BREASTFEEDING PROMOTION:
A QUALITATIVE EVALUATION

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I. Introduction

Several authors have documented the multiple advantages lactation offers to infants and mothers. Breastfeeding is the best nutrition an infant can receive until the child is 4 to 6 months old (1, 2). The benefits of lactation go beyond nutrition; human milk has immune mechanisms that protect against intestinal and respiratory diseases, ear infections and even non-infectious illnesses like asthma and allergies (2). In developing countries, the introduction of artificial milk often leads to the administration of over diluted and contaminated milk, which increases the risk of malnutrition, disease and death (2). In addition, the cost of the milk itself and the cost of medical care that a sick child requires, impose an extra burden on an already poor family (3). Lactation not only contributes to the bond between mother and child (4), but also decreases the risk of post-partum hemorrhage (2) and contributes to worldwide fertility reduction (4). For these reasons, the promotion of breastfeeding is of paramount importance in public health plans in the Third World. The World Health Organization (WHO), through its "Baby Friendly Initiative", recommends exclusive breastfeeding for four to six months and to continue lactation for 2 years (1).

The "Hospital Nacional Docente Madre-Niño San Bartolomé" (HSB) is a public maternal-child hospital in downtown Lima, Peru, that serves a mainly low-income urban population. I worked at this hospital as a pediatrician for the period of 1988 to 1991. During that time, I was actively involved with the breastfeeding promotion program at San Bartolomé. This program was initiated in 1985 by the neonatology unit of the Department of Pediatrics, but it soon became a hospital-wide program. Since the inception of the program at San Bartolomé, the in-hospital newborn mortality rate has decreased dramatically, as have cases of diarrhea and sepsis of the newborn. These data confirm findings from around the world. A study conducted in San Bartolomé in 1989, tested mothers' knowledge on breastfeeding. Mothers were asked whether they "accepted" the policy of housing the infant and mother together (rooming-in) and 73% gave an affirmative response (5). A more comprehensive evaluation of the program, however, has not been carried out.

In the past few years, there has been increasing interest in outcome-based research, which emphasizes outcomes as perceived by the population served (6, 7). According to the literature reviewed, breastfeeding programs that include rooming-in education and support, generally increase breastfeeding duration and intensity. At the same time, these measures decrease in-hospital neonatal mortality and morbidity due to sepsis and diarrhea. Few studies in the field of breastfeeding, however, have addressed what could be broadly called "patient satisfaction". The issue is important, because patient satisfaction relates not only with general well being, but also with compliance with a program’s recommendations (6, 8). This study intends to explore this issue.

Another recent trend is to pay more attention to the attitudes of health care personnel and levels of job satisfaction as important factors determining the outcome and success of health promotion programs (6, 7). The notion of health care personnel as conduits who convey whatever message is taught to them is now recognized as inadequate. Health workers can fail in this task either because they misunderstood the contents of the message or because they were not convinced of it (2, 6). The WHO explains in a publication about breastfeeding that

"Knowledge alone is insufficient, of course; also needs a positive attitude towards breastfeeding, which comes with experience and an understanding of the many incomparable advantages that this feeding mode offers mothers and infants alike" (1, p. 8)
Therefore, lactation program planners should consider health workers’ attitudes towards breastfeeding promotion programs as an important part of their planning. In fact, it has been noted that programs that are positively evaluated by the recipients themselves and those where the staff feels motivated and committed to promote lactation have a greater chance to be effective. However, there is no clear understanding of how and why these programs work. Qualitative methods are especially well suited to answer these questions.

The insights derived from this study can serve several purposes. First, it will identify strengths in the San Bartolomé program and give positive feedback to program's staff, which in turn can reinforce the health care workers' commitment to the program. Second, it can identify weaknesses in the program and assist San Bartolomé in the implementation of measures to correct such weaknesses. Third, it can give policy makers in the health care field an understanding of how patients themselves interpret and evaluate their care and how health care workers perceive their own participation in breastfeeding promotion. This can help design health promotion programs to achieve both patient and worker satisfaction.

II. Review of the Literature

A. Staff Side Issues

Several reports on breastfeeding programs make direct or indirect mention of individuals with high motivation that pushed the program forward, or special events that made the staff aware of the importance of lactation (9). In Tijuana, for example, a female resident physician gave birth to a premature infant. She was committed to breastfeed and the pediatricians at the hospital supported her decision (10). She began taking her baby to work and nurse him there. Several people among the staff began to pay more attention to lactation issues and started to pass that knowledge and support to patients. The resident physician nursed her child among the patients, which helped give them more confidence. Subsequently, other hospital workers took their babies to work. The article describes how the whole staff’s attitude toward lactation changed.

There are also many evidences of the importance of staff commitment to lactation (11, 12). In Tampere, Finland (11), it is reported that after introducing rooming-in and breastfeeding promotion, "most of the personnel felt that their work had become more challenging and meaningful. When the campaign ended, they did not wish to return to the old routine." They also described that “(T)he interventions involved are rather simple, but they must be supported by strong motivation and education of the staff. The results can be rewarding, both by promoting breastfeeding and by making the working atmosphere in the maternal wards better”. Thus, staff support is mentioned as a critical component in many articles and several of them mention that lactation promotion programs are good for the work environment (2, 9, 10, 11, 12, 13, 14, 15, 16, 17). Apparently, both things are not independent. Commitment to the program contributes to good breastfeeding promotion, and a good breastfeeding promotion program contributes to a good work environment.

B. Mothers’ Side Issues

Mothers’ satisfaction is surprisingly infrequently mentioned in the literature. Usually, breastfeeding promotion programs are conducted by pediatricians; this may partly explain why the emphasis in child-related outcomes. However, a satisfied mother is more likely to adhere to program's recommendations. A satisfied mother is also a very good goal in itself. Some authors argue that breastfeeding restores a woman's sense of value and ability to produce, not only reproduce (18). In
England, Bruce and Griffoen (19) used a self-administered questionnaire, to explore mother's opinion on a breastfeeding promotion program. They found that 60% of the mothers thought that the new program supported breastfeeding. In Como, Italy (15), a program that included education and support for the mothers, was greatly appreciated by mothers as a trend to humanize the maternity department. These studies, however, did not describe how they assessed mothers' opinions and feelings.

In most studies were mothers were "interviewed" the questionnaire used is not presented. It appears that they mainly "quiz" the mother in breastfeeding knowledge and/or ask about duration or intensity of lactation (3, 11, 12, 13, 15, 20, 21). The point of view of the mother is rarely addressed in the literature.

C. Approach to Research: Quantitative and Qualitative

There are many reports about programs to promote breastfeeding. Wilmoth and Elder group such programs into five categories: 1) hospital policies modification, 2) social support, 3) incentives for mothers, 4) education of mothers and health care personnel and 5) political action and legislation (2). Classifying each program into any category is not easy, because they usually include more than one of the above-mentioned components. Evaluation of these programs has been carried out in several ways, using quantitative or qualitative methodologies. This review is limited to breastfeeding promotion strategies that involve health services institutions.

Most reports contain descriptions of the general features of the program and how the organizers managed to negotiate them to be started. In most hospitals where rooming-in and/or personnel and maternal education are instituted, these changes are followed by a drastic reduction in hospital neonatal mortality, intra-hospital infections, such as sepsis and diarrehas, and increase in the rate of breastfeeding at discharge time. The same type of results have been found around the world in places like Philippines, Italy, Austria, Brazil, Mexico, Chile, India, Costa Rica, England, Honduras (2, 3, 11, 13, 14, 15, 19, 20, 21). A formal evaluation design is often not presented. The majority of these evaluations used a pre-post design without patient randomization and in many of them the objective was to find an increase in the duration and intensity of breastfeeding (2, 3, 8, 9, 11, 12, 13, 15, 19, 20, 21, 22, 23).

Quasi-experimental studies have demonstrated that a specific component or components of a program can affect lactation duration and intensity. In Turkey, Neyzi et al (cited in 2) randomly allocated mothers to a "treatment group" that received a film and a lecture about lactation, or to a "control group", that received a film about diarrhea. After five to seven days, the mothers were visited at home. Both, exclusive and any breastfeeding, were proportionally more frequent among the "treatment" group. At the Hospital General de Mexico, (20) a "program group" was compared to a "control group" of the same hospital. The program consisted of hospital routines that enabled mothers to start nursing in the hospital, training for health care personnel in pediatric and obstetric services, and classes about the advantages of breastfeeding for first time mothers. The control group received no special treatment. Mothers in the "program group" experienced an increase in total lactation time. However, the authors acknowledge that both groups suffered severe attrition. In a study conducted in an England hospital, a pre-post intervention design was used in to measure the impact of a rooming-in program. The percentage of mothers who continued lactation at six weeks increased and so did the percentage of health care personnel who viewed feeding policy as important (19).

There are several ethnographic studies on the determinants of breastfeeding and mother's experiences (1, 24). However, the literature is scarce or non-existent in the use of ethnographic methods for the evaluation of breastfeeding promotion programs. A study in Kenya (24) addressed infant feeding practices in rural and urban communities, the influence of health care workers on breastfeeding and the marketing of milk substitutes. The study found that mothers in Kenya tend to introduce cow's milk in the first months of age, behavior that might be reinforced by marketing strategies of formulas.
and by incorrect messages about breastfeeding -or lack thereof- given by health care personnel. However, the ethnographic technique used, the sample or the time involved are not thoroughly explained.

An ethnographic study in the Southeast US addressed mothers and health care provider views on breastfeeding counseling (6). The ethnographic techniques used were focus groups and in-depth interviews. Mothers were stratified for 35 focus groups according to age, parity, urban/rural residence and feeding method. Staff members were grouped according to geographic area, and participated in six focus groups and 22 in-depth interviews. The focus groups included four to ten people and the questions related to beliefs and attitudes that can influence one's expectations on breastfeeding counseling, experience giving or receiving advise on breastfeeding, obstacles to social support for breastfeeding and recommendations for improving the quality of breastfeeding counseling. Several points of non-coincidence are found among mothers and staff. The staff is not as knowledgeable as expected and they tend to believe they are unable to change feeding practices. Mothers feel that support is not enough and that messages are not clear. I could not find any account of an ethnographic study of lactation promotion that included a hospital setting as a case study, that would naturally involve a great deal of participant observation.

D. Choice of Methodology

Most quantitative evaluations of breastfeeding promotion programs run into three problems in practice. First, it is very difficult to clearly define the different aspects of a complex behavior, such as breastfeeding in order to measure it adequately. Breastfeeding is a behavior that includes duration and intensity, both of which may vary over time. Therefore, using standard definitions is difficult (2). For example, an infant may be exclusively breastfed on demand for a month, fully breastfed on demand the next, and then go back to exclusive breastfeeding.

Second, most programs are “packages”; they consist of a series of changes in hospital practices that are particular to each place and that are not easy to quantify. Programs are usually underway and do not have an evaluation component, which makes unrealistic the use of experimental or quasi-experimental designs. Precise conclusions regarding the effectiveness of parts of programs can often not be made, since other activities were implemented simultaneously (2).

Third, it is frequent that legislation and mass media campaigns further “confound” the results. Moreover, it is also very frequent to find written and personal indications that the program contains an important emotional component and that the people that work in breastfeeding promotion not only think, but also “feel” strongly about it.

The use of quasi-experimental designs is often not feasible, due to financial or ethical reasons. Randomization of study centers is complex and expensive. Since several small components of breastfeeding promotion programs have been proven to be effective in enhancing breastfeeding duration and intensity by themselves, it would be logical to think that more complex interventions that include many changes are going to be at least equally effective. There are cases in which a qualitative, ethnographic approach can shed more light on the way programs function. Salomon presents a case in the field of education, in which a complex learning environment that includes many equally complex interrelationships among students and students and teachers. In this case, a quantitative evaluation would not be able to tell the complete story of such case (25).

There is a great need of qualitative evaluations that help explain exactly what is what makes the programs work. The behavior I wish to study, breastfeeding, is complex and difficult to quantify. Breastfeeding promotion activities are also complex and cannot be easily individualized and/or quantified. Qualitative techniques, especially ethnographic techniques, are particularly useful to gain insights into why and how a program is effective. This knowledge can be instrumental to replicate the same characteristics in other programs.
III. Objectives

This study was designed as a qualitative evaluation of the breastfeeding promotion program of the Hospital An Bartolomé, in Lima, Peru. It addresses the following questions:
A. 1. What are the mothers’ expectations of the program?
   2. How thoroughly are those expectations fulfilled?
B. 1. What are the staff's expectations of the program?
   2. How thoroughly are those expectations fulfilled?
C. 1. What parts of the program are of most help or hindrance for the fulfillment of those expectations?
   2. Why are they important?

IV. Program and Methodology

A. Description of the Program

San Bartolomé's breastfeeding promotion program consists of a group of hospital practices, personnel training and mother education and support. Prenatal information about breastfeeding is given to every future mother. A critical component of this program is called rooming-in and consists of housing the infants with their mothers. Rooming-in in San Bartolomé usually starts within the first half-hour after delivery. However, mother-child contact starts in the delivery room. Support and information about lactation are available around the clock. Human milk is the only food newborns, full term or premature, receive. Other types of milk are severely restricted; bottles are not used. Mothers are advised, according to WHO recommendations, to breastfeed exclusively for 4 to 6 months and to continue lactation until the child is about 2 years old. Mothers are encouraged to visit their babies in the intensive care unit as much as they can. There is an area within the intensive care unit (ICU) unit where mothers talk with each other and express their breasts to obtain milk for infants who still cannot suckle. Seven to ten days after discharge infants and their mothers attend the outpatient clinic. Mothers of hospitalized newborns and of sick children 1 to 24 months of age stay at the hospital with their children; this is called "accompanying mother". Other activities related to the program include periodical conferences directed to all hospital personnel and teaching to nursing and medical students.

The program's philosophy regards human interaction as being more important than simple information in the promotion of breastfeeding. Exchange of experiences in an informal way, together with adequate information, are viewed as best to convey its message. The people involved in the conduct of the program believe that these activities are not only beneficial to mothers of newborns, but also to those who work in the hospital.

Program activities are conceptualized as an integrated part of routine work. Instead of having one specialized person that devotes her time to lactation advice, San Bartolomé aims at having everyone doing it at every opportunity. Since program activities are integrated into everybody's work, the program has no special personnel or budget.

B. Methods

The study was designed to obtain qualitative information from different sources. Methods included participant observation, a structured survey of mothers, focus groups with staff members, in depth interviews with mothers and review of existing records. All information is confidential. In this
paper, the word "mothers" refers to those mothers who are served by the breastfeeding promotion program, unless otherwise noted. The word "staff" refers to members of the health care personnel of San Bartolomé.

1. **Structured Interview** Its purpose was to investigate demographics and perspectives of mothers in relation to breastfeeding promotion at the hospital. At the same time, the structured interview provided a research method that was accepted by the hospital staff as scientifically valid. The staff's acceptance was key to conduct the study. Sixty randomly selected mothers that delivered a baby since July 8 1997 were interviewed before they left the hospital after delivery. Fifty-nine interviews were completed successfully; one mother was discharged before she could be approached and there were no refusals. The mean age was 27 years (17-41). Thirty three (56%) of the mothers were born in Lima; the others were all born elsewhere in Perú. Only 10% of the mothers had primary education or less, 62% had at least some high school and 28% had more than high school (some college, vocational). Thirty-four women (57%) were having their first child. Fifty-one percent of the babies were female. The median gestational age was 39 weeks and the mean birth weight was 3303 grams (2170 to 4340). Most of the newborns did not need any special care and stayed in rooming-in all the time (70%). Twenty-three percent required intermediate care and 7% required some ICU care.

2. **Participant Observation** It was carried out within a six-week period. It encompassed several mornings, afternoons and evenings and one overnight observation at the hospital. In addition, I had the opportunity to participate in special events, like a street demonstration in support of breastfeeding. The original plan included participant observation in the following areas: rooming-in, newborn ICU and newborn outpatient clinic. Additional areas were included after I realized they were important for integral breastfeeding promotion: newborn intermediate care unit, pre-discharge talk to mothers, pediatric medicine hospitalization, room for "accompanying mothers" of hospitalized newborns, pediatric surgery inpatient areas and workers’ day-care center. Some of these observations were carried out following suggestions of the hospital staff, who discussed with me issues related to breastfeeding promotion openly. Observations in the “Growth and Development” clinic and in prenatal care clinics were not possible due to limitations in time.

3. **In-depth Interview** The sample included five nursing mothers. Two were born in Lima, two were migrants from other areas in Perú and one lived in the countryside and was in Lima for her child's treatment. Three of them had recently given birth at San Bartolomé. A fourth mother had her eleven-month only child hospitalized in Pediatric Medicine. The fifth mother had a one year old child, hospitalized in Pediatric Surgery for an elective operation. Initially, the sample was planned to include only mothers of newborns. However, since breastfeeding promotion is not yet fully implemented (or is newer) in the areas with "accompanying mothers", it was considered important to get the point of view of mothers in these areas. Among all mothers interviewed only one worked outside the home. More interviews with outside-the-home-working mothers were desired, but time was a constraint. Most interviews took place while the child was in the hospital, either in the morning or the afternoon. One mother was interviewed at her work place, in three occasions. Two of the interviews were taped, after the mothers agreed to it. Interviews started only after all structured surveys were completed, because the results of the survey (and of the participant observation) were to provide the main themes to talk about during in-depth interviews. Questions related to the experience of women with pregnancy, delivery, breastfeeding, work outside the home and hospital treatment in general.

4. **Focus Groups** Nine focus groups with staff members were carried out. Issues discussed at the focus groups include perceptions about breastfeeding promotion and their experience with it and their
own experience with breastfeeding. The sessions took place in different areas of the hospital that allowed for private conversation. Focus groups had to be adapted to staff's work schedule. Sessions lasted between 35 and 90 minutes. Since time was reduced, the size of the groups was kept small to give each participant a chance to speak. The typical group had four participants (2 to 9). Some meetings were not taped, at the request of the participants. Staff who participated includes administrative personnel, nutritionists, social workers, midwives, nurse aids from pediatric medicine and obstetrics, nurses from obstetrics, pediatric medicine and neonatology, attending physicians from neonatology and pediatric medicine and resident physicians. It was impossible, within the timeframe, to hold a focus group with nurse assistants of neonatology, obstetricians and female security guards. Therefore informal conversations with some members of those groups were held to make up for this deficiency.

5. Review of records Hospital charts, records of outpatient and inpatient offices were reviewed. Summary data on hospital employees and regulations and laws relating to the issue were obtained.

V. Results

A. Perceptions about Breastfeeding

1. Mothers

Most mothers are convinced that breastfeeding is highly superior to formula feeding and would recommend it to friends and family. They see breastfeeding as important because it has many advantages; the one most frequently mentioned is protection against diseases of children. Mothers also appreciate human milk as the best nutrition for their infants, it is "good for growing" and it provides the baby with "more love". A few value lactation because it makes the child "more intelligent", it is cleaner than formula, it is good for the child's teeth and it prevents allergies.

Although they don't mention them unless asked, women also find advantages of lactation for themselves. It provides a rewarding experience of love and bonding, it is less expensive than formula feeding and it is convenient. Mothers see breastfeeding as an obligation for women, but not a sacrifice. It is regarded as an activity that may bring joy. Rarely, mothers feel somewhat forced to breastfeed. Also rarely, mothers view lactation as a woman's right.

Many women have experience with breastfeeding themselves or have seen it in their families. In general, they plan to breastfeed for one to two years. However, most women believe that some people just “don’t have enough milk” and that this is not a rare condition. Study and work are appropriate reasons for mothers to justify some artificial feeding. Heidi, who successfully breastfed her older daughter thirteen years ago, believes she needs to give her daughter artificial milk to continue working. María del Pilar quit her job to breastfeed her premature infant, because she can afford it; her sister had to work for financial reasons, so she had to use bottles.

2. Staff

Staff members believe breastfeeding is of paramount importance for mother and child not only because it prevents diseases, but also because it promotes adequate growth and development of the infant. Additionally, they believe breastfeeding makes child rearing more “human”. The staff too, views lactation as a woman's duty, something natural for a woman to do. They recommend breast milk to friends and family. Some women do not breastfeed because they really don’t know how to deal with breastfeeding problems. The most frequently cited problem is “not enough milk”. The staff holds contradictory views on introduction of artificial milk. Most staff members express that it is
 unacceptable under any circumstance. Some of the same people find formula justifiable if a woman holds a professional or formal job that cannot accommodate lactation.

B. Expectations and their Fulfillment

I. Mothers

All expectant mothers are to receive two separate talks or "classes" about lactation and other topics. Some women cannot take advantage of these activities because the schedule is inconvenient for them. Helen could not attend the "classes" because they are scheduled at 1 p.m. and she works until 2 p.m. as a street food vendor. Another mother said she could not attend the "classes" because she had a medical condition and could not exercise. According to midwives, she still could have attended the "classes", without joining in physical activity. Physicians, nurses, nurse aids and administrative personnel all point out that more extensive information about breastfeeding is needed in the prenatal care area. Better coordination and information about the services already offered could potentially increase utilization.

Women greatly appreciate that staff in the delivery and recovery rooms relates to them in a personalized way and understand their feelings. They like to see the same person each time they are told something or examined. Several mothers would like their husbands to be present at the time of delivery. However, this is not permitted in San Bartolomé. Midwives suggest that those husbands who attend prenatal classes with their wives could be allowed to enter the delivery room as a "prize".

"Early contact" consists in placing the baby, as soon as he or she is born, with the mother for some minutes (ranging between 5 and 30). The mother and the baby have time to get acquainted to each other and she is encouraged to nurse the baby for the first time. Mothers were pleased with "early contact"; for some it was an unexpected surprise. The mothers say,

“I didn’t know they were going to put the baby on me...It was a surprise! A good one! I liked it because I could love my child earlier. The baby was there some five to ten minutes. Then they took her away for twenty minutes or so, before leaving her with me until I was discharged.” (Helen)

“When he [the doctor] received the baby and cut the cord, he put her on my breast. I saw her and felt happy. They [the doctors] were happy, too. When they put the baby like that it must mean she is healthy. My first baby, they took inside [the neonatology ward] and I could not see her until night”. (Brisa)

Mothers who had a normal delivery are offered help to initiate lactation within the first half hour after delivery. Mothers who had a cesarean delivery receive their babies for "early contact" right after they wake up. At that time, they receive assistance on initiation of lactation. Mothers who have a baby that requires special care are offered help to initiate breastfeeding and are taught how to express their breasts to obtain milk within the first 12-24 hours of delivery. Most mothers receive their newborn in rooming-in within one hour of delivery. Once in rooming-in, babies stay there day and night, unless they experience a medical complication that requires special care.

Mothers really appreciate that staff is available at any time of the day or night and that they take time to give them emotional support and to explain them how to breastfeed. One woman was "nervous" and a nurse spent almost half the night trying to calm her down and explaining her how to breastfeed. The fact that two or more staff members give the same advice regarding breastfeeding is reassuring for mothers. Several mothers that had one or more deliveries elsewhere compare favorably the service in this hospital regarding breastfeeding.
Mothers feel at ease asking questions about lactation and find different types of staff helpful to them. Most mothers report receiving general support. This is consistent with observations in the different areas of the hospital. Support is often informal and different for each patient.

“She really tried to get the baby to breastfeed. She did not move from here until he started nursing.”

“She [the baby] did not want to take the nipple. She showed me how to get her attention by touching her feet. She also explained me the position. She was very nice and took her time to do all that.”

“The doctor was very good. He held her and showed me how to position her. It was so funny”.

“I did not know anything. Now I know that with more suckling I will get more milk”

“The hospital is very good. The other [baby] was born in X hospital and they did not help me and did not tell me how to breastfeed. They [friends] recommended me this hospital a lot; that it was good and they had faith in the hospital”.

Some of the mothers said they would like more support from staff, especially when they receive their babies for the first time. One staff member criticized a mother for not having prepared her breasts adequately and treated her rudely. Another mother said,

“She left the baby without saying anything. When I asked whether I had to breastfeed her, she said, ‘why do you think you are here?’” (A mother in rooming-in)

Pain in the nipples is not infrequent, but it is rarely seen as a "problem”. Most mothers believe it will stop in a few days. Some mothers feel guilty of not having used the correct lactation technique. In fact, two male physicians said, during an outpatient visit talk, that if mothers experienced pain, it was because they did not feed the baby correctly. Nurses, who give the pre-discharge talk, say that if they do it incorrectly, pain will last for a longer time. Nurses also address other possible causes of pain in the nipples and their message appears to have less guilt-generating potential. This difference might have to do more with gender and own experience as a mother than with the particular position of the worker within the hospital.

Mothers expect to be able to breastfeed in the hospital and to obtain information and help from staff about lactation. Not all of them knew in advance that San Bartolomé puts a special emphasis in breastfeeding and they welcome the information and help that they receive. However, some women need more information on how to deal with specific things, like pain in the nipples or work outside the home. The only advise given to mothers who need to work is to breastfeed exclusively, and express their breasts at work.

Most mothers, including those who expected to use bottles in the hospital, approve of the policy of prohibiting their use in the hospital. This policy is accepted because mothers believe breastfeeding is the best for the baby. No bottle-feeding was observed in the newborn areas nor mothers reported it.

2. Staff

Staff members believe breastfeeding promotion makes their work easier, more effective or more pleasant. It brings back to the hospital warmth and love, essential human qualities; infants who
are with their mothers are quieter; mothers who have their babies with them tend to be more cooperative. Additionally, more stimuli to the nipple are followed by better uterine contractions, thus making easier the control of post-partum bleeding.

Personnel agree that exclusive breastfeeding is the goal for the first 6 months and should be continued for 2 years. However, there are some disagreements in the way to convey this message. Some of them are minor and usually are part of the informal conversations that lead to program self-improvement. For example, some staff members believe the positive aspects of lactation should be stressed more than the negative aspects of artificial feeding. Other disagreements may require more time to be worked out, as in the case of the appropriate recommendations for mothers who work outside the home.

Several staff members believe that "early contact" is the single best feature of breastfeeding promotion in San Bartolomé. Most members of the staff regard “early contact” not only an important experience to ensure successful breastfeeding, but also an extremely rewarding personal experience. It allows for the mother to relax and enjoy her baby. Some staff members had the option of "early contact" for themselves. Therefore they would like other mothers to experience this benefit.

In all focus groups, participating staff members were confronted with a situation in which they were suddenly transferred to another hospital that did not promote breastfeeding. Most staff members, including administrative staff, would take upon themselves to change the situation in their new working center, because “we already know that breast milk is the best; it is like a moral obligation”. They would try to convince their fellow coworkers and their immediate superiors by talking one-on-one. The staff shows pride about San Bartolomé’s breastfeeding promotion, although some had some criticisms. Regarding breastfeeding promotion they said, “This hospital is a pioneer”, “it is an example to all hospitals”.

When the breastfeeding program started in San Bartolomé, policy change was not easy and it took some time for the staff to accept things like "no bottles" and "rooming-in". They feared that infants would feel hungry and that daily routines were to be interrupted by crying babies and desperate mothers. As time passed, most people embraced the "cause". For some it is a matter of scientific advancement; for some it is "natural" for female personnel to promote lactation as part of their own experience. Almost all personnel, male and female and in any clinical or administrative position enjoy promoting breastfeeding. They feel it is worthwhile.

Staff members especially praised the enthusiasm of those in charge of breastfeeding promotion, because "people have to be convinced to be able to convince others".

“There was some resistance, but not any more”; 'everybody [workers] should do promotion; it is not too much work, you do it as you go”

In some areas, where the program is relatively new, there are still some difficulties. This occurs in cases where "breast milk only" and "no bottles" policy means more work, like the nurse aids in pediatric medicine, who have to feed the patients with a spoon if the mother is not there.

“Change was slow [in pediatric medicine], it still is...It is much more difficult to give milk with a spoon than with a bottle”.

The hospital staff feels pride in the program and have a sense of ownership. The best thing of this program, according to several staff members, is that everybody is convinced of the value of breastfeeding and everybody helps in spreading the message. Leaders of the program have been able to make most staff members feel that they are part of the program and that their help is appreciated and necessary. They value their ability to participate in discussions to design
and improve the program. Some believe the best feature of the program is teamwork. In some cases, people who felt temporarily left out have been re-integrated. For example, when the "no bottles" and "breast milk only" policies were implemented, nutritionists resented losing importance as experts in infant nutrition. However, they are now again regarded as experts in infant nutrition, on breast milk's properties and on introduction of solid foods. Likewise, the worker's union has a very good relationship with the breastfeeding promotion program, and they take every opportunity to praise it as a worthwhile effort. In turn, the union uses their interest in the program as public relations, stating that they are interested not only in labor demands, but in the health of the public in general. For example, when there is a strike, workers usually stop all patients from coming into the hospital, except emergencies and premature babies who need breastfeeding support. Some staff groups still feel left out, or become "left out" due to new policy changes, like the nurse aids of pediatric medicine.

There are conflicts between the administration and different workers' groups. A street demonstration in favor of breastfeeding with the occasion of "breastfeeding week" made many of these conflicts become apparent. Many workers and some patients participated enthusiastically, walking with their children for some two hours on the streets of Lima, with posters and banners. Many brought their own posters from their homes. A marching band provided music and the atmosphere was festive. The occasion prompted several staff members to express their dissatisfaction for not having been included in the planning of the event. Others criticized the administration for being "dictatorial" and yet others criticized the Ministry of Health for giving the demonstration inadequate support. There are some long-standing conflicts between departments and between workers' groups. In some cases, both groups in conflict hold similar views, but they just cannot trust each other. Some channels of communication between departments and different types of staff do not work optimally, making change slow and allowing for misunderstandings.

C. Key Program Components

1. Informal Human Interaction and Group Settings

Delivery of information and support is carried out mostly through informal interaction between mothers and personnel and among mothers. Some contacts are scheduled and "formal", like the nurse or doctor visit every morning, or the pre-discharge talk. However, the manner in which staff relates to mothers is informal in most cases, using a conversational style and, often times, drawing from their own experience as mothers or fathers. These conversations appear to be very casual. The results are that both, personnel and mothers, feel at ease during these contacts and that the "personal" touch increases the message's acceptability. Mothers feel staff is giving them not only the advice they give to a patient as part of their job, but they are telling mothers the very same advice they give to their own family. Mothers engage in informal interaction among themselves, practice that is encouraged by the staff. Central to the human interaction success are two features of San Bartolomé. First, the fact that "everybody" tells the same message seems to reinforce it. The WHO, in his "Baby Friendly Initiative" outlines "Ten Steps to a Successful Lactation". They stress the importance of "all health personnel" to be involved in the promotion of breastfeeding, as San Bartolomé is doing (26). Second, the group settings found throughout the hospital facilitate informal communication. Group rooms are the rule in the rooming-in area, the neonatal ICU, the neonatal intermediate care unit, the pediatric and surgical medicine areas and the neonatal outpatient office.
a. The Rooming-in Area

In the rooming in area, rooms hold between 3 and 14 beds. There is only one fourteen-bed room. There is another large room with some 20 beds that are partially separated by wooden panels. Mothers take care of their children by their bed. Babies seem to be content; it is extremely rare to hear a baby crying desperately.

Mothers in the group rooms with no separations are frequently engaged in conversations of two to four women and seem to know each other. It is common for visiting family members and some staff members, especially nurse aids, to join in those conversations. In those cases, personnel relate to the patients more as mothers, fathers or grandparents, than as hospital employees. Patients seem to appreciate this. Mothers in the room with panels find it more difficult to talk to their neighbors. Most mothers like the group rooms because they allow for women to offer mutual help, and to enjoy each other's company. It is common to see women helping the mothers who have difficulty moving, like those who had recent surgery. Experienced mothers tend to advise and share experiences with first time mothers. They teach each other how to nurse, help with babysitting for bathroom leaves, and offer general support to each other. Some mothers find some problems with the group rooms, like not enough comfort or space for themselves, the risk of contamination and lack of privacy. Most mothers would prefer group rooms of two or three people, but a few mothers would prefer rooms with four or more people.

The staff likes the group settings in rooming in and in other areas because they allow mothers to teach each other about lactation. In addition, the staff believes group settings allow them to work better and more easily. More personnel would be needed to take care of people in private rooms, rising costs. The staff is more concerned about the lack of privacy and of enough space in the group rooms than mothers are. Nurse aids and midwives would prefer a room with two or three people for themselves; the majority of nurses and physicians would prefer a private room. In general, mothers seem to value more company and mutual help, and the staff values more advantages that relate to teaching and controlling the floor. Both groups value transference of information and experience among mothers.

Mothers in rooms with three sided wooden panel separations do not benefit as much of the group setting. Radical structural changes are not possible at this time, due to financial constraints. However, in the present circumstances and with the space available, perhaps mothers in the bigger room could be better off if portable space dividers were used for physical exams. In the future, when a maternal child hospital is designed, architects should take into account the advantages of including group settings that are as comfortable as possible and that can catalyze the informal transfer of experiences and information.

b. ICU and Intermediate Care Unit

In the ICU and in the intermediate care unit there is a space where mothers may sit, express their breasts, directly breastfeed their babies or just hold them. Some babies in ICU are breastfed even when they still have an intravenous solution on. These spaces are semi-private, because some staff members and other mothers go in and out. Help is available around the clock. Nurses and nurse aids and physicians teach mothers how to express their breasts, how to relief breast pain and how to feed their sick or premature babies. All of this is done in an atmosphere in which mothers and staff can engage in informal conversations. They talk mainly about breastfeeding and child rearing, but they also comment about other issues, such as the latest developments in the hottest "telenovelas" or even current political events.

Most staff members are very experienced in helping mothers and they know how to build excellent rapport. Often times they draw from their own experience as breastfeeding mothers to relate to the patients. One night, two nurse aids in the intermediate care unit, who are mothers themselves, were assisting some ten women for several hours, at least until 3 a.m. During all the time there was
talk about lactation, but other conversations went on, ranging from how to prepare certain dishes to how to get men to wear condoms. Humor is a very important piece of the conversation, especially at these late hours, when some might feel asleep. Mothers relate to staff as fellow women and mothers, and the advice is passed in a family-like atmosphere.

Mothers of ICU babies really appreciate that they can spend the day with their babies as soon as they can walk to the ICU. They receive information about their babies and they are permitted inside the ICU at any time. Their newborns usually spend several days hospitalized, giving their mothers the opportunity to get to know each other better and become friends. They talk to each other and tell confidences. Some even stay together in “accompanying mother”, which increases their sense of “a group”. One mother that had just started to do nurse said,

“Being in ICU was a great experience [...] We went early every morning to breastfeed the babies. We only left at meal times. We used to talk a lot about our babies ...and our lives...[...] One of my friends had twins; one of them died. We all supported her. We gave support to each other all the time. Most women were happy there.” (María del Pilar)

Mothers praise the patience and kindness of the ICU staff. They appreciate the staff devoting time to explain them how to feed their babies and helping them not to be afraid to hold and feed a premature infant. However, timely support and information is occasionally missing. One mother, who had a cesarean delivery, said that a member of the staff just told her to put her milk in a cup, without explaining how to express her breasts. This is the exception, but nevertheless, still happens.

c. "Accompanying mother” – Neonatology

"Accompanying mother" is a separated room that can house up to 12 mothers. Mothers who are discharged before their newborns can leave the hospital stay there. They use an adjacent restroom and receive meals from the hospital. They are expected to be with their babies in ICU most of the time. Some staff members point out that the room should be cleaned more often, that beds are uncomfortable and that heat is unbearable in the summer. Mothers, however, like it. Family members visit them in the afternoons and they sit around and talk. Mothers value the time they can spend with their newborns and the willingness of the staff to help them. The staff believes it is ideal for mothers to stay with their babies; many consider "accompanying mother" to be one of the greatest achievements of the program.

d. "Accompanying mother” – Pediatric Medicine Ward

The “accompanying mother” component of the program for mothers of hospitalized children 1 to 24 months old is relatively new, as it has little less than one year in operation. Mothers of children who are still breastfeeding and are hospitalized for medical reasons are to stay with their children in the hospital. Each room houses six to eight patients. Mothers sit on a wooden chair by the crib.

The staff is still trying to adjust to a relatively new policy of having mothers in the floor and to do the additional work that represents feeding children with spoons, since bottles are prohibited. Some staff members would prefer to use bottles and some mothers, too. There are some reports of bottle use. Some nurse aids believe mothers in this area suffer because of the bottle prohibition, but most believe that they should avoid bottle use, because "we cannot give a bad example to other mothers". It is more difficult to enforce the "no bottles" rule in medicine than in neonatology, not only because the policy is rather new, but also because some children are already using a bottle at home.
Most women complain about lack of comfort in the area. At night they sleep on the chairs. Many mothers have swollen feet because they had not slept in a bed for several days. Other logistic issues are difficult. For example, they have to use the public restroom downstairs, because they are not permitted to use the restrooms in the pediatric floor; there is no place where they can take a shower. Unlike "accompanying mothers" of newborns, these mothers do not get food from the hospital and eating is not permitted inside the pediatric ward. In addition, for some mothers, arranging care for their other children at home is complicated. Mothers feel that the staff treats them rudely and unfairly. Indeed, it is frequent that staff members give "orders" to mothers or reprehend them for not being clean enough.

Most staff members appreciate the mothers' presence in the floor, although some still find it more difficult to work this way. Some think that mothers are receptive and helpful; children are easier to feed and take care when mothers are there. However, many personnel members believe that mothers are backward and difficult to deal with.

It may look as if the staff was not sensitive to the problems of these mothers, but this is far from being true. For all staff members in this area dealing with mothers 24 hours a day is a new concept. Most rules come from an attempt by the staff to put order and to protect patients. The staff also complains about the conditions mothers endure but are faced with difficult dilemmas. If mothers were to use the restrooms floor, then the patients' restrooms would not be in good condition for the patients. If mothers were to eat in the rooms, there is a concern of having food leftovers, because there are no appropriate conditions to dispose of food and wash dishes. Some staff members try to overlook when mothers "secretly" eat inside the room or use the restrooms.

There are two the main problems in this area, and they make each other worse. First, the hospital does not have adequate physical resources to meet the needs of mothers staying with their children. Financial resources to feed all these mothers may not be available either. Second, attitudes of the staff are not appropriate in many cases. This appears to be changing, as it changed in other areas of the hospital in the past. Difficulties with a physical structure that is inadequate to meet mothers' and patients' needs make staff more frustrated, slowing their adaptation to new policies. Additionally, the staff fears losing control over their work environment and they try to ascertain their value by controlling mothers' activities. Frictions between the pediatric and neonatology departments make this transition slow, as they blame each other instead of searching for a solution. It seems that several groups react negatively to routine changes when they feel they are losing control over their work environment and status. However, when the people in charge of the program manage, as they have done repeatedly, to find a meaningful role and redefined status for the staff members involved, those staff members tend to not only accept the changes, but to promote them. This has not been achieved in this area yet, perhaps because it is the area where the newest changes have been made.

The staff recognizes the current problems that "accompanying mothers" face and many of them say that this is at the same time the best and the worst of San Bartolomé's breastfeeding promotion. If anything, it is the newest part, and one of the more daring changes that have been made recently. Personnel and mothers try to make the best of it. Mothers appreciate being able to stay with their children. Hopefully, as time goes on physical conditions will improve, the hospital and its staff will get more experience in dealing with this issue, and coordination among personnel from the different areas involved (pediatrics, neonatology, obstetrics, nursing, nutrition) will become more fluid. For this to become a reality, effective leadership that can bring together all the different staff around the same goal is needed. Finding a way to attain that change is a challenge for San Bartolomé's breastfeeding promotion at this moment.

*e. Outpatient Clinic*
At first sight, the newborn outpatient clinic looks like a social gathering, not a medical office. People of all ages are sitting, talking and laughing. A close look reveals that they are mothers and their newborn babies, older children, fathers, grandmothers and aunts. Some of the people in the conversation are the nurse aids. They are informally advising mothers about breastfeeding. On a regular visit, 12 to 25 children are seen. As the families arrive and the babies are prepared for examination, people move the chairs around and talk among them. This is perhaps the area where horizontal dissemination of information and mutual support works best.

Later on, chairs have to be re-arranged for a talk about breastfeeding and child development given by a pediatrician. The talk is never exactly the same, but it covers the same topics. It is usually interactive and the degree of participation varies according to the audience. Family members interrupt; they ask questions, voice their opinions and refer their experiences. Occasionally, a mother explains to the audience how to deal with a particular problem. Each physician has a different style of catching the audience’s attention and making them participate. A male physician explains the correct position to nurse by borrowing a baby and acting as if he were nursing. Mothers laugh. It is for sure that they will remember the position. Humor is very important in all cases to maintain attention and appeal. Even the most serious doctor gets people approval by using humor.

After the talk all babies are examined one by one. People start moving the chairs again and talking to each other. Nurse aids teach specific skills to mothers who need them. For example, they explain mothers how to prevent unwanted milk accumulation in their breasts and how to prevent cracks in the nipples. Outpatient area nurse aids are empathetic with mothers and help them in a very caring and understanding way. The presence of other relatives reinforces an atmosphere in which mothers feel at home and can discuss openly their problems.

The newborn outpatient office used to offer consultations from Monday to Saturday, only in the morning hours. Since July 1997, there is also an afternoon session on weekdays, which starts at 2 or 2:30 p.m. Attendance to the office in July represented an increase in 120 consultations a month. Nearly half of the mothers came in the afternoon, giving the new schedule instant acceptance. The number of patients seen in the outpatient office outweighs the births per month. Sometimes children of mothers who need extra assistance during the first weeks of breastfeeding are seen twice. It appears that this office is serving as a place where they can comfortably come and ask questions.

The one consistent complaint about the outpatient office regards long waiting periods prior to the consultation itself. Those who come at 7 a.m., as requested, have to be here almost all morning, because the actual visit starts at 9 to 10 a.m. This problem seems to be part of the hospital culture, because the same complaint was heard about other areas, like prenatal care or pediatrics.

2. Mothers Who Work Outside the Home

a. Mothers Served by the Program

Most mothers do not work outside the home. Those who do, do not receive any special advice, unless they ask specifically for it. In that case, the staff tells mothers that no bottles or artificial milk should be used under any circumstance and explain them how to express their breasts and store their milk. However, if the mother’s working conditions do not allow for breast expression or milk storage, there are few options. Some times staff tells mothers that they can take their child along to work, especially if they work in the informal sector. Some times they tell mothers who work in the informal sector to stop working, because their income is low and can pay little more than the cost of formula and daycare. In a few cases, staff tells mothers that if they love their children, they should stop working outside the home.

A few stories can illustrate the views of women about breastfeeding and work. Paulina lives in the country and works in her family potato plot. She takes her child along to the field and breastfeeds him there; this arrangement works well for her. However, this is not necessarily the case of all women.
in the informal sector, especially those who have migrated to the city. Heidi, who is a bookkeeper, stopped working, because she cannot afford daycare and cannot take her child along to work. Without her income, her family is struggling to make ends meet. In addition, she misses her job and is concerned about becoming outdated in her field, as taxing and other regulations change.

Maria del Pilar is a pre-school teacher. She appreciates to be financially independent. Working with children is very rewarding for her. She worked until the second month of pregnancy, when she suffered a fall and almost lost the baby. Her work requires a lot of physical activity, so she quit. She did not want to risk losing her child for anything. The baby was born prematurely. She will not work now, even when she would like to, because her daughter needs her. Next year she plans to work in a place near her home. She wants to help her husband to get money for the home and the baby, and also to feel good. There are a lot of expenses now that they have this girl. She wants her baby to grow up to have a profession, to be able to be independent. Maria del Pilar, as most mothers, puts her family before her career. She is clear to say that she can afford it, because her husband has a steady job.

Helen, has a breakfast cart in an open market. Her husband sells cosmetics informally, but he gets less money than she does. Therefore, he has been staying home to take care of the newborn baby. Every day Helen gets up at 3 a.m. to prepare the food; she leaves home at 4 a.m. and opens her stand at 5 a.m. The two kerosene burners work all morning, alternating frying pans, pots and teakettles. She cannot take the baby to the market because the only place to put her would be inside the cart, with inadequate ventilation and at risk of being burned by hot food. There is no daycare available close to her workplace. Helen's mother and sister who also work at the stand and cannot take care of the child. If Helen leaves her stand, things don't go well. She is the one who runs the business. She cannot express her breasts on the street and has no refrigerator available. Being an informal sector worker, hospital staff told her that breastfeeding at work would be no problem for her. The other alternative they hospital offered was to stop working. Since her family's subsistence depends on her, she cannot just close her business. If she would do so for some weeks, then she would risk losing not only the income but also the steady clients that stop by to eat breakfast daily. She knows breastfeeding is good.

Helen's mother breastfed Helen and Helen breastfed her older daughter. Helen is an example of a woman who works outside the home, likes her work and also is the support of her family. She is also a very good example of somebody who is convinced that breastfeeding is the best alternative. Helen and her husband are weighing the possibilities to find the best arrangement in their particular circumstance, as anyone would do. Desperate, she tried formula feeding for two days and the baby became sick. Helen and her husband have decided that he will quit his job completely and take care of the breakfast stand, so she can stay with the baby. This is an experiment and they are concerned, because he has no experience in the breakfast business. However, in the case of this family, practical circumstances are leading them to find a solution that is not easy.

Sometimes mothers are stereotyped as not understanding the importance of breastfeeding or not really caring about it. This view is generally wrong. These cases illustrate that telling mothers to just stop working or to take their child along to work is not enough. Most women work because they need the money, and that income is sometimes very important for the family's economy, even if it is meager. Women in the informal sector not always can take their child along to work. Women who work in non-professional occupations may view their work as a career. Often, mothers feel that their job gives them not only economic security, but also a sense of fulfillment.

b. Staff as Mothers

Another set of breastfeeding mothers is hospital health care personnel. They hold a formal job. Currently Peruvian law allows women to have a 90-day maternity leave. Formerly they could take only 45 days after the birth of the child and 45 days before (27). However, since 1996, they can take 90 days after the baby is born (28). During this time, women receive pay from social security. There is an additional small economic compensation for breastfeeding, also paid by social security.
Workers may take one free hour each day, called "lactation hour" until the baby turns one. The worker and the employer agree the time of the day, but the law does not allow her to combine the hours into days; it must be one hour per day. Workplaces with more than 25 employees are expected to offer daycare, but this is not always the case. Public daycare centers exist, but they are not available everywhere and their quality is a concern for mothers.

Staff members at San Bartolomé are convinced of the benefits of breastfeeding and want to practice what they preach. However, this is not always as easy as it may seem. There is a daycare facility in San Bartolomé that is available to the staff at a very low price. The daycare is currently struggling with its small budget. The main problem for breastfeeding mothers is that the hours of operation of the daycare are limited to the morning, making the schedule incompatible with many workers who stay 8 or 12 hours or that work afternoon and night shifts. Another problem is that the daycare is located across the street, separated from the main building making it more difficult to go there and breastfeed during work hours. Additionally, mothers complain of rigidity of rules at the daycare; they think it is unfair. The daycare staff is trying to offer a better service with low resources. Lack of communication leads daycare staff and other workers to blame each other for frictions that occur there.

There is no designated place at San Bartolomé where workers can express their breasts, or a refrigerator where they can keep their milk. Most workers express their breasts in the bathroom or the locker room; some have access to a more private room, like an office. Most mothers store their milk in a refrigerator, through an informal agreement with whoever is in charge of that refrigerator. Some, however, have no access to refrigerators and discard their expressed milk.

Several female workers at all levels feel they are occasionally pressured by male workers to stop using the "lactation hour" the law specifies. They are not always given fair choices when a new schedule of work is considered. A physician, who was nursing her 8-month-old son, was told that she could not take her "lactation hour" on days she was scheduled to be in the emergency room. The hospital was not prepared to offer her another free hour in compensation. She complained in writing, reminding the administration of her rights. She got her way, but some administrators criticized her...for using the law! In other cases, women cannot make their rights prevail. If they do, like in this case, they tend to feel guilty for not doing well enough as mothers, workers, or both.

Some workers believe that San Bartolomé gives nursing mothers who work at the hospital more choices and flexibility than other workplaces. In general, supervisors in San Bartolomé are said to be “more understanding” and arrangements are made on a one-by-one basis, often as informal agreements between the worker, co-workers and immediate supervisor. Resident physicians who nurse still have problems, because they have to meet academic standards. There is no written hospital policy regarding lactating employees. Most workers never thought that issues about lactation could be subject of union activism, even though in San Bartolomé women make up 70% of the employees.

c. Economics, Contradictions and Policies

Breastfeeding promotion for mothers who work outside the home is affected by various factors: 1) socioeconomic conditions of the country, 2) contradictions in the concepts of women's duties and women's work outside the home and 3) local, national and international policies to promote breastfeeding.

Peru emerged from the 1980s in a profound economic crisis. During the nineties, the country underwent structural adjustment measures that comprised the elimination of subsidies, drastic cuts in public expenditures and control of monetary emission. Labor legislation changed; "stability" is no longer the rule and there is an increasing emphasis on productivity and cost-efficiency. Formal employment decreased; by 1995, 49% of the workforce in Lima was in the informal sector (30). More women than ever are working outside the home. In 1994 they comprised 40% of the workforce (31). In 1994, 48% of the population were not able to meet a "basic family basket" and were
considered to live in poverty. Eighteen percent of the population could not meet the "basic family food basket", and were considered to live in extreme poverty (30).

Women in the formal sector have, even after the economic adjustments, the best benefits to protect lactation. However, many women cannot find a job in the formal sector. Women in the informal sector can sometimes adapt to the circumstances, but have little choice, because they need the income. Women in the "semi-formal" sector fare worst. An example of this is the female security guards in San Bartolomé, who are employed by a firm who contracts with the hospital. They work 12 hours a day under monthly contracts that offer no benefits, like maternity leave, "lactation hour" or pension. They receive a small paycheck and there are many others who would like to take over their jobs. Therefore, they have to continue working, even if conditions are not desirable.

There are contradictions in the way mothers and staff conceptualizes maternal employment. Both, mothers and staff believe childcare and breastfeeding are women's primary responsibilities. However, some of the same people believe women have the right to be economically independent and that they have to take care of their careers. Others say that a woman has to choose between family and work, clearly separating the public and private spheres and making them incompatible. The staff considers women's non-professional work to be of little value in itself. When women need to work, the staff tells them they can do it and breastfeed, with no problem. However, many women in the staff have had problems combining breastfeeding and work. These contradictions are hurting mothers who are patients and those who are hospital workers.

Hospital policies do not address the problems women face. They vaguely mention the need for "social support". This lack of explicit policies for breastfeeding women who work outside the home is not a problem exclusive of San Bartolomé, but it plagues national and international policy. There is no national policy regarding breastfeeding for mothers who work outside the home. Health service providers devise their own leaflets with advice. For example, a leaflet of the Social Security Institute (IPSS) tells mothers who work outside the home that they can continue breastfeeding and working and explains them how to express their breasts and store their milk (32). An institution that conducts service and nutritional research, the Instituto de Investigación Nutricional, recommends to take the child along to work and, if this is not possible, to express their breasts while at work (33). However, no mention is made in any of these leaflets about how to deal when breast expression is not an option. The WHO's "Ten Steps to a Successful Lactation" do not specifically mention women who work outside the home. Instead, they include teaching mothers how to maintain lactation, even if they have to be separated from their child. They too, recommend teaching how to express the breasts, but there is no recommendation on what to do when that is not feasible (26). The reason for this widespread absence of explicit policies regarding lactation for women who work outside the home, may be that contradictions regarding the concepts of maternal employment and women's duties exist at all levels of policy-making, not only in Peru, but in the WHO as well.

Most articles published in the United States list a set of instructions for mothers who want to breastfeed and return to work. They recommend taking a maternity leave as long as possible, to find a part-time job if possible and to learn methods of breast expression and milk storage. They stress the need for social support from family and friends (34, 35, 36, 37). In other words, they tell mothers to adapt to the circumstances and usually they do not mention the need to modify workplace policies (34, 35, 36, 38).

According to some authors, health care providers should advocate for policies in the workplace that favor nursing mothers (37, 38). Auerbach surveyed 577 volunteers and found that the use of breast pumps increases lactation time, but that women face the problem of not having appropriate time breaks to express their breasts. Therefore, they recommend returning to work only after adequate milk supply has been established (39). Hills and Bonzyck surveyed 688 mothers and found that for many, finding a private room to express their breasts and/or a refrigerator to store their
milk was a problem. They encourage the use of "creative solutions", like taking the child to work (40). None of these authors see women as an agent of change of their own situation.

Barber-Madden lists problems of nursing mothers who work outside the home to be "role overload", as the mother is trying to do both home and non-home work, and sexual discrimination. In addition, she cites many women may not be aware of their legal benefits as working mothers, and that precludes them from enforcing those benefits (41). Lack of information on existing benefits is a barrier that has been mentioned also in the Third World (42). This appears to be happening in San Bartolomé, where most staff members know legal benefits exist, but ignore the specifics of them.

There is an interesting study of mothers who are resident physicians. The percentage of those mothers who breastfed fell from 80 to 40% after they returned to work. Their problems were lack of time (79%) and of a place to pump their breasts (42%). The authors recommend that time and place for milk pumping should be provided and that support for nursing resident physicians should be offered in writing to be able "to practice what we preach" (43). The same could be applied to San Bartolomé.

In the US, mothers who have jobs that require more skills and who decide to continue work and to breastfeed are more likely to be successful in that endeavor than their counterparts who hold jobs that require fewer skills. More skilled mothers are more likely to be in working positions that can be more flexible, may have jobs with better benefits (i.e. maternity leave), may have educated supporting partners and may have less financial pressure, allowing them to take a part time job for several months (40). In Peru, women workers in the informal and semi-formal sectors lack economic freedom and personal control over their work environment, have no legal benefits, and more financial need to continue working. The vacuum in breastfeeding promotion policies becomes more critical when many women have to enter the workforce due to financial pressures, especially when a large segment of the population lives under poverty. Therefore, it is of paramount importance to do every effort to assist these women as mothers and as individuals.

Frequently, providers in the U.S. recommend a mother who works outside the home to initiate mixed feedings, with some formula, if other options are not possible (34, 35, 36, 38). They believe that the use of formula should not be equated with failure of lactation (35). These recommendations are less likely to induce guilt feelings for the part of nursing mothers. It is possible that Peruvian health care providers refuse to openly recommend formula introduction due to the greater probability of contamination of milk that exists there, especially for the poorer sectors of the population. This is another way in that the economic situation of the country influences policy on women who work outside the home and lactation -or lack thereof.

d. Options for Breastfeeding Women Who work Outside the Home

A question that was raised by this fieldwork is what can be done, in terms of policy and implementation, to improve breastfeeding promotion and at the same time address the needs of mothers that work both in the formal and informal sectors. Here, too, solutions may come only after contradictions are openly discussed. Some possible parts of the solution are to draft written guidelines, that would explicitly recognize the value of women's work as income generator and as a source of personal realization, that would encourage fathers to be more involved in decision-making and, perhaps in some cases, would allow for recommendation of some formula feeding.

For their own workers, San Bartolomé's could provide a room for breast expression and a refrigerator. This change would be affordable and also would be a respite for breastfeeding hospital staff. It could reflect in better working conditions, and also in better promotion of breastfeeding. Additionally, starting "at home" could give San Bartolomé more leverage when advocating ministry wide or nation wide changes in policies for women who work outside the home.

Since many of the problems are outside the control of hospital policy, it is not up to hospital administrators to change them. However, program leaders, especially nurses and physicians, are in a
position where they can make their voices heard. They can attempt to influence politicians, congressmen and civil servants who write laws and regulations, so that affordable daycare is more widely available for women and that people are educated to accept women's rights as written in the law.

A few authors consider that mothers can be agents of change of policies for their own benefit. For Barber-Madden, the work environment should offer both policy and physical structure support. Worker unions are in an ideal position to request that support, since they represent a large sector of employed women. Unions could work toward solutions like a place for breast expression and milk storage and breaks to carry out this activity, availability of affordable childcare or at least referrals to appropriate facilities, maternity leave, flexible schedules and consultation about lactation available in the workplace. In the long run, unions can advocate the passing of legislation to protect lactation, education through mass media and in schools (41). From a feminist point of view, Women and Work Taskforce World Alliance for Breastfeeding Action argues that women are exploited if they do not receive support from other workers or if they face constraints to lactation in the job. No woman should be forced to make a decision between breastfeeding and work. Nursing should be recognized as productive work. Women workers, using a woman-centered definition of work, should take the part in the developing of legislation to protect breastfeeding (44). Such legislation should include maternity leaves, breastfeeding breaks and affordable daycare, as well as an educational component to raise awareness among the general public (44, 45).

In San Bartolomé the conditions exist for women to take the leadership. They make up 70% of the employees and are represented in all occupational groups. Most workers, except nurses and physicians, are unionized. The hospital not only promotes breastfeeding, but showcases its program as the best characteristic of the hospital, thus obtaining recognition (and status) from it. That effort has much to gain from being a model of "breastfeeding-worker friendly hospital". Discussions about the contradictions in the concepts of women's employment, women's duties and women's rights may potentially allow union members to formulate more specific demands that take into account women's point of view.

VI. Conclusions

A. Maternal Expectations

Maternal expectations about the program are largely fulfilled. Mothers receive even more information than they originally expected. They appreciate support from staff and other mothers and the friendly scheduling of the outpatient clinic. "Early contact" with the newborn and the possibility to stay in the hospital in "accompanying mothers" accommodations were particularly satisfying for mothers.

There are some expectations of mothers that are unfulfilled. They do not receive the advice and support they expect when they have to breastfeed and work outside the home. They feel that the staff does not value enough their role as outside the home workers. Physical environment of the building, like absence of restrooms for mothers in the pediatric medicine ward, and lack of support from some members of the staff made the stay of "accompanying mothers" in pediatric medicine difficult. Minor difficulties include not enough comfort or space in rooming-in and inadequate information about prenatal care educational activities.
B. Staff Expectations

The staff’s expectations about the programs are fulfilled. Workers enjoy promoting breastfeeding; they feel pride and a sense of ownership about San Bartolomé’s breastfeeding promotion program. The staff highly values its ability to participate in discussions to design and improve program’s activities.

As in the case of the mothers, the staff expectations are unfulfilled in some areas. However, given the more day-to-day nature of the contact of the staff with the program, the relationships between fulfilled and unfulfilled expectations are more complex and sometimes ambivalent. Perhaps there are two main problems. First, there are conflicts and misunderstandings among staff and departments and they are sometimes slow to be resolved. Second, and paradoxically, nursing mothers among the staff do not find the necessary facilities to support lactation.

C. Key Components of the Program

Several components of the program are critical for the fulfillment of maternal and staff expectations about the program. They are: informal interaction between mothers and personnel and among mothers themselves, group settings, "early contact", the presence of "accompanying mother" accommodations, staff commitment to the program and the use of all personnel to convey the same message about breastfeeding.

There are components that interfere with the fulfillment of expectations. They are: inappropriate communication among hospital staff and departments, conceptual contradictions regarding women's duties and maternal employment and financial and physical structure limitations of the hospital.

San Bartolomé has a commitment to improve the technical and human quality of service. For example, the newborn outpatient clinic has recently extended its hours to the afternoon, which is very convenient for mothers. Over the years, many positive changes have taken place, like rooming-in and "early contact". Remaining changes are the most difficult because for two reasons. First, there are old-held values that oppose change, like in the case of women who work outside the home. Second, they have to confront policies that are often times not hospital policies, but national or international ones.

VII. Recommendations

A. Communication

- Use program accomplishments to give positive feedback to hospital employees.
- Enhance communication among staff and departments around problem areas.
- Hold open discussions that recognize that all hospital areas are trying to work for the same goal: the benefit of the patients. This would allow setting aside personal difficulties and focusing on solving existing problems.
- Educate staff members periodically so that they remain sensitive to mother's needs.
- Take into account the point of view of mothers when devising and improving program components.
B. Maternal Employment

- Hold open discussions to exchange points of view regarding the subject of mothers who work outside the home.
- Prepare a consistent message for mothers who work, avoiding generalizations and guilt inducing comments.
- Make available a room with a refrigerator for lactating hospital staff members to express their breasts and store their milk.
- Offer hospital daycare hours compatible with staff's schedule.
- Take the leadership advocating for education of employees and employers about laws regarding working mothers.
- Lobby for the creation of affordable quality public daycare.
- Consider the needs of breastfeeding mothers when preparing the union's platform.

C. Physical Structure Limitations

- Make available a restroom, beds or cots and an eating area for mothers of hospitalized children 1 to 24 months old.

D. New Programs

New programs serving similar populations should foster informal human interaction between mothers and staff and among mothers. Program planners should keep in mind the preferences and points of view of the target population. They may use group settings and "early contact" to foster such informal interaction. All personnel should be able to promote breastfeeding. This stimulates the feeling of teamwork and cuts down costs that would be necessary to hire lactation experts. Programs should work with informed and committed staff to promote breastfeeding. Program planners should keep in mind that the staff is more committed if it is made part of the program development and modification. To avoid serious problems planners should put special emphasis in maintaining strong communication among the hospital or health center staff and departments and in solving contradictions that sometimes are not obvious, like the ones on concepts on maternal work outside the home. If a new facility is being built, architects could find ways to accommodate group rooms that are comfortable and, at the same time, are able to facilitate informal communication.

VIII. References

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