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A Breastfeeding Culture Without Exclusive Breastfeeding in Lesotho

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Executive Summary

This research in Lesotho was designed to determine the influences on exclusive breastfeeding in order to guide future interventions, and to assess the adequacy of the rapid assessment procedures (RAP) used for this purpose. Data were gathered during two phases of field work in three geographically different locations. During the first phase—the rapid assessment phase—information was obtained through focus groups and individual interviews. During the second phase, another round of focus groups and individual interviews was supplemented with a clinic-based questionnaire survey. The main categories of respondents interviewed during both phases were mothers, grandmothers, and nurses.

Exclusive Breastfeeding is Not a Cultural Norm

We found that the breastfeeding culture, which ensured that most infants were breastfed, did not include exclusive breastfeeding. The grandmothers had given gruel, but only occasionally, and may thus have been closer to exclusive breastfeeding than today's mothers who gave supplements of water routinely. This water could be plain, but more commonly contained sugar, and frequently also salt. Mothers said they were giving these different types of water to prevent and counteract constipation, as a supplement or replacement for other feeds, in between breastfeeds, and because they believed the body needed water. These were also the reasons nurses gave for recommending water.

Mothers frequently mentioned nurses as their source of advice for giving water, and the grandmothers indicated that the nurses were responsible for having introduced the practice of giving water to young infants. The grandmothers claimed that they had not given water to their infants and that water supplementation was a new practice.

Oral Rehydration Therapy and Exclusive Breastfeeding: Mixed Messages?

Water with sugar and salt was commonly used as an everyday supplement for healthy infants. A number of respondents associated this practice with the promotion of oral rehydration therapy. Thus, the diarrheal disease control program which should have promoted exclusive breastfeeding may in effect have been discouraging it by encouraging early supplementation. Compared to the home-prepared sugar-salt solution given during diarrhea, the fluid used as an every-day supplement for healthy infants was said to be a more dilute solution, and the composition was less critical.

At the time of our study, exclusive breastfeeding for four to six months was a recent recommendation. Few nurses were aware that water for infants was not only unnecessary but might even be harmful. Since nurses believed as strongly as mothers that water supplementation for infants is beneficial, efforts to discourage this practice and promote exclusive breastfeeding must clearly take into account the beliefs and practices of both groups.

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Adequacy of Rapid Assessment Procedures for Program and Policy Development

The rapidity and adequacy of the rapid assessment procedures (RAP) used in this study were examined by comparing the quality and the quantity of the data obtained during the initial six-week rapid assessment phase to what was achieved by subsequent formal analysis and additional data collection. While analysis and data collection after this initial phase provided some additional insight, it was consistent with our first impressions. Thus, we found that RAP can be rapid and provide information which is adequate to inform programs and policy. We attribute this achievement to focused research topics and data gathering, effective purposive sampling, and a research team with the requisite skills and experience.

Programmatic and Policy Implications

- Water supplementation appears to be a clinic-introduced practice in Lesotho. The promotion of oral rehydration therapy has spurred mothers to give water with sugar and salt even to health young infants. Breastfeeding promotion needs to be integrated with diarrheal disease control programs to ensure coordination of efforts.

- Water supplementation is an obstacle to achieving the goal of exclusive breastfeeding in Lesotho. While removing this obstacle seems desirable, it is less clear what the best approach would be. Clearly, the beliefs of both mothers and health providers need to be considered.

- A six-week study using rapid assessment procedures (RAP) can provide relevant information for program and policy modification and development.

A Breastfeeding Culture Without Exclusive Breastfeeding in Lesotho

Background

In 1990 exclusive breastfeeding for four to six months was declared a global goal for optimal maternal and child health and nutrition at a WHO/UNICEF policy makers' meeting in Florence. Previously exclusive breastfeeding for most health and nutrition professionals had meant breastfeeding without the addition of other milks or food. An infant who received supplements of water, tea, or juice was still considered exclusively breastfed.

According to the Innocenti Declaration which arose from the meeting, exclusive breastfeeding means that an infant receives only breastmilk and that "no other drink or food is given" (1). Research had shown that the benefits of breastfeeding increase with increased exclusiveness of breastfeeding and that even supplements of water reduced benefits of exclusive breastfeeding. The revised and stricter definition was made possible because of evidence that exclusively breastfed infants did not need extra water (2-5) even under very hot and arid conditions (6).

The degree of exclusiveness of breastfeeding is important for the contraceptive effect of breastfeeding (7, 8), for protection against infections including upper and lower respiratory tract skin infections (9), and for protection against diarrheal diseases. Supplements of "non-nutritive" fluids like water and teas have been shown to be associated with two to three times higher diarrhea morbidity (9, 10) and mortality rates (11) than seen for exclusively breastfed infants.

The lower diarrhea morbidity rates associated with breastfeeding are a function of reduced exposure to contaminated foods and fluids and of the protection conferred by the anti-infective properties in breastmilk. Breastfeeding may decrease diarrhea mortality rates by reducing the risk of dehydration (12) and by positively influencing the treatment of dehydration (13). The adverse nutritional effects of diarrhea may be less for breastfed infants because the intake of breastmilk, in contrast to that of other foods, appears to be unaffected by diarrheal illness (14, 15).

Qualitative Study

Rapid Assessment Procedures (RAP)

In learning about exclusive breastfeeding in Lesotho, our starting point was one of knowing what kinds of information we wanted to obtain, but being able to anticipate only tentatively what we were going to find. Rather than testing hypotheses, we were interested in generating them. Such a situation calls for an emergent research design that evolves to fit the particular needs and questions as they arise. The early stages will by necessity be exploratory in nature and require the use of qualitative methods. We chose to obtain information through focus groups and individual interviews.

The flexible questioning in both types of interview situations facilitated the discovery of relevant findings and allowed the interviewer to pursue and probe further into issues of interest as they arose.

A factor which contributed to our decision to rely on focus groups and individual interviews was our concern that the methods also would be suitable for routine program planning. In the context of health and nutrition programs, the qualitative methods we used have been referred to as "rapid assessment procedures" (RAP) (16, 17). If methods are rapid, they have a greater potential for practical application, provided the quantity and the quality of the information obtained are not compromised. To ascertain the compatibility of rapidity with data adequacy, an assessment of RAP was built into the research design.

Focus groups as well as individual interviews were conducted using a question guide designed to obtain the following information: what was the usual or considered to be the appropriate *duration* of exclusive breastfeeding; *what* supplements or replacements might be given; *when* would such supplements or replacements be introduced; what were the *reasons* for giving or recommending such supplements or replacements.

The focus group interviews were tape recorded and afterwards translated and transcribed from Sesotho to English. During the individual interviews, conducted in English, written notes were taken. All notes and transcriptions of tapes were typed into a word processor.

Location and Sample

Lesotho is a small country with an ethnically homogenous population of around two million. To account for possible geographical differences between rural highland and urban lowland areas, data collection during the first phase was carried out in both types of areas, Quthing and Mafeteng, respectively. Analysis of the data from the first phase revealed no such differences and the second phase was conducted in a rural lowland area near the capital city of Maseru.

Sample selection was purposive to include respondents who were expected to provide relevant information regarding infant feeding. During the first phase, respondents were selected according to the following criteria: (1) mothers with children under five years of age; (2) grandmothers who took care of children under five years of age; (3) women who were paid to take care of young children whose mothers worked outside the home; (4) health professionals, mainly nurses; and, (5) village health workers. During the second phase, sampling was streamlined to include the three categories of respondents found during the first phase to provide the most useful information: mothers, grandmothers, and nurses.

Table 1 shows the number of focus groups and individual interviews conducted during each phase. Mothers and grandmothers were interviewed principally through separate focus groups while nurses were interviewed individually. Focus groups were held outdoors in a public space, in the home of one of the respondents or in the chief's yard. Participants for the focus groups were recruited in each location either by the local chief or by the study team with the permission of the chief. We aimed for

a group size of six to eight people, but occasionally accepted slightly larger groups. For logistical reasons, individual interviews were usually held at the work place of the respondent.

Table 1. Number of interviews during each phase of data collection

Respondent Category	Number of Interviews			
	Focus groups		Individual interviews	
	Phase I	**Phase II**	**Phase I**	**Phase II**
Mothers	3	4		8
Grandmothers	2	6		
Village Health Workers	3			
Paid Caregivers	1			
Nurses			19	16
Total	**9**	**10**	**19**	**24**

Quantitative Study

During the first phase of the study, early water supplementation was found to be the main deviation from exclusive breastfeeding. To obtain quantitative measures of the practice of water supplementation, we conducted a clinic-based survey during the second phase. A sample of mothers bringing their infants for vaccination was selected as reasonably representative, given Lesotho's high vaccination coverage (18). The sample included mothers whose infants were zero to six months of age, a period during which exclusive breastfeeding can be recommended.

The survey was carried out at five different clinics in and around Maseru. Interviews were conducted using a short questionnaire to determine what types of water-based fluids were given; why they were given; at whose recommendation; how much was given; and, whether these fluids were given by bottle, cup, or spoon.

Analysis and Interpretation of the Data

Analytical Procedures

Qualitative data analysis is a two-stage process. During the first stage analysis is an implicit part of data collection and begins as soon as the first question is being asked. During the second stage analysis is an explicit, systematically carried out activity which takes place after the completion of the data collection.

After having identified the different themes in our interview data, we systematically "coded" all interviews by going through print-outs of the interviews and writing the appropriate theme codes in the margin. The coded statements were then sorted into new computer files by theme and respondent category, using a word processor. By comparing the statements, theme by theme, across the three main categories of respondents, mothers, nurses, and grandmothers, we constructed and validated an overall picture of exclusive breastfeeding in Lesotho.

From the clinic survey, a total of 165 questionnaires were coded and analyzed using EPI Info, a package of microcomputer programs for handling epidemiologic data (20).

Results

Exclusive Breastfeeding

In this study of exclusive breastfeeding in Lesotho, we found that while breastfeeding was a cultural norm, exclusive breastfeeding was not part of this norm. For contemporary mothers, the major deviation from exclusive breastfeeding was water supplementation which began at birth or soon thereafter. The qualitative findings were supported by quantitative results from the clinic-based survey regarding the extent of water supplementation, types of water given, reasons for giving water, and the source of advice for giving water. Thus the qualitative finding that water supplementation now is nearly universal corresponded to 89% of the mothers in our clinic sample stating that they were giving water to their infant of less than six months of age. Sugar water was the most common type of water given (60%). By far the most common reason for giving water was to prevent or counteract constipation (58% for all types of water combined). Water was also given as a supplement or replacement (19%), and because the body needs water (15%). Nurses, who recommended water for the same reasons, were frequently cited as the source of advice for giving water (38%).

We were surprised to hear that water with sugar and salt was one of the types of water given to young infants (34%). This fluid, given to healthy infants, was said to be a more dilute solution than the home-prepared sugar and salt solution given during diarrhea. A number of respondents indicated that the practice of adding salt to the sugar water was a result of the promotion of oral rehydration therapy.

Grandmothers claimed that they had not given water to their children, and that giving water was a new practice promoted by the clinics. These claims surfaced in group after group as spontaneous explanations rather than responses to direct questions. The grandmothers' comments led us to hypothesize that water supplementation in Lesotho may be a relatively recent practice, introduced by the clinics. It should be pointed out, however, that at the time of the study, global recommendations for exclusive breastfeeding were recent, and the view that water is not beneficial but possibly harmful was new. While the grandmothers insisted they had not given water to their children, they had not been exclusively breastfeeding, but had introduced gruel at an early age. The gruel, however, appeared to have been given occasionally, not routinely the way water was being given by contemporary mothers.

The Adequacy of the Rapid Assessment Procedures

The adequacy of the rapid assessment procedures (RAP) used in this study (focus groups and individual interviews) was examined through multiple triangulation, i.e. by looking for consonance in information obtained (1) at more than one point in time, (2) in more than one location, (3) from more than one category of respondent, (4) through more than one method, and (5) using more than one interviewer. By keeping a "log," i.e. by documenting in writing our understanding at different stages of the project, we could compare findings from the initial rapid assessment to what was gained by further analysis and additional data collection. Thus we were able to determine that the key findings emerged already during the initial six-week rapid assessment. We subsequently concluded that while explicit analysis and additional data collection added depth to our understanding, RAP was adequate to inform programs and policy. We believe, however, that this was contingent upon the fact that our research topics and data gathering were highly focused, that our purposive sampling was very effective, and that we were a research team which together had the requisite skills and experience. That so much useful infomation could be generated in six weeks may be ascribed partly to the implicit analysis carried out during qualitative data gathering.

Discussion

In this study of exclusive breastfeeding in Lesotho we found that while breastfeeding was nearly universal, so was water supplementation from an early age. In a range of other geographical settings water, sugar water, and teas were given prelacteally and during the newborn period (21-24), or during the first two months of life (5, 10, 24-27).

Some of the reasons for giving water mentioned by mothers in our study have also been reported by mothers in other countries. Like the mothers we interviewed in Lesotho, mothers in Mali appeared to be concerned about keeping the digestive system functioning well and thus gave water to "open the baby's stomach" (28). Mothers in Egypt (22, 29) shared the view of the Basotho mothers that breastmilk production during the first few days is inadequate and should be supplemented with water or sugar water. Gambian mothers, like the Basotho mothers, continued to supplement the breastmilk with water during the first months of life (30).

The nurses in our study said they recommended water for young infants, and mentioned the same reasons as the mothers. Likewise, health providers in Honduras (25) and in Ghana (31) believed infants should be given water. Glucose water supplementation of newborn infants, which has been common practice in maternity wards all over the world, may have encouraged infant care givers to give water to infants also at home (22, 28, 32).

Supplemental water was believed to reduce initial weight loss in newborns and promote growth in the newborn period, reduce the severity of jaundice in newborn breastfed infants, and prevent hypoglycemia in newborns. These beliefs are not supported by recent scientific studies, however (33-36).

Many of the views regarding water supplementation cited above for mothers and nurses in Lesotho were also encountered in the medical literature, for professional as well as lay audiences, published during the early (37, 38) as well as the late (39, 40) twentieth century.

Programmatic and Policy Implications

- Water supplementation appears to be a clinic-introduced practice in Lesotho. The promotion of oral rehydration therapy has spurred mothers to give water with sugar and salt even to health young infants. Breastfeeding promotion needs to be integrated with diarrheal disease control programs to ensure coordination of efforts.

- Water supplementation is an obstacle to achieving the goal of exclusive breastfeeding in Lesotho. While removing this obstacle seems desirable, it is less clear what the best approach would be. Clearly, the beliefs of both mothers and health providers need to be considered.

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WELLSTART INTERNATIONAL

Wellstart International is a private, nonprofit organization dedicated to the promotion of healthy families through the global promotion of breastfeeding. With a tradition of building on existing resources, Wellstart works cooperatively with individuals, institutions, and governments to expand and support the expertise necessary for establishing and sustaining optimal infant feeding practices worldwide.

Wellstart has been involved in numerous global breastfeeding initiatives including the Innocenti Declaration, the World Summit for Children, and the Baby-Friendly Hospital Initiative. Programs are carried out both internationally and within the United States.

International Programs

Wellstart's *Lactation Management Education (LME) Program*, funded through USAID/Office of Nutrition, provides comprehensive education, with ongoing material and field support services, to multidisciplinary teams of leading health professionals. With Wellstart's assistance, an extensive network of Associates from more than 40 countries is in turn providing training and support within their own institutions and regions, as well as developing appropriate in-country model teaching, service, and resource centers.

Wellstart's *Expanded Promotion of Breastfeeding (EPB) Program*, funded through USAID/Office of Health, broadens the scope of global breastfeeding promotion by working to overcome barriers to breastfeeding at all levels (policy, institutional, community, and individual). Efforts include assistance with national assessments, policy development, social marketing including the development and testing of communication strategies and materials, and community outreach including primary care training and support group development. Additionally, program-supported research expands biomedical, social, and programmatic knowledge about breastfeeding.

National Programs

Nineteen multidisciplinary teams from across the U.S. have participated in Wellstart's lactation management education programs designed specifically for the needs of domestic participants. In collaboration with universities across the country, Wellstart has developed and field-tested a comprehensive guide for the integration of lactation management education into schools of medicine, nursing and nutrition. With funding through the MCH Bureau of the U.S. Department of Health and Human Services, the NIH, and other agencies, Wellstart also provides workshops, conferences and consultation on programmatic, policy and clinical issues for healthcare professionals from a variety of settings, e.g. Public Health, WIC, Native American. At the San Diego facility, activities also include clinical and educational services for local families.

Wellstart International is a designated World Health Organization Collaborating Center on Breastfeeding Promotion and Protection, with Particular Emphasis on Lactation Management Education.

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