). The adequacy of supplementary feeding is outlined in terms of adequate, timely, appropriate and safe feeding (Hunter-Adams, Myer & Rother, 2016).

This recommendation is evidence-based and adherence to it enhances infants' health outcomes which extend into adulthood (Kramer et al., 2001). Breastmilk is the natural first food for infants and it contains all the nutrients and energy that the baby requires. According to the 2016 Lancet Breastfeeding Series, investing in breastfeeding is the most effective intervention for reducing child mortality and morbidity rates that can be attributed to common childhood illnesses such as pneumonia and diarrhoea especially in resource-limited communities. Breast milk also has a powerful combination of minerals, vitamins, antibodies and nutrients that are necessary for meeting the baby's developing nutritional needs. EBF during the first six months of life leads to a reduction in gastrointestinal infections (Kramer & Kakuma, 2012), promotes rapid growth (Hop et al., 2000; Villalpando & Lopez-Alarcon, 2000), decreases the risk of postnatal Human Immunodeficiency Virus (HIV) transmission through breastfeeding when compared to mixed feeding (Coovadia et al., 2007), promotes cognitive and sensory development and protects the infant against diseases. The physical breastfeeding relationship also allows the mother and the infant to form a bond and attachment with each other which leads to the improved social development of the child (Kramer et al., 2001). The health benefits of EBF are not only limited to infants but also extend to the mothers. There are various benefits of extended durations of breastfeeding that have been linked to a mother's health. Exclusively breastfeeding an infant for six months has been linked to reductions in the risk of cardiovascular disease, ovarian cancer, premenopausal breast cancer and type 2 diabetes (Murtaugh, 1997; Afaya et al., 2017). Mothers who breastfeed also have increased levels of oxytocin released immediately after childbirth resulting in reduced levels of negative mood and stress (Mezzacappa & Katkin, 2002). Additionally, research shows that mothers who breastfeed have an earlier return to pre-pregnancy weight (Dewey, Heinig, & Nommsen, 1993). Therefore, the potential benefits resulting from combining employment and EBF influence the health of the infant as well as the mother's health.

South Africa supports The WHO's recommendation, as shown by the resolution of the 2011 Tshwane Declaration for the Support of Breastfeeding, the South African Code of Good Practice on the Protection of Employees during Pregnancy and After the Birth of a Child, and the Basic Conditions of Employment Act Section 87(1)(b). The Tshwane Declaration of Support for Breastfeeding was signed in August 2011 as a result of The National Consultative Breastfeeding meeting convened by Dr. Aaron Motsoaledi, the former National Minister of Health (du Plessis et al., 2016). It represents a strong commitment by the National Department of Health as well various stakeholders (including employers and managers) in South Africa to collaborate and work together towards advancing both infant and maternal health and nutrition

through the protection, promotion and support of breastfeeding (The Tshwane declaration of support for breastfeeding in South Africa, 2011). The need to tackle the challenges around maternity protection of working mothers were conveyed in the declaration as follows: "We specially resolve that: …Legislation regarding maternity among working mothers is reviewed in order to protect and extend maternity leave, and for measures to be implemented to ensure that all workers… benefit from maternity protection, and to include an enabling workplace" (The Tshwane declaration of support for breastfeeding in South Africa, 2011).

Siziba et al. (2016) suggested that in spite of the national and global progress and the commitment of promoting EBF, the WHO target of increasing the EBF rate in the first six months of an infant's life up to at least 50% by 2025 is not effectively being met. A review by Rollins et al., (2016) in the Lancet 2016 Breastfeeding series, which obtained data from various countries that report on the WHO infant and young children feeding indicators, found that early initiation and early breastfeeding practices are compromised in all countries. Only 37% of infants living in low-and-middle income countries are exclusively breastfed beyond the first three to four months of age (Rollins et al., 2016). In South Africa, national data shows that the challenge is not poor initiation rates (88%) (du Plessis et al., 2016) but rather the lack of EBF practices in the first six months of an infant's life. EBF is largely limited to the very early months specifically, the proportion of infants who are exclusively breastfed reduces with age, from 44% of infants age 0-1month to 24% of infants age 4-5 months (Republic of South Africa: Department of Health, 2016). Moreover, a large number of infants continue to be fed incorrectly. The Department of Health Survey (2016) found, for example, that 25% of infants below the age of 6 months were not breastfed at all; 45% were fed using a bottle with a nipple; and only 23% of young children aged 6 - 23 months received a minimum acceptable diet of milk and an adequate mix of supplementary foods. Many babies received supplementary foods and water between 2 to 3 months of age, and in some cases even within a few days of birth (du Plessis et al., 2016). Additionally, the use of commercial infant milk (hereafter referred to as formula) for infant feeding is the norm (Hunter-Adams et al., 2016). Measured against global nutrition and breastfeeding targets, it is clear that South Africa has a considerable way to go. Globally, experts estimate that the low breastfeeding rates are costing the world 0.5% of its potential gross income, a total loss of at least $341 billion per year (Smith, 2019). Furthermore the National Department of Health recommends EBF as an excellent intervention for improving economic growth and reducing poverty (Republic of South Africa: Department of Health, 2016). Focusing on the workplace to enable breastfeeding can play an essential role in improving the country's EBF rates.

Research on workplace support for breastfeeding is limited when compared to research on the breastfeeding from a health perspective. Yet return to work is a major barrier to mothers meeting EBF goals. The limited literature that does exist, has aimed to better understand the experiences and needs of working mothers to help institute support for them and to ensure success in meeting the WHO's EBF goals (Ortiz, McGilligan & Kelly, 2004; Rojjanasrirat, 2004; Witters-Green, 2003). However, most of the research that exists has been conducted in developed countries, or among white and professional or skilled workers, which are markedly different from the South African context. The gap between the current infant-feeding practices in South Africa and the infant feeding guidelines calls for a more holistic approach to understanding as well as improving workplace support for breastfeeding, particularly in a developing country context among black, low income and low skilled workers.

The Context of Low-Income Working Women in South Africa

Various socio-cultural complexities underpin the breastfeeding experiences of low-income working mothers in South Africa. Some discussion of historical and contextual factors are relevant for enabling an enhanced understanding of this particular subgroup.

Apartheid in South Africa (1948-1990) was used to separate individuals on the basis of race. Racial classifications were introduced for the purposes of social discrimination. During apartheid black women in South Africa faced discrimination on numerous fronts ("black people" is a common term which means Indians, Coloureds and Africans) (*Employment Equity Act, No. 55 Of 1998*, 1998). Black women were oppressed by the apartheid government because they were black and because they were women. As a result, black women lived under an extensive range of oppressive legislation that deprived of them of having freedom in an economic, social and political context. With post-apartheid feminist supportive legislation, there has been a significant growth in the number of women who have entered the labour market. Particularly, over the past 10 years, the greatest increase in the labour market has been among women. According to labour data released for the second quarter of 2018, women accounted for 43.8% of the employed labour force and many of these women are in their childbearing years (Statistics South Africa, 2019). Furthermore employment participation rates of low income women is higher (55%) than that of middle income (35%) and high income (10%) women (Statistics South Africa, 2019).

Breastfeeding is a natural part of their mothering responsibilities and key for sustainable societies. Hence optimal support is required from multiple stakeholders for women to be able to continue breastfeeding after returning to work, especially low-income women, who are mainly black and poor. Given the history of racial oppression in South Africa, low EBF rates

amongst women in the workplace can be linked to their oppression within society. Work-life balance may be experienced differently by middle class and white women compared to black and low income women in South Africa because they face different challenges (Potgieter & Barnard, 2010). For example the stark household earning disparity between black South Africans (R92 983 per annum) and white South Africans (R444 446 per annum) (Statistics South Africa, 2019) means that access to child care, nutrition, health services and education creates distinct experiences. In addition, as a result of the legacy of apartheid's spatial planning, South African cities continue to be economically and racially segregated, with many black low-income workers living on the outskirts of major cities, making commuting from work to home to breastfeed a baby difficult (du Plessis et al., 2016). In the low-income, low-skilled work contexts, flexibility in time and place of work is limited, and the jobs that most black women occupy are characterized by low autonomy and limited control over their work schedules (Potgieter & Barnard, 2010). These constraints therefore deprive these workers of the opportunity to use their breaks to enable them to exclusively breastfeed after returning to work (du Plessis et al., 2016).

Importantly, low-income South African women are faced with a complex set of dynamics influencing their EBF decisions, which are shaped by community attitudes towards breastfeeding at work (Spencer, Wambach & Domain, 2014). Johnson, Kirk, Rosenblum and Muzik (2015) suggest that the presence of systemic discrimination, low-income status and racial disempowerment among black people may result in disadvantageous overall health and life outcomes. Low-income mothers often do not have enough social support and they are also more likely to experience the workplace as not being supportive of breastfeeding (Johnson et al., 2015). Research shows that working mothers are not likely to change their breastfeeding behaviours solely based on the fact that their workplaces provided them with lactation accommodation, because external factors have a strong influence on infant feeding practices (Rohrbaugh, 2008). Social support has been identified, in Kronborg and Vaeth's (2004) conceptual systems model of psychosocial factors influencing the working mother's decisions to exclusively breastfeed, as a crucial link in a series of events resulting in breastfeeding. Social support influences the initiation and maintenance of EBF and it contributes to maternal breastfeeding confidence (Tohotoa et al., 2009). Community support is a particularly important source of support for low-income black working mothers (Rohrbaugh, 2008). Bigombe and Khadiagala (2003) found that in South Africa, the majority of low-income households consist of live-in extended family members. Often these extended family members and community members are put in charge of child-care responsibilities so that the child's parents can go to

work (Mazaleni & Bamford, 2010). Members of low-income communities encourage strong relationships where everyone takes responsibility for fellow members of their group (Eaton & Louw, 2000). Yet low income communities in South Africa also face challenges of increased precarious housing, limited resources and endemic violence occurring at all levels of social interaction (Arora, McJunkin, Wehrer & Kuhn, 2000). Community perceptions may therefore affect individuals' coping styles when they are faced with challenges in their lives. The support, attitude and beliefs of community members towards EBF can be a major influence on working women's breastfeeding decisions after returning to work. They can also act as either key facilitators or deterrents to EBF (Arora et al., 2000). When friends and family support working mothers and encourage them to make informed infant feeding decisions, this can have a positive influence on a woman's choice to continue EBF after returning to work. However, open opposition by community members towards a working mother for continuing breastfeeding after the mother returns to work, or community members refusing to assist in feeding expressed milk to the working mother's baby when in their care, can deter a working women from EBF (Arora et al., 2000). Therefore, how low income workers perceive community support (or lack of support) towards EBF, can be a major influence on their breastfeeding decisions once they return to work (Arora et al., 2000). In addition, infant feeding practices in low-income communities are deeply rooted in generations of conventional beliefs and practices. Though some of these beliefs and traditions promote breastfeeding, others discourage it (Osman, Zein & Wick, 2009). In most cases, these cultural beliefs, myths and misconceptions have been emphasized as some of the barriers to achieving optimal EBF rates in low-income communities, particularly in Africa (Davies-Adetugbo, 1997; Wanjohi et al., 2016) and as one of the probable causes of poor breastfeeding practices amongst working women living within these communities (Kimani-Murage et al., 2014). Cultural beliefs and practices are influential on working mother's breastfeeding decisions and have been identified as among the major determinants of EBF practices (Rollins et al., 2016). Numerous studies have also highlighted the need to recognize and incorporate local cultural beliefs, customs and traditions related to EBF into the design and implementation of appropriate workplace policies and interventions in order to provide better support for working mothers (Afaya et al., 2017).

Study Aims

To this end, this study aims to explore low income working mothers' perceptions of community support for EBF after returning to work. Because the majority of low income mothers return to work before six months out of economic necessity (Lebitse, 2018), they would have to combine employment with breastfeeding at work to achieve optimal

breastfeeding goals as stipulated by WHO. In addition, the voices of low-income, black working mothers in South Africa are all but absent in this area of research. Low income communities are characterised by collectivism and a variety of social problems including high rates of unemployment, crime, single-parent households, poor health and low levels of education which is likely to present distinct experiences of mothers from that of higher socio-economic communities characterised by individualism and who have access to greater resources (Sampson, Morenoff, & Gannon-Rowley, 2002). Hence management implications from the findings of research conducted on the latter, may not be contextually appropriate in informing workplace interventions to support breastfeeding at work for low income workers in South Africa.

Accordingly, the following research question will guide this study:

How do perceptions of community support inform low income mothers decisions to continue breastfeeding after returning to work ?

Significance of the study

Throughout the past two decades, South African organizations have increasingly been held responsible for employee safety and health especially among pregnant women. Such responsibility is evident by the aforementioned legislation: the 2011 Tshwane declaration for the support of breastfeeding; the South African Code of Good Practice on the Protection of Employees during Pregnancy and After the Birth of a Child; and the Basic Conditions of Employment Act Section 87(1)(b) of 1997. Furthermore there has been a growing importance of health promotion/health protection strategies within the workplace.

In the context of low income women in SA, given the high levels of inequality and effects of apartheid, it is necessary to consider the wider environmental milieu and understand the perceptions of community support for breastfeeding in the workplace because these mothers navigate between their workplace and community. Therefore when thinking about organisational support for breastfeeding low income women we need to focus on the workplace but also on understanding the communities that these women come from as well as to consider the effects of community support on working mothers' breastfeeding intentions after returning to work so that workplace interventions can be more context sensitive and relevant to their workers lived experiences and needs. The promotion of optimal feeding practices and the support of breastfeeding in the workplace using context sensitive and relevant interventions can reap various benefits for employers. A study of multiple companies with context sensitive and relevant breastfeeding support programmes found increased staff satisfaction, increased loyalty and an average retention rate of 94% amongst breastfeeding mothers (Garvin et al.,

2013). The health benefits of breastfeeding can also save employers money. Shortened breastfeeding duration rates can result in higher rates of infant illnesses which are linked to higher rates of employee absenteeism and lost income (Garvin et al., 2013). In fact, Cohen, Mrtek and Mrtek (1995) found that of the 40 illnesses causing one day's absence for working mothers, only 25% occurred in breastfed babies while 75% occurred in formula-fed babies. Conflict between family responsibilities and paid work have also been linked to reduced productivity (Cropanzano & Mitchell, 2005). Lastly the social exchange theory hypothesizes that if employees perceive their employers as being concerned about their well-being and are willing to invest in it, then employees will reciprocate with positive organizational behaviours (Hofmann, Morgeson & Gerras, 2003; Lee & Bruvold, 2003) such as participating in the health promotion component of the intervention.

Furthermore the inclusion of the public health perspective in workplace health efforts to promote EBF amongst working mothers can also go beyond what is mandated or what may result in financial benefits to organizations via productivity gains or reduced health care costs. Bennett and Tetrick (2013) emphasize the important role of industrial-organizational psychologists in creating healthy workplaces not only as an end in itself but also as a means for greater societal benefit, that is,. by creating a healthier society. Psychologists raised the issue that organizations should not only focus on the health protection of their employees but could also enhance the health of the their families and potentially larger communities and society in general. There can be health enhancement such that health effects diffuse into the surrounding community. In other words the concept of a healthy workplace, ties into the concept of how industrial psychology can contribute to the greater good (Bennett & Tetrick, 2013). For example, working mothers who have been educated about EBF and its importance, as well as encouraged to do so, will be able to bring that knowledge into the work-family sphere, into neighbourhoods, and the surrounding community (improving social capital).

Structure of the Dissertation

Chapter One begins with presenting an introduction of the research topic as well as a description of the context within which the participants live. The chapter also provides the study's aims as well as an outline of the structure of the dissertation. Chapter Two presents the social ecological model and social support theoretical frameworks as well as the review of literature on perceived community support and breastfeeding among low income workers. The method used to investigate the research proposals is explained in Chapter Three. This chapter described the study context, research paradigm and design, data collection, sampling and

participants, procedure and method of data analysis used as well as the ethical considerations and research rigour. Lastly, Chapter Four presents the results and discussion.

Chapter 2: Literature Review

Theoretical Framework

This section presents the main theories that help guide this study and answer the research question. First, I draw on the social ecological model to uncover the nestedness of the phenomenon of continuing breastfeeding after returning to work. Secondly, I use the social support theory to show how favourable community perceptions can serve as an important resource for low income mothers in achieving EBF after returning to work.

Social Ecological Model

In South Africa, low-income women's decisions to breastfeed are influenced by multiple interpersonal and contextual factors such as social support resources and the effects of apartheid on low income communities. Consequently, the Social Ecological Model (Bentley, Dee, & Jensen, 2003) is helpful in framing these women's experiences. According to the Social Ecological Model (SEM) (McLeroy, Bibeau, Steckler & Glanz, 1988), behaviour affects and is affected by five levels of influence and similarly to the idea of the social cognitive theory, individual behaviour shapes, and is shaped by, the social environment. Researchers have used this model in order to define the numerous spheres of influence that frame and influence breastfeeding mothers (Spencer et al., 2014; Johnson et al., 2015).

The intrapersonal level of the SEM explores individual characteristics that influence behaviour such as one's knowledge, attitudes, behaviour, skills, and self-efficacy (Dunn, Kalich, Fedrizzi & Phillips, 2015). The interpersonal level of the SEM focuses on formal and informal social networks and support systems, including the family members, friendship networks, peers, neighbours, elder members of the community and community health workers (Dunn et al., 2015). The support and opinions of the people who surround an individual everyday can be an important source of influence for their behavior, attitude and decision-making. The organizational level explores influences by established institutions with organizational characteristics and formal (and informal) rules and regulations for operation, such as the formula industry and health care institutions. The community level refers to the relationships among informal networks, institutions and organizations within defined boundaries. Lastly the influence of regulatory public policy, procedures and legislation that are set at local, state and national level, such as the Tshwane declaration for the support of breastfeeding, the South African Code of Good Practice on the Protection of Employees during Pregnancy and After the Birth of a Child, and the Basic Conditions of Employment Act Section 87(1)(b), as well as governmental and international institutions that address breastfeeding, such

as the WHO and the National Department of Health, are examined at the macrosystem/policy level (Dunn et al., 2015).

This study focuses on the low-income mothers' perceptions of community support toward continuing breastfeeding after returning to work to upkeep EBF. The study therefore deals with the interpersonal level of the SEM because members of the mother's community form part of their formal and informal social networks and support systems. Looking at all of the levels of the SEM is beyond the scope of this research. In this study, perceptions of community support include that of immediate and extended family members as well as friendship networks, peers, neighbours, elder members of the community, religious institution members, and community health workers. This wide group of stakeholders is important because in low income black communities in South Africa living arrangements tend to include extended family members and strong connections with people living in the physical community location (Bigombe & Khadiagala, 2003).

Although the use of the SEM in research on breastfeeding in the workplace is limited, SEM has been widely applied to public health promotion interventions. Therefore, the SEM framework is suitable for identifying the various determinants of behaviour that shape working mother's EBF decisions (Dunn et al., 2015). It is therefore important to realize that supporting breastfeeding among low income working mothers in South Africa cannot be achieved by solely focusing on one aspect of the phenomenon.

Social Support Theory

Social support describes the various pathways that link social relationships to wellbeing (Cohen and McKay, 1984), and it is well documented that social support can reduce work related stress, mental health issues and increase an individual's resilience (House, 1981; House, Kahn, McLeod & Williams, 1985). Research into interpersonal factors influencing breastfeeding have emphasized the important role of social support in the encouragement and success of EBF amongst working mothers (Baranowski et al., 1983; Sikorski, Renfrew, Pindoria & Wade, 2003; Ekström, Widstrom & Nissen, 2003). Furthermore, numerous authors have extended the idea of social support to influence behaviour change.

Literature provides various definitions for social support, that are derived from quantitative and qualitative studies (refer to table 2 for definitions of social support). Overall it appears that all the definitions of social support suggest some form of positive interaction or helpful behaviour provided to someone who needs support.

Table 2

Definitions of Social Support Theory

Author	Definition
Cobb (1976)	"information leading the subject to believe (s)he is cared for and loved, esteemed, and a member of a network of mutual obligations" (p. 300).
Caplan et al. (1976)	"any input directly provided by another person (or group) which moves the receiving person towards goals which the receiver desires" (p. 39).
Thoits (1982)	"the degree to which a person's basic social needs are gratified through interaction with others" (p. 147).
Castro, Campero & Hernández (1997)	"the degree to which a person's basic social needs are satisfied through their interaction with a formal and informal social network" (p. 427).
Fleury, Keller and Perez (2009)	"aid and assistance exchanged through social relationships and interpersonal transactions" (p.10).

Functions of Social Support. Research articles have identified four types of supportive acts or behaviours in the conceptualization of social support: (1)emotional support; (2)appraisal support; (3)informational support; and (4)instrumental support. While these functions of support can be theoretically distinguished, Cohen and Wills (1985) note that "in naturalistic settings they are not usually independent" (p. 313).

Emotional Support. Emotional support includes the provision of care, concern, affection, trust, empathy, love, respect and admiration. Kahn and Antonucci (1980) and later Norbeck, Lindsey and Carrieri (1981) described the emotional support component as affective assistance. Cobb (1976), suggests that social support is provided through communication that leads to the information that one (a) is esteemed and valued, (b) belongs to a network of mutual obligation, and (c) is cared for and loved. Mutual obligation suggests the "reciprocal nature of social support" (Cobb, 1976, p.302). For example, providing encouragement and empathy to a working breastfeeding mother can influence her to continue to exclusively breastfeeding their child after returning to work.

Informational Support. Informational support relates to the provision of suggestions, advice, information, opinions as well as directives that an individual can use when coping with environmental and personal problems (House, 1981; Krause, 1986). Cutrona and Russell

(1990) as well as Tilden and Weinert (1987) validate the use of informational support during decision-making operations. The information, advice, opinions and directives given to the recipients must be relevant to them in their present circumstances. For example, community members of the working mother's social network can provide her with informational support about what EBF means, and how to best achieve it while working which could greatly encourage her to continue breastfeeding after returning to work after her maternity leave.

Appraisal Support. Appraisal support is often included as part of informational support. It is the transmission of information that is relevant to self-evaluation rather than problem-solving, which may be derived from feedback, social comparison opportunities and affirmation. Appraisal support mirrors the characteristics of the Social Comparison Theory. Kahn and Antonucci (1980) use the term affirmational support to describe appraisal support. Affirmational support includes expressions that affirm the suitability of statements or acts made by another (Kahn & Antonucci 1980). Appraisal support is crucial in the development or enhancement of working mothers' self-esteem and self-confidence in the postpartum period, thus enabling them to cope with stress related to feeding their child. For example, encouraging mothers to continue to breastfeed their babies after returning to work after their maternity leave is a form of appraisal support.

Instrumental Support. Instrumental support refers to the provision of tangible goods and services or concrete assistance. It is characterized as access to behaviours that directly help the person in need, such as aid in money, time, or labour (Barrera, 1986; Cronewett, 1983; House, 1981; Tilden & Weiner, 1987). Barrera (1981) describes tangible assistance as material and physical assistance, whereas Norbeck et al. (1981) uses the label aid and Power and Parke (1984) use the label physical. The common denominator within these labels is that the provision of instrumental support is in the guise of hands-on-help. For example, for working mothers having someone to help them with caring for the baby and with household chores when they get back from work so that they can breastfeed their baby would be considered tangible support (Bennett, 1981).

The different forms of social support are informed by social networks, social embeddedness theory and the social climate.

Social Network. Definitions by Mitchell (1969) and Walker as well as MacBride (1977) are commonly used to define Social Networks. Mitchell (1969) defines a social network as "a set of linkages among persons in which the characteristics of the linkages are useful for understanding the behavior of the persons involved" (p. 2). Walker and MacBride (1977) define social network as "that set of personal contacts through which the individual maintains his

social identity and receives emotional support, material aid, services, information and new social contacts" (p. 35). Similarly, Souza, Nespoli and Zeitoune (2016) define social networks as "a set of interpersonal relationships that determine an individual's characteristics, such as: habits, customs, beliefs and values and they are a vehicle through which social support is produced and provided".

Community social networks can be primary or secondary. In primary networks, ties are defined by relationships with family, friends or neighbours. Secondary networks can be defined by relationships with members of institutions (community healthcare workers) (Souza et al., 2016). Social networks provide and produce social support which has a positive influence on behaviour (Zhao & Hu, 2016; Göksen, 2002). In other words, social networks play an integral role in the way that working mothers experience and perceive the world. Social networks are not only important channels for practical information and knowledge about EBF, but they also offer an important access to emotional, appraisal and instrumental support which is extremely helpful in encouraging working mothers to continue to exclusively breastfeed and express breastmilk in the workplace. Being socially connected is also a central element in one's "psychological sense of community" and it constitutes the opposite of social alienation and isolation. Social networks increase attachment and belongingness, and aid in creating reference groups in which members can exert pressure to conform to social roles and normative standards (Zhao & Hu, 2016; Asiodu, Waters, Dailey & Lyndon, 2015; Barrera, 1986).

Breastfeeding working women, in their own world, belong to a relational context. They have social networks which provide them with practical information and knowledge about breastfeeding as well as concrete kinds of support which are very influential on their EBF decisions.

Social Embeddedness. Social embeddedness refers to the connections people have to other individuals within their social network (Barrera 1986). Some degree of social embeddedness needs to exist for individuals to derive support from their environment. Social embeddedness is the strength and depth of the relational ties that an individual has with each member of their social network. Social embeddedness is therefore important for conveying subjective norms, values and ideologies (Göksen, 2002). Moreover, breastfeeding occurs within a broad community network, especially in the context of culturally collective communities in South Africa, where the extended family structure and strong social bonds within the community is prevalent. This interconnectedness between community members and the support offered by community members can play a central role in a working women's breastfeeding decision making (Göksen, 2002).

Social Climate. Langford, Bowsher, Maloney and Lillis (1997) define the social climate as the "personality of the environment" (p. 97). Features of the social climate which promote social support are helpfulness and protection. In order for social supportive behaviours to occur, it is necessary for individuals to become members of a social network that possess the qualities of connectedness (social embeddedness) which are necessary for creating an environment of helpfulness and protection (social climate) (Langford et al., 1997).

Perceived Community Support and Breastfeeding among Low Income Workers

Social relationships with and support from members of a working mother's community social network have been shown to be important determinants of exclusive breastfeeding during employment (Paine & Dorea, 2001; Awumbila, 2004; Seidu, 2013; Dagvadorj, Anigo, Ota & Sasaki, 2015). For working mothers to breastfeed successfully, it is not enough to just choose to practice it, they must be part of a social context that helps them to take this decision forward. Mothers returning to work tend to discuss their infant feeding decisions with other individuals within their social network (Raffle, Ware, Borchardt & Strickland, 2011; Ferreira, Piccioni, Queiroz, Ferreira, Piccioni, Queiroz, Silva & Vale, 2018). Therefore a working mother's beliefs about the advantages and disadvantages of infant feeding methods arise in part from interactions that she may have with various informal social network members in her community (such as the mother's partner/husband, immediate and extended family members, close friends and individuals in their community) and formal social network members (such as support groups, religious institutions, stokvel members and health professionals). These interactions with community members may be either positive or negative towards EBF and have been shown to affect both confidence and persistence in breastfeeding (Raj & Plichta, 1998). Furthermore findings from a qualitative study on the influence of the social network on the breastfeeding process showed that instrumental support was essential when supporting working mothers. The study participants expressed that they could count on their family members for child care help and support with the chores which enabled them to breastfeed their baby (Souza, Nespoli, & Zeitoune, 2016).

A number of studies have found that the availability of a support system to be an enabler of successful EBF amongst working mothers and the lack thereof to be a barrier. In four of the studies employing qualitative methods to explore the barriers and facilitators to exclusive breastfeeding amongst working mothers, a lack of social support from significant members of the mother's community was a commonly recurring theme. Two of these studies found that low-income mothers in Nigeria and Ghana considered the lack of support from their partners' as a significant factor leading to the cessation of exclusive breastfeeding (Otoo, Lartey & Pérez-

Escamilla, 2009; Agunbiade & Ogunleye 2012). Findings from a separate study conducted among women in employment in Tanzania showed that the mothers were often left to solve the practical problems of combining breastfeeding with employment by themselves (Shao Mlay, Keddy & Noerager Stern, 2004). This lack of community support for breastfeeding often led to many mothers ceasing breastfeeding after returning to work and choosing to formula feed, regardless of the fact that formula feeding is not safe, sustainable, acceptable or affordable. Shao Mlay et al. (2004) and Witters-Green (2003) emphasized how a partner, relative, friend or members of the women's groups with a negative attitude towards combining breastfeeding and work made it difficult for them to continue EBF after their maternity leave. Furthermore, some individuals within the mother's community physically interfered with EBF (e.g. while the mother was away at work, community members would feed the infant formula rather than breastmilk that the mother had expressed for feeding) (Witters-Green, 2003). In contrast, Nabulsi (2011) showed that mothers described that within their communities, community support of a breastfeeding mother was a cultural expectation, which served as a significant facilitator of EBF.

The opinions and experiences of the individuals in the mother's community social network are important influencers among low-income mothers' given the numerous stressors that they experience on a daily basis associated with poverty, such as difficulties affording childcare and substandard housing (Gee, Nicholson, Osborne & Rhodes, 2003; Spencer & Grassley, 2012). Furthermore the mothers' intention to express breastmilk at work are based on the high levels of perceived pressure to conform with the socially expected behaviour set by their community members (Göksen, 2002).

Perceived Support from partners/husbands. Consistent in the literature is that perceived support for breastfeeding from a partner/husband of the working mother has been found to be a significant source of instrumental, informational and emotional support. The influence of the partner/husband on a working mother's decision to breastfeed and express breastmilk at work have been emphasized in research by Rempel and Rempel (2004). A mixed methods study with 230 first time mothers investigating factors influencing working mothers' decisions to exclusively breastfeed showed that their partner's opinion and emotional support was important in influencing their infant-feeding choice. Specifically, a majority of the mothers (n=183) "strongly agreed" or "agreed" that the reassurance and support received for EBF from their partners/husbands were significant to them. This finding was supported with a high positive response rate to a question asking whether the ability of the working mother to successfully combine employment and EBF depended on their social support network (Kong

& Lee, 2004). A number of studies conducted in the United States also found that the woman's partner/husband is a significant source of support for EBF. The authors concluded that EBF support from a working mother's partner/husband is a significant predictor of breastfeeding initiation and maintenance rates (Hill-Bonczyk, Avery, Savik, Potter & Duckett, 1993; Baranowski et al., 1993). A study on Mexican women also found a positive relationship between partner/husband support and EBF behaviours after returning to work (Earle, 2002). Specifically, the study found that women whose partners accepted and supported their decision to express breastmilk at work were two times more likely to exclusively breastfeed compared to women who did not receive this support (Earle, 2002). However it should be noted that studies within the South African context have emphasized the increased prevalence of female-headed households (Posel & Rogen, 2009). For example, based on an analysis of nationally representative data collected from the 2019 general household surveys ('GHS'), approximately 6.1 million or 37.9% of the households in South Africa were headed by women and female-headed households were most common in low-income communities. Furthermore 8.1 million or 41% of all children in South Africa live with their mothers but not with their fathers; only 16% of children in the poorest 20% of households live with both of their parents; and 44% of African children live with their mother but not with their father (Hall & Sambu, 2016). Therefore the perceived support from husbands/partners may have less of an influence than other community members on South African low-income mothers breastfeeding decisions after returning to work.

Perceived Support from Community Health Workers. Support from community health workers can also contribute to breastfeeding success or failure in working women. In an article by Kassier and Veldman (2013), on infant-feeding knowledge and the practices of working mothers in a township outside Bloemfontein, Free State province, it was revealed that the secondary network was a significant source of support for breastfeeding women, particularly when difficulties happen (Souza et al., 2016). In this sense, community health workers were a major source of infant-feeding information for working mothers and caregivers (Souza et al., 2016). South African research supports these findings. In two other studies conducted in the Mpumalanga province (van der Merwe, 2012), and in Kwa-Zulu Natal, the Eastern Cape and the Western Cape (Doherty, Chopra & Colvin, 2006) it was found that most mothers based their infant-feeding decisions information that they received from community healthcare workers. Similarly, Witters-Green (2003) found that community health workers made a significant contribution to the promotion of EBF through role modelling, recommendations and encouragement. They also found that community health care workers

who have insufficient knowledge about EBF, did not make an effort to provide mothers with information about EBF, and in some cases discouraged EBF. An interesting finding was that social relationships with and support from one's informal social network have been found to be much more crucial in influencing the behavior and attitude of low-income mothers in their decision to continue breastfeeding during employment, than support from community health workers such as doctors and nurses (especially for infants born without complications) (Johnston & Esposito, 2007; Zhao & Hu, 2016; Raffle et al., 2011; Asiodu et al., 2015). In a study conducted in Langa, a township located on the boarder of the Cape Town metropolis, Sibeko, Dhansay, Charlton, Johns and Gray-Donald (2005) found that consulting traditional healers during lactation is a common practice among women living within resource-poor settings and traditional healers are valued as providers of informational support. However, traditional healers usually did not support EBF in the way in which WHO defines it, because in most cases breastfeeding mothers would be advised to supplement their breastmilk with traditional preparations (muthi) (Sibeko et al., 2005).

Perceived Support from Feminine Figures. A key finding in a qualitative study examining infant feeding practices of women with children 0-6 months in Ghana was that the infant's grandmother as well as elderly women in the communities were often the primary decision-makers regarding infant feeding practices. These women often played a dominant role in infant-feeding decision making often deciding whether or not a mother should initiate breastfeeding as well as deciding on the timing of the introduction of food complements and supplementary foods. This pattern occurred because of their higher cultural and authority status within the household, community and the extended family system. As a result, mothers often hesitated to disobey the opinion of these older women regarding feeding decisions and would often carry out these decisions even when they contradicted recommendations made by community health workers (Awumbila, 2004). Similarly, Barona-Vilar, Escribá-Agüir and Ferrero-Gandía (2009) found that women from lower socio-cultural groups' decision to exclusively breastfeed was influenced to a major extent by the women in their family (e.g. mother-in-law, mother and sisters) and they used their friends/colleagues who have already had a baby as their models. The influence of feminine figures in supporting breastfeeding reinforces the idea that the female gender entitles women as trusted caregivers, given that they are almost always mothers, who have experience with maternity and breastfeeding (Souza et al., 2016).

Focus group data from a study conducted by Witters-Green (2003) cited that family members and friends who had previously EBF or expressed breastmilk at work had a positive

impact on the working mother's successful breastfeeding. Various other research studies support this finding. Data suggests that the visual experience of breastfeeding (i.e. being exposed to what female family members and friends have done), was a factor that influenced decisively the idea of carrying out breastfeeding (Barona-Vilar et al., 2009). Findings from a study carried out by Balogun, Dagvadorj, Anigo, Ota and Sasaki (2015) show that the feeding practices of female family members and friends influenced the mothers decision on whether to breastfeed exclusively or not. Furthermore, it was found that mothers whose friends expressed breastmilk at work were more likely to breastfeed their baby exclusively and express breastmilk at work (Balogun et al., 2015).

Perceived Support from Members of Community Faith Institutions. Spencer et al. (2014) argued that research on support from members of faith-based and religious institutions or communities is under developed. Worship services and faith institutions comprise of a community of people who hold common values and beliefs, and share a belief and trust in authority figures within their church (Spencer et al., 2014). A study conducted on low-income African American women revealed mothers that were members of a community faith institution described it as a place whereby they often received informal breastfeeding support (Spencer et al., 2014). The authors concluded that breastfeeding rates among low-income women would increase if the members of these community based faith institutions embraced and supported breastfeeding as a necessity in their communities.

The review of literature has highlighted that what the members of a working mother's social network think about EBF can strongly influence their willingness to breastfeed at work (Raffle et al., 2011). A perceived lack of support for EBF in a collective community setting can send a message that breastfeeding in the workplace is an unacceptable behavior and may discourage mothers from taking up breaks at work to express breastmilk (Raffle et al., 2011). A community that supports and embraces breastfeeding mothers can positively influence women to initiate and maintain EBF after returning to work (Raffle et al., 2011). Women's perceptions of community support and beliefs are thus crucial in comprehending infant-feeding patterns as well as the decision-making processes that occur for whether or not the mothers would carry on breastfeeding after returning to work (Bentley et al., 2003). Accordingly findings from this study can inform employers on workplace practices that are necessary for supporting breastfeeding at work, particularly in workplaces such as the factory setting where employees mainly reside in collective communities. Organisations that have an understanding of the community context when creating organisational policies and interventions will be better

able to establish the appropriate efforts required to accurately meet their employees' breastfeeding needs.

Chapter 3: Methods

Study Context

This study was carried out as part of a larger project to advance support for breastfeeding at work in Cape Town clothing factories. The project is supported by the Southern African Clothing and Textile Workers Union (SACTWU), which has more than 100 000 members and covers over 180 000 workers in South Africa. In this context women comprise 89% of this industry and are mostly black, poor, and in low skilled, low wage positions.

All of the participants in this study reside in the Cape Flats area which is a legacy of the apartheid's Group Areas Act of 1950. The Group Areas Act was passed by the Apartheid government on the 27th of April 1950. The act formed the legal framework that was used by the apartheid government to establish specific areas as 'group areas', where only individuals belonging to a particular race group were allowed to live (South African Institute for Race Relations, 1952). Located on the southeast of the central business district of Cape Town, the Cape Flats is made up of various townships and the majority of the Coloured and African population in Cape Town lives here. Most of the communities of the Cape Flats area remain poverty stricken and faced with serious social problems including high rates of unemployment and gang activity (Sampson, Morenoff, & Gannon-Rowley, 2002).

Research Paradigm and Design

The study used a qualitative approach located within the interpretivist paradigm. Interpretivism focuses on "understanding the social world that people have constructed and which they reproduce through their continuing activities" (Doldor, Silvester & Atewologun, 2017, p. 523). In other words, the aim of the interpretative paradigm is to make sense of how the world is understood, seen and experienced from the participants' point of view. The participants' interpretations are accepted, prioritized and focused on, instead of being used as a basis for analyzing something else (Braun & Clarke, 2013).

Aligning the qualitative study with the interpretative paradigm is appropriate because the interpretative paradigm allowed for a far greater comprehension of the meaning that low income female factory workers give to community support for breastfeeding in the workplace. Adopting this approach, the range of knowledge and understanding of this topic was significantly opened (Braun & Clarke, 2013). Using the interpretative theoretical framework also allowed me to explore the participants' perceptions of community support for EBF after returning to work which would often mean breastfeeding or expressing breastmilk in the

workplace, as well as to comprehend the meanings produced and reproduced by them in their everyday activities (Braun & Clarke, 2013). Furthermore context played a particularly important role in this study. As the researcher I did not have much control over the phenomenon in this study, because it occurred in a real-life context. An interpretative paradigm was fitting for this study as it allowed me to explore phenomena occurring in "natural settings". It also allowed me to comprehend the context within which the female factory workers live and the influence this context has on their breastfeeding decisions (Maxwell, 1998). Lastly the interpretative paradigm is also exploratory, flexible, organic and open-ended and can change to suit the needs of the research (e.g. it is adaptable to unforeseen ideas communicated by the participants). However, a criticism of this theoretical framework is the question of whether or not subjective truth truly exists (Braun & Clarke, 2013). Dealing with this subjectivity is addressed later in this chapter.

This study used an exploratory research design which is commonly used when the subject is not well understood as well as for the exploration of areas in which there is unfamiliarity and ambiguity about a subject (van Wyk, 2018). An exploratory design further sets out to distinguish the boundaries of the environment in which the opportunities, situations of interest and problems are likely to reside, and to recognize the salient factors found to be of significance to the research (van Wyk, 2018).

This design is suitable for this study, firstly because the area under study (low income working mother's perceptions of community support for EBF after returning to work) is relatively unknown, particularly within the field of organisational psychology. Secondly, because this study seeks to explore the perceptions of low-income female factory workers regarding their breastfeeding decisions in the workplace in order to gain accurate and complete information. Thirdly, the exploratory research design is suitable because the aim of my research question is to collect new data and determine whether there are interesting patterns in the data (Mouton, 1996). The data collected explained the phenomena from the point of view of the low income working mothers.

The present study made use of the case study research which is an empirical inquiry that explores a phenomenon within its real-life context. Case studies are based on an in-depth investigation of a single individual, group or event to explore the causes of underlying principles (Yin, 1994). In this study the case is black mothers who have recently has a baby and working at a clothing factory.

Case study research can be categorized by an epistemological research framework (Gomm, Hammersley, & Foster, 2000). The study is positioned within the post-positivism

paradigm within qualitative research (Creswell, 2007). The post-positivist paradigm approach is logical with components of reductionism. Post-positivism places significance on cause-and effect relationships and on collecting empirical information (Creswell, 2007). It also focuses on multiple perspectives instead of one single reality.

Data Collection

Primary qualitative data were collected for the study via face-to-face semi-structured interviews with the selected participants. Data were collected between July 2019 and September 2019. Appendix A details the guiding questions which were used in the interviews. To maintain the necessary consistency and structure in all the interviews I conducted, I used a pre-planned interview guide consisting of open-ended questions which allowed the participants to have an opportunity to share their experiences in their own words and to expand or provide more relevant information if they wanted to. However, given that I conducted semi-structured interviews, the structure of the interview guide did not influence the flow of the interviews but rather, the interviews was guided by the responses of the interviewees (Shneiderman & Plaisant, 2005). This allowed me to be flexible in the order that I asked the questions based on the interview with each participant as not all of the participants perceived the questions in the same way (Shneiderman & Plaisant, 2005). Additional probing questions were also asked in order to explore the participants' experiences and insights. Probing questions included: "Could you please explain more?" and "Could you please provide further examples?" This allowed for the participants to be able to provide context to their responses as well as to freely share their opinions (Shneiderman & Plaisant, 2005). Given the time constraints of the master's degree and that sampling was restricted to one clothing factory, interviews were suitable because not a large number of participants were required to gather rich data (Shneiderman & Plaisant, 2005).

Each participant gave their informed consent to participate in the study (see Appendix B for consent form); moreover each individual was told that their participation was voluntary and that confidentiality and anonymity would be maintained. Participants also completed a short demographic questionnaire (see Appendix A & C). As a token of appreciation for their time and participation, each participant was given a gift bag of biscuits at the end of the completed interview.

Sampling and Participants

Interview data were collected from twelve participants who worked at Company X, a textile factory based in an industrial area in the Cape Flats. A purposive sampling strategy was used. Purposive sampling (also known as judgement sampling) allows for the isolation of

specific participant characteristics that would facilitate in addressing the aim of the study. It is a non-random sampling technique that does not need underlying theories or a set number of participants. In other words, I as the researcher will decide on what needs to be known and I will set out to find participants who are able and willing to participate and communicate their experiences in an expressive and reflective manner (Etikan, Musa & Alkassim, 2016). Purposive sampling was therefore suitable for this study because I wanted to select participants based on the purpose of the study as per a criteria relevant to the research question. Participants were selected based on following criteria: low income female factory workers working within the clothing industry in the Cape Metro area who have had a baby within the past two years. The mothers needed to have had a child in the past two years in order to ensure that they were able to accurately recall their experiences (Sutton & Austin, 2015). No further selection criteria was used. Eight mothers were initially identified as meeting the criteria and I began interviews with these mothers. However, during the data collection and analysis phase, I realized that I needed to conduct more interviews and a further four interviews were conducted until I reached data saturation (no new information emerges with the addition of new participants) (Braun & Clark, 2013). In total twelve mothers participated in this study. The average age of the study participants was 30 years (ranging from 24 to 39 years). Of the twelve participants, only five completed their matric (grade 12) . All of the participants were employed full-time and they lived in the Cape Flats areas. At the time of the interview, the average age of their youngest child was 1 year 6 months (ranging from 11 months to 2 years). A summary of the demographic characteristics of each individual participant is provided in Table 3.

Table 3

Sample Demographic Characteristics (N = 12)

ID	01	02	03	04	05	06	07	08	09	10	11	12
Current position	machinist	Machinist	Machinist	Machinist	Machinist	Machinist	Loader	Machinist	Machinist	Machinist	Machinist	Machinist
Years in current position	2	12	5	10	8	4	Few months	2	5	10	3 years 9 months	4
Years working at company X	7	4	4	5	5	4	5	3	5	3	5	4
Hours worked per week	42	42	42	42	42	42	42	42	42	42	42	42
Number of children	2	2	3	4	2	1	2	1	2	2	2	3
Age of youngest child	2 years	11 months	1 year 9 months	2 years	1 years	21 months	2 years	1 year 1 month	1 years	1 year 6 months	1 year 8 months	1 years
Home language	English & Afrikaans	English & Afrikaans	English	Afrikaans	Afrikaans	Xhosa	Afrikaans	English & Afrikaans	English & Afrikaans	English & Afrikaans	English & Afrikaans	English & Afrikaans
Mode of transport	Bus	Car	Mini taxi private transport	Walk	Bus	Taxi	Car	Bus	Bus	Taxi and Train	Bus	Public
Commute time to work	1 hour	20min – 30min	1 hour	10 – 15min	1 hour	45 min	45 min	30 min	1 hour	1 hour	20 min	15 min
Age in years	27	32	29	39	29	29	31	24	32	30	30	27
Highest level of schooling	Grade 11	Grade 10	Grade 11	Grade 10	Grade 11	Grade 12	Grade 12	Grade 12	Grade 11	Grade 12	Grade 11	Grade 12

Procedure

Prior to conducting the research, I obtained ethical clearance from the Faculty of Commerce Ethics in Research Committee (REF: REC 2019/000/072) (see Appendix D). Furthermore, approval was received from Company X to interview their employees who have a had a baby in the past two years. The participants were asked to provide their consent to participate in the study (see Appendix B for consent form). The selected participants were told briefly about the outline of the interview procedure. The interviews were conducted with each participant for no longer than one hour, as there were time constraints because the employees were interviewed during their work schedules. Furthermore, I conducted all the interviews myself in order to ensure consistency in the process. With consent, the interviews were voice recorded. The interviews were set at a convenient time for the participants and they were held at Company X. The interview setting was informal to create a relaxed and trusting environment for the participants.

The interviews were conducted over three separate days over a period of three months according to the convenience of the factory HR manager. Each interview lasted between thirty minutes to an hour. Permission from each participant was obtained to record the interviews. I conducted all of the interviews.

Method of Data Analysis

Given, the exploratory nature of the research, the interview data were analysed employing inductive and deductive thematic analysis (i.e. codes and categories emerged from the data and they were also determined a priori by me as the researcher). The thematic analysis technique is a commonly used qualitative method for analyzing, examining and describing groups of patterns found within data (Braun & Clarke, 2006).

The six-step process as explained by Braun and Clarke (2006) was followed to analyse the data. Step one began with the transcription of all the recorded data from the interviews and reading these a number of times in order to familiarize myself with the data. I used the services of a transcribing company to transcribe the recorded interviews verbatim in order to ensure complete documentation and authenticity of the information. I then read each of the interview transcripts and wrote a short summary of the important concepts and statements that I identified within the data. I then followed this step with developing an initial coding scheme of the main themes. This coding scheme was used to consistently code all of the interview transcripts and the data was arranged into manageable units according to the relevant code. Some of the initial

codes generated included: *Advice from family, friends and community members; Stress is bad for the baby; Expressed milk is dirty milk; The baby is hungry;* and *Contradicting advice – elders know best*. All of the data was managed, coded and sorted manually using tables on an excel spreadsheet. Next the codes were organized into potential themes to identify the working mothers' experiences relevant to the study. Examples of some of the initial themes were: *Perceived constraints to EBF; Women's readiness to breastfeed;* and *Cultural influences to breastfeeding.* The data collection and analysis processes were conducted simultaneously so that as new codes and themes emerged in the interviews, they could be explored in-depth in the remaining interviews. The fourth step involved reviewing and refining the themes, considering its appropriate categorisations and its relevance. I reviewed the initial themes with my supervisor and we amended them so that they would more accurately describe the participants experiences. After the revisions were made, three themes were generated: *A focus on informational support; The shared community responsibility of raising babies makes exclusive breastfeeding after returning to work harder; and It's fine for stay at home mothers to breastfeed but not for working mothers.* All the organized extracts for each theme were read and then considered whether they appeared to form a logical pattern. Next, each theme was refined to reflect the overall story depicted by the analysis. Finally, a report was compiled through the final write-up of the findings and discussion (Chapter 4).

The benefit of employing a thematic analysis technique is its "theoretically-flexible approach" (Braun & Clarke, 2006, p.2). It enabled me to analyse and explore all the data collected for recurring patterns as well as to identify three main themes and sub-themes. I also took into account the women's demographic information (see table 3) when reflecting on the differences in their experiences. The demographic data were analysed in order to determine additional insights such as 'highest level of schooling' as a potential influencing factor.

Braun and Clarke (2006) suggested that it is good practice to be clear at the beginning of the study about the theoretical framework in which the analysis was conducted. Various theoretical frameworks have several assumptions about the nature of "reality". However thematic analysis is not associated with a specific theoretical framework thus it can be used within numerous theoretical frameworks. The current analysis was conducted in a realist/essentialist framework and the themes were identified at the semantic level (i.e. within the explicit or surface meaning of the data) (Braun & Clarke, 2006).

Ethical considerations

I adhered to the American Psychological Association (APA) ethical research guidelines for conducting research with human participants' throughout the study. Written informed

consent forms were signed by the willing participants after they had been verbally informed of the purpose of the research. I explained to the participants that the study posed no direct harm or threat and that no data would be used without their consent. I also briefed consenting participants on the interview procedure and types of questions asked. Lastly, I informed the participants that their participation in the study was voluntary and that should they want to opt out of the study, they may do so at any time. Confidentiality was ensured by using pseudonyms to protect the participant's identity.

Research rigour

Trustworthiness is a way of making sure that data produced in a qualitative research study is of good quality. In order to ensure trustworthiness, I used a model of trustworthiness, developed by Guba and Lincoln (1981), which identifies the significance of credibility, transferability, dependability and conformability.

Credibility. Credibility is the degree to which the data and data analyses are believable and trustworthy (Guba & Lincoln, 1981). The descriptions and interpretations of this study's participants' experiences were presented in such a way that the reader will be able to judge the credibility of the study based on their understanding of it.

To promote overall data credibility, the initial four in-depth interviews were conducted with the help of my supervisor. My supervisor has extensive experience and knowledge on the topic of breastfeeding in the workplace. This knowledge allowed her to assist me in probing for more detail within the context of each interview. Additionally, my supervisor possessed the necessary communication skills required to quickly establish rapport, engage with the factory workers who took part of the study and to build trust; an essential set of skills that are necessary for obtaining a depth of data for the study.

Given that this study was located within the interpretivist paradigm, this meant that there was no objective reality or truth to which the findings of the study could be compared because understanding was co-created. Member checks into the findings of the study have been considered as "the most critical technique for establishing credibility" (Guba & Lincoln, 1981). I kept field notes during the interviews in order to take note of the key ideas or themes that emerged from the mothers' descriptions of their breastfeeding experiences. Therefore, as an

initial member checking strategy to check my interpretations of the data obtained during the interviews, I paraphrased responses and reflected them back to the participants to confirm.

Transferability. Guba and Lincoln (1981) defined transferability as the ability to apply the findings of a research study to other contexts outside the actual study context. In order to enhance the transferability of my study I provided detailed descriptions of all the information that formed a basis for my study in the methods chapter which consisted of the context of the study, the research method that was employed as well as the underlying assumptions of the study so that others who want to apply the findings of this study in their context will be able to do so (Seale, 1999).

Dependability. Within qualitative research, dependability refers to the stability of the data collected over a period of time (Guba & Lincoln, 1981). Specifically, the dependability of a study refers to the provision of evidence showing that if my study were to be conducted again in the same or similar context on of the same or similar participants, the findings would be similar. In order to ensure dependability for my study, I maintained a clear decision or audit trail which can be used by another researcher to follow the research process employed as well as to have an understanding of the decisions made with regards to the process of data collection, data analysis and how the data was interpreted (Koch, 2006).

Another way in which I ensured dependability for my study was by probing the participants during the interviews in a way that didn't alter the meaning of the question. The written synthesis of the concepts were also shared with my supervisor who has content expertise in the topic of breastfeeding in the workplace for the purpose of conducting an audit of the themes in order to promote overall data dependability.

Confirmability. Guba and Lincoln (1981) described confirmability as the degree to which the findings of a study can be corroborated or verified by others. According to Seale (1999), auditing can be used in order to establish confirmability of the findings. The auditor of this study needs to be able to determine whether the findings of a research study are shaped by the participant's narratives as opposed to the researcher's biases or perceptions (Guba & Lincoln, 1981). In order to establish confirmability of the research study's findings, I used the reflexivity technique (discussed below). I recorded my views on the interview process in a journal as a way to reflect on possible researcher biases as well as to interpret my own behaviour when conducting the interviews in relation to the participants (Guba & Lincoln,

1981). This allowed me to maintain an appropriate distance between the participants and myself (as the researcher) in order to avoid influencing research (Koch, 2006).

Reflexivity. Within qualitative research, reflexivity refers to the personal beliefs and background of the researcher (Snape & Spencer, 2003). Reflexivity is a technique that is concerned with the "analytic attention to the researcher's role in qualitative research" (Gouldner, 1971, p. 16) and it recognizes the significance of objectivity to minimize the influence of potential biases in the study. Reflexivity is a constant process of reflection by the researcher of recognizing, understanding and examining how their "social background, location and assumptions affect their research practice" (Hesse-Biber & Leavy, 2007, p. 17).

During the first few interviews, it became apparent that I was nervous. My lack of experience in conducting interviews was a limitation. I realized that during the interviews I felt the need to take control of the interview instead of engaging in it as an equal. I found myself wanting to perfect each interview that I conducted and me perfecting an interview meant that I needed to follow the "checklist list" of a good interview based on my learnings, from literature and class, on research methods. There were times during the interviews where my perceived lack of control left me feeling overwhelmed and vulnerable and as though I was not in control of the interview. For example, initially initially struggled to keep note of what the participants were saying in order to avoid asking the participant a question about something that they had already mentioned. For example, when I asked a participant a question about something that they had already spoken about they would generally begin their response with "as I said…". I started to comprehend how tough it is to place theory into practice i.e. how difficult it was to take note of what the participants were saying whilst also navigating my interview guide.

Secondly, it is well-established that semi-structured interviews depend on the rapport that is built between the interviewee and the interviewer (Willig, 2008). Although rapport was established in the beginning of each of the interviews, there were times when it was abruptly disrupted when my role as the researcher became apparent. This occurred when I needed to begin recording the interviews as well as when I was making notes during the interviews therefore making the interviewees aware that they are being interviewed. Recording the interviews could have also affected the interviews as well as how the participants responded to the interview questions. It may have influenced their ability to speak openly and freely because the participant may have not been completely comfortable to share their experiences knowing that they are being recorded. Accordingly, I double checked with each participant before I began recording and every participant agreed that it was fine.

Chapter 4: Findings and Discussion

This section presents the combined findings, based on my interpretation of the data, and the discussion of the findings in line with existing theory and literature. For the purposes of confidentiality and anonymity, the participants' names were replaced by their interview number (M1-M12). Quotations that best described each theme were selected from the transcript and the source is indicated after each quotation. Based on the semi-structured interviews, three major themes emerged: *A focus on informational support but not much else; The shared community responsibility of raising babies makes exclusive breastfeeding after returning to work harder; and It's fine for stay at home mothers to breastfeed but not for working mothers.* The study's findings may help to provide insight into the current perceptions of community support for EBF after returning to work and what may be further needed to improve EBF rates among low income working women.

Theme 1: A focus on informational support for exclusive breastfeeding but not much else

The first theme explores the mothers' perceptions of the type of community support received for maintaining EBF and hence continuing to breastfeed after returning to work. Most of the mothers described having received informational support from members of their communities, including nurses from their community clinics, family members such as aunts, siblings, mothers, mothers-in-law, friends as well as older women in their communities. However, there seemed to be an absence of emotional, instrumental and appraisal support for these working mothers to continue to exclusively breastfeed after returning to work.

The mothers perceived the nurses from the community clinics as the main providers of informational support. Nurses from the community clinics typically advised mothers to maintain EBF by direct feeding when they are with their baby, and expressing breastmilk when they are away from their baby. They gave mothers information on how to express the breast milk in the workplace, how to store their breastmilk supplies and how to prepare the expressed breastmilk before feeding their baby. When describing the type of informational support received from the nurses at the community clinics, one participant said:

> "I got advice from the clinic about expressing milk at the work… They just told us what to do and how to keep your baby while you are breastfeeding and things like that… they told us that we can express, put it in a container and you can put it in the fridge or freezer. If it is a lot you can put it in the freezer, so the time that she maybe wants it or whatever then you can take it out and leave it on the table so that they can dissolve. Then you can pour it and give it to her." – M5

Furthermore, one mother reflected on how the nurses made mothers aware of the immunological and nutritional values of breastmilk:

> "The nurses at the clinic told me that breastfeeding is the best way because it is very healthy your child don't get sick. There's no germs, because if you use the bottle or anything there's germs that the children pick up, they get sick… So with the breast the baby grows well, the brains grows well as well. Like all the vitamins and minerals and calcium that help with the bones and the teeth they are in the breastmilk. The vitamin E also, for the skin. Everything the milk is there for everything. " – M4

The participants described the nurses from community clinics as giving them correct and consistent information, suggestions and advice about breastfeeding and expressing breastmilk after returning to work. Informational support received from nurses supported the perception that breastfeeding is important and that it should be done even after the mother returned to work after maternity leave. This finding on the key role of nurses in providing working mothers with information about and support for EBF was substantiated by several African studies that explored the role of community health workers in EBF promotion (Setegn, Gerbaba & Belachew, 2011; Tawiah-Agyemang, Kirkwood, Edmond, Bazzano & Hill, 2008; Otoo et al., 2009; Asfaw, Argaw & Kefene, 2015; Agunbiade & Ogunleye, 2012; Joseph & Earland, 2019). Furthermore, researchers consistently identified informational support as an important source of support when assisting working mothers with making breastfeeding decisions (Hall Moran, 2007; Wambacj & Cohen, 2009).

In addition to the informational support from nurses about EBF, many participants cited that members of their community, especially older mothers, also encouraged them to breastfeed because of the benefits of breastfeeding when compared to formula feeding. However, this informational support was limited to during the mother's maternity leave and not once the mother had returned to work. By far the most common benefit spoken about was that breastfed infants were healthier than formula fed infants:

> "I know of a child that was on formula since day one and that child is so fat, and her chest is starting to weaze and they are actually putting her on a diet. So

> they [community members] always tell me that formula is not as healthy as breastmilk, children get way too sick easily." – M11

> "…my mother always tells me that children that's on formula gets much more sicker than the children that's breastfeeding, because the bottle's full of germs…you get germs so quickly on a bottle even though you sterilize the bottle, you get that germ, but the breastfeeding it's more healthier than the formula." – M10

One of the mothers shared that she had strong intentions to breastfeed her child because older women and other mothers in the community told her that it is the healthiest food for infants and that it was important for the baby's health outcomes and development. It seems that younger mothers tend to rely on the informational support of experienced mothers in the community, and may even obey these community members' instructions out of respect for them being senior or more experienced, which is a typical value endorsed in collective communities:

> "I wanted to do it because I was told that it is good for the health of the child. When you are giving her breastmilk at that age from 0–6 months, breastmilk is good." – M3

Not only were these community members providing informational support on the health benefits for the child to continue receiving breastmilk, but they also shared information based on common beliefs on the "medicinal" uses of breastmilk.:

> "If the child's eyes is like closed and has pus, they [community members] always tell me that you can use the breast milk with a cotton wool to wipe that away. And you can put it in the baby's eye. Babies nose is blocked you can also use the breast milk; if there is something wrong with the ears you can also use the breast milk; you can apply the milk on the skin when they have rashes the dry skin when they're born and yeah. Breast milk is the antibiotic of everything." – M8

The above extracts show that the mothers tended to listen to elder members of their community that they deemed as having more child rearing experience and as being senior. The mothers' motivation for their breastfeeding decisions was based on satisfying others which can be deduced from the fact that one of the mothers said "I wanted to because I was told..". In other words the mother was expected to be obedient and conform to decisions made by elders and she wasn't able to oppose their advice. In addition, when asked who within their community social network had the greatest influence on their breastfeeding practices after returning to work, the mothers identified family members including aunts, sisters, mothers and mothers-in-law, their female friends and specifically older women in their communities. Similar results were also found in national and international studies on the theme of social support for breastfeeding working mothers, evidencing the importance of community support, especially in the early stages of breastfeeding. These studies point to the fact that for working mothers to successfully breastfeed after returning back to work, it is not enough to just choose to practice it, they must be part of a social context that helps them to take this decision forward (Souza et al., 2016). Furthermore there is a predominance of feminine figures in these women's lives. The influence of feminine figures in supporting breastfeeding reinforces the idea that the female gender entitles women as trusted caregivers and as sources of support, given that they are almost always mothers, who have experience with maternity and breastfeeding (Souza et al., 2016). This is consistent with previous findings showing that, women from lower socio-economic and socio-cultural groups recognise that their choice to exclusively breastfeed is largely influenced by the women in their communities (e.g. members of their church, older women within their community) and families (e.g. mother-in law, mother, sisters) and they used peers as their models (friends who had already had a baby) (Baranowski et al., 1983; Hoddinott & Pill, 1999; Barona-Vilar et al., 2009).

Furthermore, informational support provided by community members on why mothers should continue breastfeeding, was that it was cheaper than formula feeding. One of the participants mentioned that mothers within her community breastfed out of economic necessity. As low-income workers, these mothers' budgets are usually tight, and it is often the case that they are the only income earner in an extended family, therefore they usually cannot afford to buy formula for their babies:

> "Where I live it's breastfeeding because it's cheaper and there's no money to buy formula because it's expensive. This is the milk, the water everything is in here, so you don't have to go take your money and go buy formula you

> understand… Formula is too expensive and for me that's working in a clothing factory and also at the time my husband was unemployed. I needed to consider a lot of things. I have two other kids and the money for the formula say I spent four hundred almost five hundred rand per month on the formula it's too much" – M10

Consistent with other studies, the findings above show that the mothers perceived breastfeeding as being supported and encouraged by their community members, however the form of the support received was primarily informational. Specifically, information on infant health and growth benefits as well as economic benefits associated with breastfeeding were the most common information shared by community members with mothers of young babies, which is consistent with existing literature (Sibeko et al., 2005; Ergenekon-Ozelci, Elmaci, Ertem & Saka, 2006; Souza et al., 2016; Barik & Paul, 2018). However, it should be noted that while breastfeeding was encouraged within their communities, the mothers made no mention about informational support provided specifically for EBF by family members, friends as well as older women in their communities. This can potentially be explained by the lower levels of education of community members in these low income contexts. Literature also shows that the concept of EBF in the South African low income context is not well understood (Goosen, McLachlan & Schübl, 2014).

The absence of instrumental, emotional and appraisal support for these working mothers to continue to EBF, especially after returning to work, was starkly visible when analysing the data. This was surprising as the participants mainly reside in collective communities which are generally characterized as providers of high levels of all the functions of social support (Goodwin & Hernandez Plaza, 2000). Literature shows that informational support alone isn't enough (Cobb, 1976). Instrumental, emotional and appraisal support are also important in order to maintain EBF after returning to work, especially instrumental support behaviours (Nelson & Sethi, 2005; Wambach & Cohen, 2009). This is because working mothers may need to be provided with tangible and practical assistance, especially when returning to work, such as community members helping the mothers with feeding their infants expressed breastmilk while they are at work.

Emotional support and esteem (appraisal) support were also identified as essential to facilitating working mother's breastfeeding experiences. The lack of emotional support and esteem (appraisal) support can possibly be attributed to the fact that the communities within which the participants reside are characterized by high levels of crime and gang-related

violence, limited resources and poor housing, all of which are associated with adverse mental health outcomes (Heflin & Iceland, 2009). Therefore the main focus of the participants' community members may tend to be on survival and so they may not have the capacity to provide emotional and esteem (appraisal) support. Mothers who experience problems with continuing with breastfeeding after returning to work may benefit from having someone to take the time to listen to their concerns as well as from receiving empathetic acknowledgement of the complexity of breastfeeding, particularly with transitioning into their new roles as a mother and an employee (Dykes, Moran, Burt & Edwards, 2003; Hunter, 2008; Wambach & Cohen, 2009; Spear, 2006; Wambach & Koehn, 2004). Furthermore, working mothers need to feel cared for by their community members (Dykes et al., 2003; Feldman-Winter & Shaikh, 2007). Hearing verbal praise from community members is crucial to increasing working mothers' breastfeeding confidence to continue after returning to work (Mossman et al, 2008). Esteem support can build breastfeeding confidence through empowerment and affirmation and through accepting the mother's role as a mother and as an employee and verifying her independence (Hall Moran, 2007). In other words, a working mother's intention to continue breastfeeding upon return to work will be sustained if she perceives it as being respected and supported by others within her community.

The high degree of knowledge and awareness, derived from members of the women's social networks, about the benefits of breastfeeding as well as their perception of community support for breastfeeding after returning to work influenced the women's intention to breastfeed. There seems like there is a community norm for mothers to plan to breastfeed and almost all of the women started with the intention to breastfeed (even after returning to work) stating that they were encouraged to do so because it was best or healthy for the baby. However, their intention did not match their actual practice. All of the mothers-initiated breastfeeding at the beginning of the maternity leave, but the continuing breastfeeding rate rapidly decreased after returning to work. After returning to work, of the twelve mothers, only three mothers exclusively breastfed, seven practiced mixed feeding and two mothers formula fed their babies.

Theme 2: The shared community responsibility of raising babies makes EBF after returning to work harder

The second theme explores the lack of autonomy that these low-income mothers have when it comes to making breastfeeding decisions once they have returned to work and their child is in the care of other community members. In the low-income Cape Flats community context, many people from the mothers' communities (such as family members and

neighbours) are involved in raising their children. Often these individuals (usually older women) choose feeding practices that do not support EBF as these caregivers often feel that they "know better" as they had raised their own children.

The participants all came from communities in which kinship, family, and community were perceived as extremely important. The mothers emphasized that within their communities, there is a dependence on other individuals within one's social network when raising a child:

> "Like you are one child you live in a circle or street. Everybody's child is everybodies', my child is your child to put it that way. So, as you grow up you see things, sometimes it is not important but as you grow it comes to you again... Everybody is your teacher." – M8

Often it is difficult for the mothers to continue EBF after returning to work, because of this shared responsibility, which means anyone can decide how to feed their baby. The mothers did not feel that they received strong support from community members for EBF after returning to work, because of deeply rooted generational beliefs. Mothers mostly felt that community members who were helping to look after their babies believed that breastmilk alone was not enough to satisfy the baby's hunger. These community members, in particular the infants' grandmothers and older women within the community, were not able to differentiate hunger from other reasons for crying and they believed that a crying infant was unsatisfied and needed formula milk or food to satisfy its hunger. While breastfeeding was generally understood and accepted as the default feeding option for infants under six months old within these mothers' communities, solids were introduced early in the babies' diets to supplement the breastmilk on the advice of women in the mothers' communities who helped with raising their infant. Mothers often referred to these community women as "they", indicating that several people were responsible for raising an infant in such communities:

"At a month old then they [community members] fed the child porridge. They say one teaspoon of porridge because the babies are born hungry, they say, especially when they cry, they say" – M3

Two other mothers concurred:

> "They [community members] always tell me you must give her porridge because the baby is hungry because it is crying. And before she eats, you give her a little bit of breast then you give her whatever you are giving her. After she is finished you give her another little breast milk" – M5

> "…they [community members] give food, porridge, rice cereal, yogurt, yes lots of people from the age of two months because they say that the breastmilk is not strong enough so the baby is going to get hungry and it will not grow up… Everybody - family members, friends, was encouraging me, like in the community, if you [take a] walk they ask is the baby eating and drinking this. Then they would say put them on this, put them on that…they were giving their babies home foods like the butternut from the pot, potato, nice veggies you cook by yourself from two months" – M11

Many people in the mother's lives gave them different ideas of what is the best way to feed their child, which contradicts the information that they were given by the nurses from the community clinics (see theme 1). Specifically, the perception of breast milk insufficiency is a common reason why mothers are encouraged to supplement their breastmilk with other feeds such as formula or solid foods. Findings by Fjeld et al (2008) resonate with the above extracts in the way the mothers' community members were seemingly not able to differentiate hunger from other reasons for crying. In another study conducted in South Africa, the participants stated that an infant crying signalled that it was still hungry. Furthermore, the participants reported that when they were advised by their own mother to mixed feed, not only did the infant stop crying but they slept better and they were happier (Mazaleni & Bamford, 2010). As low income mothers need to return to work early (before the end of their maternity leave) out of economic necessity, they often have to rely on community members to care for their babies. This together with a collective orientation of respecting elders, often means that the mothers have no say in what the baby is fed when they are at work. Hence despite the participants stating that (1) they understood the information given to them by the community health workers at the clinic on optional EBF practices, and (2) they intended to continue breastfeeding their children after returning to work, it just was not practical. This is because maternal grandmothers (of infants), elder women in the mothers' community and elder relatives remained key in advising the mother on the best feeding practices or in helping to feed the infant while the mother was at work. Some participants described feeling a great deal of

pressure to practise mixed feeding when instructed to do so by family members, feeling that they had no say:

> "The clinic is there for a reason. They have been trained and they learn for that so they know what's best for the child … with my first child I had to go back to work. Then they [community members] just… gave her that stuff, and I didn't agree with it, but they was, now say, I'm a child I don't know what I'm talking about" - M3

Again it is likely that because of the collective values and respect for senior community members, older women's views tended to influence the participants' infant feeding practices even when they contradicted with the participant's wishes, as illustrated in the above extract. This finding is consistent with the results of other studies (McLorg & Bryant, 1989; Dusdieker, Booth, Seals & Ekwo, 1985; Guigliani, Caiaffa, Vogelhut, Witter & Perman, 1994; Barona-Vilar et al., 2009; McInnes & Chambers, 2008; Choo & Ryan, 2015). For example, Barona-Vilar et al (2009) found that, the value that working mothers gave to their own mothers opinions about EBF decreased as socio-cultural status increased, and the opposite trend was observed for community health workers. Women from higher socio-cultural backgrounds, often found it essential to follow infant feeding advice from health professionals as they often perceived health professionals as being possessors of a more trustworthy scientific knowledge. Similar findings were reported in a qualitative paper by McInnes and Chambers (2008). It was concluded that low-income mothers may consider social support and infant feeding advice from friends and family members to be more valuable than support from community health workers. However, consistent with the findings in this study, social support may exert a negative influence if there is a lack of breastfeeding knowledge or experience within the social group, particularly given that this context is of low income women with lower educational levels.

Furthermore the tension that the mothers faced due to the opposing messages about how to feed their infants meant that the participants changed their intentions to EBF after returning to work in response to family pressure and beliefs. This can be as a result of the mothers having a high family hierarchy orientation which refers to the notion that "power and responsibility are naturally unequally distributed throughout society [and those] higher in the hierarchy have power over and responsibility for those lower in the hierarchy" (Maznevski et

al., 2002, p. 277). Hierarchy orientation is related to Hofstede's (2001) power distance and equality hierarchy culture dimension (Trompenaars & Hampden-Turner, 1997). In this case hierarchy orientation can be used to explain how individuals form and perceive relationships with authority figures (elders within their community) (Maznevski et al., 2002). Particularly, despite having knowledge about EBF (information from community health workers), the mothers still sought advice from elder members of their community prior to making important infant-feeding decisions, and they were expected to be obedient and conform to decisions made by elders and they were not able to go against their advice. Researchers such as Goosen et al. (2016) and Fjeld et al. (2008) have emphasized that in spite of good intentions, mothers might decide to stick to the advice of their elders so as to avoid disappointing them or to respect them. Furthermore, mothers are more inclined to stick to their own mothers' advice given that they themselves were living proof of their mothers' ability to raise children (Buskens, Jaffe & Mkhatshwa, 2007; Fjeld et al., 2008).

Theme 3: It's fine for stay at home mothers to breastfeed but not for working mothers

Working mothers have to grapple with the conflicting demands of employment and motherhood. Lack of support from community members for breastfeeding after returning to work presents a challenge for these mothers, and thus many working mothers either don't initiate breastfeeding or stop before returning to work. A working mother may not perceive members of her community as being supportive of breastfeeding owing to the attitudes that community members hold towards working mothers who exclusively breastfeed. This lack of community support poses as a challenge faced by these employed mothers who want to continue breastfeeding by expressing their milk in the workplace.

Within this theme, three sub-themes were identified (a) Breastfed babies are nagging; (b) Expressed breastmilk is dirty; (c) Stress and fatigued milk is of poor quality

Breastfed babies are nagging. Returning to work after the maternity leave was frequently reported to be a major barrier to EBF by the mothers in the study. The mothers explained that although breastfeeding was seen as the feeding norm and supported by members in their community, this usually applied to stay at home mothers who did not participate in paid work. One of the participants explained that working mothers were often encouraged by community members to give their babies formula as early as possible for various reasons. It was believed that the mother could be independent and return to work and that it was easier for the caregivers of the child to feed the baby formula milk because the caregivers had expressed their reluctance to look after a breastfed child saying they are too attached to their mothers, too naughty, or too difficult:

> "…during the pregnancy my mommy would tell me that listen, you got to think about when you go to work. You're not going to make my job difficult because I'm going to look after the baby…she would tell me like I'm going to look after her so you must put on a bottle even though you will come from work and breastfeed her but she must drink a bottle… Yeah because some people believe that breastfeeding babies are very like nagging and they cry a lot" – M9

The above extract shows that the community members where not supportive of working mothers breastfeeding because they are reluctant to look after breastfed babies. This finding is well supported by research conducted by Sibeko et al. (2005). Members of the mothers' community often discouraged and did not support working mothers who breastfed. Most of their caregivers discouraged them from exclusively breastfeeding because it was believed that breastfed babies are clingy, harder to soothe and have more challenging temperaments in comparison to formula fed babies (Sibeko et al., 2005). Furthermore, because of the nature of the mothers' job (i.e. limited breaks, flexibility, and autonomy) and the long commutes that they make to and from work, they would not be able to travel back home to feed their infants during their breaks (Cardenas & Major, 2005).

"Expressed breastmilk is dirty". Mothers shared that further community beliefs that affected support for EBF was that working mothers should not express breastmilk at work because of the belief that breastmilk expressed in the workplace was "dirty" as shown in the following extracts:

> "The older women in my community think that it is bad, they say the milk will turn sour…My mother don't like me feeding the baby expressed milk because she says that it is dirty and it is not safe for the baby…so I stopped" – M5

> "When I came back to work from maternity leave my mom told me that when my breast is full I must go to the toilet and take it out and flush it but I must not keep it for my baby because it's dirty and there's a lot of germs" – M9

Mothers wanting to continue breastfeeding after returning to work faced behaviour-based work-family conflicts (Greenhaus & Beutell's, 1985). This is because for these mothers, combining employment and breastfeeding meant that features of their role as a breastfeeding mother must be performed in the workplace. In agreement with a qualitative analysis conducted by Osman et al. (2009) there were concerns raised by community members related to expressing milk at work. This is because the mother's workplaces were not seen as suitable places for the mothers to express their breastmilk. The workplaces were believed to have lacked adequate facilities to express milk while at work, as most mothers could only express their milk for their child in a toilet, highlighting a lack of workplace facilities and support. A perception among community members is that milk expressed at work was bad, because it was usually expressed in unhygienic conditions, and should not be given to the infant. Bad milk could be milk that could potentially harm the baby (Osman et al., 2009). The belief that the mothers can harm their infants through her breast milk can be an important source of distress for the mothers thus explaining why many of the mothers abandoned EBF after returning to work. Research has shown that mothers who face conflict between employment and breastfeeding are more likely to cease breastfeeding prematurely (Osman et al., 2009).

Stressed and fatigued milk is of poor quality. Some of the mothers stated that within their communities expressing breastmilk at work was not supported due to the belief that stress turns the breastmilk sour and that this stress can be transferred to the baby. This finding was captured by the following extracts:

> "When I started working, I work under pressure, then the pressure was there and that's the time when I skip to the formula…I was told by my grandmother and the older women in my community that I could only breastfeed at night when I come from work but I had to take out [express] the tired milk first and then I give it to her because there is a lot of stress during the day at work and this stress can harm your baby as well. So that is why I just press it out, press it out like a lot first and then I put her on the breast" – M12

Furthermore another mother said that it was believed within their communities that when the baby is fed "stressed" milk, it would cause the baby to be sick, particularly to have an upset stomach.

> "…say for instance you are stressing now you need to express that out before you breastfeed your child again. You should express that milk, wait a while and then feed your baby because that milk they say it will turn sour and that can make the baby's stomach unpleasant also." – M8

In the study context, stress may be evoked by the nature of the mothers' occupation as factory workers as well as characteristics of their work environment i.e. job stress. Job stress is a condition wherein job-related factors interact with the worker to change their physiological and psychological condition such that the person digresses from their normal functioning (Beehr & Newman, 1978). Conditions most frequently identified as producing stress for low income factory workers are task demands (i.e. work overload or an underload); adverse physical conditions of a job (e.g. noise, physical exertion, poor illumination, heat); time pressures; low career prospects and the occupation's hierarchical level; low extrinsic rewards received; lack of intrinsic job qualities (e.g. opportunities provided by the job for self-utilization, self-development, autonomy and value expression); role demands (i.e. role ambiguity and role conflict); and job insecurity (Shankar & Famuyiwa, 1991). Given that the job of a factory worker is inherently stressful, much of the mothers shared that their jobs often made them feel stressed and so they would be encouraged to express this "stressed" breastmilk manually and discard it. This perceived lack of community support resulted in the women opting to rather choosing to use mixed feeding methods, so that they did not need to express milk at work.

Furthermore, this finding was also observed by Sibeko et al. (2005). They found that mothers discarded their breastmilk prior to each breastfeed after returning back home from work because they were told, usually by a family members, that culturally they must discard their breastmilk if they have been exposed to stresses at work as a means of ridding their milk of stress. Similarly, in Nigeria it is believed that mothers experiencing negative emotions at work should discard their breastmilk in the attempts to avoid harming the infant (Ergenekon-Ozelci et al., 2006). Gill, Reifsnider, Mann, Villareal and Tinkle (2004) found that low-income Mexican Americans believed that working mothers should avoid being stressed while breastfeeding because the stress would be transferred to the baby and it dries up breastmilk. Women who perceived their work to be stressful would be encouraged to choose to formula-feed (Gill et al., 2004).

Lastly, mothers were not only discouraged from expressing breastmilk at work due to the belief that expressed milk is dirty and that a working woman generally produces "stressed"

milk. One of the mothers also reported that people in their community did not support working mothers breastfeeding decisions because they believed that it would be inappropriate to feed the baby breastmilk immediately after returning home from work because a baby cannot drink "tired" milk:

> "Like my mother-in-law always tell me when I came from work and I may be tired but he still needs to drink maybe he's thirsty and now I rush home, I get home on time and she will tell me no you first need to sit down and relax he must wait until you calm and then he can drink… Because she will always tell me he can't drink tired milk." – M12

Mothers were encouraged to squeeze their breast to get rid of this milk that had stayed in the breast while they were at work as it was believed in their community that it had stayed in the breasts for too long, therefore it was "stale and dirty". In this case all of the mothers are full-time employees working for 42 hours per week and take on average 42 minutes to travel to and from work, mostly using public transport, therefore most of the time these mothers are physically and mentally exhausted from each day of work. Ergenekon-Ozelci et al (2006) found that mothers explained why they stopped breastfeeding because they worked for a very long time in the sun. They believed that if a breastfeeding mother works under the sun and gets tired, her milk is called 'warm milk' or 'fatigue milk'. 'Fatigue milk' is also believed to be harmful for the baby. Furthermore, milk which is believed to have been "sitting" for too long in the breast will become stale (Ergenekon-Ozelci et al., 2006; Sibeko et al., 2005). These findings of the perceived lack of community support for breastfeeding after returning to work suggest that employment interferes with the mother's ability to continue to exclusively breastfeed. The working mothers who face employment related barriers to breastfeeding are, fundamentally faced with a conflict between their family and work roles and this conflict results in reduced breastfeeding durations amongst working women (Cardenas & Major, 2005).

Research Implications

The findings of this study have implications for theory. The utilization of the social support theory provided a theoretical framework for comprehending the specific challenges encountered by low-income women when it comes to combining employment and breastfeeding. The framework also specified additional potential conflicts associated with a working mother's perceived community support that may aid in explaining why some working mothers don't initiate, or prematurely cease breastfeeding, even with the knowledge of the

health benefits associated with breastfeeding. While most research on maintaining EBF has been located in the health sciences research domain (Rollins et al., 2016), this social science perspective, using social support theory, helps to gain a more nuanced understanding of the complexities in supporting low income mothers to continue breastfeeding after returning to work.

Practical implications

The findings of this study help to show that workplace policies, practices, or interventions developed without considering the particular community context of the workers for whom it is designed, could fail. These findings suggest that community views can influence the mothers decisions to breastfeed as a working mothers, especially when the working women reside in low resourced and collective communities such as the Cape Flats, or other township areas in South Africa. Organisations that understand the community context of their employees when constructing organisational policies, practices, and interventions will be better able to identify appropriate efforts that will aid in meeting the employee's needs more accurately. From the findings of this study, employers of low income factory workers can educate all employees (not such mothers of infants) about the WHO goals and benefits of six months EBF, by providing back to work education with health professionals; and incorporating ongoing education through educational materials that mothers can share with their community members (Haviland, James, Killman & Tribovich, 2015), as maternal education has been reported to be among the strongest predictors of breastfeeding duration (Ryan et al., 2002). By offering seminars at the factory, in partnership with the union, workplaces can assist in dispelling any breastfeeding misconceptions, and in turn employers can lessen some of the tension for working mothers wanting to combine breastfeeding and work by providing a supportive working environment, the legislated breastfeeding breaks, a private and clean space for the mother to express milk, and a fridge to store her breastmilk. These efforts would be to the benefit of the organisation, because research found that companies with context sensitive and relevant breastfeeding support programmes have increased staff satisfaction, increased loyalty and an average retention rate of 94% amongst breastfeeding mothers (Garvin et al., 2013). The health benefits of breastfeeding can also save employers money through reduced absenteeism and increased productivity levels (Cohen, Mrtek, & Mrtek, 1995).

Secondly, the social ecological model can also be a useful conceptual model that can be used as a tool to assist programme planners in the definition, design and implementation of

workplace breastfeeding support interventions (Al Ghazal, Rashid & Ruf, 2015). In this study, the model was used at the interpersonal level to identify people who influence the working mothers' breastfeeding decisions within the workplace. Given that support from feminine figures tends to have the greatest influence on these mothers' breastfeeding decisions, employers could match pregnant women and new mothers in the workforce with mothers who have effectively combined breastfeeding with work in order to establish a mentoring relationship and share practical advice. Exposing pregnant women and new mothers to other mothers who have effectively combined breastfeeding and work can potentially motivate and empower these women to initiate and continue breastfeeding after returning to work as well as strengthen the belief that it is possible for working mothers to manage breastfeeding and work (Rollins et al., 2016). Furthermore, the mentors can encourage dialogue and participatory problem-solving to overcome psychological, social and cultural barriers to the initiation and maintenance of EBF after returning to work which in turn may improve their perceptions of emotional and appraisal support for breastfeeding continuation on returning to work.

Factories who really want to make a difference to their employees lives, and who see the societal case for investing in EBF, could work with communities to improve knowledge on optimal EBF practices and its benefits and to encourage them to support breastfeeding in the workplace. They also need to be attentive to social norms (e.g. perception that breastmilk is not sufficient for a babies hunger, traditional beliefs encouraging pre-lacteal and supplemental feeding) that guide infant feeding practices and limit women's decision making ability regarding infant feeding. To shift these social norms, influential community members could be included in the workplace breastfeeding support interventions such as voluntary workshops at the factory on the weekend (Dinour & Szaro, 2017).

Limitations

The present study elicited meaningful information from the participants but like any other research it is not without limitations. Thus, the findings of this study should be interpreted within the context of the proposed limitations, which would impact the transferability to other contexts.

A limitation of this study is that I was given a 1-hour limit within which I could conduct the interviews with each participant. because the interviews were conducted at the factory that the participants worked in during their work hours. Because the interviews could not go over this time-limit, this meant that some of the participants were limited in terms of the amount of additional insight and information that they could provide. Another limitation of the study was that, although the business language in the factory was English, a majority of the participants

spoke Afrikaans as their first language therefore they were not fluent in the English language. This affected how well the participants were able to respond to some of the interview questions as they were limited in their vocabulary when wanting to describe their experiences.

Future research

The study findings showed that while community support significantly affected women's breastfeeding decisions after returning to work, it was somewhat surprising that for three of the mothers, perceptions of community support did not directly influence their behavioural intention to continue breastfeeding after returning to work. It is probable that the mother's breastfeeding self-efficacy may play a role. Future research could examine self-efficacy as a mediator in the relationship between mothers' perceptions of community support for breastfeeding and their intention to continue breastfeeding after returning to work. Researchers could also evaluate the impact of interventions that empower women by increasing their self-efficacy for breastfeeding upon returning to work. Based on the multiple sources of social support, future research might examine the influence of different types of social support (i.e. emotional, esteem, informational and tangible support) on women's self-efficacy to continue breastfeeding after returning to work. Lastly, future research could examine the specific verbal and non-verbal messages sent by community members to working mothers that are either considered as support or disproval of breastfeeding at work. By doing so, future studies can better address how to educate and support these low income mothers to reach optimal breastfeeding while working.

Conclusion

Returning to work after maternity leave provides a challenge to the continuation of breastfeeding for working mothers, especially those in low income jobs, as they are often faced with immense challenges in striking the balance between home and work. The findings in this study have demonstrated that a mother's perceived community support is a particularly relevant source of support for low-income black working mothers in Cape Town, South Africa. Community members in low-income communities tend to foster strong relationships where everyone takes responsibility for raising a child hence the perceived support of community members towards EBF can either encourage or discourage working women's breastfeeding decisions after returning to work. With the rising number of mothers in the workforce, as well as the fact that low income jobs are still predominantly occupied by black women, this research has demonstrated the importance of gaining a culturally sensitive understanding of these women's context and of the perceived influence of community members on their infant-feeding decisions after returning to work. The insights learned can therefore be used to inform South

African workplaces on how to better support low income mothers and ultimately empower breastfeeding working mothers to sustain breastfeeding after returning to work, benefitting their babies and their own health, the organisation and the South African society.

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Appendix A

Semi-structured in-depth interview

1. I am going to begin by asking you some questions about yourself:
    a. What is your current position?
    b. How long have you been in this position? And at this company?
    c. Is it part time or full time?
    d. How many hours a week do you work?
    e. Is there any shift work?
    f. How many children do you have? And how old is your youngest child?
    g. What is your home language?
    h. How do you travel to work and back home?
    i. How long does it take to get to work in the mornings and home in the evenings? Probe where they live?
    j. How long is a usual working day? (starting and ending)
    k. How old are you?
    l. What is the highest level of schooling?
    m. Can you please tell me about your work and what you do? (Establish what their day to day work life looks like / nature of activities / which part of the business / and their work space?

2. Breastfeeding information

While on maternity leave:

Probes:

    a. How did you feed your baby since birth? (Probe: Did you feed the baby water? What else did you feed your baby (solid foods/ medicine) *(try establish how long they exclusively breastfed for which is no water at all).*

b. What made you decide that this was how you wanted to feed your baby? (Probe: Did anyone help you with this decision? Who gave you advice on how to feed your baby? What advice did they give you? Do you know someone else that breastfed their child?)
c. If initially breastfed then stopped, what made you stop? Why? What age did you introduce solids?
d. Tell me about how you got most of your information about breastfeeding. (Probe: Where did you get information? From whom did you get your information?)
e. In your opinion how long do you think a baby should be only fed breastmilk for? (no water, no medicine) why do you say so?
f. What help did you have while you were on maternity leave for feeding and caring for your baby?

3. Can you tell me about your return to work after your maternity leave?

Probes:

a. What kind of advice or support did you receive from anyone about breastfeeding? And breastfeeding at work? (i.e. role models, family, friends, partner, church, community, social groups, social media, childcare arrangements in/near work, paid help)?
b. If no support, how does that make you feel? Probe. Does it influence your approach to community / partner? How did you still manage to breastfeed your baby? Did you speak to anyone?
c. How long did you take maternity leave for? How old was your baby when you went back to work?
d. Tell me about when you returned to work, how did you feed your baby? (Probe, if expressing, where, when, how was it stored and experiences in general). When did you return to work? Did you stop breastfeeding because you had to go back to work? what are the reasons? Who influenced your decision to stop? Why did you choose to listen to them? Would you have wanted to continue breastfeeding when you returned to work? Who helped/helps take care of the baby while you are away at work? What type of help/support did you need after your return to work? What do they feed your baby? What did they recommend as the right way to feed your child? Why?

4. Support Systems

a. Tell me about your relationships with the people close to you.

b. How would you describe the support you have received with breastfeeding, so far? (What support systems do you have now?)
c. What support systems are most important to you achieving your breastfeeding goals? (Who or what helps you the most and what do they do that is most supportive to you?)
d. What kind of help do you receive

5. Community perceptions

a. When you were growing up what was viewed as the normal way in your community/family to feed a baby? – How do you know this/ what have you seen being done? How were you and your siblings fed?
b. What is viewed as the normal way now in your family or community to feed a baby? – How do you know this/ what have you seen being done? Why did they tell you that? What are some of the reasons for people not breastfeeding their babies within your community?
c. What are your own views on how members of your family/ community choose to feed their babies? Did you feel like you had to do the same with your child(ren)? Why/why not. How was your decision shaped? Who is shaping it? Is it the church/grandmother/spouse/neighbor/friends/clinic etc?
d. What are the beliefs about feeding a child in your community? Why do they believe this? How have these beliefs influenced how you feed your baby?
    - Religious/ cultural beliefs,
    - breastmilk not enough for a baby
    - stress/ tiredness
    - views about how women with HIV should breastfeed,
    - breastfeeding in public
    - Using contraceptives while breastfeeding
    - for working mom, baby may get too attached?
e. What is your view on expressing breastmilk in the workplace? How do others in the community feel about this practice? Do you know anyone who is doing this? How do you know? Do you express any breastmilk/ when your breasts are full do you express breastmilk? What do you do with that milk?
f. Has anyone been against you breastfeeding? What did they say or do? Why?

g. Have you ever assisted another women with regards to their breastfeeding needs and if you did what did you do?
h. What are some of the challenges faced within your community? (Unemployment? Alcoholism? Crime? Long commute to and from work? Violence). How have these challenges shaped the way that you breastfeed? Do they prevent you from breastfeeding?
i. do you think that there is anything that happens in the community that makes it difficult for mothers to breastfeed?

6. What do you think are the benefits of supporting a breastfeeding mother when she returns to work to continue feeding her baby? (Benefits for mother, baby, organization, society, economy)

7. Do you feel that there is anything that I have missed? Do you have any questions for us? Thank you!

Appendix B

In-depth interview consent form

Informed Consent Form

Hello!

My name is Kabelo Malatjie and I am a masters student at the University of Cape Town. I am conducting a study exploring breastfeeding at work. I am doing this study because South Africa has very low breastfeeding rates and this has important health, social and economic consequences. It is important that women have the opportunity to attend to their babies' needs while also continuing to work. My main focus lies in exploring the perceptions for community support for breastfeeding among low income factory workers in Cape Town.

I would like to talk to you about your experiences and discuss with you how you feel that community support influences mothers breastfeeding decisions once they return to work.

This research has been approved by the Commerce Faculty Ethics in Research Committee at the University of Cape Town (UCT). Your participation in this study will consist of an interview and I will need approximately 30 minutes of your time. If you agree, the interview will be audio recorded so that I can accurately capture your insights in your own words. Due to the nature of this study you will need to provide me with some form of identifiable information however, all responses will be confidential and used for the purposes of this research only, and your anonymity will be ensured. This means that your name will not appear anywhere.Your participation is voluntary. You also have the right to withdraw from the study at any time following which none of the information collected from you will be used.

Should you have any questions regarding the research please feel free to contact
Kabelo Malatjie:
Email: mltkab003@myuct.ac.za phone: 082 920 0889

Kindly complete

By signing below I acknowledge that I have read and understood the above information. I am aware that I can discontinue my participation in the study at any time.

Signature and full names _____

Date_____

Appendix C

Demographic Questionnaire

Please can you provide us with some demographic information (Please place an X to indicate your response)?

1. What is your highest educational qualification? _____
2. What racial group do you identify with?

   ☐ asian
   ☐ african
   ☐ coloured
   ☐ indian
   ☐ white
   ☐ Prefer not to answer
3. In what year were you born? _____

Appendix D

Ethical Clearance

Faculty of Commerce

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29 July 2019

Ms Kabelo Malatjie
School of Management Studies
University of Cape Town

Dear Kabelo Malatjie

REF: REC 2019/000/072

An Exploration into the perceptions of community support for breastfeeding at work among low income mothers in Cape Town clothing factories

We are pleased to inform you that your ethics application has been approved. Unless otherwise specified this ethical clearance is valid for 1 year and may be renewed upon application.

Please be aware that you need to notify the Ethics Committee immediately should any aspect of your study regarding the engagement with participants as approved in this application, change. This may include aspects such as changes to the research design, questionnaires, or choice of participants.

The ongoing ethical conduct throughout the duration of the study remains the responsibility of the principal investigator.

We wish you well for your research.

Shandre Swain
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