Nurses’ experiences of breastfeeding and breastfeeding counselling at Mulago Hospital in Kampala, Uganda

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SAMMANFATTNING

Inledning: Majoriteten av barn i Uganda ammas, men de som ammas exklusivt i enlighet med Världshälsoorganisationens rekommendationer är få. I vissa delar av Uganda förväntas mammor amma samtidigt som exklusiv amning upplevs som nästintill omöjlig att få till. Amningsrådgivning har visat sig förlänga varaktigheten av exklusiv amning.

Syfte: Studiens syfte var att undersöka sjuksköterskers erfarenheter av amning och amningsrådgivning vid Mulagosjukhuset, Kampala, Uganda.


Slutsats: Fattigdom, bristande kunskaper och kvinnornas arbetssituation leder till att mödrar har svårt att amma så mycket som vore önskvärt. Eftersom amningsrådgivning är en viktig grundpelare i mödrars amningsframgång bör fokus läggas på att optimera dess kvalité. Genom att arbeta för involvering av fäderna och utöka information till mödrarna, kan chansen till förlängd exklusiv amning öka.

Nyckelord: Uganda, amningsstöd, information, sjuksköterska
ABSTRACT

Introduction: The majority of infants in Uganda are breastfed but the rate for exclusive breastfeeding accordingly with WHO’s recommendations is low. In parts of Uganda mothers are expected to breastfeed but find it hard to achieve. Breastfeeding counselling has shown to prolong the duration of exclusive breastfeeding.

Purpose: The purpose of the study was to investigate nurses’ experiences of breastfeeding and breastfeeding counselling at Mulago Hospital, Kampala, Uganda.

Method: A qualitative method was used for this study. Eight nurses working at the low risk delivery ward and the postnatal ward at Mulago Hospital were interviewed through a semi-structured approach. The informants were picked through a strategic sample. A qualitative content analysis was used for data analysis.

Result: Through data analysis four categories emerged; Comprehension of the multidimensionality of breastfeeding, Training and guidelines, Experienced obstacles for breastfeeding and Vocational pride in counselling. Nurses saw exclusive breastfeeding as an essential part of the health of the mother and child. Heavy workloads for the mothers, lack of knowledge and physical difficulties was identified as obstacles for breastfeeding. Better communication between instances involved in maternal and child health along with available guidelines and more in-job training was suggested to improve the breastfeeding counselling.

Conclusion: Many obstacles hinders mothers from breastfeeding successfully. Focus should be put on optimizing the breastfeeding counselling. This can be done through better communication between instances, available guidelines and more in-job training. Enhanced involvement of fathers and better support to mothers might prolong the duration of exclusive breastfeeding.

Keywords: Uganda, breastfeeding counselling, information, nurse.
Acronyms

HIV - Human immunodeficiency virus
IRB - Institutional Review Board
UN - United Nations
UNICEF – United Nations Children’s Fund
WHO - World Health Organization
3.4.4 Wish for supportive partners

4. DISCUSSION

4.1 Summary of results

4.2 Discussion of results

4.2.1 Comprehension of the multidimensionality of breastfeeding

4.2.2 Training and guidelines

4.2.3 Experienced obstacles for breastfeeding

4.2.4 Vocational pride in counselling

4.3 Discussion of method

4.3.1 Ethical considerations

4.3.4 Confirmability

4.3.5 Transferability

4.4 Clinical implications

4.5 Conclusion

5. REFERENCES

Appendix 1. Interview guide
Appendix 2. Information Letter
Appendix 3. Consent form
1. INTRODUCTION

1.1 Physiology of breastfeeding

An adequate and good quality diet is essential for the good health, growth and development of a new-born baby. Breast milk contains all the nutrients that an infant needs; fat, carbohydrates, proteins, vitamins, minerals, water and antibodies to protect the infant against infections (Ip et al., 2007). The breast milk produced in the first few days after delivery is called colostrum. It is rich in antibodies, white cells and Vitamin A, which is important for the immune system. Also the colostrum contains purgative, which clears meconium and helps to prevent jaundice, and growth factors that contribute to intestinal development and prevention of allergy and intolerance. The breast milk is later transformed into mature milk and the quantity becomes larger. The mature milk has two stages. The foremilk is the milk produced early in a feed in large amounts. It contains plenty of protein, lactose and other nutrients. Thanks to the large volume the baby gets the satisfactory amount of water as well. Later in the feed the hind milk is produced and contains mostly of fat. The baby’s energy is provided mostly from this part of the feed. This is an important reason why the baby should be allowed to feed until satisfied (WHO 1993a).

Reduced risk of different types of cancer and developing diabetes can be traced back to good breastfeeding practices. Benefits from successful breastfeeding is also found as improved maternal recovery after child delivery (Jones et al., 2003). By initiating breastfeeding in the right time and manner many preventable deaths of children can be averted (Bhutta ZA, Lassi Z, Pariyo G, Huicho L, 2010).

By breastfeeding a bond between the mother and child is created. It has been shown that breastfed babies cry less. If breastfed directly after delivery they may also develop faster. Mothers who breastfeed tend to create a more affectionate bond to their babies. They complain less about the baby's need for attention and feeding at night. Mothers who breastfeed has been shown to be less likely to abandon or abuse their babies. Exclusive breastfeeding is also a tool in family planning as it delays a new pregnancy (WHO 1993a).
1.2 Breastfeeding globally

Of the 6.6 million deaths of children under the age of five in 2012 half of these could have been prevented by simple interventions. Almost all of these children are found in poor countries (WHO, 2013). Improving breastfeeding is established as such an intervention. Estimations show that the lives of 1.5 million children could be saved just through the improvement of breastfeeding practices. Improving breastfeeding rates plays a major role in order to reach the Millennium Development Goals regarding health and nutrition that the United Nations have set for 2015 (Bhutta et al., 2010).

The World Health Organization (WHO) recommends exclusive breastfeeding - where breast milk is the only source of nutrition - for the first six months of the life of a child. Thereafter breastfeeding should continue to be an important part of the everyday diet for at least the two first years (World Health Organization, 1993a). WHO’s recommendations are not followed all over the world. Cultural practices are for example used for postpartum care, which are not aligned with the recommendations (Illiyasu et al., 2006).

If a mother is infected with HIV, the recommendations by The World Health Organization (WHO) is align with the general recommendation, to breastfeed their infants exclusively for six month, unless artificial feeding is available, feasible and safe. It is stated that the most important factor of helping the women to make the right decision, whether or not to breastfeed if infected by HIV, is counselling. The rapport by WHO also elucidate the importance of the HIV infected mothers taking their antiviral medication in the effort of reducing the risk of infecting the child through breast milk. (World Health Organization, 2007)

A systematic review made by Kramer and Kakuma (2012) established that morbidity from gastrointestinal infections become less prevalent in infants who are exclusively breastfed for six months compared to those who are partially breastfed for three or four months. The importance of exclusive breastfeeding for at least 6 month has been recognized by Unicef and WHO. This backed the launching of the "baby friendly hospital initiative" that globally aims to encourage and support mothers in the subject of breastfeeding (WHO, 2009). Declercq, Labbok, Sakala and O’Hara M (2009) studied mothers in the United Stated who delivered in hospitals that practiced the “Baby-Friendly Ten Steps”. These steps consist of evidence-based
practices that have been shown to both increase breastfeeding initiation and prolong the breastfeeding duration. Those mothers who deliver in hospitals that fulfil at least six or seven of the ten steps have a better chance of being successful in breastfeeding. The women are six times more likely accomplish the goal of achieving their intention to exclusively breastfeed than those in hospitals that practice none or one of the steps. The same tendency is noticed in mothers who report supplemental feedings to their infant (Declercq et al., 2011).

The rate of exclusive breastfeeding during the first six months in low income countries ranges between 30-50 percent. At the same time a similar rate for complimentary feedings conducted in an unsatisfactory way is observed (Bhutta, Lassi, Pariyo & Huicho, 2010).

1.3 Breastfeeding in Uganda

In 2006 the median duration of any breastfeeding in Uganda was 20.4 months, but the median duration of exclusive breastfeeding was as low as 3.1 months (WHO, 2006). In Eastern Uganda breastfeeding is an occurring phenomenon, but the rate of exclusive breastfeeding is low. Almost 50 percent of the babies in the area receive prelacteal supplements. The most common reasons to this are waiting for breast milk to come, not having enough breast milk to satisfy the baby’s hunger, cleaning the baby’s throat or giving the mother a chance to recover from delivery (Engebretsen et al., 2007).

Even though breastfeeding is regarded as the correct way to feed the baby, according to a study from Eastern Uganda mothers find exclusive breastfeeding next to impossible. The limiting factors for exclusive breastfeeding mentioned are lack of time, exhaustion and limited breast milk due to poverty and hunger. Despite the antenatal teaching given to the women they still express the need of more information regarding breastfeeding. Most of the men feel excluded from the health education over all (Engebretsen et al., 2010). A study from southwest Uganda show that breastfeeding exclusively for six months is one of the factors that reduce the risk of child mortality in a rural population in south-west Uganda (Zhang, Maher, Munyagwa, Kasamba, Levin, Biraro & Grosskurth, 2013). In 2011 the under-five mortality rate was 90 per 1000 live births in Uganda (Unicef, 2011).

1.4 Breastfeeding counselling
Through breastfeeding counselling the health care worker aims to support mothers and provide them with accurate information regarding breastfeeding. It is not meant to be used as a tool for ordering the parents what to do regarding breastfeeding. The health care worker can instead help the parents to decide themselves what would be best for them. In working with breastfeeding counselling, listening skills and skills in building confidence are important health care worker traits (WHO, 1993a). Counselling should be done not only prenatally but continue all the way through the second year of the child’s life. Counselling can involve such as helping the mother to assure adequate milk supply, give advice about frequency of infant feeding and to help with breastfeeding difficulties. Breastfeeding counselling directly after birth should aim to create a supporting environment for breastfeeding, make sure the baby attaches to the breast to ensure effective suckling as often and for as long as the baby chooses and to empower the mother (WHO, 1993a).

It is established that breastfeeding counselling as part of new-born care education plays a key role in the matter of protecting the infant and ensuring proper nutrition and good health. The lack of training in this area limits the health care worker and prevents him or her from executing this part of the job in a satisfying manner. In actuality antenatal breastfeeding counselling plays a very limited role and is seldom an integrated part in the education, care and service offered by the health care team consisting of doctors, nurses and midwives (WHO, 1993b). Research done in health centres in Tanzania show that parents are not given sufficient information concerning breastfeeding and its importance in avoiding health problems. (Mbekenga et al., 2011).

According to the World Health Report from 2006 the community health worker plays an important role in solving the human resource crisis. They make sure that many patients who otherwise would not get any health care are reached through patient home care, outreach and counselling. In order to optimize the effect of implementing government health care programs and strategies community health care workers need to be inserted and included in the wider health system both on country and local level (Bhutta ZA, Lassi Z, Pariyo G, Huicho L, 2010).

Support in breastfeeding offered either by professionals or peers, or a combination thereof, could prolong the duration and exclusivity of breastfeeding. However the support needs to be tailored to fit each individual and also to meet the needs of the population group in question (Renfrew, McCormick, Wade, Quinn & Dowswell, 2012; Bhutta et al., 2010; Bhutta et al.,
Studies have also shown that another important part of implementing better breastfeeding practices is to promote home based peer counselling (Bhutta et al., 2010). Haider, Ashworth, Kabir and Huttly (2000) come up to the same conclusion. By educating local mothers in Bangladesh into becoming peer counsellors in breastfeeding practices the initiation and duration of exclusive breastfeeding is effectively increased. Peer counselling have been established to have a positive impact on the rate of exclusive breastfeeding all over the world. In periurban Mexico City Morrow et al. (1999) show that educating peer counsellors from the community significantly prolong the duration of breastfeeding. The same result is found by Tylleskär et al. (2011) with peer counsellors trained in breastfeeding counselling with standard training packages recommended by WHO from 82 local communities in South Africa, Uganda, and Burkina Faso. Community-based promotion and support is identified as a particularly important component for exclusive breastfeeding. In order to achieve successful counselling improvements of interpersonal counselling and problem solving skills is needed (Mangasaryan et al., 2012).

A study from Uganda shows that the amount of support and information given differs depending on where in Uganda the counselling is given (Waiswa et al., 2010). Nankunda, Tumwine, Nankabirwa and Tylleskär (2010) show that more than 95 percent of the women in Mbale district in Uganda who is offered support in the form of peer counselling express satisfactions with the service.

1.5 Nurses’ experiences of breastfeeding counselling

A study from Eastern Uganda showed that the counselling sessions offered by the health care workers are often improvised. The attitude of many mothers is coloured by obstacles such as poverty, stigma and concealment of HIV. This forces the counsellors to have a pragmatic approach to the support given. The health care workers perceived the task of breastfeeding counselling as challenging, for HIV-positive mothers as well as for the general population. Outdated training and confusion regarding breastfeeding counselling due to changes in programs and guidelines result in health workers improvising and providing parents with answers that do not conform to current recommendations (Fadnes et al., 2010).
1.6 Theoretical framework

Dennis (1999) describes self-efficacy as a process where the individual creates their confidence through the perceived ability to have control over their motivation, thought processes, states of emotions and social environments.

Dennis’ (1999) theory about breastfeeding self-efficacy states that a mother’s confidence in her ability to breastfeed her infant is dependent on four different factors: (1) whether a mother makes the decision to breastfeed or not; (2) how much effort she puts in to it; (3) whether she will have self-enhancing or self-defeating thought patterns; and (4) how she handles breastfeeding difficulties. To accomplish breastfeeding self-efficacy four main sources of information need to be taken in to account: (1) performance accomplishments (for example past breastfeeding experiences); (2) vicarious experiences (for example watching other women breastfeed); (3) verbal persuasion (which could be encouragement from influential people in one’s life such as friends, family, including extended family, and lactation consultants); and (4) physiological responses (from fatigue, stress, anxiety for example). The theory states that through impacting these sources health professionals may enhance a mother’s confidence to breastfeed (Dennis, 1999). To use this theoretical framework in this study seems relevant for the purpose of the study. The authors of the study find it interesting to compare the results of the study with Dennis’ theory in order to explore the relevance of said theory in context of Mulago Hospital, Uganda.

1.7 Statement of the problem

Breastfeeding is important and vital for the diet and health of the infant. Uganda has a low percentage of exclusive breastfeeding and the rate of child mortality in the area is high, partly on account of malnutrition (Kramer & Kakuma, 2012). It is therefore relevant to investigate the perception of healthcare workers on breastfeeding counselling in Uganda.

1.8 Purpose

The purpose of the study is to investigate nurses’ perceptions and experiences of breastfeeding and breastfeeding counselling at Mulago Hospital, Kampala, Uganda.

2. METHOD

2.1 Design
This study has an explorative and descriptive qualitative design. The design allows a phenomenon to be studied and described so that valuable reflections of the individuals can be presented (Polit & Beck, 2008).

2.2 Sample

The sample consist of eight nurses; six working in the low risk delivery ward and two in the post natal ward at Mulago Hospital, Kampala, Uganda. The nurses were 30-40 years old and the range of working experience was 13-20 years. In order to qualify into the sample group for this study certain inclusion criteria had to be met. These were: English speaking nurses with at least six months experience of working at a ward that deals with maternity and infant health. They also had to be willing to share their experiences. Therefore the selection process was performed by a strategic sample. The authors were assisted by Ms. Susan Nassaka Byekwoso in establishing relevant contacts for the selection process.

2.3 Data collection

A semi structured interview guide with open ended-questions was used for this qualitative study to obtain data based on the informants own perceptions of breastfeeding counselling. Questions on the same topics were asked to all informants but the query sequence needed to be different in some instances, due to the interview situation and the informant’s “responses”. Open ended questions give the informants a chance to offer their own opinions (Polit & Beck, 2008). Follow – up questions were asked in order to receive more detailed answers.

The interview guide was created by the investigators through literature review and discussions with the supervisors. In order to ensure that collected data answers the aim of this study in a relevant way a template from Hansen and Hormazábal Contraras (2012) was used in constructing the interview guide. The interview guide (Appendix 1) have five questions for background data. These questions introduced the informants and aimed to make them feel comfortable so that they could talk freely about their experiences, feelings and own beliefs. It is also gave the interviewer a chance to get more detailed facts from the informants, such as; age and years of work experience. The first introductory question served to introduce the aims of the study (Kvale, 1997). Nine more questions were focused on the aims; experiences of breastfeeding and breastfeeding counselling. All interviews were tape recorded. All interviews were executed in English.
2.4 Procedure

Before the start of the fieldwork ethical clearance were applied for and guaranteed by the Research and Ethics Committee at Mulago Hospital (see Appendix 2).

A pilot interview were executed to test the interview guide, the investigator’s interview style and the functionality of the recorder. Since the interview was of good quality it was kept as data for the study. The interviews were performed in the wards. The interviews lasted between 11 and 28 minutes. Two people were involved in the interviews; the informant and the interviewer.

It was ensured that the informants were given written and verbal information about the confidentiality of their answers before starting the recorder. The informants were told that they were free to decline answering any question at any time without giving a reason and also that they were free to stop the interview if they wanted to (Ethic Review Board, 2010).

The questions of the interviews were altered as they went along depending on the situation and understanding of the informant. The investigators aim was set on trying to build up a safe atmosphere so that the informant could trust the investigators and talk about their experiences and feelings. The investigator acted in a polite manner and the interview process was designed like a normal conversation. To avoid misunderstandings intonation and gestures were tried to be avoided by the investigators (Kvale, 1997).

2.5 Ethical considerations

When performing a study it is necessary to obtain an authorization from relevant organizations before the interviews take place. This is due to the fact that the sample group selected to participate in the interviews work in an organization where they have responsibility for other people. Authorization is essential in order to give reliability to the study (Descombe, 2000).

Ethics clearance and the approval to conduce a minor field study were established before the study starts through Clara Aarts, who is one of the International co-ordinators at Uppsala University. The project plan was then analysed and approved by Makerere University School
of Health Sciences Institutional Review Board in Kampala, Uganda (Appendix 2). To conduct the interviews permission was asked from the block manager from the low risk delivery ward and post natal ward before nurses were asked to participate in the study.

Participation in the study was completely voluntarily. The nurses got written information about the aims of the study, about the investigators and their supervisors, the role and the full rights of the informant, the confidentiality of the study and the non-economic benefits (Appendix 3). Information about the study was also given to the informants verbally before performing the interviews. The participants signed a consent-to-participate form (Appendix 4). It is important that confidentiality is secured so that no identity can be withheld (The Northern Nurses’ Federation, 2003). The informants are free to decline answering any question at any time without giving a reason. The data was kept confidential during the analysing process and kept that way through the whole of the study (Ethic Review Board, 2010).

The authors did not consider the questions to be of sensitive or offensive nature.

2.6 Data analysis

A content analysis as described by Graneheim and Lundman (2004) was used for data analysis. Directly after each executed interview the interviewer wrote down what intuitive perception she got of the content before transcription.

Each interview was listened to in its entirety to create a general understanding for the material. Then each interview was transcribed verbatim by one of the authors. To limit the risk of gaps in the transcription process both authors listened to the interview and discussed the content.

To make each transcript anonymous and yet still manage to separate them from each other during the processes of analysis a unique colour was assigned to each transcript. In order to perform the content analysis both authors read each transcript from beginning to end repeated times to achieve an apprehensive perception of its content. Thereafter the transcripts was formed into meaning units through extraction. Such meaning units consists of phrases referring to a concept relevant for the aim of the study.
The meaning units were shortened into sentences that captured the essence of the phrase through condensation. The condensed sentence was given a code which summarized and clarified the core content of the meaning. Depending on core content the codes was grouped into sub-categories. From the sub-categories a certain number of categories emerged (see Table 1) in accordance with Lundman and Graneheim (2008).

Table 1. Example of meaning units, condensed meaning units, codes, sub-categories and categories

<table>
<thead>
<tr>
<th>Meaning units</th>
<th>Condensed meaning units</th>
<th>Code</th>
<th>Sub-category</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Me I feel proud. Because when the mother gets the information and I see how she is breastfeeding the baby. I go and I am happy. The message is taken in. So to me it’s important as a midwife I’m proud of being a midwife, I teach so many things.”</td>
<td>I feel proud because I teach so many things. When the message is taken in I am happy.</td>
<td>Proud being a teacher.</td>
<td>The effect of breastfeeding counselling</td>
<td>Vocational pride in counselling</td>
</tr>
</tbody>
</table>
“After the delivery we talk to the mother about putting the baby to the breast but then they go home and you don’t know if they continue the practice or not. To make them follow what we teach them the community need to be on board too.”

Don’t know if they continue breastfeeding practices at home. Depends on the community.

Influences from the village determines breastfeeding practices.

Cultural influences

Experienced obstacles for breastfeeding

3. RESULTS

During the analysing process of the nurses’ experiences of breastfeeding and breastfeeding counselling four categories emerged; Comprehension of the multidimensionality of breastfeeding, Training and guidelines, Experienced obstacles for breastfeeding, Vocational pride in counselling. For those four categories 14 sub-categories were formed (Table 2).

The results from the data collection are presented for each category. Quotes for each category’s sub-categories will illustrate the finding of the study.

Table 2. Overview of results

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehension of the multidimensionality of</td>
<td>Superiority of the breast milk</td>
</tr>
</tbody>
</table>

11
3.1 Comprehension of the multidimensionality of breastfeeding

The category concerns how the nurses experience the phenomenon breastfeeding. All of the nurses expressed only positive attitudes regarding breastfeeding. They agreed on that exclusive breastfeeding for at least six months was the preferable practice. They all had a lot of knowledge about the different traits of the breast milk and how breastfeeding affected both the mother and child in a good way.

3.1.1 Superiority of the breast milk
The fact that the breast milk for the child is constantly available was something the majority of the nurses mentioned. Also the financial aspect of breastfeeding came up several times.

“It’s cheap for the mother. It doesn’t cost her anything- it’s free. // wherever she goes she goes with the baby, she’s carrying everything. She doesn’t have to think have to go to buy this if forgotten there is no. The milk is ever ready so she doesn’t have to get too worried.” (Nurse 1)

The knowledge of the physiology of breastfeeding seemed to be high among the nurses who were aware of what the qualities of the breast milk were. One nurse said:

“Actually we tell them that it is very good for the mother to start breastfeeding immediately because even in the first minute you have what they call the colostrum. It is very good for the baby.” (Nurse 2)

3.1.2 Maternal and child benefits

When discussing breastfeeding the nurses expressed the complexity of the phenomenon several times. The fact that it had clear benefits for the child and also the mother was stated by the majority if the nurses.

“It even prevents postpartum haemorrhage. As she breastfeeds it helps the uterus to contracts and prevents a lot of bleeding.” (Nurse 2)

“The baby will get the right nutrients. The first 6 months you should breastfeed exclusively. It helps the baby to thrive.” (Nurse 8)

What also was mentioned on additional occasions were the indirect benefits for the child. By breastfeeding the mother have to sit down and put all other things aside. This means that the child get undivided attention from the mother which helps to create a bond between them and also gives the mother time to assess the health of the baby.

“I really like it because this baby is well cared for. Is getting all the nutrients and the mother will give time for the baby. When breastfeeding what you always
"remember is, how is my baby? // I really like it because it means time for the baby." (Nurse 3)

3.2 Training and guidelines

The category describes the different sources of information that grounds the breast feeding counselling that the nurses are conducting. The nurses stated three different domains from which they gathered the information for breast feeding counselling.

3.2.1 Official guidelines

The majority of the nurses claimed that some guidelines were provided and presented as charts on the walls. One nurse claimed the charts to be helpful for both the mothers and the nurses:

"We have some guidelines, they are put on the walls... // So the moment they enter the ward they read those guideline lessons then they start doing so, then later on you add on accordingly...// They are helpful. Yeah. And in the case we get more I think we shall be rendering fantastic services” (Nurse 6)

It was stated by most of the nurses that the charts and guidelines are there but most of the nurses expressed that the basics of breast feeding, such as the importance of exclusive breast feeding for the first 6 months, was known to the nurses since before taking part of guidelines and charts.

"Like especially exclusive breast milk for, exclusive breastfeeding for the first 6 month, at least all nurses know, all midwives know that” (Nurse 4)

3.2.2 In-job training

Some of the nurses claimed that they are sometimes offered in-job training such as workshops and seminars. It was expressed that this opportunity was appreciated by the nurses and would improve the quality of the breastfeeding counselling.

"And sometimes midwifery yeah they carry out some referential courses. They select a few and take for training in that // You have a chance to go and you, you gain it, the benefit” (Nurse 5)
3.2.3 School as a source of information

The majority of the nurses claimed nursing school laid the foundation of the information they based their breast feeding counselling up on. One nurse experienced that she had never seen any guidelines but used her education from school when counselling the mothers:

"Guidelines? That I have never seen, but I follow those I was told from training school". (Nurse 3)

3.3 Experienced obstacles for breastfeeding

This category describes the nurses’ experiences of obstacles for breast feeding that they come across when they conduct breastfeeding counselling.

3.3.1 Ignorance regarding breastfeeding

One of the main issues that nurses experienced as an obstacle during their work with breast feeding counselling was ignorance and lack of correct information regarding breastfeeding and the process of the production of breast milk. The nurses elucidated the issue with mothers believing that they could not breastfeed because the milk would not come in directly, or soon after, giving birth. The nurses experienced that many times the mothers lacked knowledge in the production of breast milk and the existence of colostrum. Because of this the mothers might believe that they are not capable of producing breast milk and therefore turning to artificial substances or other fluids. One nurse described a perceived problem among the mothers:

"Because some they may, they may come here and they may think that giving, there is no breast milk for they have just delivered but when we told them that breast milk is not there, it should be establish within the third day, on the third day of delivery and there is colostrum and the babies should be fed colostrum within, within the first two days then the third day breast milk will be established." (Nurse 6)
3.3.2 Cultural beliefs

Different religious and cultural beliefs was also perceived to affect breastfeeding. Because of the difficulties that may emerge surrounding breastfeeding, some mothers seek other solutions. One nurse described the phenomenon of turning to religion to explain the obstacles of breast feeding. The nurse quoted one mother:

"Me, I don’t have breast milk, maybe I am not blessed by god" (Nurse 6)

The beliefs of the mother depended on their origin. One nurse portrayed the situation with cultural traditions and convictions as a clear obstacle for breast feeding and also a source of illness for the child. The nurse said that some mothers might think that there is a need to cleanse the baby with other liquids before starting the breast feeding.

"It is the culture which tells you that for them they believe that they have to clean the inside of the baby with some other things that will make the baby sick. So that is a problem. They say they have to clean before breastfeeding. So that’s a bad practice” (Nurse 8)

3.3.3 Stigma around HIV and breastfeeding

HIV positive mothers and their fear of passing on the virus to their child through the breast milk were also expressed as a common obstacle for breast feeding by the majority of the nurses. The nurses perceived that the stigma that surrounds HIV positive mothers leads to many of these mothers avoiding breast feeding in fear of infecting their baby.

"Another one is HIV, still people have that stigma of like, maybe when I breastfeed I will transfer the infection to, from me to the baby” (Nurse 4)

It was explained by the nurses that the risk of passing on the infection through the breast milk as very small and combined with the medication provided should not be seen as an obstacle. One nurse explained how she looks upon the problem with lack of information regarding breast feeding and being an HIV positive mother.
"The positive mothers have that unease ‘wont I pass on the virus to my baby when I breastfeeding?’ some of them say ‘I’m not breastfeeding completely because I am positive’... // I encourage them to breastfeed, that if you breastfeed exclusively for the first 6 month the chance of infecting the baby are very low. And encourage them to take their drugs for, their ARV’s so it reduce the chance of infecting the baby” (Nurse 7)

3.3.4 Absence of maternity leave

Mothers having to return to work were identified as another essential obstacle for breast feeding. A shortage of maternity leave concludes in mothers having to leave their babies to caretakers and therefore not being able to breastfeed their babies.

"The working matters, the working sometimes it’s not possible, sometimes they give you a leave for 3 month or 2 month and then you need to go back at work and you leave them at home with the caretaker” (Nurse 7)

When asked how to overcome this problem one nurse claimed they encourage the mother to express the breast milk, leaving it with the caretaker so that the child can still be given the breast milk.

"Yeah when the mother is working, and she has to leave the home to go to work so we, we, we advocate for expressing the breast milk in a clean container. // We tell them to express the milk, keep it in the container and the baby can be given that milk instead of giving some other fluids” (Nurse 4)

Though advocating for expressing the breast milk it was perceived as a dilemma by some of the nurses, claiming that the expressed breast milk caused infection when stored in a contaminated container. It was also described that expressing the breast milk manually was many times too difficult for the mother and the usage of a breast milk pump was not an option because it was too expensive to obtain.
…majority of them they complain that the breast milk cannot, normally express manually, they can’t buy pumps because sometimes they are expensive” (Nurse 7)

3.3.5 Poor socio-economic environment

The nurses’ working with mothers and breast feeding counselling would come across mothers who experienced that they did not have any or enough breast milk as a result of poor nutrition and/or dehydration. Many of the nurses raised the issue with the lack of nutrition among breast feeding mothers as a result to the low economy of the family.

"Financially, they don’t have money. And as you know very well that when this breast, breast feeding mother is not being fed well, don’t ex, don’t expect such mother to have plenty of breast milk” (Nurse 6)

Another factor that was described by the nurses was the inconvenience of getting fresh water entailing to mothers not getting sufficient fluids to produce enough breast milk to provide for their baby. One nurse claimed that one of the problems is the woman being physically unable to get the water:

"She is too biggish to fetch water, it also becomes a problem” (Nurse 6)

According to the participants of the study they put an emphasis on encouraging the mothers to eat and drink well during the period of time that they are breast feeding. Many of the nurses’ claimed this was one of the recurring obstacles for breast feeding and addressed the correlation between the mother’s diet and the production of breast milk.

“They say the breast milk is not, not there. So we think maybe no proper diet, the mother is not having, not drinking enough. Not taking food which can make the body produce that now. But those ones who drink because we normally encourage them; “Drink as much water as you need. You can three litres per day, drink 24 hours. You can even drink so that to help the body to produce and eat what is available” (Nurse 5)
3.4 Vocational pride in counselling

The category describes what breastfeeding counselling means to them. Also, how they perceive their role as a counsellor and what effect that has on the mothers and their ability to breastfeed. This category consists of three sub-categories. The results for each sub-category are presented separately below.

3.4.1 Individual counselling

All of the nurses took great pride in their role as counsellors and saw it as an important factor for good breastfeeding practices. The way they performed the counselling was tailored to the individual mother; what the nurse saw as her problem area. One nurse describes:

“"You keep checking, how are you? How is the baby? How’s the breastfeeding? Is it how I told you? Yes, if they say so that one is okay. Yeah. But if they have come with the husband you sit together and teach them. // Yes, as a midwife I’m a teacher. Whenever they come I am ready and I teach. Like the ones we deliver here we give them a lecture before they go. They come back and appreciate us.””
(Nurse 1)

When it comes to breastfeeding there is not only one group of women that struggle. Many of the nurses had had experiences with primigravidae who needed help to get started.

“"The mothers giving birth at the first time don’t have much experience so we help them to actually start breastfeeding. We tell them the importance and help them to breastfeed.”” (Nurse 2)

Also the mothers’ with bad previous experiences were described as in need of a specific type of counselling.

“"Like those ones who had challenges before. In those situations it is all about counselling. It’s all about ‘when that happened, what did you do?’, ‘okay and before that how do you put the baby on the breast?’” (Nurse 3)

The majority of the nurses also highlighted HIV positive mothers as a sensitive group that is important, but hard, to support regarding breastfeeding.
“So there is no harm in breastfeeding the baby. This you explain to the mother. And she knows you’re a medic she always takes the idea if you explain it to her in a good way. // A few who will resist like I got one mother for her she told me she breastfed the baby and the baby got HIV. The other one she didn’t breastfeed and that one is okay. So for that one is hard to convince. Of course you can’t force.” (Nurse 3)

3.4.2 Positive effects of breastfeeding counselling

All of the nurses expressed a unanimous opinion about the positive effect of the counselling. To be able to be there and share their experience and knowledge regarding breastfeeding was a task they all took very seriously.

“Me I feel proud. Because when the mother gets the information and I see how she is breastfeeding the baby. I go and I am happy. The message is taken in. So to me it’s important as a midwife I’m proud of being a midwife, I teach so many things.” (Nurse 1)

Even though the nurses highly value the breastfeeding counselling they perform they still experience that they are not working as effectively as they could. One reason to this is the lack of communication between the different health care instances that deal with pregnant mothers at the hospital. One nurse addresses the issue:

“Sometimes when they’re being tested or when they are counselled when they have found that they are HIV positive some are told not to breastfeed and some are told to breastfeed. // It depends on the mother and her counsellor. So those are the challenges actually while you’re telling them about breastfeeding.” (Nurse 2)

Another nurse had a suggestion how to solve the problem:

“If we have everything in the same place. The delivery room and next door is post natal clinic then like breastfeeding counselling. Antenatal clinic here and then the labour ward. // then we know what everyone is doing and their system.” (Nurse 8)
3.4.3 To have the mothers on-board

To have the mothers on board is according to the nurses essential for getting the message across on how and why it is important to breastfeed. In their role as a nurse they experience having an authority that most mothers respect and listen to. Because of that most of the nurses experienced it easy to make the mothers apply their advice, with positive results. One nurse said:

“They really like it, after they thank you ‘I didn’t know, but thank you very much I have come to know how to breastfeed my baby, how to hold my baby.’” (Nurse 1)

One group that some nurses have experienced as not being as positive and trusting their advice regarding breastfeeding is the HIV positive mothers. This is explained by some as an effect of lack of knowledge as thus fear.

“I don’t know if any breastfeeding attitudes except from the HIV positive mothers. They are normally worried; ‘can I pass the virus to my child?’” (Nurse 8)

Neither of the nurses experienced that the mothers’ generally that many questions. But if they asked for some information it was usually regarding practical advice like for example how to position the baby or questions about artificial feeds. One nurse expressed some worries that the lack of questions from the mothers had to do with them in the role as nurses overpowering the mothers.

“Normally they don’t have so many questions. I don’t know if I overpower them. That’s my problem because I have been talked to them so much and tell them so much about breastfeeding the baby and how to position and how they are supposed to do that in the end they don’t ask questions they just tell me ‘how should I carry’ and ‘how often should I breastfeed’ that the questions only that they ask.” (Nurse 8)

3.4.4 Wish for supportive partners
Some nurses claimed that the absence of the fathers is one of the reasons that mothers lack to get sufficient nutrition and access to drinking water that they need when breastfeeding. The nurses expressed that the situation could improve if the fathers were to be more involved.

“We normally need to encourage the husbands to come on-board and support these mothers. Because sometimes they are single and maybe the husband is not supporting, she cannot get enough to take in, so that she gets enough breast milk. So in case, If every husband would come on-board to support the wife to promote breastfeeding” (Nurse 7)

4. DISCUSSION

4.1 Summary of results

During the data analysing process four categories were formed; Comprehension of the multidimensionality of breastfeeding, Training and guidelines, Experienced obstacles for breastfeeding and Vocational pride in counselling. This study has demonstrated that nurses see breastfeeding as an essential part of the health of the mother and child and that exclusive breastfeeding is the desired practice. The main obstacles for achieving this is identified as heavy workloads for the mothers, lack of knowledge and physical difficulties. Suggestions to how the quality of the breastfeeding counselling and support given to the mothers could improve are creating a better communication between instances involved in maternal and child health and available guidelines and more in-job training.

4.2 Discussion of results

The result is discussed under each category presented below.

4.2.1 Comprehension of the multidimensionality of breastfeeding

The results of this study show that the knowledge of the nurses meet the standards of the current information given out on nutritious aspects of breastfeeding and breast milk (Ip et al., 2007; WHO, 1993a). Even physiological effects of breastfeeding which aligns with Bhutta et al. (2010) are mentioned as an important aspect of breastfeeding. Both maternal benefits like reduced risk of postpartum haemorrhage and child benefits as for example a boosted immune system and growth factors to help the baby to thrive were emphasized during the study. The
worldwide acknowledged guidelines from WHO (1993a) on exclusive breastfeeding for at least six months are followed by the nurses in this study. Even the part with how breastfeeding creates bonding between the mother and child which WHO (1993a) underlines as an important part is mentioned by the nurses.

Engebretsen et al. (2010) find that the general view on the correct way to feeding your child is to breastfeed which is confirmed by the result of this study.

For health care professionals Dennis (1999) states that one part of enhancing the mother’s confidence to breastfeed is through verbal persuasion. In order to do that the health care professional needs to be well educated on the health benefits of breastfeeding. The result of this study shows on that aspect of accomplishing breastfeeding self-efficacy for the mothers the nurses have the tools they need. They use the health benefits for the mother and child as a way to motivate the mother to breastfeed, which is important for the individual to succeed in creating confidence (Dennis, 1999).

4.2.2 Training and guidelines

The result of the study shows that the nurses were well educated regarding breastfeeding. Most nurses claimed that their education provides them with information on how to conduct breast feeding counselling and stated that the basics are common known facts among nurses and midwives. Some of the nurses felt that they had been offered in-job training, but not on a regular basis. To have further education for all nurses and midwives was thought to be an encouragement to make sure all mothers got the essential information regarding breastfeeding. This goes along with the findings of Fadnes et al. (2010) where outdated training is being a contributing factor to health care workers not providing mothers with correct information regarding breast feeding.

Ip et al. (2007) states that nurses’ play an important role in ensuring sufficient nutrition for the infant by providing information regarding breast feeding. The result of this study states that the nurses expressed a perception of significance in their role as nurses when giving advice and helping the mothers to achieve an optimal breast feeding. The mothers were perceived as appreciative and positive about the knowledge gained and support given by the nurse. This in line with the findings of Nankunda et al. (2010).

4.2.3 Experienced obstacles for breastfeeding
The lack of information and education among the parents were explained to be one obstacle for breast feeding counselling. The stigma surrounding HIV positive mother and breastfeeding was stated a problem according to the nurses, leading to mothers not wanting to breastfeed in fear of transferring the virus to their baby. According to recommendations by WHO, HIV-infected mothers should breastfeed exclusively for 6 months if supplements are not available, affordable and safe. In order for HIV positive mothers to make the correct decision regarding whether to breastfeed or not breastfeeding counselling plays an important role (WHO, 2007).

It was mentioned by the nurses that one source of misinformation that contributed to the idea of breastfeeding as impossible was different cultural and religious beliefs. Mothers that use different cultural and religious beliefs as a source of information regarding postpartum concerns, such as breastfeeding, may be unbeneﬁcial to mothers and their babies. The result is in line with the ﬁndings of Illiyasu et al. (2006).

According to the nurses of this study, lack of nutrition and drinking water is one of the reasons that breastfeeding is not being conducted according to prevailing guidelines (World Health Organization, 1993a). The nurses stated that poverty is the main reason why mothers are not getting sufﬁcient nutrition and liquids to maintain a production of breast milk. Engebretsen et al. (2007) describe this issue as being a contributing factor to artiﬁcial supplements and liquids other than breast milk being given to babies.

Many mothers in Uganda are working mothers and the maternity leave is between two and three months. This study showed that having to return to work makes it impossible for the mothers to breastfeed their babies for the full six months that is recommended. According to WHO (2006) the median rate of exclusive breastfeeding in Uganda is 3.1 months. The study substantiates the complications of mothers having to return to work after two to three months. This is coherent with Engebretsen et al. (2010) were the mothers state the wish to breastfeed but due to circumstances in their lives find it next to impossible to achieve. Dennis (1999) theory states that an important factor for enhancing the mother’s conﬁdence in breastfeeding her infant is her perception of handling breastfeeding difficulties. By enlightening the obstacles for breastfeeding the nurses can be aware of this when tailoring the breastfeeding counselling. Also promoting and working towards including the fathers in the care of the infant might be a way to overcome many if the mentioned obstacles.
4.2.4 Vocational pride in counselling

The result of the study shows the nurses took great pride in counselling the mothers in breastfeeding. They adjusted the counselling depending on what they perceived as the main issue for the mother in question. This is coherent with Renfrew et al. (2008) where support in breastfeeding offered either by professionals or peers, or a combination thereof, to prolong the duration and exclusivity of breastfeeding. But in order to be effective the support needs to be tailored to the individual.

WHO (1993a) holds listening skills and skills in building confidence as essential qualities in a health care professional. This was not mentioned as a part of the counselling in this study. According to WHO (2006) the median duration of any breastfeeding in Uganda was 20.4 months, but the median duration of exclusive breastfeeding was as low as 3.1 months. Engebretsen et al. (2010) find that in Eastern Uganda the general opinion is that a mother should breastfeed but according to the mothers this is next to impossible to achieve. One nurse in this study expressed concern about the way they conduct breastfeeding counselling. She was afraid they might overpower the mothers instead of letting them lift issues that they perceived as problematic regarding breastfeeding. Dennis (1999) theory states that the confidence of an individual is achieved through finding the factors in that person’s life that affect his or her perceived ability to control the situation. Through a more person-centred approach in their breastfeeding counselling it might be possible to empower more mothers to feel confident in solving the obstacles regarding breastfeeding in their lives. By accomplishing that it might be possible to prolong the duration of breastfeeding for these women.

Peer counselling in the communities has shown to have great impact on breastfeeding. According to the World Health Report 2006 the community health worker play an important role in making sure everyone get access to health care (Bhutta et al., 2010; Haider et al., 2000). Bhutta et al. (2010) and Haider et al. (2000) show that an important part of implementing better breastfeeding practices is promoting home based peer counselling. Renfrew at al. (2012) and Bhutta et al. (2008) show that offering support in breastfeeding either by professionals or peers, or a combination thereof, could prolong the duration and exclusivity of breastfeeding.

The nurses in this study mentioned the lack of influences in the villages and communities as a big problem for them getting through to the mothers. They counsel them at the hospital and give them good advice on how to breastfeed and how to overcome eventual obstacles. But
they expressed a feeling of frustration due to the fact that the mother’s adherence to their advice were in the hands of the voices in the community. The lack of chance to have follow ups with the mothers was expressed as a factor affecting the effectiveness of the breastfeeding counselling.

Established peer counsellors in the communities might be part of a solution for prolonging the duration of exclusive breastfeeding. That way the health care system can more easily influence what information that is spread and be a more accessible resource for the mothers. This conclusion is supported by the results of Tylleskär et al. (2011) where educating peer counsellors from 82 local communities in South Africa, Uganda, and Burkina Faso through standard training packages recommended by WHO significantly prolong the duration of breastfeeding. Nankunda et al. (2010) also show that more than 95 % of the women in Mbale district in Uganda who were offered support in the form of peer counselling express satisfactions with the service. To establish available peer counsellors aligns with Dennis (1999) theory where they could support the women with performance accomplishments, physiological responses and perform verbal persuasion in order to help them to accomplish breastfeeding self-efficacy.

4.3 Discussion of method

4.3.1 Ethical considerations

The questions posed to the informants were considered not to be of sensitive or offensive nature. This was also a shared opinion from the ethical board which reviewed and approved the project proposal. To fully ensure that the informants did not feel pressured into talking about topics they did not feel comfortable with it was emphasized both orally and in writing that they could decline answering any question without further explanation. To have the participation completely voluntary enhanced the aim of having an ethically appropriate study.

One ethical dilemma of the study was the fact that the interview occurred in the ward where the participating nurses work, while they were on a shift. That might have resulted in the study affecting the patients in the ward negatively due to less working staff. But the interviews in the low risk delivery ward took place during a less intense period of time, with not so many women in labour. Both in said ward and in the post natal ward the fellow nurses would cover their tasks. Also it was made clear before the start of each interview that if the
patients needed their care the interview were to come to a halt so that the information could attend to the person in need.

Pre-understanding is explained by Dalén (2008) to be of importance to qualitative studies because it can contribute to a wider understanding of the respondents’ experiences. It is also possible that it affects the interpretation of the result. The authors had a pre-understanding of breastfeeding counselling due to research and preparation for the study. The literature research might have affected the results by possible preconceived ideas of the outcome of the findings. In addition, the authors were both stationed at a delivery ward as part of their clinical practice gained before the data collection for the study. This created a pre-understanding for the work of the nurses and the settings at Mulago hospital. The authors also possessed certain knowledge in obstetrics due to a mandatory university course as a part of their education. The knowledge in the subject and experience of the environment might have affected collection and analysing of the data. The experience of the work environment for the nurses, on the other hand, might have enhanced the understanding of their attitudes and perceptions of breastfeeding counselling. The authors believe it mostly contributed in a positive way.

4.3.2 Credibility
To be able to answer the purpose of the study the authors found that a qualitative method was suitable. A qualitative approach makes it possible to explore a phenomenon through experiences and perceptions of the informants. A quantitative study will not give as explanatory and in-depth answers (Polit & Beck, 2008) and was thereof not selected.

With the open ended questions the semi-structured interview guide (see Appendix 1) holds the informants are given a chance to offer their own opinions and in depth describe their perceptions. That creates a possibility for each interview to steer in to whatever direction the informant chooses but still in a structured way (Polit & Beck, 2008). The fact that a pilot interview proved the interview guide to be a well-functioning tool for opening up for answers that could create a deeper understanding for the phenomenon breastfeeding counselling. No big modifications of the interview guide seemed necessary for the rest of the study.
The sample size consisting of eight nurses may affect the credibility of the result of the study. The data had not yet reached saturation as new information still occurred by the last interview transcribed. Due to lack of time related to a drawn-out ethical approval processes and unforeseen events additional interviews were not possible to execute. But since the nurses varied in age, number of years as a practicing nurse and at the current ward it seem likely that the sample showed a good variety of aspects of the research questions which is coherent with Graneheim and Lundman (2004).

One factor that strengthens the credibility of the study is that all the interviews were performed by the same author. An interviewing-technique can be established. This decreases the chance of the interviews being influenced by the personal connection between interviewer and informant. This is in line with Graneheim and Lundman (2004) who states that interviewing is a process constantly evolving which gives the interviewer new insights about the studied phenomenon. Such acquired insights can narrow the focus for observation through better aimed follow-up questions.

A possible limitation of the credibility is that the transcription work was split between the two authors instead of them processing all of the material individually due to time shortage. In order to make this limitation less prominent both of the authors listened and discussed sequences that was hard to grasp. That was also necessary because of the sometime poor quality of the voice recordings. Another preferable action to avoid loss in credibility would have been to let the informants read through the transcribed material to make sure the data was interpreted correctly. Lack of time is the reason even here for this not being done.

The sub-categories and categories were created by both of the authors together after agreeing upon the meaning units. A few of the meaning units were only expressed by one sole informant but was presented as a part of the result since both of the authors considered it as important material for the purpose of the study.

4.3.3 Dependability
As a part of an exchange program between Uppsala University and Makerere University the authors had undergone a clinical rotation program with one week at the high risk delivery ward at Mulago Hospital before the data collection for this study. This created a sense of understanding of the context in which the nurses carry out their health care practices. That
understanding can maybe have affected the collection and analysing of data. Exploring previous research done on the subject can have altered the outcome of the data analysis due to expectations of what to find.

Since there was no financial compensation for participating in the study the interviews had to be held during the nurses’ ordinary shift. This could have created a subconscious stress among the nurses which affected the quality and duration of the interviews. Under different circumstances the interviews could have gone differently. The six interviews done at the low risk delivery ward were executed in a room offering privacy was used which created a quiet and calm atmosphere. That worked favourably for making the informants speak freely and relaxed. The two interviews from the postnatal ward had to be done in a less private setting which might have affected the content of the interviews.

English is the second language for the author who performed the interviews. Also the English spoken by Ugandans has an accent unfamiliar to the authors, which can have affected the interview process as well as the understanding of the transcribed data. Certain words can be unheard of and expressions lost in translation. More experience in interview techniques would have been preferable to achieve more in-depth answers. To only have one interviewer was one measure taken by the authors to compensate for this.

4.3.4 Confirmability

The confirmability of this study might have been affected negatively by factors in the process of data collection and analysis. Firstly, not both authors were present at all interviews which might thought to have decreased the possibilities for objectivity in the analysing process. It might be possible that some non-verbal communication was missed or misinterpreted. At least both authors heard all interviews. Secondly, without a chance for the informants to approve the collected data as accurately interpreted it is hard to measure the objectivity of the study results. The fact that both authors were involved in the transcription process was thought be a slight compensation for this and to affect the confirmability in a positive way. The acquired pre-understanding of the context in a delivery ward at Mulago Hospital might alter the analyse process but do not affect the objectivity.

4.3.5 Transferability
Using a qualitative design out rules generalisation to other health care settings.

This study shows that breastfeeding counselling is experienced as an important part of accomplishing a good breastfeeding practice. This confirms the results of previous research (Tylleskär et al., 2011; Bhutta et al., 2010; Haider at al., 2000; Bhutta et a., 2008; Renfrew et al., 2012 & Mangasaryan et al., 2012). The lack of updated guidelines is coherent with other studies (Fadnes et al., 2010; Waiswa et al., 2010). The nurses’ experienced problem of lacking influence in the communities in this study could be used for further research with similar topic. This seem important due to previous research on the positive effects from having community peer counsellors (Bhutta et al., 2010; Haider at al., 2000; Renfrew at al., 2012; Bhutta et al., 2008 & Tylleskär et al., 2011). Since this study was executed in the capital city of Uganda at a national referral hospital the study might have had generated different results if performed in another health care setting.

Also as an addition to earlier research which has gotten the same results this study can make the proof of the benefits of breastfeeding counselling even stronger. That can help raise awareness among health care workers and health care institution about the importance of breastfeeding and how to empower the mothers in order to prolong the duration of breastfeeding. More locally at Mulago Hospital the study results could be used as a helpful instrument to create better routines around the breastfeeding counselling. Also, to coordinate the breastfeeding support in order to create the best foundation for the mothers to keep breastfeeding exclusively. From the nurses’ experiences of breastfeeding counselling it was clear that better guidelines in needed at the hospital. The result of this study might be a help to enforce such an improvement.

To have the obstacles for breastfeeding identified might help the nurses to tailor the counselling to help the mothers in the best possible way to achieve exclusive breastfeeding. Furthermore raising awareness on the fact that most fathers are absent in the infant care and on how it would contribute to prolonging the duration of breastfeeding could be a starting point for more research on the subject. By studying how to include them in the best way and what factors needed to be worked on to make this happen might also be beneficial for the rate and duration of breastfeeding in Uganda.

4.4 Clinical implications
This study further states the importance of having breastfeeding counselling for achieving successful breastfeeding. As a nurse you empower the mothers and give them the tools to be prepared to be successful at breastfeeding on their own. As the study states there are many obstacles for women to keep breastfeeding like work, lack of knowledge, physical issues and influences from the community. That makes it even more important to support the health care workers performing breastfeeding counselling to find ways to overcome such obstructions.

More in-job training to keep the nurses updated on the latest recommendations is one key figure in the support. But also education in empowerment so the counselling is focused on the mother’s thought around her ability and perceived struggles in order not to have the nurses overpower the women.

Many nurses stated that they could not influence the women so much after discharge from the hospital. That the voices in the village would determine the duration and success of the breastfeeding for the mother and child. By educating and introducing peer counsellors in the communities this obstacle might take care of that problem.

Further studies on how the mothers would like the breastfeeding counselling to be designed, how to support the nurses in the best way to promote breastfeeding counselling and the effect of having peer counselling in the communities might shed light on how to improve the rate and duration of breastfeeding in low-income countries.

4.5 Conclusion

The results from this study shows that Ugandan nurses understand the importance of breastfeeding and breastfeeding counselling. It was expressed by the participants of the study that mothers appreciate receiving breastfeeding counselling and that the nurses tailor the support they give depending on the needs of the mothers. In summary, the knowledge of the nurses is in accordance with the guidelines offered. Since breastfeeding counselling is shown to be an important part of helping the mothers to find ways to breastfeed focus must be put on optimizing it. This can be done through better communication between instances, available guidelines and more in-job training. Poverty, ignorance and inadequate maternity leave are reasons why for mothers not being able to conduct exclusive breastfeeding regardless of the breastfeeding counselling offered. By working towards enhanced involvement of fathers, extended information and support provided to mothers, both in the hospital and in the community, it might be possible to prolong the duration of exclusive breastfeeding.
5. REFERENCES


Muhimbili University of Health Nursing, Tanzania. Department of Community Health Nursing.


Appendix 1

Interview guide

Background data

1. How long have you been working as a nurse?
2. How long have you been working at this ward?
3. How old are you?
4. Are you married?
5. Do you have any children of your own?

Introduction

1. How do you experience your role in supporting mothers to achieve successful breastfeeding?

Questions related to Aim

1. What kind of counselling do you give to parents to help the infant start breastfeeding?
   - are there guidelines that you follow? If yes, do you find them helpful?
   - from where do you get the information of what you are recommending the parents?
   - how important do you think breastfeeding counselling is?

2. When do you conduct breastfeeding counselling?
   - Prenatally? After childbirth? If yes, for how long? Individually? In group?

3. What attitudes around the counselling do you experience from the parents?

4. What is your attitude regarding exclusive breastfeeding?
5. What do you experience as the most common obstacle for exclusive breastfeeding?

- What do you do in those situations?

6. What kind of information regarding breastfeeding do parents usually ask for?

7. According to your experience are parents worried about breastfeeding after childbirth?

- if yes, what are they worried about?

8. What are the most common problems with breastfeeding?

- What do you do in those situations?

9. Would you like to add something?
Information Letter

Dear Sir/Madam,

We are two nursing students from Uppsala University in Sweden who are in Uganda to write a bachelor thesis in nursing. The thesis is about nurses’ experiences about breastfeeding and breastfeeding counselling. This aim is to gain a deeper understanding of the phenomenon breastfeeding through interviews.

The purpose of the study

The purpose of this study is to examine experiences of nurses working with breastfeeding and breastfeeding counselling as a part of their work duties.

Method of the study

Interviews will be performed in privacy and the participant will be anonymous. The interviews will be audio taped and thereafter analysed. Participation is voluntary and the participant can choose to withdraw his or hers participation in the study at any time without giving any reasons. The material will be collected and analysed completely confidential.

Your participation is highly valuable for our study. If You have any questions we are happy to answer them.

Kind regards,
Appendix 2

Tove Näslund and Sanna Syding

Responsible for this study:
Tove Näslund	Tove.naslund@hotmail.com
Sanna Syding,	Sanna.syding.islas@gmail.com
Supervisor in Uganda	Dr. Susan Nassaka Byewkwaso
Supervisor in Sweden	Clara Aarts, Associate Professor
INFORMED CONSENT TEMPLATE FOR INTENDING RESEARCHERS

Title of the proposed study:
Nurses’ experiences of breastfeeding counselling at Mulago Hospital, Uganda.

Investigators:
Sanna Syding, Uppsala University, Sweden. Email: Sanna.syding.islas@gmail.com
Tove Näslund, Uppsala University, Sweden. Email: Tove.naslund@hotmail.com.

Background and rationale for the study:
In 2003, The World Health Organization recommended exclusive breastfeeding for the first six months of age for an infant, with continuing of breastfeeding together with other food for about two years. Therefore breastfeeding should be an important part of the everyday diet until at least two years of age for the child. WHO´s recommendations are not reached in Uganda.

Support offered either by professional or peer supporters, or a combination of both, might prolong the duration and exclusivity of breastfeeding. The support needs to be tailored to fit each individual and also meet the needs of the population group in question.

Purpose:
The purpose of the study is to investigate the nurses’ experiences of breastfeeding counselling and their role in giving breastfeeding counselling in Mulago Hospital, Kampala, Uganda.

Procedure:
The participants of this study are asked to be interviewed about his or her work with postpartum guidance with focus on breastfeeding counseling. The interviews will be held in English and will last approximately 30 minutes. The interviews will be audio recorded and then analyzed confidently.

Who will participate in the study?
The participants in this study will be nurses working in different wards that deal with maternity and infant health at Mulago Hospital in Kampala, Uganda. The estimated number of participants is eight to ten.
Appendix 3

**Risks/Discomforts:**
There are no risks identified for participating in this study. The participant has the right to cancel the interview and to withdraw from the study at any point without given any reason.

**Benefits:**
The results of this study will have relevance for the nursing profession globally since the aim is to create a deeper understanding of nurses’ attitude towards, and role in, breastfeeding counseling. The expected results of this study is that Ugandan nurses’ experience will be beneficial for the mothers in need of breastfeeding counseling and possibly prolong the duration of exclusive breastfeeding among Ugandan mothers.

**Cost:**
There are no identified costs to participate in this study.

**Compensation for participation in the study:**
No compensation will be given for participation in this study.

**Reimbursement:**
In case the interviews will be held apart from the hospital area the investigators will cover the participants’ transport fee.

**Questions:**
If any questions arise by the participants considering the study, the investigators can easily be reached by email. See above for contact information.

**Questions about participants’ rights:**
If the participants have any questions about their rights, they can contact the School of Health Sciences Institutional Review Board (MakSHS-IRB) Dr. Lynette Tumwine, Tel: (+256) 772-494119 or Uganda National Council of Sciences and Technology. Tel: (+256) 414705500.
Confidentiality:
The results of this study will be kept strictly confidential, and used only for research purposes. My identity will be concealed in as far as the law allows. My name will not appear anywhere on the coded forms with the information. Paper and computer records will be kept under lock and key and with password protection respectively. The interviewer has discussed this information with me and offered to answer my questions. For any further questions, I may contact Sanna Syding and Tove Näslund or the Chairperson, School of Health Sciences Institutional Review Board (MakSHS-IRB) Dr. Lynette Tumwine, Tel: (+256) 772-494119, E-mail: irbbiomedicalsciences@gmail.com or Uganda National Council of Sciences and Technology. Tel: (+256) 414705500.

STATEMENT OF CONSENT/ASSENT
Sanna Syding and Tove Näslund have described to me what is going to be done, the risks, the benefits involved and my rights regarding this study. I understand that my decision to participate in this study will not alter my usual medical care. In the use of this information, my identity will be concealed. I am aware that I may withdraw at any time. I understand that by signing this form, I do not waive any of my legal rights but merely indicate that I have been informed about the research study in which I am voluntarily agreeing to participate. A copy of this form will be provided to me.

Name:…………………………. Signature of participant……………………..
Age………………
Date …………………………
Name……………………………………..Signature of Interviewer
………………………………
Date……………………….