PROVIDING BREASTFEEDING SUPPORT IN THE COMMUNITY: THE PERCEIVED SELF-EFFICACY OF PLUNKET NURSES

A thesis presented in partial fulfillment of the requirements for the degree of

Master of Nursing
at the
Eastern Institute of Technology
Taradale, New Zealand.

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2008
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Abstract

The aim of this research was to describe the factors that Plunket Nurses identified as contributing to their level of perceived self-efficacy when providing breastfeeding support to mothers in a community setting. The need to improve breastfeeding rates and outcomes in New Zealand has been identified as a current issue and is being addressed within national initiatives. Primary health care providers, including Plunket Nurses, have been identified as current and potential contributors to improvements within these initiatives. The preparation of health providers to be successful in providing breastfeeding support is important and was identified within the literature reviewed. The availability of New Zealand based research undertaken in primary health care and community settings was found to be minimal.

The research design considered most appropriate for this study was that of a qualitative descriptive analysis with a purposive sample. Nine Plunket Nurses who currently provide breastfeeding support in the community provided an account of a breastfeeding support situation from which they reflected on the factors that contributed to their perceived self-efficacy in this role. A thematic analysis was used to generate seven themes. The themes were presented using excerpts from the narrative of the participants.

Bandura’s self-efficacy theory (Bandura, 1995) was indicated within the literature review as a useful conceptual framework for use in research looking at the education, knowledge, experience, skills and attitudes of health providers involved in the provision of breastfeeding support. In this study, findings related to the factors that contribute to the level of perceived self-efficacy of the Plunket Nurse participants, were used to inform conclusions and recommendations for processes that contribute to confidence and ability. These include orientation, education, and ongoing professional development programmes that benefit professional practice and contribute to improving breastfeeding rates and outcomes in New Zealand within current initiatives.
Acknowledgements

Thank you to Dr Elaine Papps and Kathy Manhire who provided professional and academic support and guidance at each stage of the development and writing of this manuscript. I never felt that any question was not worthy to be asked. Your ongoing encouragement to “keep writing” and your help with the nuts and bolts of academic writing was appreciated.

I would also like to thank those Plunket Nurses who agreed to participate and who shared some very personal and poignant stories and reflections. Thanks also need to go to those within the Royal New Zealand Plunket Society (Inc) who provided assistance along the way. In particular, Jenny Prince who allowed me to access the Plunket Nurses in their areas of work around the country and the Clinical Leaders who helped distribute the invitations to participate within their areas. Also, to Florence Trout and Joy Bickley Asher for their help in developing the research question and proposal.

To Jan, Jan and Jill at the Hawkes Bay Plunket Area Office, who listened and provided feedback over the year. Thank you, your encouragement was important.

I would like to acknowledge the support that came from within my Masterate Research class. The email network, the face to face meetings on campus, and the welcome social gatherings provided encouragement, humor, and an impetus to keep going when the process became difficult.

Most of all I would like to thank my family and friends for their support and patience during my journey.

“To experience the awesome complexity of clinical nursing practice is to spend time in the swamp. This time spent in the swamp is important. It is a time to lay aside preconceived expectations and unexamined habits- time to reject mythical thinking and easy solutions to well-known questions. It is a time for nurses to put their role as a nurse, their nursing actions, and the clinical setting in which they practice, under close scrutiny. It is time to examine everything- and not just to examine, it is time to reflect on all these things and on the process of reflection itself” (Street, 1990, p 16).
# Table of Contents

**Abstract**  

**Acknowledgements**  

**Table of Contents**  

**Chapter One: Introduction**  

Introduction  
Background  
Infant and maternal health benefits  
Economic benefits  
New Zealand: a breastfeeding culture?  
Global strategy  
New Zealand initiatives  
Researchers interest  
The significance of the study  
Research aims  
Thesis outline  

**Chapter Two: Literature Review**  

Introduction  
Maternal views of health and breastfeeding promotion and support  
New Zealand studies of the experience for Maori women  
The role of health providers in breastfeeding promotion and support  
Education of nurses in breastfeeding  
Nurses knowledge of breastfeeding  
The impact of personal breastfeeding experience  
Nurses support of breastfeeding  
Summary  

**Chapter Three: Methodology**  

Introduction  
Research design  
Qualitative descriptive analysis
Chapter Four: Findings

Introduction

Step one: Gaining a sense of the whole

Step two: Identifying units of meaning

Step three: Essential themes are generated and described

Theme one: The contribution of personal breastfeeding experience

Theme two: Observing and then doing

Theme three: The impact of feedback

Theme four: Sharing knowledge and experience

Theme five: The place of formal education

Theme six: The context and reality of the breastfeeding experience

Theme seven: The nature of support

Summary

Chapter Five: Discussion

Introduction

Theme one: The contribution of personal breastfeeding experience

Theme two: Observing and then doing

Theme three: The impact of feedback
| Theme four: Sharing knowledge and experience       | 67 |
| Theme five: The place of formal education         | 69 |
| Theme six: The context and reality of the breastfeeding experience | 71 |
| Theme seven: The nature of support               | 75 |
| Summary                                           | 77 |
| **Chapter Six: Conclusions and Recommendations** | 78 |
| Introduction                                      | 78 |
| Conclusions                                       | 79 |
| Recommendations for orientation, education, and ongoing | 82 |
| professional development                           | 82 |
| Recommendations for future research               | 84 |
| **References**                                   | 85 |
| **Appendices**                                   | 91 |
| Appendix A: RNZPS (Inc) ethics committee approval  | 91 |
| Appendix B: Eastern Institute of Technology research approval | 93 |
| Appendix C: Participant information sheet         | 95 |
Chapter 1

INTRODUCTION

Introduction

The New Zealand Breastfeeding Authority (2008) identified community based health providers as being able to be effective in helping sustain breastfeeding up to two years and beyond. Registered nurses, who deliver well child and well family care in the community and are employed by the Royal New Zealand Plunket Society (Inc), hereafter to be known as the RNZPS (Inc), are known as Plunket Nurses. The Plunket Nurse delivers primary health care based on the Well Child/ Tamariki Ora Schedule that includes health promotion, education, clinical assessment, and family/ whanau support (RNZPS (Inc), 2003). The Well Child/ Tamariki Ora Schedule states, in regard to breastfeeding, that the nurse will assess the need for support and information; will provide practical breastfeeding management and support; and will provide information and anticipatory guidance relevant to parents (Ministry of Health, 1996). This is acknowledged within an organisational Breastfeeding and Nutrition Policy which states that “the Royal New Zealand Plunket Society (Inc) strongly encourages breastfeeding as the optimal way of feeding infants and therefore seeks to promote, protect and support breastfeeding” (Royal New Zealand Plunket Society (Inc), 2005a, p 3). The authors of this organisational policy state that evidence supports the contribution that breastfeeding makes to achieving optimal population health goals.

In New Zealand, statistics show that breastfeeding rates decline markedly within the community setting and there is also concern that there has been no significant improvement evident in breastfeeding rates over a nine year period from 1997 to 2006 (Ministry of Health, 2008). Breastfeeding data is collected by lead maternity carers and well child providers. Rates at six weeks, three months, and six months are based on data from Plunket and cover approximately 90 percent of all births in New Zealand (Ministry of Health, 2008).

The Baby Friendly Hospital Initiative (BFHI) was launched internationally in 1992 and was aimed at increasing breastfeeding rates and encouraging global breastfeeding standards for maternity services through the implementation of the ten steps to successful breastfeeding (Ministry of Health, 2002). Step two recommends the training of all health care staff in the skills needed to implement breastfeeding policy but also points out that there is a need to change attitudes which can create
barriers to breastfeeding promotion and support. Health workers can actually undermine a mother’s confidence by implying criticism or doubt during their contact with them (Division of Child Health and Development, 1998). Breastfeeding rates reported for the Hawkes Bay District Health Board area showed that at the time of discharge from Ata Rangi maternity unit, breastfeeding rates had risen from 48.9 percent in 2000 to 86 percent in 2003 (New Zealand Breastfeeding Authority, 2008). BFHI status has been achieved by 59 out of 79 maternity units in New Zealand (New Zealand Breastfeeding Authority, 2008).

The following statistics as reported by The Ministry of Health (2008) demonstrate the steep decline in breastfeeding rates that following discharge from maternity units. In 1997, 54 percent of Maori and Pacific women were exclusively or fully breastfeeding compared to 67 percent of New Zealand European and others (NZE/O) at six weeks of age. In 2006, 59 percent of Maori and 57 percent of Pacific women were exclusively or fully breastfeeding compared with 70 percent of New Zealand Europeans and others. This reflects the large drop in rates during the early period of breastfeeding initiation. By three months of age rates for Maori had dropped to 36 percent, 41 percent for Pacific women, and 53 percent for NZE/O in 1997. By 2006 rates had showed some improvement for all ethnic groups reported with 45 percent for Maori, 48 percent for Pacific women, and 60 percent for NZE/O at three months of age. Another large drop in rates occurs between three months and six months of age. In 1997, 12 percent of Maori, 13 percent of Pacific women, and 19 percent of NZE/O were still exclusively or fully breastfeeding at the recommended age of six months. By 2006 rates had improved but are still not meeting national targets with 17 percent of Maori, 19 percent of Pacific women, and 29 percent of NZE/O still exclusively or fully breastfeeding at six months of age. Data are reported as exclusive or fully breastfeeding because the “definitions for both terms indicate that the infant is likely to be meeting their nutritional requirements and receiving the benefits from breast milk” (Ministry of Health, 2008, p 9).

The report of an audit of breastfeeding in Hawkes Bay by the New Zealand Breastfeeding Authority (2008) showed lower rates than the national average for infants at six months of age that were still exclusively or fully breastfeeding. The rates as reported by Plunket for the Hawkes Bay area demonstrate the pattern of drop off rates once mothers and infants are back in the community setting. In 2007 only 7 percent of Maori, 11 percent of Pacific, and 15 percent of NZE/O were still exclusively or fully breastfeeding at six months of age. These area rates fall well below national reports and reflect the effect of the complex factors in societies, communities and families that can impact on continued breastfeeding. The Ministry of Health has set targets for 2007 to 2008 for
exclusive or fully breastfeeding of 74 percent at six weeks of age, 57 percent at three months of age, and 27 percent at six months of age (Ministry of Health, 2008).

Clinical barriers that have been identified within the breastfeeding care and support provided to mothers and infants by health providers include the following. The communication of negative or ambivalent attitudes by health providers. The communication of inappropriate and inconsistent advice to breastfeeding mothers. The low level of health provider knowledge on problems and solutions. The recommendation by health providers to use infant formula within the first month of life (New Zealand Breastfeeding Authority, 2008; Ministry of Health, 2008). In a study conducted by Abbott, Renfrew, and McFadden (2006) it was acknowledged that most formal education does not adequately prepare health care professionals to either promote breastfeeding or to support breastfeeding mothers. Research reported by Smale, Renfrew, Marshall, and Spiby (2006) found that health professionals felt unprepared to confidently support breastfeeding mothers and that preparation for this role played only a very small part of their training. Furthermore their knowledge was stated to be fragmented, and gained in an “ad-hoc” manner. Personal breastfeeding experiences were seldom discussed or utilized as part of education programmes. It was reported that courses seldom taught the skills needed to support breastfeeding. The findings of this research call in to question the ability of health providers to respond to recommendations to increase support in order to improve breastfeeding duration rates within present education design and availability.

This thesis presents a qualitative descriptive analysis of information emerging from the reflections of Plunket Nurses of providing breastfeeding support to mothers in a community setting. An analysis was undertaken to identify what factors contributed to the perceived self-efficacy (confidence and ability) of Plunket Nurses when providing breastfeeding support. The purpose of this research was to gain information from a population of primary health care providers identified as being able to be effective in helping sustain breastfeeding duration (New Zealand Breastfeeding Authority, 2008). Information gained is intended to provide insight into strengths in this area of practice and to provide direction for future design of orientation, education, and ongoing professional development programmes.
Background

Infant and Maternal Health Benefits:
Increasing breastfeeding rates is important because of the health benefits for mother and child, the benefits to society, and the economic benefits. Lauwers and Swisher (2005) describe the benefits of breast milk as the “infant’s first immunization” (p 3). The immunological properties in the breast milk and the method of transmission from mother to infant are unique. The Ministry of Health (2008) states that the importance of breastfeeding includes the provision of the optimal nutrition for infants and contains properties that assist in gut maturation, physiological development and immunity. It also contains optimal amounts of polyunsaturated fatty acids for retinal and brain development, and taurine for fat absorption.
The practice of breastfeeding promotes optimal development of the oral cavity that allows better swallowing and may also help reduce sleep apnea (Lauwers & Swisher, 2005) and may affect later speech development (Ministry of Health, 2008). Breastfeeding decreases the incidence of otitis media, acute respiratory infections, diarrhoea and gastroenteritis, urinary tract infection, sepsis and meningitis. Hospital admission rates are decreased with breastfeeding as is infant mortality (Ministry of Health, 2008). Breastfeeding may also reduce chronic childhood illness and those of later adult life such as diabetes, cardiovascular disease, hypertension, food allergies, asthma and eczema, and digestive tract disease (Ministry of Health, 2008). The contribution of breastfeeding to attachment between mother and infant and the early sensory stimulation that is provided by skin to skin contact has been shown to be significantly beneficial to breastfeeding initiation and continuation during the early months of life (Lauwers & Swisher, 2005). The benefits to women’s health include a better uterine contraction outcome due to the oxytocin released during breastfeeding thereby reducing the risk of post partum hemorrhage; the feeling of well being resulting from the release of oxytocin and prolactin hormones; and a decreased risk of pre menopausal breast cancer and ovarian cancer (Lauwers & Swisher, 2005). Breastfeeding can provide emotional and physical satisfaction for the mother and enhance self-esteem in her role. The impacts of this can be positive in the prevention of or recovery from postnatal depression (Ministry of Health, 2008).

Economic benefits:
The World Alliance for Breastfeeding Action (1998) believes that when breastfeeding occurs families save on the cost of formula and on health spending. Employers save on absenteeism and have lower staff turnover rates by providing family friendly workplaces. Government spending on
the treatment of sick infants and children is reduced. Frick, Milligan, White, Serwint, and Pugh (2005) presented a report on the economic benefits of nurse-supported breastfeeding promotion. The authors believe that health promotion programmes need to be economically justifiable and used breastfeeding promotion as an exemplar of understanding this. The role of nurses in promoting breastfeeding has been acknowledged (Bernaix, 2000). Success of promotion programmes can be measured by duration rates for example, or hospitalization data and outcomes in morbidity and mortality, or comparison research into interventions affecting different conditions or outcomes. All the roles that nurses’ play in this activity “involve using their time as a resource to help bring about changes in breastfeeding behaviour, which results in measurable costs and benefits that can be assigned a dollar value” (Frick et al., 2005, p 168). Those that could be affected by breastfeeding promotion activities are the mother, the infant or child, the father, other members of the family, taxpayers, employers, health insurers, the health system, childcare providers, other health providers, and the general public according to Frick et al. Finally the authors say that nurses can be agents of change where there is a need to collaborate with other providers and with the community when beliefs are being challenged and behaviour changes are sought.

New Zealand: a breastfeeding culture?
Research has shown that societal attitudes to breastfeeding are based on the dominant values and norms in society, and individuals find it difficult to go against these norms (Hunt, 2006). In 1907 Sir Truby King joined the scientific childrearing advocates while developing ways to increase the birth rate of white middle class infants in New Zealand (Watson, 2001). He opened a Karitane Hospital, trained nurses to teach mothercraft with scientific reasoning, and developed an infant formula (Watson, 2001). The knowledge of the Plunket Nurse was believed to be above that of the other women in the family and community. By the 1960’s the women’s movement began to question the attitudes, values and beliefs of society about childbirth and infant feeding. The right of the woman to choose what happened in her life became paramount (Bradfield, 1996). It was at this time that the La Leche League, originally formed in the United States of America, spread to New Zealand bringing with it support for women who chose to breastfeed (Butts, 1997). The gender equality sought throughout this time and the latter part of the 20th century caused breastfeeding to remain a woman’s choice and not an infant’s right (Walker, 1996). Most women make the decision to breastfeed prior to conception or birth (Rawley & Dixon, 1997). The decision is influenced by family, friends, and society along with previous exposure to breastfeeding (Scott, Landers, Hughes, & Binns, 2001). Society can remove some of the barriers to breastfeeding and move toward a
breastfeeding culture by working to provide more conducive environments to breastfeed in (Ministry of Health, 2002).

The breast is viewed by many as a sexual object only (Mulford, 1995). Modern media plays a role in exacerbating this view. Henderson (1999, p 4) says that the media “impacts on peoples attitudes, beliefs, knowledge, and experiences.”

Henderson, Kitzinger and Green (2001) reported on a study of the British media portrayal of formula and breastfeeding by examining visual and verbal portrayals of infant feeding. Findings showed that nearly all references pertained to formula feeding. Breastfeeding references were found in soap and medical dramas with the storylines being negative or problematic. Other portrayals focused on providing humour on the themes of sexuality or on the “out of control” body. The visual images of formula feeding led to a conclusion that formula feeding had become symbolic of babyhood.

Beasley (2002) describes a breastfeeding culture as one where breastfeeding is seen as normal and natural, and is the taken for granted infant feeding choice. In this culture breastfeeding is visible and acceptable in families, communities, and work places and the breastfeeding mother and child are valued, supported, protected and nurtured. All women are able to access culturally appropriate professional, community, and social support. The right of the infant to be breastfed for the first six months of life is prioritized over the right of the woman to choose to do so. Finally, the social benefits are acknowledged and accepted.

Global Strategy:
The Global Strategy for Infant and Young Child Feeding (World Health Organisation, 2003, p v) tells us that there is a need to “revitalize world attention to the impact that feeding practices have on the nutritional status, growth and development, health, and thus the very survival of infants and young children.” Heinig (2004), in a summary of this strategy, points out four factors to be considered. Firstly, that there is a need to promote breastfeeding as a natural act and a learned behaviour. Secondly, that educated and skilled support is needed from the health system to ensure mothers have the opportunity to breastfeed wherever they are situated within communities. Thirdly, that the role of lactation consultants’ is important in their ability to help mothers manage breastfeeding problems. Finally, that supportive maternity leave policy and legislation and work environments are needed as more women with children are in paid employment. Heinig also says that a global strategy should develop from, and strengthen past and current initiatives. Two examples already adopted and utilized in New Zealand are the Baby Friendly Hospital Initiative (BFHI) and the International Code of Marketing of Breastmilk Substitutes in which a health
workers code and guideline is included. The BFHI, as discussed previously, has helped to raise breastfeeding implementation rates within maternity units across New Zealand (New Zealand Breastfeeding Authority, 2008). The International Code of Marketing of Breastmilk Substitutes was adopted 25 years ago by the World Health Assembly in response to aggressive marketing by infant formula companies during the 1970’s and 1980’s (Heinig, 2006). The Code states that health workers are to give clear consistent and accurate information about the importance of breastfeeding, encourage informed feeding decisions, and help prevent and resolve common problems that can compromise breastfeeding success (Ministry of Health, 2007).

**New Zealand Initiatives:**
Currently there are two national initiatives that are being implemented collaboratively in New Zealand to address the need to improve breastfeeding duration rates. The National Strategic Plan of Action for Breastfeeding 2008-2012 was developed for the Ministry of Health by the National Breastfeeding Advisory Committee of New Zealand (2008). The plan is “set in the context of existing work and emerging programmes, and establishes the health sector as the leader in promotion, protection, and support of breastfeeding in this country” (National Breastfeeding Advisory Committee of New Zealand, 2008, p 2). The four settings for the plan are Government, family and community, health services, and workplace, childcare and early childhood education. Clinical barriers addressed include “specific conditions or situations that affect breastfeeding, and issues concerning design and delivery” of services (p 31). The author cites lack of access to services, clinical problems such as pain and perceived milk supply, use of formula in the first month of life, communication of negative or ambivalent attitudes by health professionals concerning breastfeeding, inappropriate and inconsistent advice, and low health provider knowledge on breastfeeding problems and solutions as barriers. Such factors are important when considering the role of the health provider as being central to promoting and supporting breastfeeding. Evidence also shows that community based health providers can be effective in helping sustain breastfeeding up to two years and beyond (New Zealand Breastfeeding Authority, 2008). Development, implementation, and evaluation of area level strategies to improve breastfeeding uptake and duration are called for. Secondly, the Baby Friendly Community Initiative (BFCI), an adaptation of the BFHI, is to be rolled out in New Zealand in 2008. Primary health care providers are among identified groups that can adopt practices that aim to protect, promote, and support mothers to not only initiate breastfeeding but to improve the duration of breastfeeding. The overall aim of this initiative is to make breastfeeding the cultural norm in all societies (New Zealand Breastfeeding
Authority, 2006). The need to improve the education, knowledge, skills and ability of health professionals to support breastfeeding is recognized within these two initiatives.

**The Researcher’s Interest**

My interest in supporting breastfeeding mothers in the community has developed over time from both a personal and a professional perspective. As a breastfeeding mother I experienced first hand the social, environmental, and clinical barriers that are identified by the Ministry of Health (2008). Specifically the lack of family and broad social support, a lack of knowledge about the normal course of breastfeeding, limited support from health professionals when experiencing problems and the necessity of returning to paid work combined to impact on my experience.

As a Plunket Nurse I found that my personal breastfeeding experiences provided the initial knowledge and skill base which enabled me to provide support to breastfeeding mothers. The acquisition of breastfeeding education, knowledge and clinical skills followed and were partially provided in accordance with organisational policy and initial education expectations. As identified earlier breastfeeding education is often provided and accessed in an ad hoc manner by health professionals as was my experience.

Static breastfeeding rates and the opportunity to work collaboratively with other health providers at a regional and national level to address this issue presented itself to me while working as a Plunket Nurse and more recently in a Clinical Leader role. This has provided the impetus for this research study.

**The significance of this study**

The introduction and background information presented demonstrates that the need to improve breastfeeding rates in order to contribute to improved child health outcomes is of international, national, and regional level significance. Primary health care providers, including Plunket Nurses, have been identified as potential and current key contributors to breastfeeding support activities in community contexts. Therefore the need to prepare health care professionals to be successful in providing breastfeeding support is important. This research study is “strengths based” and seeks to benefit nurse practice and contribute to improved breastfeeding outcomes.

Bandura’s self-efficacy theory states that people who are confident in their abilities to successfully perform a task are more likely to be positive and successful in both intent and actual performance of
that task (Bandura, 1995). In this research study, findings related to the factors that contribute to the perceived self-efficacy of Plunket Nurses in supporting breastfeeding in the community can be used to inform a review of, and possible redesign of orientation, education, and ongoing professional development programs for the benefit of professional practice.

**Aim of this research**

The research question is:

What factors do Plunket Nurses identify as contributing to their level of perceived self-efficacy when providing breastfeeding support to mothers in a community setting?

The research objectives are:

- To identify the strengths in Plunket Nurses’ breastfeeding support practices.
- To use Bandura’s self-efficacy theory to provide a framework for the discussion of findings, the conclusions and recommendations that may inform future orientation, education, and ongoing professional development design.
- To use the findings to benefit and improve breastfeeding outcomes.
- To contribute to the body of knowledge on breastfeeding with a qualitative descriptive study undertaken in a unique practice role and setting in New Zealand.

**Thesis outline**

Chapter One: *Introduction*

The chapter is an introduction and background to the research issue. My interest in and the significance of the topic are presented. The research question and objectives are identified.

Chapter Two: *Literature Review*

This chapter provides a comprehensive review of international and national literature related to the research topic. The literature has been drawn from relevant published documents, texts, journals, and databases. The literature included in this review further informs the background and relevance of this study.
Chapter Three: **Methodology**
The research methodology is described in terms of the design and methods used. Participant selection and recruitment are presented along with both data collection and data analysis procedures. Ethical considerations including gaining approval from the Royal New Zealand Plunket Society (Inc) Ethics Committee and the Eastern Institute of Technology Research Approvals Committee are included.

Chapter Four: **Findings**
This chapter presents the research findings from the analysis of data collected from Plunket Nurses’ that provide breastfeeding support to mothers in a community setting. Research findings are related to the research question and objectives.

Chapter Five: **Discussion**
The research findings are discussed in detail in relation to the identified themes. Previous research and identified literature are discussed in support of and in contrast to the research findings.

Chapter Six: **Conclusions and Recommendations**
Conclusions and recommendations from the findings along with recommendations for future research are presented in this final chapter.
Chapter 2

LITERATURE REVIEW

Introduction

The literature review is a “comprehensive, in-depth, systematic and critical review of scholarly publications, unpublished scholarly print materials, internet materials, audiovisual materials and personal communications” (Schneider, Whitehead, & Elliott, 2007, p 58). Schneider et al. (2007) state that a review of literature is an essential part of the research process. It is used as a source of knowledge, to identify what is already known and to identify gaps in relation to a topic or issue. It contributes to the development of the research question as well as the design and methods used. It also allows the outcome of the analysis to be related back to previous studies.

This chapter will review literature related to the role of health providers, including nurses, in providing breastfeeding support. The key areas of research examined include: the maternal views of health and breastfeeding promotion and support; the role of health providers in breastfeeding promotion and support; the education of nurses in breastfeeding; the nurse’s knowledge of breastfeeding; the impact of personal breastfeeding experience; and nurses’ support of breastfeeding.

The literature reviewed and discussed has been drawn from nursing and allied health journals and on-line internet based allied health journals. Searches were conducted on Proquest, Cumulative Index for Nursing and Allied Health Literature (CINAHL), and the electronic library catalogues at Eastern Institute of Technology Hawke’s Bay. Key words/phrases used in the literature search included: breastfeeding, nurse/s, health provider/s, primary health care, community, promotion, support, practice, health, human lactation, infant feeding, nutrition, New Zealand, education, knowledge, attitudes, beliefs, behaviours, personal experience, experience/s, ethics, culture, society, and various combinations of these.

Maternal views of health and breastfeeding promotion and support

In 1999 Rempel (2004) conducted a longitudinal infant feeding study using the theory of planned behaviour (TPB) to explain intended and actual breastfeeding duration. This study, The Waterloo
The Region Infant Health Study, was conducted in Ontario, Canada. The study tested the ability of the TPB to explain the prenatal breastfeeding intentions of a sample of 317 pregnant women. The specific aim was to answer questions about the role of attitudes, subjective norms, and perceived behavioural control in the sub sample of 80 breastfeeding mothers and their actual breastfeeding duration. Additionally Rempel examined the explanations of the mothers about why they discontinued breastfeeding between nine months and a year of age. The collection of data before and after initiation of breastfeeding was expected to provide a clearer understanding of what factors influence long term breastfeeding decisions. Quantitative analysis was used to reveal from data collected that the Duration Intention Scores were significantly related to actual breastfeeding duration. Qualitative findings revealed that general breastfeeding attitudes did not explain long term breastfeeding outcomes, while perceptions of the degree of control over breastfeeding did have a significant effect on duration. Reduced control was related to breastfeeding problems, reduced milk supply and biting, and perceiving that the infant was ready to wean. Social norms were also found to significantly affect breastfeeding duration. Rempel found that the opinions of others and a decrease in support for breastfeeding as the infant gets older were contributing factors. The results suggest that interventions to change social norms and increase social support could impact positively on breastfeeding duration up to one year and beyond. The future for breastfeeding research according to Rempel, lies in the direction of developing and evaluating such interventions.

An earlier study conducted in 1992 examined the effects of a partner supported incentive based programme on breastfeeding knowledge, attitudes and support; and the relationship between feeding intentions and feeding behaviours among low income women (Sciacca, Dube, Phipps, & Ratliff, 1995). The sample, recruited from two clinic sites in Flagstaff, Arizona, comprised 68 women who were to be first time parents. The women were randomly assigned into a treatment group or a control group. The treatment group (n= 34) received an intervention programme known as “Caring Connection”. The control group (n=34) received the usual level of breastfeeding education. All participants and their partners were asked to complete questionnaires pre and post programme completion to gauge differences in outcomes in the levels of attitude, knowledge, and support and intended versus actual breastfeeding outcomes. Results showed that there were no differences between the groups prior to the intervention but that there was an increase in breastfeeding knowledge in the treatment group post intervention. There was a corresponding increase in partner knowledge also. The same findings for positive attitude changes were also found in the treatment group. More actual partner support was reported from mothers in the treatment
group. Finally breastfeeding rates and duration were higher in the treatment group. Incentives were seen as a motivating factor to take part in breastfeeding education programmes. 

Even though this study was directed at low socioeconomic women and their partners the results may be transferable to other socioeconomic groups. The authors suggest that the study has implications for breastfeeding education programmes directed at pregnant women to ensure the inclusion of social support information, and the inclusion of those that will be directly supporting them.

Adewale (2006) conducted a qualitative descriptive study set in a metropolitan city in south eastern Canada, to explore the perceived usefulness of breastfeeding information provided by healthcare professionals to a group of five breastfeeding first time mothers. A limitation of this study is the very short timeframe of breastfeeding as a lived experience. The mothers needed to have been breastfeeding for longer than one week and not less than three weeks. The questions posed by the researcher were: what was the lived experience of the first time breastfeeding mother? ; what is the client’s perception of the nurse’s role to promote breastfeeding?; and what are the difficulties with breastfeeding as stated or perceived by first time breastfeeding mothers? By using an interview guide with open ended questions some unique experiences were revealed. Common themes and concepts were extracted from the data. Results showed that the lived experiences of these mothers featured physical problems such as difficulty latching, and having painful, cracked nipples. It was also revealed that antenatal classes were not effective in preventing these problems. The mothers wanted visual demonstrations in classes and wanted antenatal education to start earlier in the pregnancy. There was a difference in the role of nurse in providing antenatal education as opposed to the actual support when in hospital revealed through the mothers’ experiences. Adewale (2006) concluded that collaboration between mothers, family, and health care professionals could enhance breastfeeding experiences. The author suggests that further study should include the impact of breastfeeding challenges on infants, mothers and environments; the impacts of identified values and beliefs on breastfeeding; and the strengths and weaknesses of breastfeeding mothers. Adewale admits that the addition of follow up confirmatory interviews would strengthen data and findings in future studies such as this one. Future studies of similar design should also be considered with larger samples, and other demographic and socio economic groups. This study is valuable as it contributes to qualitative research outcomes that go beyond informing into description and understanding from the mother’s perspective.
In 2004 Maunders, Giles, and Douglas (2007) conducted a qualitative study to explore maternal experiences of the support received from community health professionals. The researchers were aiming to enhance knowledge in this area, improve clinical practice, and inform research in to the phenomenon. The participants were selected from a National Health Service Trust database in England. Women were identified with whom the Home Visiting Nurses used the Solihull Approach of early intervention to address problems identified such as behaviour, toileting, sleep and nutrition. The approach focuses on the strengths of the mothers. Every third mother (42) was sent an information pack, consent form, and invited to participate. Nine women were subsequently interviewed. Using a phenomenological analysis model, ten sub-ordinate themes were found to fit under four super-ordinate themes. The super-ordinate themes are labeled as faith in self; trust in the Home Visitor relationship; the health professional’s appreciation of the perspective of the mother; and the perception of the outcome after the health professionals input. The mothers in the study wanted to be seen as “good mothers”. Positive health professional attributes were described as being understanding, reliable, and believable in their expertise. The researchers concluded that the study was successful in clarifying meaning behind the concepts of the client-professional relationship. The study implies that it is important to understand and respond to women’s beliefs about trying to be “good mothers”. Also it is recommended that health professionals tailor their responses to the needs of the individual in any health promoting, educating, or support situation.

A further study undertaken in 2004 in a low socioeconomic ward in London, England sought to gain an understanding about how mothers protect and promote their family’s health- particularly that of their children (Price, 2007). The researcher wanted to identify how resources were used and how constraints were overcome. This was a small qualitative study with a sample size of ten out of the original 30 who were invited to participate. The researcher also used a snow ball method in obtaining the sample of mothers. The small sample size seems appropriate considering the researcher was looking for information rich in detail. A limitation to the study findings stems from the small sample size though, as data saturation was not possible. The possibility of research bias from the perceived status of the Health Visitor conducting the interview by the mother in giving her information was identified by the researcher. The qualitative research design used an interview method of data collection and an inductive approach of data analysis which produced eight themes. The mothers were found to be motivated and revealed that the health of their children were of daily concern to them. The choices they made as mothers depended on what resources were available to them and how they could access these. Varying levels of medical knowledge, lay understanding, and personal experience contributed to the health behaviours and activities of the mothers. As with
the previous study discussed, it was revealed that it is important to be considered a “good mother”. Implications for health professionals are to remember the need to recognize the strengths of mothers in caring for their children and. Price also recommends that health providers understand mothers within their social contexts. This will enable health messages to be relayed and related in understandable and acceptable ways. Factors concerning access need to be addressed with consideration given to timing and location of contacts, and by inclusion of extended family and social supports. Further research around these needs could further inform how services are delivered and by whom.

In a retrospective exploratory study conducted by Hagan (2004) to examine the influence that perinatal events had on breastfeeding duration, it was found that conflicting advice, differing breastfeeding views, a lack of concern, and some behaviours of nurses and midwives impacted negatively on the breastfeeding experiences of mothers. This research study, undertaken in Hawke’s Bay, New Zealand, recommended the need to improve technical expertise, clinical and communication skills, and sensitivity to support breastfeeding. The open ended responses from this research were later used to describe breastfeeding experiences in New Zealand in a descriptive qualitative study (Manhire, Hagan, & Floyd, 2007). Responses came from the original sample of 153 primiparous and multiparous breastfeeding mothers, 20 to 49 years of age, who had given birth between four months and three years previously. Findings included the negative effects on breastfeeding of inconsistent health professional support. The implications for practice were identified as the importance of giving consistent advice and having the skills necessary to be able to support breastfeeding. Health professionals need to have good listening skills and be able to understand the responses of mothers to breastfeeding support within the context of their lives. The need for encouragement and support to be ongoing was also implicated. The researchers agreed with original research findings and recommended that breastfeeding education include technical expertise and communication skills.

**New Zealand studies of the experience for Maori women**

Heath, Tuttle, Cleghorn and Parnell (2000) wanted to explore the knowledge, attitudes and practices associated with infant feeding in a New Zealand Maori population. The study was conducted in Gisborne and collected information from a self-selected sample of 59 Maori mothers with infants born between July 1996 and August 1997. Interviews were undertaken when the infants were between three and eight weeks of age to establish what infant feeding practices had occurred since
birth, and the knowledge and attitudes of the mothers toward breastfeeding, and her intended infant feeding practices. The design of this research was a survey which allowed for the use of statistical analysis and regression analysis to discover what factors were associated with successful breastfeeding initiation. Results showed that although the initiation rate was high at birth (87 percent) that rate had dropped markedly by three weeks of age with only 68 percent still being exclusively breastfed. The researchers found that intention to breastfeed before birth was associated with successful initiation along with the age of the mother. Older mothers were more likely to have success at this time. The mothers reported that a perceived insufficient milk supply was a major reason for weaning early or for introducing infant formula occasionally. A high number of mothers told the researchers that they had not been encouraged to breastfeed and that breastfeeding in a public place was an embarrassing experience. The researchers concluded that more support was needed for these mothers which should begin with encouragement to breastfeed during their antenatal care. Education should be culturally appropriate for Maori and include common breastfeeding problems and how to deal with these. The researchers also recommend that change take place within society in regard to the acceptance of breastfeeding as the norm in order to remove the feelings of embarrassment that impacted on breastfeeding decisions around duration. The discrepancies in breastfeeding rates between Maori and New Zealand European ethnic groups was included throughout the discussion in this research and contributed to the recommendation that further research be done to address the needs identified by Maori women in antenatal and continuing breastfeeding promotion and support.

A further study was undertaken by Glover, Manaena-Biddle and Waldon (2007) to identify the factors that influence Maori women’s decision to breastfeed or not. Thirty participants were recruited from a wide range of Maori women and whanau members from the major urban, small towns, and rural areas of Auckland and the Bay of Plenty. A qualitative research design was used in this study where data was collected from interviews and analysed using a general inductive approach. It was discovered that most of the women in the study had breastfed and that their determination to do so was strong. Five influences that potentially diverted Maori women from breastfeeding were identified. Firstly, interruptions to a breastfeeding culture which means that breastfeeding is no longer seen as the norm within their whanau and as such was not encouraged or supported. Secondly, the early interruptions to, or difficulties with, establishing breastfeeding. This usually occurred at some time during the first six weeks. Thirdly, a perception of negative or insufficient maternity support for breastfeeding. This included the absence of effective antenatal education and a lack of postnatal instruction or support. Insensitive support and conflicting advice
caused the development of distrust for some mothers which affected future access to breastfeeding support. Fourthly, the occasional use of infant formula was occurring due to a lack of knowledge around breast milk supply and demand when mothers perceived their breast milk supply was insufficient. The final influence identified was that of returning to employment. This impacted significantly as the mothers were often in part time or casual employment situations and not well supported within the parental leave legislation. The researchers reported that mothers who had chosen to feed with infant formula or had weaned early were not well represented in the study sample and concluded that this was probably due to the motivation of those who had breastfeed to respond to the recruitment process. The findings of this study support the need to focus on reestablishing breastfeeding as tikanga for Maori and not merely a lifestyle choice according to the researchers. A major implication is the need to ensure that initiatives to improve breastfeeding uptake and duration gain the participation of Maori in planning and implementation.

The Ottawa Charter which addresses the process of health promotion as one which enables people to increase control over and to improve their health includes the steps needed to create supportive environments and develop personal skills (World Health Organisation, 1986). The research discussed here presents the maternal view of this quantified and qualified in various ways. The contribution to knowledge around breastfeeding is important and directs where future research needs to go and what questions need to be asked. The following studies describe the activity of breastfeeding promotion and support from the perspective of health providers.

**The role of health providers in breastfeeding promotion and support**

Health providers, other than nurses, have been the subject of research in regard to understanding breastfeeding promotion and support behaviours and outcomes. The two studies included here come from Canada and the United States of America (USA).

In Canada the psychosocial determinants of dieticians were examined along with nurses in their intent to recommend breastfeeding (Daneault, Beaudry, & Gaston, 2004) The study was undertaken from 1997 to 1998 and sought to contribute to the knowledge necessary to help raise breastfeeding rates in Canada. The research design was not stipulated but is described by its elements. The sample was purposive and while being considered large enough for the research purpose does indicate the need to do similar research with larger and/or other groups. The data collected served to describe and inform while the statistical analysis served to find correlations between variables. Findings
revealed that the main determinants of the intent to recommend breastfeeding were perceived behavioural control and perceived professional norm. The researchers concluded that there is a need to improve the intent to recommend breastfeeding and this needed to focus on enabling strategies for health professionals and social support for mothers in order to strengthen the recommendation to breastfeed. As with other breastfeeding research the limitations in the use and generalisability of findings is affected by the possibility that those with the strongest interest in breastfeeding responded to the invitation to participate. Daneault et al. (2004) suggest further research should be undertaken with other health professional groups. More in depth research should focus on what motivates health professionals to recommend breastfeeding.

Dillaway and Douma (2004) provide a report of research conducted in 1999 and 2000 at a paediatric practice in a Midwest state in the USA. The aim of the research was to understand the depth of breastfeeding support within paediatric clinics and to clarify what individual health professionals actually intend when they are supportive of breastfeeding. It was hoped that ways to improve support would become evident. Three hundred and ninety three breastfeeding mothers’ who were identified from an earlier chart review within three paediatric practices, responded to the questionnaire that was used to inform the qualitative part of the research. This consisted of focus groups of mothers (n=16) and individual health care provider interviews (n=21). The health care providers included 10 paediatricians, 13 nurses, and four medical assistants. Data were analysed using a qualitative method and revealed that mothers and health care professionals have different perceptions of support. Those health professionals with no personal breastfeeding experience saw that as a barrier to providing support. A fear of being too biased in favour of breastfeeding sometimes led to passive or reactive support being given only. There was a difference noted between favouring breastfeeding and being able to provide support when difficulties arose, or when the health professionals doubt their own ability to do so. Health providers also felt ineffective in addressing social barriers to breastfeeding. Dillaway and Douma (2004) conclude that support can be improved by reconciling the definitions of breastfeeding support as understood by both mothers and health care professionals. The need to be self aware of their own breastfeeding stance is an important step in being open to a mother’s need for support. An implication for practice in supporting breastfeeding was highlighted by the discrepancies between health care provider groups of what their own role actually was and who would be better suited to fulfill a support role.
Education of nurses in breastfeeding

Tschetter (2001) used Bandura’s theory of self-efficacy to examine the ability of nursing students to manage breastfeeding with new mothers and infants. Would self confidence in performing a task be associated with a involvement in that activity and success in performing the activity? (Bandura, 1995). Tschetter used a convenience sample of 249 nursing students who were to graduate from a Baccalaureate or associated degree programme in the spring semester of 2001 in South Dakota, USA. The response rate was good at 78.8 percent overall. The highest number of respondents was from Bachelor of Nursing programmes. This was a quantitative research study, using Likert type scales to rate the level of self-efficacy in performing a variety of nursing measures designed to assist breastfeeding mothers. Analysis was performed using descriptive and inferential statistics. The results showed the effectiveness of using Bandura’s self-efficacy theory in nursing education and learning design. Self-efficacy was affected by previous task performance, observing others do the task, and from verbal feedback. There were no significant differences in self-efficacy based on prior personal breastfeeding experience or gender found. The greatest tool for increasing self efficacy was identified as clinical experience. These student nurses were shown to have a moderate level of self-efficacy in breastfeeding management and believed their education programme was adequate in providing information. This finding is different to those previously discussed that recommend changes to the education of nurses to better equip them for breastfeeding promotion and support.

Recommendations for practice according to Tschetter (2001) include the use of Bandura’s theory as a framework for teaching design to include practical, observation, and feedback components. Secondly, the importance of role modeling in practice is encouraged. Recommendations for research are to conduct similar research with other populations, on larger geographical areas and with a more random sample, and also to undertake a longitudinal study to establish changes to self-efficacy with experience in practice settings.

Perhaps in opposition to the finding reported above that self-efficacy levels were not affected by personal breastfeeding experience, research by Marzalik (2004) showed that personal breastfeeding experience explained the greatest variance for both knowledge and attitude scores in breastfeeding. However it was unclear in the findings as to the affect on self-efficacy levels. The aim of this study was to describe the current state of breastfeeding education in university nursing programmes, and to determine the knowledge, attitudes, and self-efficacy scores of senior nursing students. Marzalik
also used Bandura’s theory as a framework for the study. The study used a survey method with a sample population of 385 from 36 randomly selected US Baccalaureate Nursing programmes. The most common teaching methods were lectures by nursing faculty, use of a textbook, and written test questions. The recommendations from this study are the same as presented by previously. These included, to provide education using simulated breastfeeding support situations and provide feedback, and to provide clinical experience that models breastfeeding support.

Whaley (2003) wanted to answer the question- does education change the attitudes of student nurses toward breastfeeding? This study used a descriptive comparative design and a survey tool to collect data from a convenience sample (n=103) of junior and senior Bachelor of Nursing students in Midwest Universities in the USA. The sample was divided into two groups- one that completed a women’s health nursing course, and one that did not. Data were analysed using Excel Descriptive Statistics to describe the demographics of the sample and the SPSS computer programme for the data on attitudes. Findings indicated that those who had taken the women’s health course were slightly less inclined to choose breastfeeding themselves in the future and also felt they would be less sexually attractive while breastfeeding. There was no influence to breastfeed from their clinical nursing experience to date. The limitations to this study were many and include the use of a convenience sample, the demographic makeup of the group as mostly middle class young adults in a university setting, the low number of students who were parents, and the limited personal breastfeeding experience of the students. The survey validity is also noted by the author as a limitation in the study. The surprising results that provide little evidence for the benefits of certain types of breastfeeding education is a concern but highlights the differences in research design and method on the integrity and usefulness of results.

Smale, Renfrew, Marshall, and Spiby (2006) conducted a qualitative learning needs analysis of breastfeeding training and education in a northern city in England. The significance of the study was indicated by the recognition of breastfeeding as an important public health strategy and the significant impact that health provider support can have on both the initiation and duration of breastfeeding. Improvements were seen as being dependent on the appropriate education and training of health providers. A learning needs analysis was to provide direction for the future provision of breastfeeding education among health professionals. The purposive sample was drawn from populations of health providers, including nurses, who advise and support breastfeeding mothers, and breastfeeding mothers themselves. Seventy three individual interviews with health providers and nine group interviews with breastfeeding mothers were conducted. The breastfeeding
mothers reported both conflicting information and a less than desired level of support from health providers. Those with serious problems felt the least supported. The health providers felt unprepared to confidently support breastfeeding mothers. This was the case whether this role was a small or a large part of their work. Education and training to fulfill this role formed only a small part of their training. Health providers also reported that their knowledge was fragmented and gained in an ad hoc manner. This led to a limited use of evidence based practice in breastfeeding which in turn led to a continuation of the promotion of harmful practices. The use of personal breastfeeding experiences as a discussion and learning tool was reported as seldom being used in education. Finally, it was reported that breastfeeding courses were hard to access or attended by those most interested in supporting breastfeeding rather than those most in need. The courses provided seldom taught the skills for health providers to be able to support breastfeeding particularly when problems occur. The researchers concluded that the findings brought into question the ability of health services to adequately respond to policy recommendations that support initiatives to improve breastfeeding rates in their current state.

The research of Abbott, Renfrew, and McFadden (2006) supports the above findings. The researchers stated that formal education does not adequately prepare health professionals to promote or support breastfeeding. Therefore there is a need to ensure continuing education opportunities. This qualitative study focused on three different health economies in England and included a sample of informants (n=31) drawn from populations of health visitors, midwives, infant feeding advisors, senior nurses, trainers, and volunteer organisation representatives. The aim of the study was to explore the informal learning opportunities available to, and accessed by, those who have contact with breastfeeding mothers. Semi structured telephone interviews and a thematic analysis were conducted. The findings revealed that local learning opportunities were overly dependent on individual breastfeeding champions or small groups that worked in relative isolation. There was little evidence of co-ordination or networking between organisations. The researchers found that where breastfeeding education opportunities were offered for National Health Service staff it was most often accessed by midwives and health visitors. Doctors were the least likely health provider group to attend. Other breastfeeding education opportunities such as conferences, web-based learning, and volunteer organisation training were more likely to be accessed by those health providers with a particular interest in promoting and supporting breastfeeding. This was often done without the support of employing organisations. The researchers concluded that more support was needed in local communities to facilitate continuing breastfeeding education programmes.
Nurses’ knowledge of breastfeeding

The quest to find out how much knowledge nurses had about breastfeeding and what other factors along with knowledge enabled or disabled nurses in their promotion of and support of breastfeeding has been ongoing for many years. Anderson and Geden (1991) conducted a study to survey the breastfeeding knowledge of nurses and to assess whether education, clinical experience, or personal experience predicted their knowledge. The sample was a convenient, nonrandom one of 293. The response rate to the mail out of questionnaires of 38 percent is low and could be considered a limitation of the study results. Quantitative statistical analysis revealed that no single predictor variable consistently distinguished nurses that were knowledgeable and those who were less knowledgeable on breastfeeding. Considering the wide demographic placement of the sample this could be cause for concern as it reflects stagnation in the improvement of breastfeeding knowledge over many years. Clinical experience and personal experience were both significant variables. Nurses who had breastfed their own infant scored significantly higher than those who had never breastfed. The authors suggest that those who had breastfed could be reflecting a higher level of interest in the subject of breastfeeding. Anderson and Geden (1991) implicate the nurses themselves in the role of professional responsibility to update their skills and incorporate new knowledge into practice. This self responsibility has not been mentioned in the other studies presented here. Further research would be helpful in understanding if and how much the nurse understands the concept of self responsibility in updating skills and knowledge, and if so to what extent is this acted on.

Nearly ten years later, Kershner (2000) used a quantitative, descriptive co-relational study to explore the level of knowledge related to breastfeeding among maternal-infant nurses and whether there was a relationship between knowledge, education, clinical experience, and personal experience of breastfeeding. Again a convenience sample was used that this time consisted of 67 maternal-infant nurses from a hospital in Michigan, USA. A version of a previously developed Knowledge and Attitudes Survey was modified to collect data. Descriptive and co-relational statistics were used in the analysis between variables and the knowledge of the nurses. No significant differences were found in knowledge based on education, clinical experience, accumulated years of experience, or personal experience in breastfeeding.

The findings from research undertaken only a few years later by Hennessey (2003) supported those of the earlier study of Anderson and Geden (1991). In this study of 87 nurses who worked with mothers and children in Yakima, Washington, Hennessey wanted to determine how the nurses’
knowledge of breastfeeding affected their attitudes, and practices toward breastfeeding promotion. As previously a survey method was used along with quantitative statistical analysis. Breastfeeding promotion practices were shown to be influenced by age, experience, personal breastfeeding experience, and the nurses’ current practice setting. While the majority were knowledgeable about breastfeeding and had positive attitudes and beliefs about breastfeeding promotion they also believed that they had not had enough instruction and training during their basic nursing education. Additional findings highlighted the concerns of a third of the nurses about the possibility of making women feel guilty by promoting breastfeeding when she had chosen to formula feed. This was suggested as an area for further study. Hennessey also raised the question about how the personal experiences of nurses could best be utilized in breastfeeding promotion and support considering the positive impact this factor had in the study.

The differences in findings between these studies raises questions about the use of quantitative research design to give true understanding to the obvious complex issue of providing breastfeeding promotion and support and how to ensure good outcomes.

Furber and Thomson (2006) moved research on nurses’ knowledge of breastfeeding to a qualitative level that wanted to discover the views of English midwives in relation to their breastfeeding support role. In depth interviews were carried out with 30 midwives from two maternity hospitals in Northwest England between October 1999 and October 2001. Constant comparison data analysis was carried out which led to snowballing in sample selection to further clarify data that came from the initial sample of nine midwives. Data collection only stopped when saturation was achieved as proven by the emergence of no new data. The results of this study indicated that intense emotions were created for these midwives due to differing professional knowledge and beliefs about breastfeeding support. The emotions were reported as being mainly negative. This theme was labeled as – the emotionalisation of breastfeeding- and had four sub themes. These were anger in practice; fear in practice; sadness in practice; and happiness in practice. Tensions arose out of differing beliefs in the value of certain sources of knowledge over others, and also out of differing philosophies of practice. The belief held by some that research based evidence was the only knowledge of importance created irritation and despair for other nurses when working within research based policy and protocols. It was also evident that certain knowledge was kept within professional settings and groups. Happiness was described in relation to positive relationships with mothers rather than with other nurses. The emergence of such strong emotions was not expected by the researchers but demonstrates the way that qualitative research design allows for the data to lead
the analysis and that unexpected outcomes are valuable as an addition to practice implications and direction for further research. The authors do suggest a replication of this study, considering the unexpected findings, in countries where breastfeeding prevalence is higher.

**The Impact of Personal Breastfeeding Experience**

Hellings and Howe (2004) conducted research to examine and report on Paediatric Nurse Practitioners’ (PNP) attitudes, experience, and knowledge about breastfeeding and to compare the results with those from a random sample of paediatricians and midwives. The study was a secondary analysis using a questionnaire sent to PNPs in a North West State, USA. The response rate was high at 81 percent and yielded a sample of 95 PNPs. The research method was applicable in this type of study that seeks to inform and not necessarily to understand. It was a unanimous finding that breastfeeding is the best option for mothers and infants. It was also unanimous that it is the role of PNPs to recommend breastfeeding. Seventy four percent thought that they were effective or very effective in meeting the needs of breastfeeding patients but did lack some skills in managing specific breastfeeding problems. Personal experience was named by many as the most valuable source of information. Once again the lack of knowledge gained in basic nursing education programmes appears lacking. In the comparison with paediatricians and midwives it was found that PNPs appeared more supportive and had better information. The PNPs though thought that they were less effective that their colleagues in providing one on one problem management. The researchers suggest a national level replication of this study.

Ekstrom, Matthiesen, Widstrom, and Nissen (2005) wanted to create an instrument to measure attitudes toward breastfeeding in a group of midwives, maternity nurses, and post natal nurses who were experienced in breastfeeding counseling. The researchers developed a questionnaire from World Health Organisation Standards that contained 47 statements with fixed answers on a four point response scale, and a visual analogue scale to gain information on breastfeeding interest. Quantitative statistical analysis consistent with the research method was used to first ensure content validity in the questionnaire on a sample group of nurses, before being used on the final data collected. The researchers found that there were harmful attitudes identified which suggests the need to reorient the education programmes for health professionals including nurses. The need to be able to identify harmful attitudes and reconcile these is vital if improved breastfeeding outcomes are to be seen. The research has provided a valuable instrument to provide insight into breastfeeding attitudes and how these affect ways of providing information and support. Four factors represent the
four different types of attitudes among the health professionals in this study. They are regulating; facilitating; disempowering; and antipathy. The facilitating attitude factor correlates highly with a positive attitude and interest in breastfeeding while the antipathy factor reflected less interest in breastfeeding generally with an inability to empathize with the breastfeeding mother and infant. A replication study would give valuable information and insight in most practice settings where health providers, including nurses, work to promote and support breastfeeding. The authors also suggest the use of reflection on individual experiences in breastfeeding. This could be translated into use of the reflection process by nurses to describe and understand their own experiences of providing breastfeeding support.

**Nurses Support of Breastfeeding**

Taveras et al. (2004) sought to identify practices that were associated with the continuation of exclusive breastfeeding. The research design is described a prospective cohort design with sample populations of low risk mother- newborn pairs and another made up of doctors, nurse practitioners, and midwives. Telephone interviews at four and twelve weeks post partum were conducted. The resulting data was linked to obstetric and paediatric clinician responses to a cross sectional mail survey conducted during the same period. Quantitative analysis using bivariate and multivariate analysis was used to identify the characteristics from both groups that predicted exclusive breastfeeding at 12 weeks of age. One hundred and fifty two out of the original sample of 288 mother and infant pairs were still exclusively breastfeeding at 12 weeks. Those that had stopped reported problems with latching, or suckling, or the recommendation for formula use by a health professional as reasons for doing so. Findings indicated that not all clinicians thought breastfeeding support was an important part of their work. The authors recommend the use of policy to stop the recommendation of formula use by health professionals without adequate information and support being given.

Bernaix (2000) found that intentions to provide support did not necessarily influence the actual behaviour of a group of 50 maternal- newborn nurses and 136 breastfeeding mothers. Bernaix said that few studies had attempted to identify factors that may explain the support behaviours of nurses to breastfeeding. In this study the two questions were asked. Firstly, what are the relationships between the nurses’ attitudes, subjective norms, selected demographic variables, and knowledge about breastfeeding and their behaviour intentions to provide support to breastfeeding mothers? Secondly, what is the relationship between the intent to provide support and
the actual provision of that support as perceived by mothers? A prospective study design was used that was guided by Ajzen’s and Fishbein’s theory of reasoned action. Is the intent to perform an action due to personal (attitudes) and social factors (subjective norms). The data collected from the questionnaires used was submitted to multiple regression analysis and revealed that the best predictor of supportive behaviour was in fact the breastfeeding knowledge and attitudes of the nurses. Intent to provide support is best predicted by attitude and social pressures of nurses. The findings indicate that if knowledge is the best predictor of supportive behaviour then that knowledge needs to be accurate and complete to ensure breastfeeding success. The researchers thought that intention should predict actual behaviour but the relationship was not proven.

The experience of nurses of inconsistent breastfeeding support was researched and reported by Nelson (2007). Nelson noted the reports on inconsistent breastfeeding support of nurses and the negative influence it had on the breastfeeding experiences of mothers. A qualitative existential phenomenological approach was used. Interviews with 12 maternal-newborn nurses were carried out between October 2005 and January 2006. The data collected was analyzed using thematic analysis. Nelson found that inconsistencies occurred due to the fact that breastfeeding support is a dynamic process with many dimensions that rely on situation, context, and relations. Influences come from many sources including personal and institutional. Collaboration between the many health providers that can actually come into contact and be called on to provide support to breastfeeding mothers is important.

The themes that emerged from the data included: inconsistencies still exist but things are changing; a need for buy in; there is no escaping personal experience; what works for one does not work for all; time impacts on recommendations; a privileged vantage point; my job, what it is and what it is not; and after all, breastfeeding is a maternal choice. Nelson (2007, p 36) summed up the findings from this research and what they added to the topic. Firstly, there is a need for buy in related to the newest recommendations, personal experiences, and material needed to individualise support. Secondly, that the personal, privileged vantage points and differing role perceptions related to breastfeeding among health professionals contributed to inconsistencies. Finally, that regular opportunities for team members to discuss the support role and participate in updating the breastfeeding policies of their own organisations would be beneficial.
Summary

A paucity of breastfeeding research in New Zealand was found that was focused on the promotion and support of breastfeeding by nurses in care settings, including that of Primary Health Care and the provision of nursing care in the community. The majority of the research found was conducted in Canada, England, or the USA. Quantitative research was useful in informing about the state of breastfeeding education, knowledge, attitudes, and practices and in guiding future research possibilities. Valuable qualitative research was done by Nelson (2007) in regard to inconsistencies in breastfeeding support experienced by nurses, and by Furber and Thomson (2006) in regard to nursing knowledge in providing breastfeeding support. The use of a qualitative research design to add depth to findings is useful and supports the research question in this study. The review of literature indicates that there is a need to know more about what factors enable nurses to be supportive of breastfeeding. Bandura’s self-efficacy theory has been identified as a valuable framework for research on breastfeeding education and has been used in research with undergraduate nursing students. A recommendation to undertake research using Bandura’s theory on a sample of experienced nurses was identified.

The research reviewed and analysed includes studies focusing on maternal views of health and breastfeeding promotion and includes two studies undertaken among Maori women in New Zealand; the role of health providers in breastfeeding promotion and support; the education of nurses in breastfeeding; nurses’ knowledge of breastfeeding; the impact of personal breastfeeding experience; and nurses’ support of breastfeeding. Implications for practice and research and the rationale for further research have been included. This process has identified gaps in breastfeeding research in New Zealand in community care settings and has highlighted the rationale for my planned research issue, research question, and chosen research design.
Chapter 3

METHODOLOGY

Introduction

The introduction and background information presented previously demonstrates that the need to improve breastfeeding rates in order to contribute to improved child health outcomes is of international, national, and regional level significance. Primary health care providers, including Plunket Nurses, have been identified as potential and current key contributors to breastfeeding support activities in community contexts. Therefore the need to prepare health care professionals to be successful in providing breastfeeding support is important.

The literature review provides evidence that there is a need to know more about what factors enable health providers, including nurses, to provide breastfeeding support. The use of Bandura’s self-efficacy theory as a framework in previous quantitative research demonstrates its value when asking questions concerning the ability of health providers to be confident in providing support. The literature review also indicates that the use of a qualitative research design would add depth to what is already known about the issue. Dykes (2006) provided a critical discussion paper of the educational requirements of health practitioners to equip them for their supportive role. This paper supports the literature reviewed by saying that health practitioners can provide positive breastfeeding support but can also have a negative impact when inconsistent or inaccurate information is given. Dykes points out that “conflicting information appears to be a continuing problem that undermines women’s confidence in relation to breastfeeding” (p 205). Dykes acknowledges that health practitioners need the requisite skills to achieve positive outcomes. In order to ensure this, more needs to be known about the education needs of health practitioners. The social context of any breastfeeding dyad and the knowledge, attitudes and skills of the health practitioners must be considered.

This chapter will describe the chosen research design for this study. The methods used in the implementation of this study will be discussed and will include participant selection and recruitment, data collection and analysis, and ethical considerations.
Research Design

Schneider et al. (2007) identified the nature and place of nursing research in constructing quality nursing practice. Research is described as a systematic and logical process that generates and tests knowledge. The authors state that research can be divided into two paradigms known as quantitative and qualitative research. Paradigms are described as sets of beliefs and practices that inform a researcher’s decisions when conducting research activities. Schneider et al. (2007) provide further classification of research paradigms as positivist, critical, and interpretive. The positivist approach is a philosophical position that sits within traditional scientific inquiry and encompasses quantitative research design and methods. Polit and Beck (2006) describe quantitative research as the retrospective or prospective study of independent and dependent variables for correlations that may or may not prove causation. An alternative term for this paradigm is that of deductive reasoning whereby reasoning moves from the general to the specific. The critical approach according to Schneider et al. (2007, p 23) seeks to “enable empowerment, emancipation and equality for the research participants and to challenge and change social structures.” Qualitative research designs and methods are generally used with this approach and include that of feminist research. The researcher’s role is as a transformation agent, an advocate, or an activist (Polit & Beck, 2006). The interpretive approach aims to “describe, explore and generate meaning within a social or practice context” (Schneider, 2007, p 24). Qualitative research designs such as phenomenology, ethnography, grounded theory and exploratory or descriptive research sit within this approach. Inductive reasoning is related to this paradigm as reasoning moves from the specific to the general.

Qualitative research can guide nursing practice by using personal stories to enlighten and enrich understanding of everyday experiences in health care according to LoBiondo-Wood and Haber (2002). It allows reflection on one’s own experiences and encourages thinking beyond proving facts (Schneider et al., 2007). The aim is to discover meaning and understanding through the revelations of the participants and a thorough analysis of the emergent themes. Roberts and Taylor (2002,p 307) clarify qualitative research as “using thinking that starts from a specific instance and moves to the general pattern of combined instances….it grows to make larger statements about the nature of the thing being investigated.” This process refers to inductive reasoning as previously discussed. Field and Morse (1985) say that inductive theory is directed to bringing knowledge into view by describing and naming phenomenon and suggesting relationships. Researchers using inductive reasoning seek to identify patterns or commonalities by looking at specific instances. Borbasi, Jackson, and Langford (2004), state that these activities allow the researcher to generate new concepts and theories.
Qualitative Descriptive Analysis

For the purposes of this study a qualitative research design is indicated as I am seeking to give meaning to the reflections of individual Plunket Nurses in considering from where their confidence and ability when providing breastfeeding support has been derived. Annells (as cited in Schneider et al, 2007) argues that even though Qualitative Descriptive Analysis is not linked to a particular qualitative tradition it is fast emerging as an acceptable form of descriptive exploratory methodology. It can be used to describe and explore a phenomenon in a holistic fashion and within a practice or social context. It can also provide rich descriptive data (Polit & Beck, 2006; Stevens Barnum, 1994). Other advantages not already stated are the ability to use reflexivity as part of the research design and include the researcher’s experiences in the study (Streubert & Carpenter, 1995) and the ability to use it as a tool for change. Disadvantages of using a qualitative research design can include the timeframes required to undertake such studies, ensuring that there is an audience for the research findings, and the personal style of the researcher including their ability to engage with the phenomenon (Streubert & Carpenter, 1995). It is also important that the researcher ensures saturation of data.

Sample

Participant selection
A sample size of ten Registered Nurses who work in a Plunket Nurse role was sought. The inclusion criteria were that they have had at least two years experience in a Plunket Nurse role including completion of the required education for the role. They must also be currently practicing in a community setting. The sample is purposive which assumes the researcher has knowledge of the population (LoBiondo-Wood & Haber, 2002). Participants are thought to be typical of the population or the issue under study. Purposive sampling provides “information-rich cases for in-depth study” (Schneider et al, 2007, p 124). It is a sampling method frequently used by qualitative researchers as it enables the researcher to select people with the required experience or in the required context to provide the information sought. A common qualitative research sample size according to Schneider et al (2007) is eight to fifteen but can vary widely. This small sample size is acceptable due to the richness of the data being collected. LoBiondo-Wood and Haber (2002) also say that there is no single rule for sample size and it can often depend on factors such as design and cost. Qualitative sample sizes tend to be small due to the sheer volume of data to be analysed.
Participant recruitment

Distribution of the Participant Information Sheets, which included an Intent to Participate return slip, were staggered to ensure the sample size was reached and also to ensure that participant time was not wasted by the return of data that could not be included in the research.

The data collection tool was included in this distribution. The expected date for return to ensure inclusion in the research was stipulated in the Participant Information Sheet and agreement to return by this date was implied on return of the Intent to Participate return slip.

Distribution of 18 prepared packs by mail occurred in two areas in the first instance. Two further areas had agreed to allow access and undertake distribution should this be necessary. A further six prepared packs were distributed in a third area two weeks after the first distribution occurred. This was deemed necessary due to the return of only one Intent to Participate slip at this time in the data collection process. Access was agreed by the RNZPS (Inc) General Manager of Operations and the selected area Clinical Leaders. Their involvement entailed placing the names and addresses of Plunket Nurses on the prepared packs and posting. Prepared packs also included self addressed stamped envelopes for return of the Intent to Participate and the data collection tool to a research intermediary. Areas distributing the prepared packs were only aware of who had been invited to participate but not who had agreed to participate. The use of an intermediary to receive posted replies ensured participant anonymity. Hawkes Bay Plunket Nurses were not included in this research due to my position of leadership and management held in the area within the organisation. This was deemed necessary in order to avoid potential issues around perceptions of power and coercion.

Participant recruitment and data collection were combined over a period of five weeks. There were ten Intent to Participate slips returned and a total of nine completed guided reflections returned by the date specified for inclusion in the research. The ethical considerations of voluntary participation, implied informed consent, confidentiality and anonymity, potential risks or harm to the participant, and data access, storage and disposal were addressed in the Participant Information Sheet.

Limitations/ delimitations

The sample for this research study was recruited from the population of Plunket Nurses working in community settings in New Zealand. While the role and community contexts of the research sample and setting may be seen to be unique, the issue under study sits within organisational, regional, national, and international contexts. It also sits within the domain of primary health care and
nursing roles in general. For this reason the generalisability of findings may reach beyond the sample population. There is a potential for respondents to be those who are most interested in the issue of breastfeeding outcomes and those who have either very positive or very negative views and experiences in providing breastfeeding support. A delimitation strategy is the use of a strengths based data collection tool that is known to and used by the sample population in developing practice.

**Data Collection Method**

A researcher designed reflection on practice tool was used to collect data in this study. The reflection guide invited participants to tell me about an experience where they have provided breastfeeding support to a mother in a community setting and to reflect specifically on from where they believe their confidence and ability to provide breastfeeding support has been derived. Use of reflections on practice as a useful tool in learning and growth as a nurse was identified in the literature review by Ekstrom et al. (2005). Reflections on practice form a part of the academic assessment expectations in the post graduate education requirement of the Plunket Nurse role. Through reflection, practitioners can come to see themselves in the context of their practice and develop skills and values associated with learning in both formal and self directed learning opportunities. Steps in learning can become more visible from the use of the reflective technique. Hesook (1999, p 1205) presents reflective inquiry as a method that “uses nurses’ situated, individual instances of nursing practice as the basis for developing knowledge for nursing and improving practice.” The use of the reflection technique can become a tool in the Plunket Nurse’s ongoing professional development.

Roberts and Taylor (2002) identify reflective writing for the purpose of research. Journal keeping uses reflective writing over a period of time but the process can be used for specific accounts of experiences relevant to a research topic. These authors go on to say that it is an effective way of involving people in research while removing possible intimidating situations such as interviews and observations. Reid (cited in Bulman and Schutz, 2004) describes reflection as a process of reviewing an experience of practice in order to describe, analyze, and evaluate it. This process informs learning from practice. There must be a willingness and commitment to the endeavour and the ability to be open minded when undertaking the process. Bulman and Schutz say that other advantages to using this process are its ability to raise levels of consciousness to an experience in practice; the use of emotions and feelings that can add further to new insights and ideas; and the possibility of enhanced future decision making. The authors point out that those undertaking a
reflection on practice do need to be aware of their own beliefs, values, qualities, strengths, and limitations. Heath (cited in Bulman & Schutz, 2004, p 161) states that “like life, nursing involves situations that are complex and if we are to understand nursing and ourselves as nurses, we need to try to make sense of the complexity.”

Participant recruitment and data collection occurred simultaneously and began after the required ethical approval had been granted from the RNZPS (Inc) Ethics Committee and approval for the research activity was approved by the Eastern Institute of Technology (EIT) Research Approval Committee. Recruitment and data collection occurred over a five week period during June and July 2008.

**Data Analysis**

Data were analysed using qualitative thematic analysis. I have used Giorgi’s four step method of analysis as a guide to ensure there was a clear process to follow that proceeds to an end point. Qualitative data analysis seeks to organize, provide structure to, and elicit meaning from the research data (LoBiondo-Wood & Haber, 2002; Polit & Beck, 2006). Crotty (1996) states that Giorgi’s method of analysis lets the experience unfold as it exist for the participant and looks for description of the phenomenon under study. Four steps were followed during the data analysis process.

Firstly, the entire set of data was read to gain a sense of the whole (Schneider et al., 2007). Secondly, each individual reflection was examined to identify units of meaning and to extract statements that are relevant to the research topic. Thirdly, essential themes were generated and described with the use of narrative to illustrate. The final step is described by Schneider et al (2007, p 111) as “synthesizing the essential aspects of understandings and reflections into a consistent statement”. I have ensured that the data collected has been stored securely to ensure participant confidentiality has been maintained. Rights to access the data was limited to me and the research supervisors as identified to the participants. Each returned reflection was coded with an identifying reference number and photocopied to allow the original to remain unaltered during any data analysis procedure. Each reflection was then transcribed onto computerized word documents for data management and analysis.

LoBiondo-Wood and Haber (2002) describe the data analysis process in qualitative research as inductive. Inductive analysis is used to lead to a “narrative summary, which synthesizes participant
information, creating a description of a human experience” (p 130). The data is analysed to address a specific research question. When using an inductive data analysis approach LoBiondo-Wood and Haber (2002) state that conceptual frameworks may be identified in the literature review from use in previous research. While a conceptual framework does not provide a framework for the study itself it can be used in understanding the findings, conclusions and recommendations.

The use of Bandura’s self-efficacy theory as a conceptual framework was identified in the literature review and was used in this study to provide a framework for the discussion of emergent themes and for resulting conclusions and recommendations. A recommendation from previous research was to use this theory as a framework when studying a more experienced population of nurses. Bandura (1995) describes the sources of information for self-efficacy judgments as actual experience (also known as mastery of experiences); vicarious persuasion (also known as observing others in the task or situation); verbal or social persuasion such as receiving feedback in a mentoring situation; and personal psychological, physical and emotional arousal and the effects on perception on the likelihood of being successful in any given situation or task.

**Trustworthiness**

Truth in qualitative research according to Roberts and Taylor (2002) is relative and its status is uncertain. Creditability, auditability, fittingness, and confirmability are four criteria for establishing the trustworthiness of qualitative data. Creditability, according to Schneider et al. (2007, p 149), lies in the “truth of the findings as judged by the participants and others within the discipline”. An element of confidence is in the truth of the reflections on practice written in the context and truth of the Plunket Nurse experience. Researcher credibility and the supervision of the researcher during the study enabled peer debriefing that provide additional elements of credibility (LoBiondo-Wood & Haber, 2002). Fittingness refers to the faithfulness of the research to the reality of the participants (LoBiondo-Wood & Haber, 2002). Schneider et al. (2007), state that the ability to fit into other contexts outside the study needs to be evident. This has been addressed while discussing participant selection. It is also measurable in terms of the fit of the findings from my data analysis with that from previous research findings that formed the literature review of this study (Beanland et al, 1999). Auditability refers to the need to ensure the dependability or accountability of the research with an information trail from the research question, the raw data, through the analysis to the interpretation of the findings (LoBiondo-Wood & Haber, 2002). This has been addressed by ensuring that the decisions made by the researcher and the processes followed are transparent and consistent (Roberts & Taylor, 2002) and additionally by the use of a data analysis guide and a conceptual framework for the discussion of findings, and conclusions and recommendations. The
reporting and feedback processes with the research supervisors provide a further measure of auditability. Confirmability is seen to be achieved when all of these have been demonstrated (Schneider et al, 2007).

**Ethical Considerations**

**Ethical Approval**

Approval was gained from the RNZPS(Inc) Ethics Committee and the Eastern Institute of Technology Research Approvals Committee prior to the commencement of this study. These approval letters are included as Appendix A & B.

**Cultural consideration**

Demographic data including ethnicity of participants was not requested as this research was not intended as a cultural or ethnically centred study. It was identified that it was possible that it may be identified by participants as a contributing factor to their perceived self-efficacy in providing breastfeeding support. It was decided that any such findings are to be included within the context of the study should they occur in professional practice. Findings may contribute to recommendations and include future research directions. This was discussed with the Kuia for the RNZPS (Inc) in Hawkes Bay and a representative from the RNZPS (Inc) National Project Review Group.

**Informed consent**

Participation in this research has been voluntary. This was emphasized in the Participant Information Sheet which invited Plunket Nurses who met the inclusion criteria to take part in the research. Due to the anonymity factors built into the study, withdrawal was not possible after return of the completed reflection on practice. Informed consent was implied on return of the reflection on practice. A copy of the Participant Information Sheet is included as Appendix C.

**Confidentiality and anonymity**

The elements of participant confidentiality and anonymity were addressed in the Participant Information Sheet. The recruitment process, the distribution process, the data collection tool, and the use of a research intermediary for the return of the completed reflections have ensured participants have remained anonymous in this study. Every effort has been made to ensure confidentiality by limiting access to the data collected to me and the research supervisors only and by the storage of data in a secure environment. The disposal of reflections on practice will occur after the completion of this study.
Risk/ harm
While it was not my intention to cause harm or distress to participants it has been acknowledged that reflecting on practice situations can be emotive. Peer supervision and access to an external counseling service (EAP) were included in the Participant Information Sheet. The research has been described previously as “strengths based” and seeks to benefit nurse practice and contribute to improved breastfeeding outcomes.

Summary
In this chapter I have discussed research paradigms in nursing research in general and the chosen research design for this study. A qualitative, inductive research design was indicated from the literature review and the research question. A qualitative descriptive analysis was appropriate to answer the research question as it allows the gathering of rich data and the emergence of themes that both describe and provide meaning for human experiences. Also discussed in this chapter are the process of selecting and recruiting participants, the data collection method and the data analysis method. Finally the ethical and cultural considerations inherent in this study have been discussed.
Chapter 4

FINDINGS

Introduction

As discussed in the previous chapter the data in this study has been analysed using qualitative thematic analysis. I have used Giorgi’s four step method of analysis as a guide to ensure there was a clear process to follow that proceeds to an end point. As stated previously qualitative data analysis seeks to organize, provide structure to, and elicit meaning from the research data (LoBiondo-Wood & Haber, 2002; Polit & Beck, 2006). Crotty (1996), states that Giorgi’s method of analysis lets the experience unfold as it exists for the participant and looks for description of the phenomenon under study.

In this chapter I will demonstrate the data analysis process using the first three steps of Giorgi’s four step method. The findings will be presented as themes that emerged from the participants’ reflections. It is important at this time to reiterate the research question as this informed the data collection tool used. It also provides an auditable trail from the purpose of the study, through the data analysis process, to the findings presented here. The research question is:

What factors do Plunket Nurses identify as contributing to their level of perceived self-efficacy when providing breastfeeding support to mothers in a community setting?

For the purpose of presenting the narratives from the participants’ reflections I have given each Plunket Nurse participant a name using the first nine letters of the alphabet consecutively from participant one to nine. The participant’s name and the page where the narrative occurs within the relevant transcript is provided after each section of text is presented.

Step one of Giorgi’s method: Gaining a sense of the whole

Breastfeeding support as a Plunket Nurse role was clearly identified throughout the entire set of data. This general sense of purpose supports the opening statement of this thesis from the New Zealand Breastfeeding Authority (2008) that community based health workers are identified as able to be effective in helping sustain breastfeeding up to two years and beyond. “Providing breastfeeding promotion, education and support is a part of every working day” (Cath, p.1).
My interpretation of the data is supported further by narrative that refers to specific breastfeeding support scenarios as common within the participants’ practice.

“During the visit it appeared that baby was doing the normal things that seven week olds do—wakeful in the afternoon/evening and wanting to feed “all the time when I’m trying to do dinner.” …… I thought—here we go again. This is such a common scenario” (Fran, p.1).

Hana’s story of providing support contributes a similar occurrence but this time with a different problem. “Perceived insufficient milk supply is common and something I help Mums understand on a regular basis” (Hana, p.1).

The data collection tool used in this study invited the Plunket Nurse participants to share a time when they have provided breastfeeding support to a mother in a community setting and to use this experience to reflect on from where their confidence and ability to provide this support has come. By focusing their reflections in this way a second stream of data has been provided that offers more than the research question seeks to answer. These are the rich descriptions of providing breastfeeding support in the context and reality of the breastfeeding experience at the time of the contact with the mother and baby. Secondly, there is rich description of what the actual breastfeeding support activities are. This data relates to the first research objective that seeks to identify the strengths in Plunket Nurses’ breastfeeding support practice. I have included these as serendipitous findings which have formed the sixth and seventh themes in the overall findings summarized in this chapter.

While the descriptions of context and support will be described later in this chapter an example is included here to illustrate my reason for including them in the research findings and following discussion.

“Breastfeeding is a personal emotional process that defies the black and white textbook knowledge and learning of practical skills in many instances. I have learned that family, culture, and society impact on the infant feeding decisions of every mother. From the initial decision on whether to breastfeed to how the experience will develop for the mother and her baby. Formal learning about breastfeeding and the learned skills in practical support such as latching, positioning and dealing with common problems such as blocked ducts, engorged breasts, mastitis etc provide a toolkit for supporting mothers. The usefulness of and
the confidence to use these tools is entirely dependent though on the context and setting of the breastfeeding experience. It is in recognizing and working around and with this factor that require most confidence and ability” (Cath, p.2).

Step Two of Giorgi’s method: Identifying units of meaning

After reading the complete set of data as a whole, firstly in their original returned form and secondly after being transcribed to computer word documents, the ‘units of meaning’ were beginning to emerge. ‘Units of meaning’ refer to specific words or combinations of words identified within text according to Roberts and Taylor (2002). Units of meaning that are explicit in their descriptive meaning and contribution to the research aims are easily identified and often emerge from the first readings of data according to Roberts and Taylor (2002). These authors go on to state that it is possible for interpretive units of meaning to be identified within the context of the data and lead to the emergence of implicit themes. Both descriptive and interpretive units of meaning were identified during my analysis of data. The individual reflections were read and the text contained in a unit of meaning was underlined and a description or my interpretation of the content was written in the margin beside it. I repeated this process with all individual reflections. This inductive process allowed ideas and units of meaning to emerge from the text (Schneider et al., 2007). The second step in this part of the data analysis involved cutting and pasting units of meaning onto new word documents as similarities, differences and relationships emerged. A collection of similar or related units of meaning is what makes up a sub-theme or theme. Sub-themes are “related to main themes, and are like subsections, or further elaborations on a theme” (Roberts & Taylor, 2002, p 432). The potential to combine some of the emerging themes at this stage of the data analysis became apparent as similarities were identified in the units of meaning within each one. The elements of each of the merged themes did not lose their essential identity but instead provided a depth to the description of the new main theme. A new document was created for each emerging main theme.

Step Three of Giorgi’s method: Essential themes are generated and described

Due to the process I used during coding, the text that relates to each of the emergent main themes was already clearly identified and grouped together. The development of the themes was discussed with a group of my colleagues and also with my research supervisors. The data analysis and resulting findings produced seven themes. Themes one to five are explicit themes that revealed themselves in direct relation to the research question. Theme six and seven emerged from the
inclusion of the stories provided within the participants’ reflections as a source of data worthy of analysis. These two implicit themes emerged from the stories shared and fit into the total context of what the experience under study was (Roberts & Taylor, 2002). The seven themes are:

**Theme One:** The contribution of personal breastfeeding experiences.

**Theme Two:** Observing and then doing

**Theme Three:** The impact of feedback

**Theme Four:** Sharing knowledge and experience

**Theme Five:** The place of formal education

**Theme Six:** The context and reality of the breastfeeding experience

**Theme Seven:** The nature of support

I will now describe each theme and illustrate with quotes from the narrative of the participants’ reflections. The description of each theme and the narrative used to illustrate them include the elements of previously merged findings to ensure depth and understanding.

**Theme One: The contribution of personal breastfeeding experiences**

The participants clearly identified their personal breastfeeding experience/s as a contributing factor to their confidence and ability when providing breastfeeding support in the community setting. This factor featured in all except one of the reflections. It was described in its impact as an initial source of breastfeeding knowledge for the participants’ support role. Other elements described were the positive and negative experiences of the participants and the contribution of these to the development of empathy and understanding. The actual experience of an activity is described as a major source of self-efficacy (confidence and ability) by Bandura (1995).

Anne described her personal experiences as a contributing factor as a first source of breastfeeding knowledge in her Plunket Nurse role. “Right from my first days as a Plunket Nurse I have used my personal breastfeeding experiences when providing support” (Anne, p.1).

Deb described a similar experience of starting in a new nursing role and bringing with her a personal knowledge base to use in her clinical practice. “In the early years of my Plunket Nurse practice I drew a lot of information and encouragement on breastfeeding from my own experience of breastfeeding my three children” (Deb, p.2).
Eve, like the previous participants, described why her personal breastfeeding experiences were important in the first instance and why they have an impact on her intent to support and her actual support practice.

“Initially when I think about this question my confidence comes from having been a mother whom has successfully breastfed two children. For me this was the most wonderful experience and I try to impart this to women by providing the best, and best practice support for them in my Plunket Nurse practice” (Eve, p.1).

The personal breastfeeding experiences of the participants are described in both positive and negative terms. The impact of their experiences is described in a way that imparts the emotions of their personal journeys and the ongoing effects on both the intent and actual support of breastfeeding mothers. Cath was clear in the following statement. “I believe my ability to support breastfeeding has come from my own breastfeeding experiences which were turbulent and tearful to say the least” (p.3).

Anne shared that she doesn’t recall making a conscious decision to breastfeed but this did not affect her resilience to keep breastfeeding when she had problems. Anne also described her experiences as providing a good grounding in her breastfeeding support practice.

“Breastfeeding for me was something I did without seeming to choose to do so……never thought to give up. I don’t know where this belief in infant feeding came from or my confidence to keep going in adversity because I had no previous experience with it- with family, friends- and very little to do with breast-feeding mothers professionally” (Anne, p.2).

For Fran her personal breastfeeding experiences were secondary to her clinical experiences of providing support. She described how her personal experiences gave her additional confidence to support mothers as she learnt “firsthand” what she had been imparting as a health professional previously.

“Since becoming a Plunket Nurse I have had two children and have breastfed both. I enjoyed the experience and this has boosted my confidence to support other mothers hugely. I learnt firsthand when breastfeeding my children how to latch and position well, the signs of a good feed, how to take care of my own needs, and how to unblock ducts and stop mastitis from
A shared outcome for some of the participants of their personal breastfeeding experiences is that they gained an empathy and understanding of what the mothers they were providing support for were possibly going through. Anne described her breastfeeding experiences as both positive and negative. “I really think my confidence in supporting mothers comes from my own experiences-positive and negative in the first instance. They gave me a good grounding and an empathy with what might be going on with these mothers” (Anne, p.3).

Cath shared that while her own experiences were “tearful and turbulent” this did not impact negatively on her clinical role. Instead the outcome has been the addition of this dimension to her role as a nurse.

“……my own breastfeeding experiences which were turbulent and tearful to say the least. On the positive side though I have realized the place my breastfeeding played in forming early bonding with my children and in allowing me to bring empathy and understanding to my support role” (Cath, p.3).

Eve posed the question: What does successful breastfeeding experience look like? This is a relevant question to ask when providing individual breastfeeding support for a mother/infant dyad. While Plunket Nurses can empathize and understand in support situations there is a need to remember just who’s breastfeeding experience it is that they are now a part of.

“What does successful breastfeeding experience look like? Maybe it’s that confidence to ‘just sit down and breast feed/ secure attachment with your child/ have the confidence that your child reflects that by being healthy/ no illness in the first two years/ steady growth marked by your intuition’. I can remember that I did not worry or “get hooked” on weighing my children, the visit from the health professional was a social time for me- some adult contact rather than an affirmation that I was doing well- I already intuitively knew that” (Eve, p.1-2).

Theme Two: Observing and then doing

A majority of the participants identified the act of observing others in breastfeeding or in their support of breastfeeding as a contributing factor in their confidence and ability to provide
breastfeeding support in the community setting. Bandura (1995) defines this type of learning as vicarious persuasion. The development of self-efficacy has been shown in previous research to impact on both the intent to perform an activity and the actual performance of that activity. The elements that contribute to this theme are described by the participants in terms of being able to learn on the job and to reflect on the outcomes of these learning experiences. A third element clearly described was that this type of learning continues across clinical roles and time as an accumulating body of knowledge and skills.

Anne described the contribution that observing and learning during her orientation into the Plunket Nurse role had on her confidence and ability to support breastfeeding mothers. “During my orientation into Plunket I was lucky enough to spend a week with an experienced Plunket Nurse. From her I observed and learnt skills in latching and positioning and some clinical information to help mothers through problems” (Anne, p.2). Anne has described her observation of and learning from a health professional she identifies as experienced in her role. Anne goes on to say that she feels she would have benefited from more time observing experts in their supporting roles. These are interesting concepts as they are revealed within the findings and will be addressed in the discussion to be presented in Chapter Five of this thesis.

Beth stated that learning on the job contributed to her breastfeeding knowledge. Observing and doing allowed her to reflect on breastfeeding support outcomes within a clinical role. “My breastfeeding knowledge is gathered from experience ‘on the job’. Seeing what has worked/not worked previous times” (Beth, p.3).

Deb found that observing and doing as a form of learning could be derived not only from other health professionals but also from her clients. This also indicates that vicarious learning is ongoing. “I have been a Plunket Nurse for 16 years and have learned a lot about breastfeeding from my clients- their experience and what other people have told them” (Deb, p.2).

Eve shared her experience of reflecting on the outcomes of a breastfeeding practice in her clinical past and how this experience translated into a willingness to replicate this practice in a new environment.

“It was easy to see the benefits of putting baby to the breast soon after delivery and most had their baby with them in their rooms.... Thus babies were able to go straight to the breast after delivery and suckle well. I think this ability gave me confidence to continue this practice while
working in maternity settings in New Zealand” (Eve, p.4).

Eve also recognized the contribution of observing the breastfeeding of her friends to her knowledge. Eve was able to reflect on their successes and achievements. “Friends having their own children and breastfeeding successfully and how they achieved that also contributed to my body of knowledge around this time” (Eve, p.5).

Within her role as a Plunket Nurse, Gail stated that the outcomes of her previous breastfeeding support endeavors have given her confidence in her ability to offer support. “Having supported several mothers and babies with breastfeeding issues and having positive feedback gives me confidence in my ability to offer support again.” Gail (p 2-3)

Not all knowledge comes from formal education avenues according to Daly, Speedy, and Jackson (2006). Practical knowledge can be picked up from everyday experience. Reflection both on actions and in actions, is a process that allows nurses to process their actions, justify them, and also to pass them on to their colleagues. The accumulation of knowledge and experience begins as nursing students and grows as nurses take on new roles over time. Eve gave a detailed account of the development of her breastfeeding knowledge which began with recounting her initial nursing education.

“My breastfeeding knowledge, which underpinned this confidence, has come from various sources- and that knowledge is recent as well as historic. My base knowledge has been built on over the years from when I first received knowledge about breastfeeding. Interestingly this knowledge has changed and how it has changed over the years. Some of the information has been discarded as knowledge about breastfeeding has grown over the last thirty years for me. ……..Maybe it was what I learned as a student nurse away back in the 70’s- but I don’t thing so as I hardly remember it. It did provide the building blocks for future knowledge” (Eve, p.2-3).

Eve did not experience breastfeeding support for mothers in a practical way as a student nurse either. She shared that, “as student nurses we were the “workforce” and to stop and help a breastfeeding woman seemed to be something to be avoided” (Eve, p.3).

Anne had a similar memory from a more recent time. When thinking back to her nursing diploma she stated that she could not recall breastfeeding education at all. Knowledge that is embedded in
nursing practice is knowledge that accrues over time in a practice discipline according to Tomey and Alligood (1998). With the gaining of experience the clinical nurse progresses through various levels of practice. Benner (as cited in Tomey & Alligood, 1998, p 159) expands on this by saying that as nurses gain experience “clinical knowledge becomes a blend of practical and theoretical knowledge”.

Fran described the impact of her role as a neonatal nurse on her breastfeeding support practice.

“My confidence and ability to support this mother stem from my professional experience working in Special Care Baby Unit before coming to work for Plunket. The knowledge gained in managing early breastfeeding in SCBU was a huge help when I started to support mothers in community settings” (Fran, p.2).

Eve shared the contribution to her knowledge and thereby her confidence and ability of both her nursing and her midwifery roles in maternity delivery unit and postnatal unit settings. Gail had a similar experience while nursing and supporting breastfeeding mothers in a postnatal ward.

Anne indicated that the time she spent with an experienced Plunket Nurse during her orientation was valuable and enabled her to observe and learn new skills in providing breastfeeding support. Hana also gained practical skills when entering the new role of the Plunket Nurse.

“My confidence comes from multiple sources including my own experiences of breastfeeding, some knowledge gained in the Plunket course, and practical skills learned from other Plunket Nurses and an amazing Community Karitane who is very passionate about breastfeeding” (Hana, p.2).

Benner’s model of the progression between levels of expertise in clinical practice is a situational model and therefore there is the expectation that as nurses move from one clinical role to another their level of expertise may alter (Tomey & Alligood, 1998). Some of the participants in this study have described the accrual of new knowledge and skills as they have changed roles. Cath has been a Plunket Nurse for six years and described her journey in providing breastfeeding support during that time.

“In the beginning it was the wish to do “good” that moved me over each new doorstep and into
forming a relationship with each new client that I quickly realized entailed a fast assessment of what of myself I had to leave at the door and what of myself to bring to each contact…….To move into their home environment moves the support role to a different level. It takes a confident Plunket Nurse to put themselves in a fairly vulnerable position in advising and supporting a mother in the community” (Cath, p-2-3).

The characteristics of any given breastfeeding support situation are recognized and understood in context because of prior experience according to Tomey and Alligood (1998).

Theme Three: The impact of feedback

Most of the participants included the effects that feedback on their breastfeeding support practice had on their confidence and ability to continue to do so. They described this contribution in terms of the increase in confidence provided by positive feedback and the inverse effect of negative feedback. The wish to be seen to be achieving a ‘good’ outcome is a third and related element of this theme. Bandura (1995) includes feedback in his social cognitive learning theory and defines it as verbal or social persuasion.

Cath was very clear that the outcomes of her breastfeeding support provided important feedback for her. “My confidence is an ever changing concept that is boosted by success and deflated by failures” (Cath, p.4).

Gail and Hana have also shared the impact that feedback has had on their confidence to repeat the activity. “Having supported several mothers and babies with breastfeeding issues and having positive feedback gives me confidence in my ability to offer support again” (Gail, p.2-3).

Hana shared that: “I am pleased to say that these four mums are still breastfeeding……Succeeding in helping a mum keep breastfeeding is a huge boost to confidence” (p.2).

In their quest to succeed in their breastfeeding support role two participants described in different ways how they justify what they have achieved as a good thing. Cath explained how she uses a reflection process for this purpose.

“I use the reflection process after contacts with clients on a regular basis as a way of pulling apart and seeing if there were other ways of approaching them, what worked and what didn’t,
Eve described her experience of listening and learning from the reflections of others who support breastfeeding mothers. She told of her observation of support outcomes followed by listening to those who may be seen to be in a mentor role and using this process to form conclusions on what works and is therefore to be considered as good.

“It was easy to see the benefits of putting baby to the breast soon after delivery and most women had their baby with them in their rooms. The atmosphere was relaxed and some of the older midwives had time to talk and reflect on their breastfeeding knowledge and practice” (Eve, p.4).

Just as positive feedback from others and our perceptions of success in providing breastfeeding support boost confidence and make the participants want to continue to provide support, the opposite can be seen to occur with negative feedback. Isla stated that the effects of negative feedback or the absence of the perception of being useful in providing support have impacted on her in two ways. Firstly in her intent to provide support and secondly in her willingness to stay informed and skilled in this area of her practice.

“I work mostly with Maori mums who are very shy and rarely ask questions and instead, just start formula when baby starts to want to feed more frequently. So it’s hard to educate people when they don’t have much resilience to keep trying, and I believe this has led me to reduce the amount of updating in my own breastfeeding education” (Isla, p.5).

Isla’s description of her experiences has highlighted issues that are worthy of discussion. Firstly, in terms of the impact of ethnic culture on the breastfeeding experience of the mother/infant dyad and secondly, in terms of the implications for the nurse bound by professional standards of practice to demonstrate cultural safety and professional responsibility for her own knowledge and practice.

**Theme Four: Sharing knowledge and experience**

Many of the participants in this study shared the belief that the opportunity to share knowledge and experience with others who also support breastfeeding mothers is a contributing factor to their confidence and ability. The value of dialogue with others within their organisation as well as other breastfeeding support providers external to the organisation was identified. A number of
participants have described instances of sharing knowledge and experience with others within their organisation that support breastfeeding. These opportunities are described as both informal and formal.

Anne and Fran shared that informal sharing was beneficial to their confidence and ability to support mothers. “I have gained from some peer discussions and there have been some very heated discussions with others about this. Everyone definitely has a view though and wants to share experiences whenever there is an invitation” (Anne, p.3). Fran supported this statement by saying: “I have learnt a lot from other Plunket Nurses over the past few years and have tried to keep up with changes and new knowledge” (Fran, p.2).

Deb identified a more formal sharing forum within their organisation and explained why she found it valuable to her in her practice.

“Opportunities to discuss concerns and unusual situations are gained by interaction with colleagues and also four to six weekly peer supervision. Discussion with colleagues on a regular basis is a valuable way of triggering your memory about other ways of doing things, alternative suggestions, provides reminders of different options and solutions” (Deb, p.3).

Deb stated that she found the process of peer supervision a positive way on which to learn during the presentation and discussion of specific breastfeeding support scenarios with another Plunket Nurse. This process is a form of reflective practice that is built into organisational policy and professional standards of practice as a requirement for continuous quality improvement in practice.

Cath identified her experience of having a different opinion than some of her peers and other health professionals and the belief she developed through reflecting on what she had heard.

“I have listened to peers and other health professionals who are passionate about breastfeeding say that ‘people need to be educated about breastfeeding’ and this will ensure more women breastfeed and for longer. I believe it goes far beyond this” (Cath, p.2-3).

The opportunity to share knowledge and experience across the boundaries between different professional and community roles has also been identified as a factor that contributes to Plunket
Nurses’ confidence and ability in providing breastfeeding support in the community. The sense of the non-exclusive ownership of breastfeeding knowledge and skills is also indicated.

Deb referred to her access to a Lactation Consultant as valuable in gaining specific information she sought to help her in her practice. “Very recently we had a talk from a lactation consultant and I was able to ask some specific questions which had concerned me” (Deb, p.3). Eve recalled a time when she gained confidence from a learning opportunity with another health professional.

“We also had a dietician speak to us who also reinforced this and gave great information on nutrition which had solid introduction at six months (I thought this was great and this has stayed with me for all this time)” (Eve, p.6).

Isla found that sharing breastfeeding update opportunities with nurses and midwives from her local District Health Board had contributed to her knowledge and therefore her confidence. From this forum a new avenue of learning opened for her.

“Annually Plunket Nurses are invited to the hospital to receive breastfeeding updates. Recently we have been invited to do an online breastfeeding course which I will do, as I have realized there’s so much more to learn and teach mums when problems arise” (Isla, p.4).

Hana included in her reflection the importance of consistent information and support across providers.

“I feel it is important that Plunket Nurses are given the skills and ongoing up to date knowledge to ensure we are consistent in our support endeavors in the community. It would help if others in contact with Mums and breastfed babies have access to the same information and resources for this reason” (Hana, p.3).

**Theme Five: The place of formal education**

Most of the participants have identified that formal education has had a place in the overall development of their breastfeeding knowledge and the accumulation of ongoing knowledge and skills to use in supporting breastfeeding mothers. The theme emerged around the descriptions of basic nursing education, access to ongoing education, and formal education that supports what
Plunket Nurses are already doing in their everyday work. The education received as a nursing student on the road to becoming a Registered Nurse is broad in nature and designed to provide a sound education base that allows for a safer and quicker experience based skill acquisition according to Benner (as cited in Tomey & Alligood, 1998, p 161).

Eve clarified the contribution of her original nursing education to her current confidence and ability in providing breastfeeding support. “Maybe it was what I learned as a student nurse away back in the 70’s- but I don’t think so as I hardly remember it. It did provide the building blocks for future knowledge” (Eve, p.3).

Anne stated that breastfeeding education did not feature in her original nursing education. She went on to say that until her role as a Plunket Nurse, breastfeeding did not feature in any formal way in her professional development.

“Thinking back to my nursing diploma- I cannot recall breastfeeding education at all. I had no other formal breastfeeding education until I started with Plunket and did the Post Grad Diploma. There were some excellent readings provided from current professional journals at the time. I also chose to do a written assignment focusing on breastfeeding and infant nutrition during the course from which I learnt a lot” (Anne, p.2).

Previous research has shown that self-efficacy in providing breastfeeding support as student nurses is most successfully formed through clinical experience which is designed using the elements of observation and feedback. The place of role modeling was identified in this process (Tschetter, 2001). This finding will be developed further during the discussion to follow in chapter five.

While most participants included various types of ongoing formal education as a contributing factor to their perceived self-efficacy in this study the findings indicated that access and opportunity were varied. Some of this appears to be dependent on what is available in a demographic area but also is self directed in many cases. Currently Plunket Nurses are required to undertake and achieve a post graduate certificate in order to deliver the Well Child/Tamariki Ora programme in the community. The contribution of this programme has been described above by Anne. Deb, Eve and Fran have also included their formal education when starting in their Plunket Nurse roles. Deb stated: “I also consolidated knowledge in Plunket training” (p.2). Eve shared this experience: “Probably the start of the knowledge base that really impacted was gained in the Plunket course...” (p.6). Fran agreed
by sharing that: “I also gained knowledge from the Plunket course during my first year on the job” (p.2).

Access to other post graduate level education was described by Anne and Eve. “Since then I have taken the opportunity to do a Breastfeeding and lactation paper at university level, and attend various seminars at the local DHB. I have attended these in my own time and paid fees myself” (Anne, p.2-3). Supporting this statement Eve said: “Further knowledge gained that has underpinned my breastfeeding practice has come from the infant feeding and lactation paper delivered by Massey University” (p.7).

Deb included her attendance at a conference in the past as still being an important factor in her current knowledge.

“In recent years there has been a trend to be less concerned about babies weight gain to fit neatly within growth charts. This was specifically highlighted to me during a La Leche League conference I attended five to seven years ago” (Deb, p.3).

Eve described the element of self responsibility in accessing education opportunities as a nurse.

“I have been aware of the need to keep updated and have generally availed of opportunities to increase knowledge -which in turn increases confidence in breastfeeding support. La Leche League study days have been important for this. More recently the opportunity to complete an online breastfeeding education course has been an asset. The course reinforced the knowledge already gained and assimilated into my practice” (Eve, p.7).

Along with practical experience and skills there is a need to base nurses’ work on evidence. Theoretical knowledge and explanations are required to make sense of what nurses do. It also lends credibility to our practice in breastfeeding promotion and support. Previous research has found that mothers want health professionals to be understanding, reliable and believable in their expertise (Price, 2007).

Anne described the contribution that formal education made to her practice. “Secondly I have learnt from formal education- this explained my own experiences and provided evidence to back up what I was advising mothers, and the information I am giving them” ( p.3).
Cath talked about developing a toolkit for supporting mothers and the contribution that formal education made to this. “Formal learning about breastfeeding and the learned skills in practical support such as latching, positioning, and dealing with common problems such as blocked ducts, engorged breast, mastitis etc provide a toolkit for supporting mothers” (p.2).

Eve described how formal education enabled all that she had previously learnt to make sense and become usable for her in her practice.

“Probably the start of knowledge base that really impacted was gained in the Plunket course…. For some reason it all “gelled”- the information was the best around at the time but was also timely, sensible, user friendly and easily adapted to all situations” (Eve, p.6).

Theme Six: The context and reality of the breastfeeding experience

The participants in this study were asked to focus on a specific breastfeeding support experience and to use this to then reflect on their confidence and ability in providing this support. Seven of the participants shared an experience and have articulated the context in which the experience occurred with clarity. The complexities faced as a nurse providing breastfeeding support in the community are identified. They include that of adapting support to fit the breastfeeding reality of the mother and infant and the impact of their professional responsibilities as nurses on the role of providing breastfeeding support in community settings.

Cath portrayed the provision of breastfeeding support in the context of the mother/infant dyad as a dynamic process.

“Breastfeeding is a personal emotional process that defies the black and white textbook knowledge and learning of practical skills in many instances. I have learned that family, culture and society impact on the infant feeding decisions of every mother. From the initial decision on whether to breastfeed to how the experience will develop for the mother and her baby ..... usefulness of and the confidence to use these tools is entirely dependent though on the context and setting of the breastfeeding experience. It is in recognizing and working around and with this factor that require most confidence and ability” (Cath, p.2).

Fran described the provision of breastfeeding support as a dynamic process also.
“There are times when it seems to be pure adrenalin that helps me through a support situation when there is so much going on around a mother who wants to breastfeed- family violence, lack of money in the home, whanau that want to take baby for a night, a weekend, a week- to give Mum a rest and show their support of her- for example” (Fran, p.3).

Anne described the context of her breastfeeding support experience and showed the emotions involved and the inclusion of family and other maternal supports in the visit.

“This was the first time I had seen this mum and baby since they were referred by the midwife. The baby was five weeks old and was exclusively breastfed. Rose (name changed) had mastitis and had visited her GP that morning. She was prescribed antibiotics and advised that breastfeeding may not be an ongoing option for her in the future (by the GP). Rose was tearful and had a lot of questions for me. She was upset at the thought that she may need to give up breastfeeding, had no information on how to continue doing so, and really didn’t understand why this had happened and how to manage it…..Her family and social support network were brought in to help for a few days” (Anne, p.1).

Deb shared what had been happening in the reality of the breastfeeding experience she chose to focus on for her reflection. The expectations and wishes of the mother are described: “the mother was keen to have baby sleeping well at night and in a routine in the day” (p.1). Fran shared the expectations of the mother, her family and friends for the breastfeeding experience and how the opinions of others impact on the breastfeeding experience.

“Jane had been exclusively breastfeeding without any problems for the past six weeks. When I visited her at seven weeks she told me she wanted to put baby on a bottle for his evening feeds. A friend had told her that this would make him settle better in the evening and make him sleep through the night sooner. Her mother had said that she and all her sisters had been bottle fed- and they were all fine!….. During the visit it appeared that baby was doing the normal things that seven week olds do- wakeful in the afternoon/ evening and wanting to feed ‘all the time when I’m trying to do dinner’. Her mother had also made her doubt her milk supply was enough or good enough for her baby” (Fran, p.1).

Fran went on to conclude that in the context of this situation this scenario would most likely be ongoing for this mother: “With the opinions of her mother, family and friends being important to
her that this would probably not be the last time she felt compromised in her decision to breastfeed” (p.2).

Eve believed that it is necessary to have the confidence in providing breastfeeding support to adapt that support to the situation as it arises.

“The confidence you have provides the ability to change with each situation as you temper the support to suit the client- or you can provide a variety of choices and allow the clients to have the ability to have the confidence to select what would suit her lifestyle/situation. Also to try something else” (Eve, p.2).

Isla found it difficult to provide breastfeeding support and described the realities of her clients as she observed them in her practice.

“I work mostly with Maori mums who are very shy and rarely ask questions and instead, just start formula when baby starts to want to feed more frequently. So it's hard to educate people when they don’t have much resilience to keep trying...” (Isla, p.5).

When breastfeeding support is provided by a nurse there are factors in the provision of care that must be carefully considered. Some of the participants have acknowledged that they are aware of the potential conflicts when providing nursing care in the community.

Beth described the place of maternal resourcefulness and choice in a breastfeeding experience.

“Mrs X felt her milk supply was adequate- she had commenced herself on some homeopathic remedy and felt as though her milk had increased....His weight gain at each visit remains minimal, but Mrs X is determined to continue with exclusive breastfeeding” (Beth, p.2).

Eve included in her narrative the question: “What does successful breastfeeding look like?”(p.1). Eve went on to say that she believes it is part of her support role to provide a variety of choices and to allow the client to have the ability to select that which she believes is best for her breastfeeding reality.

Hana stated that there is a need to remain open minded and non judgmental in her practice.
“Many scenarios bring with them many ‘buts’ or ‘so and so said’. I have to remain non judgmental and realize that just because I would like each support effort to succeed there will be times when I visit again and see a baby who is now on formula” (Hana, p.2).

Hana also stated: “I have to support the decisions made but always make sure they are fully informed decisions” (p.2).

Francis, Chapman, Hoare and Mills (2008) point out that due to the “complexities of communities it makes it unlikely that any initiative or activity will be uniformly beneficial to all” (p.89). These authors go on to say that in striving to be beneficent or in our desire to help there is the potential for conflict with respecting a person’s right to choose.

Theme Seven: The nature of support

The Plunket Nurse according the Well Child/Tamariki Ora Schedule (Ministry of Health, 1996) is to assess the need for support and information, provide practical breastfeeding management and support, and provide information and anticipatory guidance relevant to parents. The participants described these requirements in their breastfeeding support stories. The descriptions include the elements of the ongoing nature of support and the need for consistency in the content and delivery of support. The essence of not supporting in a silo provides a further component to this theme and is described by three participants in terms of seeking information themselves, recommending other support providers and referring to other providers more support. The participants saw themselves as part of a network of breastfeeding support and information rather than as isolated sources.

Beth told a story that unfolded over time and numerous visits to the home of a mother needing breastfeeding support. The pattern of assessment, planning, interventions, and evaluation as time goes on was evident.

“At the first visit she was exclusively breastfeeding and there had been no weight gain from the previous midwife visit. (This can be quite common due to the difference in scales). I arranged to visit again in a weeks time. The following week weight gain was minimal. I suggested waking and feeding three hourly in the day and discussed techniques for feeding as she seemed to have a good flow…. I arranged to visit the next week……..We have continued with regular weighs” (Beth, p.1-3).
The experience that Gail shared took place over a period of at least five months. She described the types of support provided over that time as observing and advising, offering more frequent monitoring, giving other contacts to facilitate breastfeeding support access, and encouraging the continuation of breastfeeding even beyond the introduction of solid foods. Cath talked about the forming of relationships with clients. Relationships formed in partnership over time enable the effective delivery and acceptance of information and support between the nurse and client: “In the beginning it was the wish to provide whatever support was needed for each mother and the wish to do “good” that moved me over each new doorstep and into forming a relationship with each new client (p.1).

Hana was adamant in her belief that consistency is important among those who provide breastfeeding support.

“I feel it is important that Plunket Nurses are given the skills and ongoing up to date knowledge to ensure we are consistent in our support endeavors in the community. It would help if others in contact with mums and breastfed babies have access to the same information and resources for this reason” (Hana, p.3).

Anne supported this finding and talked about the contribution of consistency to her confidence: “My confidence would be better supported if we were all on the same page so to speak and all giving the same information and the same level of support” (p.4).

Many of the participants described supporting mothers by informing them of other breastfeeding support options. This is essential if access to support that suits the individual is to be improved. The practice of referring to other providers within the organisation and to external providers was evident also.

Anne talked about the inclusion of another avenue of breastfeeding support in her plan of care with one mother: “Her family and social support network were brought in to help for a few days, she was referred to the Plunket Family Centre when she felt able for assessment of latch and position” (p.1). Gail described the support she provided which included information and recommendations of other services.
“I observed a feed, advised on breastfeeding position, offered more frequent monitoring of his weight, gave phone numbers of La Leche League and Healthline and encouraged continuation of breastfeeding exclusively (going over what to do if she decided to compliment with formula)” (Gail, p.1).

Isla also included information about another avenue of breastfeeding support available in her community with a mother: “I also reminded mum of the Lactation Consultant available free” (p.2).

**Summary**

This chapter has described the first three steps of the data analysis process I followed in order to generate themes and provide descriptive narrative from the reflections of the Plunket Nurse participants. In summary, seven themes were identified. The inductive process allowed five of the themes and to emerge that relate specifically to the research question. The data collection tool used in this study provided a second stream of data that I have termed serendipitous findings. The sixth and seventh themes emerged from this data and relate to the research objective that seeks to identify the strengths in Plunket Nurses’ breastfeeding support practice.

The fourth and final step in the data analysis method of Giorgi is intended to “synthesize the essential aspects of understandings and reflections into a consistent statement” (Schneider et al, 2007, p 111). To achieve this final step a full discussion around the seven themes will be presented in the following chapter.
Chapter 5

DISCUSSION

Introduction

In the previous chapter, seven themes were identified. Each theme was described and illustrated using selected exerts of narrative from the reflections provided by the Plunket Nurse participants. The following discussion completes the fourth and final stage in Giorgi’s data analysis. This stage seeks to “synthesize the essential aspects of understandings and reflections into a consistent statement” (Schneider et al, 2007, p111). To synthesize individual ideas and experiences is to combine them into forming an impression of the whole.

In this chapter the research findings are discussed as an interpretation of each identified theme. The discussion will be related to the existing literature and the research question and objectives.

Theme One: The contribution of personal breastfeeding experiences

The majority of participants in this study felt that their personal breastfeeding experiences were a contributing factor to their confidence and ability to provide breastfeeding support to mothers in the community. These findings are supported in part by a study conducted in the United States of America by Hellings and Howe (2004) to examine the attitudes, experience, and knowledge of breastfeeding among a group of Paediatric Nurse Practitioners (PNPs). Personal experience was named by many in the study as the most valuable source of breastfeeding information for them. While the PNPs were found to be more supportive and better informed they perceived that they were actually less effective in supporting breastfeeding than their paediatrician and midwife colleagues.

For a number of the participants, personal breastfeeding experiences were their first experience with breastfeeding in any context in their personal or professional lives. Their experiences whether described as positive or negative had an impact on their beliefs and attitudes around breastfeeding and their intent to provide support in their Plunket Nurse role. One participant described the wish to impart breastfeeding as a wonderful experience by providing the best support practice that she could. Other participants found that their personal experiences allowed them to approach support
situations with empathy and understanding as they could understand what may be happening for the mothers they were supporting.

Attitudes towards breastfeeding were found to have an impact on breastfeeding information and support provided by a group of midwives, maternity and postnatal nurses in a study conducted by Ekstrom et al. (2005). A positive attitude and interest in breastfeeding contributed to the ability to facilitate breastfeeding support situations. Those with less interest in breastfeeding or an inability to empathize with the mother and infant were found to approach the support situation with antipathy. The researchers suggested that education programmes for health professionals needed to account for the identification and reconciling of harmful attitudes. The findings of a study conducted in New Zealand by Hagan (2004) found that the duration of breastfeeding could be affected by the communication of a lack of concern for the mother’s breastfeeding experience or that of negative behaviours from health professionals who are providing care. The later findings from the open ended responses of Hagan’s research stated that health professionals need to be able to listen and understand the responses of mothers to breastfeeding support within the context of their lives (Manhire et al., 2007).

In previous research around the education of nurses in breastfeeding the findings of the contribution that personal breastfeeding experiences make to self-efficacy have been mixed. Tschetter (2001) reported no significant difference in self-efficacy based on prior personal breastfeeding experience. In contrast Marzalik (2004) showed that personal breastfeeding explained the most variance for both knowledge and attitude in breastfeeding. The effect on self-efficacy however was not clear in this study. Both of these studies used Bandura’s theory of self-efficacy as a framework to examine whether self confidence in performing an activity is associated with previous involvement in and success in performing that activity. Bandura (1995) states that actual experience, or mastery of an experience, is a valid source of information for self-efficacy judgments. Lowenstein and Bradshaw (2001) discuss Bandura’s theory as a cognitive theory of social learning. Cognitive theory according to these authors addresses the perceptual aspect of learning where a person is able to develop gestalt, or insight, through a change in thought processes and thereby the related activity. These moments of learning can be referred to as ‘aha!’ moments. The style of learning inherent in Bandura’s theory can be explained as “a natural, unconscious internal process concerned with thinking and memory” (Lowenstein & Bradshaw, 2001, p 5).

The contribution of the participants’ personal breastfeeding experiences to their perceived self-efficacy in providing breastfeeding support has been strongly identified. The previous research
findings of Smale et al. (2006) from a qualitative learning needs analysis of breastfeeding training and education conducted in England indicated that health providers felt unprepared to confidently support breastfeeding mothers. Education and training to fulfill this role formed only a small part of their training. The use of personal breastfeeding experiences as a discussion and learning tool was reported as seldom used in their education. The comments made by these authors is consistent with the current recognition of breastfeeding as an important public health strategy in New Zealand and the role that health providers have in supporting breastfeeding mothers and infants (National Breastfeeding Advisory Committee of New Zealand, 2008; New Zealand Breastfeeding Authority, 2008). Smale et al. (2006) believe that improvements in the preparedness and ability of health professionals to provide this support are dependent on appropriate training and education.

Hennessey (2003) conducted a study among nurses who work with mothers and children to determine how their knowledge affected both attitude and practices toward breastfeeding. While the majority of the participants were knowledgeable and positive about breastfeeding they reported that their education was lacking. Considering the positive impact that personal breastfeeding experience had on the findings in Hennessey’s study the researcher questioned how these personal experiences could best be utilized.

Within the discussion around empathy and understanding sits the question of what does successful breastfeeding look like, as posed and answered from her own experience by one participant. The concept of successful breastfeeding as an individual understanding is inherent in the personal experiences that each participant holds. Dignam (2001) holds the position that “successful breastfeeding is that which the breastfeeding mother identifies as successful” (p 38). This definition of success may be seen to be in contrast to what the international and national strategies describe as successful in terms medical and research based definitions and acceptable target measures to be met. Nelson (2007) found that the positive or negative nature of personal breastfeeding experiences often influenced the information and support provided to breastfeeding mothers. The manner in which the provision of breastfeeding support was approached was also affected. The influence was apparent in regard to both the level and consistency of support provided. The potential effect on the breastfeeding experience of a mother as one she would define for herself as being successful could be significant in such scenarios.

**Theme Two: Observing and then doing**

Most of the participants in this study indicated that the process of observing another person in the
act of breastfeeding or in the support of a breastfeeding mother, followed by the opportunity to then participate in the activity of providing support, contributed to their perceived self-efficacy. Bandura (1995) describes this form of learning as vicarious persuasion. Lowenstein and Bradshaw (2001), state that human learning comes from others, through observation and imitation.

A number of the participants described how they were able to learn on the job in this manner of observing and doing. These findings are supported by those of Tschetter (2001) who concluded that clinical experience was the greatest tool for increasing self-efficacy among a group of nursing students in the USA. Tschetter reported that the findings from this study showed the effectiveness of using Bandura’s self-efficacy theory in the planning and delivery of nursing education and learning design. The elements of observation and practice in a teaching framework are believed to be necessary along with a third element of feedback.

An earlier study of the knowledge of a group of more experienced nurses about breastfeeding and what other factors enabled or disabled their support of breastfeeding also included clinical experience as a significant variable (Anderson & Geden, 1991). Other variables studied were education and personal experience. In contrast to these findings, Kershner (2000) did not find any significant differences in the knowledge of a group of maternal- infant nurses based on education, clinical experience, accumulated years of experience, or personal experience of breastfeeding.

A number of participants shared their experiences of reflecting on the outcomes of breastfeeding support practices that they had observed or participated in. Lowenstein and Bradshaw (2001) describe reflection as a way of absorbing, considering, speculating, and deliberating on an activity or event. Reflection allows understanding of an experience and can provide reasoning for action in the future. Schon (as cited in Lowenstein & Bradshaw, 2001, p 6) states that reflection can be seen at work in three ways. Firstly as ‘knowing in action’, whereby a nurse uses personally constructed knowledge. Secondly as ‘reflection in action’ whereby a nurse consciously thinks about what she is doing and is aware that knowledge is being used. Thirdly as ‘reflection on action’ whereby a nurse looks back on an event, examining actions and thoughts to enable decisions to be made about how she may act in similar situations in the future. Daly et al. (2006) describes reflection as a process of continuous quality improvement and monitoring of practice. The process of reflection as a tool in the professional development of nurses is a key competency for Registered Nurses in regard to communication, professional judgment, management, and quality improvement (Daly et al., 2006; Nursing Council of New Zealand, 2007).
Dillaway and Douma (2004) conducted a study in order to understand the depth of breastfeeding support within a health care setting in the USA and what health professionals actually intended when they were supporting breastfeeding. The researchers found there was a difference between favouring breastfeeding and actually being able to provide support when difficulties arose. The need to be self aware of their own breastfeeding stance and some clarity in what their role entailed were seen to be an important steps in the ability to support a mother in breastfeeding. Ekstrom et al. (2005) suggested the use of reflection on individual experiences on breastfeeding as a way to gain insight to the attitudes that surround breastfeeding and to enable the reconciling of harmful attitudes before they impact on practice. Anderson and Geden (1991) implicated the nurses themselves in the role of their professional responsibility to update their knowledge and skills and incorporate these into their practice.

The accumulation of experience across roles and time was indicated as a contributing factor to confidence and ability in providing breastfeeding support by a number of participants in this study. The research of Tschetter (2001) and Marzialik (2004) found that learning by observing and doing is an effective method of gaining knowledge and skills in breastfeeding as nursing students. Daly et al. (2006) tells us that not all knowledge comes from textbooks, research journals, lectures and classrooms. In reality, nurses continue to gain practical knowledge from their everyday practice experiences.

Benner (as cited in Porter, 1998) seeks to show how the clinical nurse progresses through various levels of practice with the accumulation of experience. The novice nurse provides care that is dependent on formal knowledge and procedures. Tomey and Alligood (1998) point out that this level of expertise is not only that of the nursing student but also a nurse who begins in a new clinical role or area of practice. The expert nurse according to Benner (as cited in Porter, 1998) has an intuitive grasp of clinical situations gained from learning in clinical situations and reflecting on outcomes. At this level of experience the nurse is confident to rely on her own judgments. The movement through levels of experience is described by participants in this study.

One participant referred to the contribution of the opportunity to learn from an expert to her self-efficacy in providing breastfeeding support. This participant may have been referring to another nurse who practices at a more experienced level. She may also be referring to having access to a lactation consultant who is considered to be a specialist health worker who may or may not also be a nurse. Within New Zealand the majority of certified lactation consultants are also either midwives.
or nurses (Dignam, 2001). Pessl (as cited in Dignam, 2001) expressed concern that lactation consultants can portray attitudes of rule keeping and control over breastfeeding in the delivery of their service. Within New Zealand it has been suggested by Beasley (as cited in Dignam, 2001) that lactation consultants need to be vigilant in maintaining a balance in their practice that is not weighted toward the medicalisation of breastfeeding. The participants in this study referred to lactation consultants as a valued and socially acceptable source of information that assisted them in decision making and offered additional options in access to breastfeeding support. Wilkinson and Miers (1999) provide a poignant reminder though that the perception of the presence of ‘elites’ among health care providers has been developed alongside society’s beliefs in the medicalisation of health. The result is that society can become dependent on the believability of the experts knowledge above that of others. These authors go on to say that ‘elites’ in nursing are not useful when the perception of special or distinct knowledge or abilities is passed on to their clients. This then impacts on how nurses and clients form relationships and interact. The “implication is to be aware of the roles of other providers and to use that knowledge in an informed way” (Wilkinson & Miers, 1999, p 62).

**Theme Three: The impact of feedback**

As reported in the findings most of the participants in this study identified the effects that feedback on their breastfeeding support practice had on their confidence and ability to continue to do so. Bandura (1995) describes the part that feedback has to play in his theory of self-efficacy. Verbal or social persuasion is the act of giving or receiving feedback. Bandura also includes the effects that personal physical, psychological and emotional arousal on the perception of the likelihood of being successful in any given situation. The participants in this study refer to feedback as a contributing factor in terms of the effects of positive feedback, the wish to do good when providing breastfeeding support, and the effects of negative feedback on ongoing practice.

Tschetter (2001) sought to establish whether firstly being involved in an activity, and secondly being successful in the performing of that activity would contribute to the self confidence of nursing students when managing breastfeeding with new mothers. The findings showed that receiving verbal feedback did affect self-efficacy. Tschetter recommended the use of Bandura’s theory as a framework for teaching design as stated previously. Tschetter also found that there was a place for the role of mentor or role model in teaching design.
Vance and Olson (1998) state that Bandura’s theory provides a backdrop for mentoring and describe the benefits of mentoring in terms of the personal and professional developmental outcomes of the nurse. These authors go on to say that learning through modeling or by receiving feedback of success and satisfaction from outcomes of care is a better way of acquiring and integrating knowledge and skills than by trial and error. The participants in this study describe the impact of feedback from their own practice outcomes as contributing to their self-efficacy within their current roles as Plunket Nurses. The contribution of this factor though is seen to be accumulative and dynamic in nature. The element of feedback is closely associated to the previous theme of observing and doing but is identified by participants in its own right. Lowenstein and Bradshaw (2001) refer to feedback as reinforcement. This explanation of the process lends itself to the context of feedback from one’s own practice. Within the RNZPS (Inc) a programme of preceptorship begins for newly appointed staff in the recognition that this will more likely result in quality care for clients as well as increased job satisfaction (RNZPS (Inc), 2008). The role of the preceptor includes support of the new Plunket Nurse in their adaptation the workplace and new clinical experiences, to provide feedback, and to encourage the preceptee’s self directed learning and reflection.

A number of participants talk about being successful in providing breastfeeding support as being seen to achieve something that is ‘good’ or to be able to see the ‘good’ in the support practice. Maunders et al. (2007) conducted a study in 2004 to explore maternal experiences of the support received from community health professionals. The four themes generated from the data in this study focused on the views of the mothers but provide a commentary on what the Plunket Nurse participants are alluding to in their reflections. These are to have faith in self, to have trust in the health professional, for the health professional to appreciate the perspective of the mother, and for the outcome to be perceived favorably. The mothers in Maunders et al.’s (2007) study wanted to be seen as ‘good mothers’. Price (2007) reported similar findings in a study conducted to understand how mothers protect and promote their family’s health- particularly that of their children. The choices made by the mothers were dependent on the availability of and access to resources at the time of the health need. It was revealed that it was important for these women to be seen as ‘good mothers’. The researchers concluded that health professionals need to recognize the strengths of mothers in providing care for their children. In interpreting the relevance of these findings to the meaning of being seen to do ‘good’ as nurses who support breastfeeding mothers, the views of Hickey, Ouimette and Venegani (2000) are useful. These authors state that a person’s view of self
will impact on the roles she is able and willing to assume as a nurse. The professional self emerges from the personal self and will be supported or impeded because of this factor.

The effect of receiving negative or no feedback is the opposite of that already discussed. One participant in this study described the impact that her perception of not being useful in providing support had on her future intention to support and also on her willingness to remain up to date in her knowledge and skills in the area of her practice. Lowenstein and Bradshaw (2001) refer to this as not receiving reinforcement from previous efforts to support mothers in her community. The outcomes then are that of failure and dissatisfaction (Vance & Olsen, 1998). Without personal and professional satisfaction this participant is unable to achieve self-esteem and confidence and cannot strengthen or progress in this area of her practice. The explanation offered by Bandura for the way in which such responses or lack of responses to feedback is that of the decreasing likelihood of being successful lowers the confidence and ability to offer breastfeeding support in the future. The impact of ethnic culture on the breastfeeding experiences and decisions of the mothers she worked with was indicated by this participant. Two studies conducted in New Zealand have focused on breastfeeding among Maori women. Heath, Tuttle, Cleghorn and Parnell (2000) surveyed the knowledge, attitudes and practices associated with infant feeding in a New Zealand Maori population. The researchers found that although breastfeeding initiation was considered high, many mothers had stopped exclusively breastfeeding by three weeks of age. Among the reasons for this outcome was the lack of encouragement to breastfeed encountered by these women and the feeling of embarrassment at breastfeeding in public. The authors acknowledged that this problem could probably not be tackled on an individual basis. The findings in this study support the experiences encountered by the Plunket Nurse participant in regard to working with Maori mothers who appear very shy and rarely ask questions. The perception of low maternal resilience when breastfeeding problems occur was identified by this participant. Manhire et al. (2007) said that breastfeeding outcomes differ within different sociocultural contexts and while breastfeeding promotion is increasing in New Zealand there are many factors that influence maternal breastfeeding decisions and practices. These authors found that persistence and determination, or resilience, to breastfeed even through difficulties is affected by internal and external environmental factors. Encouragement is required along with individualized assessment and advice according to Manhire et al. (2007). The confidence and ability to provide these in dynamic and often complex breastfeeding realities is the ongoing responsibility of the Plunket Nurse providing support. Heath et al. (2000) recommend that health professionals address areas of misunderstanding as early as possible during the antenatal period but also continue to encourage breastfeeding. The need to reconcile possibly harmful
attitudes and behaviours has been identified previously in this discussion and is alluded to within the findings of the study conducted by Glover, Manaena-Biddle and Waldon (2007). This study explored influences that affect Maori women’s breastfeeding decisions. These researchers found that most of the participants had breastfed and their determination to do so was strong. Five factors that diverted the Maori women from breastfeeding were identified. The theme described as the experience or perception of negative or insufficient maternity support for breastfeeding relates supports other findings already discussed. This includes the absence of or ineffective antenatal education as well as postnatal support and instruction. Insensitive cultural information or support was shown to lead to a distrust of health professionals and therefore unwillingness to access services available. Another theme identified by the researchers was that the perception of insufficient milk supply often led to the occasional use of artificial formula. The researchers state that health professionals can impact negatively on breastfeeding success for Maori if they have rigid or negative attitudes and inappropriate management strategies. The study concludes that to promote and support breastfeeding to Maori the focus needs to be on re-establishing breastfeeding as tikanga rather than a lifestyle choice. This study while substantiating the experience of the Plunket Nurse participant does not advise the removal of support from Maori but implicates the ongoing professional responsibility of nurses to provide breastfeeding support that is determined by the Maori mother and her whanau as appropriate and effective.

Francis, Chapman, Hoare and Mills (2008) state that the nurse delivering a service will undertake a process of reflection on their own cultural identity and will be able to recognize the impact on that on their practice. The ability to do this in the community and provide acceptable and appropriate care implies an understanding of the individual and the whanau in the context of their culture. The responsibility to meet the competencies for registered nurses resides with the nurse in providing evidence of cultural safety and professional responsibility (Nursing Council of New Zealand, 2007). Standard six of the Plunket Nurse Standards of Practice (RNZPS (Inc), 2005b) relates to the provision of culturally effective practice and is defined as practicing in a manner which the client determines as being culturally safe. Particular competencies within this standard of practice that are of relevance to this discussion include the demonstration of a working knowledge of the differing health needs for Maori considerate of health and socio-economic status and the corresponding ability to reduce health inequalities. The need to recognize ones own beliefs, values and prejudices that may arise is expected of the Plunket Nurse along with the recognition of the impact of the culture of nursing care on the client.
Theme Four: Sharing knowledge and experience

The participants in this study shared the belief that the opportunity to share knowledge and experience with others who also support breastfeeding mothers is a contributing factor to self-efficacy. A number of participants indicated that sharing in this way with other Plunket Nurses increased their confidence and ability. Previous research has indicated that providing consistent support and information is valued by mothers and will contribute to improved breastfeeding outcomes. Maunders et al. (2007) reported that mothers who participated in a study of maternal experiences of support by community health professionals wanted health professionals to be reliable and believable in their expertise. These findings are further supported by the New Zealand based study of Hagan (2004) and the ensuing use of the open-ended responses from this study in a descriptive qualitative study by Manhire et al. (2007). Conflicting advice and differing breastfeeding views of health professionals were cited as influencing breastfeeding duration. The negative effects of inconsistent health professional support were also reported. Implications for practice were the need to ensure consistent advice and having the skills to support breastfeeding.

Smale et al. (2006) found in their qualitative learning needs analysis conducted in England that in general health providers reported a fragmented and ad hoc breastfeeding education with limited use of evidenced-based practice and therefore a continuation of the promotion of harmful practices. The opportunity to dialogue with peers is valuable in providing a forum for informal education. Abbott et al. (2006) sought to explore the informal education opportunities available to and accessed by those who support breastfeeding mothers. These authors found local opportunities were most often dependent on individual breastfeeding champions or small groups working in isolation. Coordination among organisations was not evident and access was self-directed in many cases. Those with a particular interest in breastfeeding were seen to be most likely to access education. These findings indicate that opportunities to increase dialogue and learning among peers within organisations is valuable.

Sharing knowledge and experiences across professional and role boundaries was also identified as a requirement in improving access to continuing breastfeeding education (Abbott et al., 2006). This factor was identified by a group of participants in this study. Participants described the importance of non-exclusivity or ownership of breastfeeding knowledge and skills to support mothers and the contribution of sharing across boundaries in promoting consistency in the information and support provided. Previous research has reported findings that support this concept of sharing as valuable.
Daneault et al. (2004) in a Canadian based study found that the factors of perceived behavioural controls and perceived professional norm contributed to the intent to recommend breastfeeding in a group of health professionals. To improve the level of intent the researchers concluded that there should be a focus on strategies that enabled health professionals to undertake this role. Such strategies include that of sharing knowledge and experience.

Furber and Thomson (2006) discovered the views of English midwives in relation to their breastfeeding support role. The findings indicated that intense emotions resulted due to differing professional knowledge and beliefs about breastfeeding support. Tensions arose when different beliefs in the value of some knowledge sources over others were experienced. Irritation and despair resulted when some believed that research based evidence was the only source of importance. The gate keeping of some sources of knowledge was also identified in the research as a negative factor.

Nelson (2007) researched the experiences of nurses of inconsistent breastfeeding support and reported that inconsistencies occurred due to the dynamic nature of the breastfeeding experience and the support that is subsequently provided. The support process is dependent on situation, context and relations according to Nelson. Influences in the support provided come from personal and organisational sources. It is because of this that Nelson recommends collaboration between health providers that come into contact with breastfeeding mothers and infants. Nelson summarizes that health professionals need to buy in to the latest recommendations, the importance of personal experiences and the need to individualize support. Nelson adds that gate keeping knowledge and differing role perceptions contribute to ongoing inconsistencies in health professional support. The summary concludes with the observation that regular opportunities for team members to discuss their support roles would be beneficial.

Reflective practice within this theme of sharing knowledge and experience was described by participants in terms of a formal process of peer supervision and as an individual endeavour. Peer supervision is a professional development tool that provides evidence of reflective practice and continuous quality improvement of individual nursing practice. Within the competencies for registered nurses (Nursing Council of New Zealand, 2007) the nurse is required to provide evidence of reflecting upon, and evaluating with peers and experienced nurses, the effectiveness of nursing care. Plunket Nurses are required to provide evidence of the participation in peer reciprocal or professional supervision and the reciprocal nature of critical and reflective feedback according to Standard Four of the Plunket Nurse Standards of Practice (RNZPS (Inc), 2005b).
Peer supervision is seen by the RNZPS (Inc) (2004, p 1) as an “important tool to maintain safe practice for community health workers. It is a supportive process, encouraging the worker to take responsibility for her/ his own professional development.” Several functions of peer supervision are detailed in this document. These are to assist the worker to carry out their role by developing competencies, assist with professional development by providing constructive feedback, and as a source of support as the demands of community health work are recognized.

**Theme Five: The place of formal education**

Some of the participants in this study found that formal breastfeeding education had a place in their perceived self-efficacy in providing breastfeeding support in the community. The place of formal education was described in terms of providing a basic level of nursing knowledge from which to develop in future clinical roles. As previously discussed Smale et al. (2006) found that the preparation for the role of providing breastfeeding support played only a small part in nursing training. Abbott et al. (2006) supported this finding and states that most formal education does not adequately prepare health care professionals to promote breastfeeding or to support breastfeeding mothers.

One participant in this study expressed the contribution that initial nursing education had on providing the building blocks for future knowledge. Daneault et al. (2004) found that in order to improve the intent to recommend breastfeeding and contribute to improved breastfeeding rates in Canada, there are a need to focus on enabling strategies for health professionals. Paterson (1991) points out that knowledge gained in the classroom provides a guide to practice. Benner (as cited in Tomey & Alligood, 1998) supports this sentiment by saying skilled nursing requires a sound education base. The study undertaken in the USA by Tschetter (2001) of the ability of nursing students to manage breastfeeding with new mothers and infants found that these student nurses had a moderate level of self-efficacy in breastfeeding management and believed their education programme had been adequate in providing information. Marzalik (2004) in a study also involving nursing student sin the USA reported that the most common teaching methods used were lectures, using textbooks, and written test questions. Marzalik recommended providing education using the methods of simulated support situations and feedback and providing clinical experience that models breastfeeding support even at baccalaureate level. A third study involving nursing students in the USA conducted by Whaley (2003) found that by providing a women’s health course actually led to these students being less inclined to choose breastfeeding themselves in the future. The clinical
placements they had experienced prior to the study also had no influence on their breastfeeding
decisions. The findings provided little evidence of the benefits of certain types of breastfeeding
education.

Educated and skilled support is needed from the health system to ensure mothers have the
opportunity to breastfeed according to the World Health Organisation (2003) in the Global Strategy
for Infant and Young Child Feeding. The National Strategic plan of Action for Breastfeeding 2008-
2012 (National Breastfeeding Advisory Committee of New Zealand, 2008) cites health services as
one of the four settings for the implementation of the plan. The provision of education to support
the expectations of health providers within area level strategies to promote and support
breastfeeding in New Zealand communities. The Baby Friendly Community Initiative (BFCI)
identified primary health care providers among those who can have a positive impact on improving
breastfeeding duration (New Zealand Breastfeeding Authority, 2006). The need to improve the
education, knowledge, skills and ability of health professionals to support breastfeeding is
recognized within this initiative also.

Most of the participants in this study included various types of ongoing formal education as a
contributing factor to their self-efficacy. The contribution of this factor was also described by
participants as supporting their practice while fulfilling this role.

The ad hoc nature of access to these education opportunities was noted. Smale et al (2006) support
this finding with their study of learning needs undertaken to provide direction for the future
provision of breastfeeding education among health professionals who advise and support
breastfeeding mothers. The health providers, including nurses, reported that their knowledge was
fragmented and gained in an ad hoc manner. This led to limited use of evidence based practice and
a continuing promotion of harmful practice. The health providers also stated that breastfeeding
education was difficult to access and often attended by those who were particularly interested in
breastfeeding rather than those most in need of up to date knowledge. The courses that were
provided did little to contribute to their skills in providing support when problems occur. The
inability of health providers to support mothers through problems when breastfeeding has been
identified in the literature as a clinical barrier that needs to be addressed (New Zealand
Breastfeeding Authority, 2008; Ministry of Health, 2008).

The research of Abbott et al. (2006) supports these findings and states that there is a need to ensure
continuing education opportunities. Within the Breastfeeding and Nutrition Policy of the RNZPS
(Inc), (2005a) the commitment is made to ensure that all Plunket staff are skilled to promote and support breastfeeding by use of policy in practice, access to 18 hours of breastfeeding education initially and a minimum of three hours annually thereafter. There is a commitment to supply suitable reference material and information that is accessible to all Plunket staff for use in their work.

The access to breastfeeding education opportunities described by participants demonstrates self-responsibility in developing this area of their practice. As discussed previously nurses are required to demonstrate competencies within standards of practice of continued professional development. Self directed development is a necessary element of the professional role (RNZPS (Inc), 2005b).

**Theme Six: The context and reality of the breastfeeding experience**

The participants provided rich description of providing breastfeeding support in the context and reality of the breastfeeding experience. This was an added dimension to the findings in this study and links back to the research objective that seeks to identify the strengths in Plunket Nurses’ breastfeeding support practice. The participants have provided insight into the complexities faced as a nurse providing care in a community setting. The descriptions and interpretations relate to the experience of providing support in the community, adapting support to fit the reality, and the professional responsibilities of a nurse practicing in the community.

Daly et al. (2006) say that nursing does not occur in a vacuum. Nursing actions are in fact produced by and structured around social and cultural environments. Francis et al (2008) tell us that nurses demonstrate a process whereby they promote and support change by developing caring relationships with the community and fostering interactions between health, environment, client and nurse. These authors believe this process is integral to professional practice. Building relationships is certainly a focus for the community nurse but this is not restricted to the client/nurse relationship. Community nurses are constantly faced with understanding who is the family around the client, how do they interact, and how do they influence the health and wellbeing choices made? While each member of the family is identified as an individual the strength of Plunket Nurses is indicated in their identification of the composition of and influences of relationships within the mother’s family and social support network. Francis et al. (2008) state that the community nurse “needs a positive, respectful attitude and a willingness to engage with family around issues of common interest in order to establish rapport” (p 251).
A study conducted by Sciacca et al. (1995) in Arizona, USA, examined the effects of partner support in increasing the intention to breastfeed and the duration of breastfeeding among a group of low income women. The researchers found that encouraging partner support of breastfeeding with incentives had positive outcomes for initiation and duration rates among these women. They concluded that antenatal education should include social support information and the participation of those that will be directly supporting them. The Canadian based study conducted by Adewale (2006) to explore the perceived usefulness of breastfeeding education provided by health professionals supports the previous study. Collaboration between mothers, family, and health care professionals was identified as a way to enhance breastfeeding experiences.

Research conducted by Maunder et al. (2004) and discussed previously is also related to the need to consider context when providing support. The researchers recommend that health professionals tailor their responses to the needs of the individual within the reality of their breastfeeding experience. Price (2007) also recommended that health providers understand mothers within their social contexts in order for health messages to be understandable and acceptable. Price adds that by including the extended family and social supports breastfeeding outcomes can be enhanced. Hagan (2004) and Manhire et al. (2007) support these findings with a New Zealand study and recommend that health professionals understand the responses of mothers to breastfeeding support within the context of their lives.

The participants provided descriptions of adapting support to fit the reality of the breastfeeding experience. While this has been shown to be a necessary part of providing support within the research already discussed here, the level of nursing expertise required to be able to practice in this way will be included in the discussion.

Wilkinson and Miers (1999) believe that nurses are responding creatively to providing care in the community and developing new ways of doing so. Benner (as cited in Wilkinson & Miers, 1999) described the impact of the use of intuition by nurses in allowing them to respond easily to clients in community contexts. Benner (as cited in Tomey & Alligood, 1998) describes the movement of nurses through levels of experience. The five levels are that of the novice, the advanced beginner, the competent nurse, the proficient nurse, and finally the expert nurse. At the proficient level of experience and practice the nurse can perceive situations as a whole and has an intuitive grasp of what is happening based on their knowledge and understanding. At this level the involvement with the client and family is enabled by the nurses increased confidence in their abilities and knowledge.
The data provided by the Plunket Nurse participants is indicative of proficient practice in action. In some instances the elements inherent in expert levels of practice are described. At this level the nurse displays “a clinical grasp and resource based practice, embodies knowing and acting at the intuitive level, sees the big picture, and also sees the unexpected (Benner, as cited in Tomey & Alligood, 1998, p 162). Paterson (1991) discusses the place of intuition in nursing as a legitimate tool. Dreyfus and Dreyfus (as cited in Paterson, 1991, p 13) say that intuition is “a product of deep situational involvement and recognition of similarity”, and add that “this is what distinguishes human intelligence from artificial intelligence.” The use of intuition by nurses working in the community may be supported as their practice environment encourages its development according to Paterson.

It is important to include as part of this discussion that the attainment of the proficient or expert / accomplished level of practice within the domains of the Plunket Nurse Standards of Practice (RNZPS (Inc), 2005b) is removed from the context of the day to day delivery of breastfeeding support to mothers in the community. The evidence of providing proficient or expert practice in the provision of this part of the Plunket Nurse role can be made visible within observation of clinical practice but is often unable to be linked to competencies at these levels.

Some of the participants in this study described areas of professional responsibility as a nurse providing breastfeeding support in their reflections. Nurses are required to practice within a code of conduct in New Zealand (Nursing Council of New Zealand, 2008). The Nursing Council both sets and monitors the standards of nursing practice to ensure the interests of both the public and the profession are upheld. The Code of Conduct for Nurses includes four principles. Firstly, that the nurse complies with legislated requirements. Secondly, that the nurse acts ethically and maintains standards of practice. Thirdly, that the nurse respects the rights of clients. Finally, that the nurse justifies public trust and confidence.

Participants revealed potential conflicts that could arise and their need to be mindful of the clients’ right to make informed choices and not to be judged in doing so. The ethical issue of beneficence versus autonomy is a part of this discussion as it is interpreted within the data.

Price (2007) found that mothers wanted to be seen as “good mothers” in the choices they made in caring for their children. Their choices were seen to be motivated by the resources available and accessible to them at the time which includes access to reliable health care and information. It is
because of this finding that the researcher recommends that health providers are mindful of the
strengths of mothers and understand their decisions made in the context of their lives.

Hennessey (2003) wanted to determine how knowledge affected the attitudes and practices of
nurses in providing breastfeeding support. While Hennessey found that the majority of the nurses in
the study had positive attitudes, they felt unprepared to actually provide support. An additional
finding highlighted that a third of the nurses were worried about making women feel guilty by
promoting breastfeeding when they had chosen to formula feed.

Francis et al (2008) discusses the ethical principles of beneficence and non-maleficence in the
delivery of nursing in the community setting. These authors ask the reader to consider the principle
of non-maleficence in the situation of promoting breastfeeding as the best thing for an infant over
what may be considered the best care for a mother with severe postnatal depression. The principle
of beneficence as defined as the desire to do good is portrayed in conflict with the principle of
autonomy which in this context refers to a respect for a persons right to choose. Dignam (2001),
when referring to the problems of arguing the case for breastfeeding over formula feeding in the
promotion of psychological benefits for the maternal role, states that for many women the highly
valued right to choose would be threatened. Francis et al. (2008) state that “the complexities of
communities makes it unlikely that any activity will be uniformly beneficial to all” (p 89).

Essential elements required to ensure empowerment within the community are the ability to be
nonjudgmental, mutual, provide choices, allow the right to make decisions, and the ability to
promote effective participation (Francis et al., 2008). Watson (as cited in Francis et al., 2008, p 103)
tells us that “nurses are thought to facilitate wellbeing through interactions with clients based on
moral agency of nonjudgmental caring”. Some of the participants in this study reflected on the need
to be nonjudgmental and to support the choices made by breastfeeding mothers within the reality of
their breastfeeding experiences. The need to ensure the choices were informed was also indicated as
important. It remains important for the health professional to be aware of the impacts of the current
sociopolitical context within society on breastfeeding. The Baby Friendly Community Initiative
reflects the historical impacts of various social forces on current breastfeeding practices in New
Zealand and seeks to manage change in a way that results in a breastfeeding culture. The
identification of barriers and the part that health professionals can play in removing these is inherent
in the initiative.
Theme Seven: The nature of support

The participants in this study have included description of what support can look like within the scope of their practice. The Plunket Nurse according to the Well Child/ Tamariki Ora Schedule (Ministry of Health, 1996) is to assess the need for information and support, provide practical breastfeeding management and support, and provide information and anticipatory guidance relevant to parents. Support for breastfeeding is described by the Ministry of Health (2008) as accessible and appropriate and situated within communities and society. Support services are designed to foster and encourage breastfeeding in any identified context where a mother chooses to breastfeed.

There is good evidence of the effectiveness of interventions in providing support such as hospital and health professional support that is consistent and ongoing (National Breastfeeding Advisory Committee of New Zealand, 2008). These factors were identified by some of the participants.

Rempel (2004) found that individual maternal breastfeeding attitudes did not explain individual maternal long term breastfeeding outcomes while the perception of the degree of control a mother over her breastfeeding experience had a significant impact on duration. Mothers reported that encountering breastfeeding problems, reduced supply, biting, and a perception that the infant was ready to wean contributed to a perception that they had a reduced control over their experience. Encountering negative or unsupportive opinions and a decrease in actual support from others in regard to breastfeeding as the infants gets older also effected decisions made around duration for some mothers. The need to increase social support was indicated from this research. The value of partner, family, and other social supports in an ongoing manner has been revealed in previous research. Adewale (2006) concluded from research that collaboration between mothers, family, and health care professionals could enhance breastfeeding experiences. Breastfeeding support needs to be ongoing in nature including and beyond what is provided by the health care professional. An assessment of what support is needed and how to achieve the best outcome for the mother and infant over time is indicated.

The New Zealand based research of Manhire et al. (2007) using the open ended responses from a study conducted Hagan previously supports the findings that support for breastfeeding mothers needs to consistent and ongoing in nature. Nelson (2007) noted the effect that inconsistent support of nurses had a negative effect on the breastfeeding experiences of mothers. Nelson found that the
inconsistencies occurred due to the dynamic nature of the breastfeeding experience and suggested the importance of collaboration between providers.

The support provided by various groups of health professional including nurses has been shown to be dependent on many factors. Adewale (2006) identified the impact of identified values and beliefs on breastfeeding on the actual support provided. Ekstrom et al. (2005) add to this identified factor by saying that harmful attitudes effect the breastfeeding support provided has the potential to impact on the ongoing nature of accessing support by mothers in need. Maunders et al. (2007) described the affect of the development of the nurse/ client relationship on the delivery of appropriate support for mothers that is relevant to the context of their lives. Price (2007) recognized that the ability to understand mothers within their social contexts was an important factor in providing breastfeeding support. The concepts of empathy and understanding have been identified and discussed previously in this discussion. Having the intent to support breastfeeding was identified by Daneault et al. (2004) as a contributing factor to the actual support being provided. Bernaix (2000) had found in an earlier study that the expected relationship between intent to support and actual support was not shown. Enabling factors need to be developed for intent to become actual support. Taveras et al. (2004) found that not all health care providers included in their study thought that breastfeeding support was an important part of their work.

The participants in this study have clearly identified that providing breastfeeding support is a part of their role as Plunket Nurses. Many participants have indicated the recognition of the need for support to be ongoing and consistent. Many of the participants have also identified that they do not provide support in a silo. The participants share knowledge and experience to better inform their own support practices, ensure that mothers are aware of the range of support available in their communities, and refer to other breastfeeding support providers to provide alternative or more intensive support.

The research conducted by Nelson (2007) and discussed above supports the importance of collaboration in working with breastfeeding mothers and infants. Collaboration begins as early as the antenatal period when it is beneficial to include social support information in the programme according to Sciacca et al (1995). Adewale (2006) found that there was a difference in the role of the nurse providing antenatal education to the actual support when in the delivery unit and postnatal environments of a hospital. Adewale concluded also that collaboration between the mother, family, and health care professionals would enhance breastfeeding experiences.
For collaboration to be effective it is necessary to ensure that providers are aware that firstly breastfeeding support is an important part of their role, and secondly that they are aware of the roles and contribution of others in providing support. Dillaway and Douma (2004) found the need to do this was implicated from their research as it became evident that there were discrepancies between health provider groups of what their own role was and who was considered to be best suited to provide breastfeeding support.

Furber and Thomson (2006) discovered in a study of the views of English midwives in relation to their breastfeeding support role that emotions of anger, fear, and sadness were felt at the differing beliefs and valuing of some knowledge sources above others and also at differing philosophies of practice that appeared to keep certain knowledge within professional settings and groups. Nelson (2007) confirms this finding by saying that personal and privileged vantage points and differing role perceptions related to breastfeeding among health professionals contributed to inconsistencies.

Discussion around the value that participants in this study place on the opportunity to share knowledge and experiences as a way of learning and reflecting on practice has occurred within this chapter. This willingness to participate in such forums is strength in their practice and a contributing factor to their perception of self-efficacy in providing breastfeeding support in the community. Many participants have also described the place that recommendations and referrals to other providers forms a part of their support practice. A guiding principle within the National Strategic Plan of Action on Breastfeeding 2008-2012 (National Breastfeeding Advisory Committee of New Zealand, 2008) is that of cooperation and efficiency. This means that there will be “communication, collaboration and effective planning between and within agencies with roles and responsibilities that effect breastfeeding” (p 8). The participants in this study have indicated a working understanding of this principle.

Summary

The discussion presented here has completed the fourth and final stage of Giorgi’s data analysis method. It has provided the process to achieve the “synthesizing the essential aspects of understandings and reflections into a consistent statement” (Schneider, 2007, p 111). The discussion also provides an auditable progression from the findings of the research to the conclusions and recommendations as related to the research aims, and the recommendations for future research which will be presented in the following and final chapter of this thesis.
Chapter 6

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The significance of this study was introduced in chapter one. The need to improve breastfeeding rates in order to contribute to improved child health outcomes was identified as being of international, national, and regional significance (National Breastfeeding Advisory Committee of New Zealand, 2008; New Zealand Breastfeeding Authority, 2008; Word Health Organisation, 2003). Primary health care providers, a group that includes Plunket Nurses, were identified as potential and current key contributors to breastfeeding support activities in community contexts (New Zealand Breastfeeding Authority, 2008). The breastfeeding support expectations of Plunket Nurses were identified as the assessment of the need for support and information, the provision of practical breastfeeding management and support, and the provision of information and anticipatory guidance relevant to parents (Ministry of Health, 1996). Clinical barriers identified within the breastfeeding care and support provided by health providers in general included the communication of negative or ambivalent attitudes, the communication of inappropriate and inconsistent advice, a low level of health provider knowledge on problems and solutions, and the recommendation for the use of infant formula during the first month of life (New Zealand Breastfeeding Authority, 2008; Ministry of Health, 2008).

This study is timely when placed in the context of current initiatives in New Zealand that are being implemented collaboratively to address the need to improve breastfeeding rates in the community. The development, implementation, and evaluation of area level strategies have been called for within the National Strategic Plan of Action for Breastfeeding (National Breastfeeding Advisory Committee of New Zealand, 2008). Alongside this initiative sits the 2008 rollout of the Baby Friendly Community Initiative in New Zealand which aims to make breastfeeding the cultural norm in all societies (New Zealand Breastfeeding Authority, 2006). Within these two initiatives the need to improve the education, knowledge, skills, and ability of health professionals to support breastfeeding is recognized.

The literature reviewed in this study identified gaps in breastfeeding research and knowledge in New Zealand community care settings. It also provided the rationale for the research issue,
question, and design used. The need to know more about what factors enable nurses to be supportive of breastfeeding is a strengths based approach to the research issue. Bandura’s self-efficacy theory was identified in the literature reviewed as a valuable framework for research on the sources of breastfeeding education, knowledge, skills, and ability. Bandura’s theory states that people who are confident in their ability to successfully perform an activity are more likely to be positive and successful in both intent and the actual performance of the activity (Bandura, 1995). This study sought to identify what factors contribute to the perceived self-efficacy of Plunket Nurses when supporting breastfeeding in the community. The use of a qualitative research design was identified in the literature review as a way to add depth to what was already known. The decision to use a qualitative descriptive analysis for this study allowed an inductive analysis of data, guided by Giorgi’s method, from which seven themes were generated. The conclusions and recommendations in this chapter have emerged from the findings and discussion and are related to the research question and objectives.

Conclusions

The first five themes generated from the data collected from the Plunket Nurse participants describe the factors that contribute to their perceived self-efficacy when providing breastfeeding support to mothers in community settings. These five factors were personal breastfeeding experience, observing and then doing, receiving feedback on their support activities, sharing knowledge and experiences with others who support breastfeeding, and finally the contribution of formal breastfeeding education. The first four factors can be related to Bandura’s self-efficacy theory and indicate the value of a social cognitive teaching and learning theory in the design and delivery of breastfeeding support education, clinical experience, and fostering positive attitudes and behaviours in this area of practice.

This study found that personal breastfeeding experiences were a contributing factor for most of the participants to their perceived self-efficacy. Bandura’s theory that actual experience or mastery of the experience is a valid source of information for self-efficacy judgments was supported. The question has been asked within previous research conducted by Hennessey (2003) as to how personal breastfeeding experiences could best be utilized in breastfeeding education considering the positive impact identified? The contribution that using this information within breastfeeding education could make to reconciling harmful attitudes and beliefs held by health professionals and as a tool to help develop understanding of maternal responses to breastfeeding support was
identified by Hagan (2004). It can be concluded from this study that personal breastfeeding experiences could be utilized as a learning tool for Registered Nurses new to the Plunket Nurse role and/or the breastfeeding support role in the community.

Bandura describes the factor identified in this study as ‘observing and then doing’, as vicarious persuasion (Bandura, 1995). Clinical experience as a contributing factor to perceived self-efficacy was strongly described in this study in terms of learning ‘on the job’ within various clinical roles as well as an accumulating source of knowledge and skills. This form of acquiring confidence and ability was seen as important as it allowed continual reflection on what the participants had seen and done. The understanding gained from this process was seen as valuable in providing insight into their role. The process of gaining practical experience from the time of initial nursing education onwards was described as a progression through levels of experience. Some participants included the orientation process as a time of valuable clinical learning. This study supports the conclusion that the orientation period is a valuable time to establish levels of breastfeeding knowledge, experience, skills, attitudes and beliefs. This would allow the formalizing of a personalized plan to address any identified gaps. Clinical experience with experienced Plunket Nurses as well as other breastfeeding support providers within the community would provide valuable role modeling.

The contribution of a preceptor or mentor at the orientation and early development stage of the health professional’s development for the breastfeeding support role would be beneficial. The third factor identified by the participants in this study generated the third theme labeled the ‘impact of feedback’. Bandura (1995) stated that verbal or social persuasion had an impact on personal physical, psychological, and emotional arousal on the perception of the likelihood of being successful again in a similar situation. This study supported previous findings that positive feedback increased self-efficacy (Tschetter, 2001) while receiving negative or no feedback resulted in a sense of failure and dissatisfaction (Vance & Olson, 1998). Preceptors support new Plunket Nurses to adapt to a new workplace and clinical experiences, provide feedback and reinforcement of breastfeeding support provided, and encourage self directed learning and reflection. The Royal New Zealand Plunket Society (Inc) (2005a) recognizes that positive feedback impacts on the ability and willingness of the Plunket Nurse to assume her professional role, including the provision of breastfeeding support by increasing job satisfaction and quality care for clients.

Theme four described the contribution of sharing knowledge and experience with others to the participants’ perceived self-efficacy in providing breastfeeding support. Opportunities were
described as informal and formal. The contribution of these opportunities was in increasing the consistency of information and support provided in the community by sharing with more experienced peers and also across the boundaries of roles and organisations. Peer supervision was indicated as a contributing factor in this study. This formal process of sharing in a reflective manner with a peer is used by Plunket Nurses currently as a recognized professional development tool (RNZPS (Inc), 2004). The current New Zealand initiatives to improve breastfeeding rates and outcomes are dependent on the success of collaborative strategies. The participants in this study have indicated that this as important to them.

The final factor that the participants indicated as contributing to their perceived self-efficacy formed the fifth theme in this study. ‘The place of formal education’ was recognized as necessary in providing a sound knowledge base from which role specific knowledge and skills could develop. The contribution of formal education in breastfeeding for the participants was in supporting their practice. While providing education in an organisational commitment according to policy it has also been strongly identified as a collaborative commitment within current initiatives. Adequate access and opportunity to education have been identified as issues. The effectiveness of using a combination of learning strategies and ensuring breastfeeding education is relevant has been identified also. Additionally the element of professional self responsibility for Plunket Nurses to remain current in their knowledge and skills within Nursing Council competencies and organisational standards of practice exists (Nursing Council of New Zealand, 2007; RNZPS (Inc), 2005b).

The sixth and seventh themes generated from findings in this study relate to the objective that sought to identify the strengths in the breastfeeding support practice of Plunket Nurses. Providing breastfeeding support like any nursing practice does not occur in a vacuum (Daly et al., 2006). The participants in this study described the complex contexts within which breastfeeding support is provided in the community. The use of intuition when working in the community was described by some participants. The level of experience that allows the use of intuition in practice develops along with increasing self-efficacy. The community as a practice environment also encourages its use. The use of the term ‘expert’ within standards of practice does not reflect this level of experience as observed in direct client care situations in the practice setting as described by participants in this study. Placing the ‘nurse’ in the breastfeeding support role brings certain dynamics of working within a professional role to the reality of the breastfeeding situation. These have been described in terms of ethical and legal considerations in the delivery of support in the community. The
participants have indicated that knowing the nature of support allows them to continue to develop ways of providing acceptable and appropriate support within their professional Plunket Nurse role. These include the ongoing nature of support, the need for consistency, and the recognition that Plunket Nurses’ are not the only avenues of breastfeeding support in the community. Schon (as cited in Street, 1990) describes the contextual realities of environments as part of the swampy lowlands of practice. The “context specific knowledge acquired by the nurse immersed in the practice situation” is important according to Schon (as cited in Street, 1990, p 14). It often involves providing care in complex situations that defy technical or policy bound solutions. In such situations the nurse often has to improvise or invent ways of providing solutions that are relevant and therefore appropriate and acceptable to the client at the time. Street (1990) points out that nurses need to document and share their practice experiences to build a greater understanding of not only what they do but why, how and to what effect. By doing this a platform is developed from the analysis of experiences that can lead to change and a closing of the theory/practice gap. In 1982, Styles (as cited in Street, 1990) recognized that greater collaboration between nurses must be based on reciprocity, collegiality and respect for their contributions toward a common goal. The current initiatives in New Zealand can provide a vehicle for collaboration.

**Recommendations for orientation, education, and ongoing professional development**

Personal breastfeeding experiences need to be utilized in the planning and delivery of breastfeeding education at all levels. For example, in the development of personalized orientation plans, the design of organisational breastfeeding updates, and the design of formal education on breastfeeding support practices. The opportunity to reconcile harmful attitudes, beliefs and behaviours in the provision of breastfeeding support is ongoing through all levels of experience. Supporting practice and/or facilitating changes in practice can occur by combining ways of knowing with evidence from accepted sources.

There is a need to evaluate breastfeeding knowledge, skills, attitudes and beliefs at the onset of the orientation period for those new to the Plunket Nurse role. This needs to go beyond knowledge of breastfeeding policy and knowledge of breastfeeding support providers in the community. The inclusion of goals to address identified gaps in education, knowledge and experience should include time spent in the community with experienced Plunket Nurses as well as with other providers who work with breastfeeding mothers and infants. Knowledge of breastfeeding support activities across the breastfeeding continuum is important in providing consistency in information and support.
The need to support the current preceptor role is necessary in terms of ensuring financial resources allow for the time away from Ministry of Health contract work by Plunket Nurses who are providing the role, and also for the preceptees. Financial provision within the Ministry of Health funded contract to provide the Well Child/Tamariki Ora schedule, which includes the provision of breastfeeding support, needs to be addressed. This would allow for the provision of relief to ensure contract contacts continue. Preceptor education needs to be accessible across all regions and available in a timely manner. This is critical with the ongoing nature of recruitment to the Plunket Nurse role in terms of ensuring there are enough preceptors available and prepared to provide quality outcomes for the preceptees.

Peer supervision needs to be encouraged as a valuable professional development tool for Plunket Nurses. Plunket Nurses not accessing peer supervision may be experiencing barriers in perceived effects from time away from Ministry of Health contract work, access to suitable supervision partners, or a lack of understanding of how the process can benefit their practice. The model used in peer reciprocal supervision assumes that the participants have the resources within to “actively address most issues” that are brought to the forum (RNZPS (Inc), 2004, p 3). It is also necessary to ensure participants can work effectively within the model by providing the initial education on the process along with regular updates for those who have been using the process for some time.

There is a need to utilize the climate of change inherent in the current initiatives to foster collaborative relationships that allow the sharing of knowledge and clinical experience at all levels of the breastfeeding support continuum and across community provider roles. This must include formalized agreements and avenues to share education opportunities and to ensure they are accessible and relevant. It needs to also include memorandums of understanding between stakeholders in the provision of breastfeeding support to provide mentoring and clinical experience across the boundaries of role and organisation to benefit breastfeeding outcomes.

Plunket Nurses need to be encouraged to make their breastfeeding support practice visible to others within and external to the organisation. This occurs informally during dialogue with peers and others. Reflection on clinical practice is a recognized professional development tool that contributes to understanding and future actions by placing their “role as a nurse, their nursing actions, and the clinical setting in which they practice, under close scrutiny” (Street, 1990, p 16). The ability to be reflective and to document and share the process is an important requirement in the professional
development needs of all Plunket Nurses from their entry to the role and throughout their employment.

**Recommendations for future research**

Considering the current initiatives in New Zealand to improve breastfeeding rates and outcomes, it would be helpful to conduct research that can provide information from other providers who also have contact with breastfeeding mothers and infants/children. Areas of interest would include what they perceive their role in supporting breastfeeding to be and how prepared they perceive themselves to be? The attitudes, beliefs and behaviours of those in acknowledged support roles within New Zealand contexts would contribute to this area of interest also.

A similar study among other breastfeeding support providers using interviews or focus groups could contribute the ability to generalize the current findings to other populations. Others within the RNZPS (Inc) who support breastfeeding mothers are among populations of interest in this instance.

Research that is related to the findings of this study would be beneficial to increasing what is already known in New Zealand contexts. For example, the outcomes of breastfeeding education utilizing personal breastfeeding experiences as a teaching/learning strategy on the perceived self-efficacy Plunket Nurses would strengthen the findings of this study and contribute to future education design. Also, what is the actual likelihood of achieving an agreed consistency in advice given the contextual nature of breastfeeding and the experiential range of knowledge applied to any advice provided?

An exploration of the perceptions of mothers of the breastfeeding support provided by Plunket Nurses would provide important information on the effectiveness of practices that are informed by current and future breastfeeding education and strategies used in developing knowledge, skills and attitudes.
REFERENCES


**Dissertation obtained from Masters Abstracts International (MAI)**


**Dissertation obtained from Masters Abstracts International (MAI)**


Dissertation obtained from Dissertation Abstracts International (DAI-B)


**Dissertation obtained from Dissertation Abstracts International (DAI-B)**


Appendix A

RNZPS (Inc) Ethics Committee Approval

Royal New Zealand Plunket Society (Inc.)

Ms Tracey Armstrong
507 Southland Road
Hastings

15 May 2008

Dear Ms Armstrong

The perceived self-efficacy of Plunket Nurses when providing breastfeeding support to mothers in a community setting . . . .

The Ethics Committee has considered your application, and has given it approval. However, the Committee considers that you should ensure that the following points are covered before proceeding with the study:

1. The information statement should emphasize that the study is voluntary, and that those who do not participate will not be disadvantaged in any way.
2. Since the protection of third parties is of utmost importance, particular care should be taken in reporting the results of the study. Additionally, no identifiable features should be included in the report.
3. The wording of the information sheet should be simplified, such as references to the study as being “reflection on practice”.
4. A copy (possibly electronic) of the resulting thesis should be made available to Plunket.

Please feel free to contact me on: gareth.jones@stonebow.otago.ac.nz or via the Plunket National Office.

Yours sincerely

[Signature]

D. Gareth Jones
Chair, Plunket Ethics Committee
Appendix B
Eastern Institute of Technology Research Approval

HAWKE'S BAY
Te Whare Taiao e Kahurangi

Ref: 10/08

24 June 2008

Tracey Armstrong
907 Southland Road
Hastings 4120

Dear Tracey

Master of Nursing Student Research – Faculty of Health & Sport Science

I apologise for the untimely delay in notifying you that your research project 'The perceived self-efficacy of Plunket Nurses when providing breastfeeding support to mothers in a community setting', was examined by the Research Approvals Committee at their meeting held on 30 May 2008.

I am pleased to advise that the Committee has approved your project.

We wish you well for the project.

Yours sincerely

[Signature]

Jeannette Fifield
Secretary
Research Approvals Committee

Cc: Head of School, Nursing – Faculty of Health & Sport Science

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FLAXMERE CENTRE Flaxmere Village, S mónes Road, Flaxmere 4120. Telephone 06 874 8945
WAISCA CENTRE Cnr Pult & Queen Streets, Waipa 4104. Telephone 06 852 7349

92
Appendix C

**PARTICIPANT INFORMATION SHEET**

**Research Title:** Providing breastfeeding support in the community: The perceived self-efficacy of Plunket Nurses.

Researcher Information: My name is Tracey Armstrong and I am enrolled in a Master of Nursing programme at the Eastern Institute of Technology. As part of the requirements for this programme I am undertaking a research project to describe what factors contribute to the confidence and ability of Plunket Nurses when providing breastfeeding support in the community. The Royal New Zealand Plunket Society Inc Ethics Committee approval and the Eastern Institute of Technology Approval of Research Activity have been given for this research to take place. I would like to invite you to participate in this research with me.

**Purpose/Aims of the research:**

- To identify the strengths in Plunket Nurses’ breastfeeding support practice.
- To use Bandura’s self-efficacy theory to provide a framework for findings, conclusions and recommendations that may inform future orientation, education, and ongoing professional development design.
- To use the findings to benefit and improve breastfeeding outcomes.
- To contribute to the body of knowledge on breastfeeding with a qualitative descriptive study undertaken in a unique practice role and setting in New Zealand.

This project is designed to be strengths based and involves gathering information from you in the form of a reflection on practice, undertaking a descriptive analysis from the data collected, and using the theoretical framework of self-efficacy developed by Albert Bandura, to provide structure and meaning.

It is not envisaged that you will suffer any harm or distress by participating in this research. Peer supervision is encouraged within the Royal New Zealand Plunket Society Inc and counseling is freely available to Plunket staff from EAP services, phone 0800 327 669.

This project requires between 10 to 15 Plunket Nurses to participate. You must have been qualified as a Plunket Nurse for at least one year and be currently working in a community setting. By returning the Intent to Participate form the researcher will be able to continue to invite participation only until the sample required is reached.

The reflection on practice is a tool many nurses use to develop practice and can be used as evidence of competency in Professional Portfolios. The time needed to complete will vary but is estimated to be 30 minutes to one hour.

Your participation will involve the following:

1) Returning the Intent to Participate form in the stamped addressed envelope which will indicate that you agree to participate and will return your completed reflection by the……………… (date)

2) Complete the reflection on practice using the Reflection Guide provided and return in the stamped addressed envelope supplied by the ………………..(date)

Return of your completed reflection on practice indicates your implied
informed consent has been given.
3) Ensure any identifying features- names, locations- are changed in your reflection to ensure privacy and confidentiality.
4) Ensure you do not identify yourself to protect your anonymity.

*Your intent to participate return slips and your completed reflections will be mailed to an intermediary and removed from envelopes before being returned to the researcher to further protect your anonymity.
*Only the researcher and supervisors will have access to the collected data. This will be stored in a secure environment at the home of the researcher throughout the research and will be destroyed five years after the research has been completed.
*The findings from this research will be published in a thesis. They may also be published in a professional journal or presented at future conference opportunities.

Thank you for agreeing to participate in this research project.

Student Researcher
Contact Details: Home Ph- 06 8782267 Cell Ph- 027 246 1280
Email- traceyA@slingshot.co.nz or armstt1@student.eit.ac.nz

Research Supervisors: Principal Supervisor- Dr Elaine Papps (Professor of Nursing at EIT- Hawkes Bay)
Associate Supervisor- Kathy Manhire (Lecturer in Post Graduate Nursing- Breastfeeding and Human Lactation- at EIT-Hawkes Bay)

Cut here and return in envelope supplied: (Please do not supply your name or location).

Yes- I agree to participate in this research project and agree to return the completed reflection on practice by ................. (date)