

## Psycho Social Factors Associated With Exclusive Breast Feeding (EBF) of Nursing Mothers in the Bolgatanga Municipality

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### *Abstract*

*This study employed a qualitative approach and used in-depth interviews to explore the experiences of nursing mothers in the Bolgatanga municipality regarding psychosocial factors influencing their practice of EBF. From the interviews, psychosocial factors influencing the practice of EBF include the health of the mother, public attitude, work and customs and beliefs of society. Very important findings also emerged indicating the poor efforts put in by health workers in the promotion of the practice. These findings include inadequate knowledge on EBF by participants, a high influence of customs and norms of society on EBF, absence of mother support groups in the municipality and inadequate knowledge on when to introduce complementary feeding. These psychosocial factors have contributed immensely to the low patronage of EBF in the municipality. Also breastfeeding mothers are faced with multiple challenges as they strive to practice exclusive breastfeeding. Recommendations included intensification of education on EBF in the media, hospitals and homes by the MOH/GHS and health personnel; making clear the position of MOH on the policy regarding whether or not HIV/AIDS mothers should breastfeed to all healthcare institutions and promotion of peer counseling on exclusive breastfeeding among mothers.*

**Key Word:** *Exclusive Breast Feeding, Psychosocial Factors, Nursing Mothers, Peer Counseling.*

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### **Introduction**

The importance of exclusive breastfeeding for the first six months of life cannot be over emphasized as it has been widely acknowledged by the scientific community and recommended by a number of health and professional medical organizations including the World health organization (WHO) and the American Academy of Pediatrics ( Jones, Kogan, Singh, Dee & Grummer- Strawn, 2011; WHO, 2003). Breastfeeding in general and particularly exclusive breastfeeding (EBF) for the first 6 months is strongly encouraged as it is the optimal form of infant nutrition (Nascimento et al, 2010; Schwartz, D'Arcy, Gilliespie, Bobo, Longeway & Foxman, 2002) because of its numerous benefits such as fewer morbidity (Raisler,

Alexander & O'Campo, 2000; Singh, 2010), and mortality (Setegn, Belachew, Gerbaba, Deribe, Deribew, & Biadgilign, 2012) decreased maternal risks of premenopausal breast cancer, reduced postmenopausal lactation amenorrhea for the mother, quick return of the uterus to its normal size, prevention of postpartum hemorrhage, low risk of osteoporosis and emotional satisfaction. As reported by Setegn et al. (2012), it is estimated that non-exclusive breastfeeding in the first 6 months of life results in 1.4 million deaths and 10% of diseases in under-fives. Non-exclusive breastfeeding has also been reported to have long term impact including poor school performance, reduced productivity and impaired intellectual and social development. Exclusive breastfeeding refers to feeding infants with only breast milk either directly from breast or expressed with no addition of any solids apart from drops or syrups consisting of vitamins, mineral supplements or medicine, and nothing else (Setegn, et al., 2012).

Despite the numerous documented benefits of exclusive breastfeeding for the first 6 months of life and the global efforts to promote it, fewer number of mothers is generally reported as initiating and continuing breast feeding (e.g. Forster, McLachlan & Lumley, 2006) not to talk of exclusively doing so for the first 6 months of the baby's life.

Evidence show that globally, not more than 35% of infants are exclusively breastfed during their first four months (WHO, 2001; Du Plessis, 2009). Generally, the prevalence of EBF in most places as reported by various researchers is by WHO standards less than desired. For example the prevalence of exclusive breastfeeding up to four months and six months in Malaysia was reported to be 19.3% and 14.5% respectively (Tan, 2011). Similarly, as reported by Forster et al. (2006), although 80-90% of women in Australia initiate breastfeeding, less than half are breastfeeding by six months. To enable mothers' breastfeed exclusively for 6 months, it is important to understand the factors that influence exclusive breast feeding for the first 6 months.

Although past research has found various factors associated with breastfeeding as reported by Tan (2011) and other researchers, there is limited published research on factors associated with exclusive breast feeding in Bolgatanga, Ghana. Therefore, in the present study, we explored various factors that are associated with exclusive breastfeeding for the first 6 months of life in the Bolgatanga Municipality using a qualitative approach. This study in the Bolgatanga municipality is particularly important since the Municipal Health Directorate of Bolgatanga reported in 2011 that exclusive breastfeeding rate is as low as 0.21%. This failure to exclusively breastfeed young infants and the introduction of liquids and solid foods at too early an age increases the risk of diarrheal disease, an important cause of mortality in Africa (GDHS, 2005).

The municipality is also located in the Upper East Region (UER) of Ghana, where according to the Ghana Living Standards Survey 2005; the percentage of the population living in poverty is as high as 88%. Further, the Ghana demographic health survey report, in 2003 indicates that 9% of mothers of children under age five in Ghana are undernourished and the highest level of maternal under nutrition is in the Upper East region (22%). A key question then is whether poverty and maternal under nutrition is implicated in exclusive breastfeeding. In general the present study answers the question as to what factors influence EBF in the Bolgatanga municipality.

### **Significance of the Study**

The study will contribute to enriching current education programs on exclusive breastfeeding. In addition, the findings of the study will help shape policies on exclusive breastfeeding and assist mothers and the society to understand and support the practice of EBF thus helping in the attainment of MDGs 4 and 5 which stipulates a reduction by two thirds the mortality rate among children under five and a reduction by three quarters the maternal mortality ratio respectively. Benefits of EBF which include the prevention of postpartum hemorrhage as well as reduced risk of getting cancer of the breast and ovary will contribute to the attainment of MDG 5. Lastly, the study will provide the impetus for further research into the area of exclusive breastfeeding.

## Literature Review

Previous research has documented numerous factors affecting breastfeeding initiation and duration in both developed and developing countries. Some researchers (e.g. Forster et al., 2006) have categorized them into socio-cultural, religious, physical, work, mode of delivery among others.

Empirical evidence suggests that the attitude of the society as well as the culture in which the mother breastfeeds could either influence the mother positively or negatively in the practice of EBF. For example, a study in Enugu, Nigeria suggests that the presence of extended family members did not seem to have any significant effect on EBF rates (Ogbonna, Okolo & Ezeogu, 2000). Another study in Enugu however revealed that a significant number of women who did not breastfeed were opposed by extended family members while none of those who had exclusively breastfed all their babies (100% EBF) had ever experienced opposition (Uchendu, 2009). Factors such as encouragement and support from the husband (Aghaji, 2002) were found as influencing Hong Kong Chinese mothers to breastfeed. The husband's opinion was the second most important influence in the mother's decision to breastfeed (Leung et al, 2006).

In Zambia, majority of grandmothers responded negatively to practicing EBF arguing that the child needed to get used to eating foods in case the mother fell sick or died. They would recommend their daughter/daughter-in-law to start giving the child other foods before six months. The influence of the child's father and mother-in-law in breastfeeding decisions were also reported by the nurses as being strong (Fjeld et al, 2008). In Dhaka-Bangladesh, Peer counseling was found to significantly improve breastfeeding practices (Haider, Ashworth, Kabir & Huttly, 2000). Research also revealed that in Hong Kong, some mothers experienced embarrassment as they were asked to leave public places such as restaurants, shopping centres and hotels for breastfeeding their babies (Leung, et al, 2006; Kong & Lee, 2004; MHSS, 2003).

The influence of cultural factors in breastfeeding is closely linked with social factors as discussed above. Different cultures perceive and practice breastfeeding differently. Among the Oromo people the initial breast milk of "yellow water" (Colostrum) is viewed as nutritionally useless "just like water" and it is sometimes expressed and discarded. Oromo people perceive this "water" as void of nutrition and do not drink it. Even breast feeding among them is initiated in the second or third day of life when the mothers' milk comes in. Prior to this, infants are given fresh butter which is supposed to "cleanse the gut". The practice is similar among the rural communities of a semi-arid district of Rajasthan, India, where 77% of a study population discarded colostrums (Singh, Haldiya & Lakshminarayan, 1997). However, the practice of prolonged breastfeeding and delayed supplementation to infants are prevalent in this area with a reported mean age of weaning being 27.1 months. This not only affects the health status of the mothers and their children but also leads to under nutrition (Singh, Haldiya et al., 1997).

In Bawku-Ghana, although colostrum is traditionally perceived as dirty and unwholesome, the practice of discarding it is currently not widely practiced. In a study conducted by Abugri and Heide, (1997), about three-quarters of babies were given colostrum. A quarter of mothers however thought that colostrum should be expressed and discarded and that breastfeeding should not be initiated until "white or clean milk" begins to flow. The practice of discarding colostrum was higher in the rural area (40%) than in the urban area (14%), probably indicating the influence of health education and public health interventions and urbanization on child feeding practices. The common belief in the area is that colostrum is; "dirty" and can cause a baby to contract diseases, contains blood or pus and is therefore not good for babies, causes abdominal pains, diarrhoea and other digestive problems and is bad blood, which has stayed in the breast for nine months of pregnancy (Awumbila, 2003).

The health of the mother, type and place of delivery has also been reported as having a great influence on a mother's choice and decision to breastfeed. Data from interviews and focus group discussions clearly showed with few exceptions that nurse-counselors in South Africa did not see breastfeeding as a safe infant

feeding option for HIV-positive women (Leshabari, Blystad, Marina de Paoli & Moland, 2007). Almost all counselors stated that from their point of view infant formula was the preferred infant feeding method for HIV-positive women. When they were asked "What their opinions were about HIV-positive women who breastfeed?" only the two counselors who had participated in the national HIV and infant feeding training said that the women were doing the right thing to breastfeed, while 19 said that the women were doing the wrong thing to breastfeed (Leshabari et al, 2007). Similarly, in the United States of America, breastfeeding is contraindicated for HIV positive women. This is said to eliminate the risk of postnatal transmission (Branson et al, 2011). Abnormal delivery such as breech birth, vacuum extraction and even Caesarian section (Hull, Thapa & Pratom, 1990) has been found to delay breastfeeding beyond 24 hours. The reason for delayed initiation of breastfeeding given were rather based on breast feeding problems like breast / nipple problems, soreness and engorgement and a perception of insufficient breast milk and prematurity of babies (Hull et al, 1990). Similarly in Zambia some mothers complained that after delivery, they normally develop sores on their breasts and that for some, the milk does not completely flow (Leshabari et al, 2007). In another study, vaginal deliveries increased the odds of exclusive breastfeeding at 6 months. Pain and discomfort associated with Caesarean section also prevented some mothers from breastfeeding (Al-Sahab et al 2008 and Sharief, Margolis & Townsend, 2001).

Another factor that has been found crucial in the successful practice of EBF especially among working mothers is work place environment. For example Singh (2010) found breastfeeding duration to be low among working women in Brazil due to reasons like short maternity leave, workplaces where babies were not allowed or lack of privacy for breast feeding. However, important changes in the extension of maternity leave of 120 days in various industries was associated with 97% of working women breastfeeding for a median duration of 150 days. Higher socio economic status, nursery facilities and existence of a place in which to extract and store mother's milk at work place have generally been associated with longer duration of breast feeding (Rea, Venancio & Batistaa, 1997).

## **Methodology**

### **Research Setting**

The study was carried out in the Bolgatanga municipality which is the capital of the Upper East Region of Ghana. Bolgatanga municipality is the 18<sup>th</sup> biggest human settlement in the country with a total population of 147,864 people. The participants for this study were nursing mothers who attended postnatal clinic at the Reproductive and Child Health clinic (RCHC) of the Bolgatanga Regional Hospital which is a Baby Friendly Hospital. They were recruited from four communities in the Bolgatanga municipality namely; Soe and Bukere representing Bolga urban, and Zaare and Yikene representing Bolga rural. The total RCH attendance from the beginning of the year till June, 2012 was 4116, comprising both new and old members.

### **Study Design**

To achieve the objective of this study, a descriptive qualitative approach was employed. Such a study basically provides in-depth knowledge that is holistic, incorporating contextual influences (Larrabee, 2009). As such it is the most suitable approach to unearth the experiences of nursing mothers regarding factors that influence EBF.

### **Sampling technique and Sample Size**

A purposive sampling technique was used to select participants. As the study sets out to explore the experiences of nursing mothers who were practicing EBF, the following inclusion and exclusion criteria was used to purposively select the participants. The participant;

- Must be a nursing mother practicing EBF with a baby between the ages of zero to six months,



- Must be resident in any of the following communities in the municipality namely; Soe and Bukere representing Bolga urban and Zaare and Yikene representing Bolga rural.
- Must be the biological mother of the baby
- Must have an infant not older than 6 months of age at the time of the interview.

This selection criterion was made known to the nurses so they could assist in identifying the participants. Selection of participants was done on Tuesdays and Thursdays which were the postnatal clinic days. A number of visits were done on these weekly clinic days until the required sample size was obtained. On each visit, the researchers identified some potential participants. Upon identification, the purpose of the study was explained to the participant and an information sheet made available to the participant for further reading. A total number of 12 mothers participated in this study. Three mothers were selected from each of the four communities. Each participant was given the opportunity to choose a suitable venue for the interview. All twelve (12) mothers indicated that they wanted to be interviewed in their homes and so researchers collected addresses and phone numbers of all the participants of those who owned phones for ease of contact and arranged to interview them at their various homes.

### **Data Gathering Procedure**

A semi-structured interview guide was used to collect in-depth information from each participant. These interviews were conducted personally by the researchers. All participants signed a consent form before the commencement of the interviews. Those respondents who could not sign were provided a stamp pad to thumb print. The interviews were audio taped. Each participant's demographic data was collected along with the interview data. Semi-structured interviews permit participants to respond freely to questions and also enable the researcher to get participants to describe and explain situations in a way that provides rich descriptive data. The questions posed by the researchers were based on factors associated with EBF, the benefits or problems they encountered with EBF among others. Participants were encouraged to express themselves freely on all questions raised. Probing questions were asked during the interviews to obtain maximum variation, richness, and depth of responses. Each interview session with a participant lasted between 45 to 60 minutes, while the data gathering was conducted within a period of two months. Each audio taped interview was transcribed after each session and the transcribed data reviewed to gain a proper understanding of each respondent's experiences. The transcribed data were later complemented with field notes. The audio taped interviews were transcribed verbatim in to a note book and later typed. Labels were used to identify various participants on the transcribed data. These labels were 'P1' which stands for participant 1, then P2- for participant 2 up to P12. Participants were assured of maximum confidentiality.

### **Pretesting of interview guide**

The interview guide was pre-tested on three mothers by the researchers. These mothers did not form part of the main study. They were purposively sampled from Daporetindongo a suburb of the Bolgatanga municipality which has both rural and urban characteristics.

### **Data Analysis**

Content analysis was used to analyze the data after the interview responses were transcribed verbatim into English by the researchers. The first level of analysis included coding which involved identifying words, phrases and paragraphs within the data and assigning a label to apportion the data to give it meaning. Initial lists of codes were prepared to label the themes emerging from the data. The codes in the list were revised grouped together into larger thematic areas. In the search for core meanings and essence, researchers also paid attention to nonverbal communications but eliminated redundant information in participants' responses.

## Results

Participants were interviewed on factors that influence EBF. They included work, public attitude, health status of the mother as well as customs and beliefs of breastfeeding. All these factors could affect a mother's EBF practice positively or negatively. When participants were interviewed on the interference of EBF with their jobs, almost all participants did not see any hindrance at all with their jobs. This was because majority of the participants had their own businesses and most said they will resume work at their own convenience. One participant a seamstress from Yikene, Bolga-rural said;

*"I hope to start work when my baby starts taking water or walking. My fear is that when I start work now and leave my baby behind and she starts crying, the person taking care of her will be tempted to give my baby water and that could result in diarrhoea".*

Others felt EBF was posing a problem to their jobs because they had to put their business on halt to complete the EBF period before returning to it. A participant from Zaare who sells food said:

*"For now my daughter does the selling since she is on holidays. But when she leaves I'll need someone to help me if not I will not start now".*

Although some participants did not state clearly whether EBF will serve as a hindrance to their job or not, the statements they made gave an impression that they would have to stop working for now and attend to their babies and resume later after the baby is old enough. This meant losing clients or money.

With regards to how participants felt when breastfeeding in public, majority of the participants did not have a problem breastfeeding in public. Some participants made the following remarks:

*"I don't have a problem with it I will take out my breast and breastfeed in public".*

*"I don't have a problem. I can breastfeed her anywhere".*

*"I don't mind taking out my breast in public to breastfeed my daughter".*

*"I don't feel bad breastfeeding in public at all. After all I can't refuse my baby food"*

Other participants did not mind breastfeeding in public but added that they either had to hide in a corner and breastfeed or cover their breast while breastfeeding. One participant said:

*"Usually I look for a corner and breastfeed when I'm in public".*

While another said;

*"Normally I use a handkerchief to cover the top part of my breast and breastfeed when we are in public".*

The reactions of these two participants indicate that they are either shy or they feel the public frowns on mothers breastfeeding in public.

Meanwhile another participant said she will hide in a corner because of her beliefs about some individuals in public.

*"What I do is that I move aside to breastfeed because you can't tell who is a good person and who is evil. Besides, there are some people when their sweat touches you it could harm the baby. Even with the breast when you go out and come back you need to wash it with cold water before breastfeeding or else your baby will develop high temperature or run diarrhea".*

Whether or not a mother will breastfeed in public depends on the environment or the society in which she finds herself. On the other hand even if society accepts it, the decision still rests on how the mother feels and her personal beliefs.

On the health of the mother, most participants mentioned HIV/AIDS as a condition that could prevent a mother from breastfeeding. This was because most participants who attended antenatal classes were informed that a mother with HIV/AIDS should not breast feed. One participant said;

*“We were told at the antenatal that if you the mother have AIDS, you should only breast feed for 3 months and stop, so that the hospital will put you on treatment and that you will have to continue feeding the baby with artificial milk.....”*

Others also mentioned Hypertension, Hepatitis B, engorged breast amongst others as conditions that can prevent a mother from practicing EBF. In line with this a participant said that a mother with an engorged breast could not breastfeed because her breast milk was poisoned and as such not wholesome for her baby. However, medically this assertion is wrong because as part of the management of an engorged breast, the baby needs to suckle to help relieve the engorgement. Almost all the customs and beliefs mentioned by participants had negative implications for the practice of EBF. Although some participants said they were not aware of the existence of customs regarding breastfeeding/colostrum in their communities, others were able to narrate their experiences and explain some customary rites in their communities. The following are some narrations regarding colostrum from a seamstress:

*“The custom is that when you first deliver, you are asked to express the first breast milk into a calabash. Then a live black ant is kept into the calabash. If the ant is able to move in the milk and climb out of the calabash then your breast milk is good but if the ant is not able to move in milk and dies in the milk it is not good for the baby. So I was made to do that in the case of my first child. But the ant survived in my breast milk and so I was allowed to breastfeed”.*

*“In our custom we allow our babies to breastfeed from the start. But if it is a girl the good milk is said to flow on the 4<sup>th</sup> day but in the case of the boy it flows on the 3<sup>rd</sup> day. What I know is that when the baby is sick and refuses to suck the mother’s breast and the breast engorges she is asked to express and bury it so that she will not be sick. If not the mother develops headache and when the baby sucks it develops diarrhea. But if the mother expresses and discards it, fresh milk appears and the baby can suckle. Also if a mother is one who takes pork, then hair from a pig is kept into a calabash with water and sorghum (red millet), and given to her to drink. But this is not done in our house.”*

*“Usually the herbs are kept in water, then it is fetched and given to the baby to drink This concoction is called “sigirekoo” (which is supposed to be from the ancestor whose name the baby is adopting). This concoction is kept in a calabash and the one bathing the baby gives some to the baby to drink by pinching the baby’s nose while some is added to the bathing water. This is done for several days”.*

*“There’s this custom that certain herbs are mixed with water and forced down the throat of the baby. But the fear has always been that the baby may faint or die due to aspiration, so most people are scared of the practice and so that custom is rare. Usually the baby is placed on the lap lying on its back. Then warm water is continuously forced down the throat of the baby. This is to fill the baby’s stomach making the baby satisfied so he /she can sleep. Sometimes herbs are kept in water and given to the baby to drink in the same manner as already described. Now when this is successful it is said that the baby likes water so more of the concoction is given to baby. Some are used to bath the baby”.*

*“I don’t know much about our customs regarding breastfeeding. But I know that our mothers used to give some concoctions but now the practice is no more. Besides, my mother told me that they used to mix the local flour (“zom” made up of roasted millet plus a little pepper and milled) with water and give to the baby from 6months onwards and not earlier”.*

Although most of these practices existed in the past, some are still being practiced in some communities. These factors together greatly influence a mother's EBF practice in the Bolgatanga municipality.

### **EBF promotion and support systems**

For EBF to be effectively practiced there should be systems to promote its practice as well as support from the family whom the mother returns to after delivery. As a result, participants were interviewed on whether or not some of these breastfeeding support systems exist in their various communities. All participants reported that they had full support to practice EBF from their families. A participant who sells food and comes from Zaare (Bolga-rural) made the following remark;

*"My family has been supportive".*

Whiles a Christian hair dresser said;

*"My husband is supportive and he encourages me. My mother in-law is even doing more to support the practice".*

Husbands were reported to be especially supportive towards the practice. A participant who is a Muslim by religion made the following remarks;

*"Yes, my husband is supportive"*

As to the existence of a mother support group, all participants said there was no such group in existence and others even said they have never heard of them. Some made the following remarks;

*"I have not heard of a mother support group in our community".*

*"No, I'm not aware of the existence of a mother support group but there is a nurse who stays nearby she comes around to give information to us when the need arises".*

One participant said she used to hear of them but lately she has not. Few participants had heard of EBF promotion programs on radio but none on T.V. This is probably because most of the participants did not own T.V sets. A participant who is a teacher by profession indicated;

*"....there's a program on radio (healthy life) they talked about EBF".*

Another participant from Bukere (Bolga-urban) also said she only saw nurses coming around during immunizations. She remarked;

*".....the only time I saw nurses coming here was during the CSM outbreak to talk to us about it then they came round again to immunize against Polio".*

Also a participant from Yikene (Bolga- rural) added;

*"No nurses come round to talk to us about EBF, except at the clinic".*

With the issue of the radio, some participants said they did not listen to radio, others said they did not have lights whiles other said they did not own radio sets as such could not tell if there were programs on EBF or not. Findings regarding the lack of visits by nurses suggest that nurses in the municipality no longer embark on home visits possibly due to the lack of staff and logistics considering the fact that there is the need to follow up clients to their homes to study their home situation, teach them about issues concerning their health as well as address health problems that emanate from the communities.



## **Discussion**

The practice of EBF is influenced by several factors. The findings of the present study revealed that in the Bolgatanga municipality these factors include public attitude, work, health of the mother and customs and beliefs of society among others.

### **Public Attitude**

Almost all participants did not have a problem breastfeeding in public. This is probably so because it is culturally acceptable in the Bolgatanga municipality to breastfeed in public. As such the society does not frown on it. It is even very common to find people telling the mother of a crying baby to breastfeed her baby regardless of where they are. Therefore the inability of a mother to breastfeed in public could be attributed to the mother feeling uncomfortable and shy. The story however is different in Hong Kong, where some mothers experienced embarrassment as they were asked to leave public places such as restaurants, shopping centers and hotels for breastfeeding their babies (Leung, et al. 2006; Kong & Lee, 2004; MHSS, 2003). These findings indicate that various societies react differently to certain practices possibly due to the customs and norms governing them. As such a negative reaction from the public has the tendency of deterring a mother from practicing EBF.

### **Work**

With regards to work, most participants were self employed and so decided to put their businesses on hold and complete the six months duration of EBF before going back to work, while others felt they could comfortably combine their jobs with EBF. The only highly educated person amongst them (a teacher) was yet looking for a job and stated that she would complete the six months EBF period before starting work. In line with this a study conducted by Singh (2010) in Kumasi- Ghana on occupation and duration of breast feeding reported that, not a single percentage of teachers, house wives, and unemployed group in Kumasi-Ghana breastfed for less than 6 months. These findings are encouraging for the practice of EBF since regardless of their occupations mothers were still committed to the course of completing the six month period of EBF. In addition most mothers in the municipality are in the informal sector and so are in a better position to practice EBF. It is a common practice among mothers in the municipality to go to their farms and even to the market carrying their babies with them and as such can breastfeed their babies whenever the need arises.

### **Health of Mother**

In terms of the health of the mother, most participants reported that they were informed by the nurses at the antenatal clinics that mothers with HIV/AIDS should not breastfeed. In line with this, data from interviews and focus group discussions clearly showed with few exceptions that nurse-counselors in South Africa did not see breastfeeding as a safe infant feeding option for HIV-positive women (Leshabari et al, 2007). Almost all counselors stated that from their point of view infant formula was the preferred infant feeding method for HIV-positive women. Only two counselors who had participated in the national HIV and infant feeding training said that the women were doing the right thing to breastfeed, while 19 objected (Leshabari et al, 2007). Similarly, in the United States of America, breastfeeding is contraindicated for HIV positive women. This is said to eliminate the risk of postnatal transmission (Branson et al, 2011). The differences in opinion among nurses regarding EBF and HIV/AIDS affects the knowledge and practices of mothers with HIV/AIDS and as such confuses these mothers depriving them of any benefits they would have gained from the practice. In addition, other participants in this study also mentioned that mothers with engorged breast should not breastfeed; however one participant thought otherwise. Such was the general perception among most participants, a common custom in the Bolgatanga municipality is that a mother with an engorged breast is said to produce "poisoned milk" which is not wholesome for the baby and so is told to

express and discard it instead of allowing the baby to suckle to reduce the engorgement as advised medically.

### **Customs/Beliefs of Breastfeeding**

The customs and beliefs surrounding breastfeeding in this study were different from what has been reported in literature. This is because different cultures perceive and practice breastfeeding differently. Even though some participants from the urban communities said they were not aware of some customs or that some of the customs were outmoded, participants from the rural communities narrated their experiences with some of the customs surrounding breastfeeding. Herbs, concoctions, water and millet flour were still being given to babies for the following reasons; to satisfy their hunger, make the babies sleep, treat diarrhoea, prevent heart burns, treat abdominal upsets and supplement breast milk. Although discarding colostrum was not a common practice among the participants, they had other ways of making breast milk wholesome for the babies. These included putting an ant in a calabash containing breast milk to see if the ant will die or not, putting the hair of a pig in the breast milk for a mother who eats pork to drink to purify her breast milk before allowing her baby to breast feed and so on.

Despite all these practices to purify the breast milk, some of the babies of these participants still had diarrhoea at least once. This confirms Abugri and Heidi's (1997) study in Bawku-Ghana that although colostrum is traditionally perceived as dirty and unwholesome, discarding of colostrum is currently not widely practiced. About three-quarters of babies were given colostrum. A quarter of mothers however thought that colostrum should be expressed and discarded and that breastfeeding should not be initiated until "white or clean milk" begins to flow. The practice of discarding colostrum was higher in the rural area (40%) than in the urban area (14%). The findings however contradicts practices among the Oromo people where the initial breast milk of "yellow water" (Colostrum) is viewed as nutritionally useless "just like water" and it is sometimes expressed and discarded. Oromo people believe so and see it as "water" and void of nutrition and so do not drink it (Singh, Halidiya & Lakshminarayan, 1997).

In this study some participants from the rural communities mentioned that colostrum was discarded in the past but none of the participants said they discarded their colostrum. This shows that the practice is no more in existence probably indicating the influence of health education and public health interventions and urbanization on infant feeding practices.

### **EBF Promotion and Support Systems**

Findings from this study suggest that breastfeeding promotion systems are inactive in the Bolgatanga municipality. Most participants reported that they have never heard radio or TV programs on EBF, they did not have nurses visiting them in their homes to talk to them about EBF and the mother support group was also non-existent. The issue regarding the radio and TV could be because most participants said they did not own radio or TV sets and so did not have the opportunity of listening to the programs. The fact that no nurses visited the communities to talk to them about EBF also suggests that home visits are no longer effectively carried out probably due to the shortage of nurses. The absence of the mother support groups in the communities has also affected the promotion of EBF. The presence of these support systems would have aided in the promotion of EBF in the communities because the mothers in the communities are comfortable with their fellow women in their communities and so will listen to them better.

With regards to family support, most participants mentioned their husbands especially as being supportive. This confirms findings in a study among Hong Kong Chinese mothers which reported that the decision to breastfeed, included encouragement and support from the husband (Aghaji, 2002). None of the participants in this study gave negative comments about support from their husbands partly because culturally it is unacceptable to speak ill about one's husband.

## Recommendations

EBF was recommended by WHO in 1992 and has since been adopted by Ghana. In line with this, the MOH/GHS established baby friendly hospitals in almost all the regions. While this move is a step in the right direction, it is imperative that the MOH as a policy making body of health services in this country ensures that policies they adopt are well implemented. Although some efforts have been made in the form of in – service training and workshops to educate a number of health professionals, it is apparent that not all of them have sustained interest in EBF promotion.

This is evidenced by the lack of human resources to completely handle the challenges faced by nursing mothers interested in and practicing EBF. It is therefore necessary to evaluate the breastfeeding education offered to health professionals as well as an evaluation and monitoring of the dissemination of this information from health professionals to nursing mothers. This is important for the growth and sustenance of EBF. From the findings of the study, the following recommendations could be made.

1. Based on the findings that mother support groups on EBF are either inactive or non-existent in the Bolgatanga, It is recommended that these support groups are reactivated or established in areas where they are not functioning or non-existent. Since the establishment of a mother support groups is an important part of the ten steps to establishing a successful EBF, its absence will negatively affect the promotion of EBF in the Bolgatanga municipality and other communities that lack it.
2. From the findings, it also seems communities in the municipality are more culturally inclined and as such the mothers will prefer and comply with information given them by their fellow women folk than from health workers. It is therefore recommended that peer counseling on exclusive breastfeeding among mothers be encouraged and promoted.
3. Based on the contradictory information given by nurses on whether or not HIV positive mothers should breastfeed, it is recommended that the policy regarding HIV/AIDS mothers and breastfeeding should also be made clear by the MOH to all healthcare institutions so that health workers do not give contradictory information as to whether or not mothers with HIV/AIDS should breastfeed. Literature from other countries has shown that these countries have taken different stands regarding this issue and so a clear policy on this issue by the MOH will be of immense importance.
4. There should also be intensification of education on EBF in the media by the MOH/GHS to promote EBF and to educate the public. Nurses, midwives and other health personnel should also make it part of their responsibility to counsel and educate mothers and potential mothers who attend the clinics for antenatal and postnatal services. This will help eliminate some of the barriers and cultural beliefs negatively influencing EBF.
5. It is recommended that further research on EBF should be conducted using various samples such as grandmothers, nurses, husbands and community birth attendants as to gather their views on EBF. In line with this, more qualitative studies are required in this area so that mothers can express their own opinions of EBF, rather than quantitative studies where questionnaires are used and options provided to influence the responses of the mothers. In addition, the effectiveness of the practice of EBF should be assessed to find out how effective EBF is being practiced since some may perceive that they are practicing EBF while in actual fact they are not as was shown in the findings of the present study where all participants reported they were practicing EBF, yet they were not doing so and some babies were falling sick.

## Conclusion

EBF is by far the best feeding practice recommended for infants. This is so because of its enormous benefits to both mothers and infants. It is also a practice that can be undertaken by both the rich and the poor. However, the Bolgatanga Municipality has registered a very low patronage of the practice, yet it is located in one of the poorest regions in the country with a high rate of infant mortality and morbidity rate. This study employed a qualitative approach and used in-depth interviews to explore the experiences of nursing mothers regarding factors influencing their practice of EBF.

From the interviews, factors influencing the practice of EBF include the health of the mother, public attitude, work and customs and beliefs of society. Very important findings also emerged indicating the poor efforts put in by health workers in the promotion of the practice. The findings include inadequate knowledge on EBF by participants, a high influence of customs and norms of society on EBF, absence of mother support groups in the municipality and inadequate knowledge on when to introduce complementary feeding. These findings have contributed immensely to the low patronage of EBF in the Bolgatanga municipality. Also breastfeeding mothers are faced with multiple challenges as they strive to practice exclusive breastfeeding. Thus, scaling up of exclusive breastfeeding among mothers requires concerted efforts at all levels of the Ghanaian society.

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