Original article

Breastfeeding In Addis Ababa, Ethiopia: Results of a focus group study

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Abstract: A large shift has been observed from breastfeeding to bottle feeding in the urban areas of developing countries. Non-optimal breastfeeding patterns are contributing to the diarrhoeal diseases and malnutrition problems in such areas. To examine the existent of non-optimal breastfeeding, to identify the segment of the population in which these practices exist, and to ultimately carry out well targeted interventions, a situation analysis study on the breastfeeding patterns of infants was undertaken in the capital city of Ethiopia, Addis Ababa. In-depth interviews and focus group discussion were used in this study. The in-depth interviews revealed out that there was no policy 9! the Ministry of Health concerning breastfeeding and supplementation and there was a delay in the rooming-in of babies delivered at health facilities during evening and night hours. Newborns were also given non-nutritive fluids in the first three days of life. Working mothers were allowed to have a 45-day paid maternity leave. The focus group discussions undertaken wi!h mothers and grandmothers revealed that most newborns were given water just after birth. Itwas generally found out that women from low socio-economic status (SES) had negative attitude while those from middle and high socio-economic status and grandmothers had positive attitude towards breastfeeding regardless of their ethnicity. Recommendations are made based on the results obtained in the study. [Ethiop. J. Health Dev. 1996;10(3):133-143]

Introduction

several studies indicate that infants not breastfed have an increased incidence of diarrhoeal, respiratory and skin infections compared to those breastfed. In Lima, Peru, for example, the incidence rates of diarrhoeal diseases in those for whom breast-feeding had been discontinued were 15-48% higher than those of the breast fed infants (1). Though initiation of breastfeeding is universal in most developing countries, cessation of breastfeeding and early supplementation have been observed in a substantial proportion (2,3).

The changes in the types of supplements used and in breastfeeding duration are analogous to the changes observed in industrialized countries from the mid 19th century and many of the associated factors are similar: urbanization, female participation in labour force, increased availability of processed milk and their promotion both by companies and health sectors and regimentation of breastfeeding (4).

With the decline in breastfeeding, there is a shift to bottle feeding which could be hazardous in that the bottle or the content can be contaminated and/or the baby gets inadequate supplement as a result of over dilution (5) which is the case in most developing countries. These predispose young infants and children to diarrhoea and/or malnutrition.

In Ethiopia, like in other developing countries, diarrhoea is a major contributor of morbidity and mortality in young infants and children as demonstrated by diarrhoeal diseases morbidity, mortality and treatment surveys conducted between 1983-89, by the National

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Control of Diarrhoeal Diseases Programme in Ethiopia (14). Specially in urban areas, it seems that non-optimal breastfeeding patterns are contributing to the diarrhoeal diseases problem. It is, therefore, essential to examined the existence of non-optimal breastfeeding and to identify the segment of the population in which these practices exist so that well targeted interventions could be undertaken.

Different studies have been conducted in different parts of Ethiopia to study breastfeeding patterns. In a study of socio- cultural factors related to breastfeeding in Jimma (a town in south-western part of Ethiopia) (6) where 79% of the women claimed to have initiated breastfeeding in 12 hours time after delivery, duration of exclusive breastfeeding was found to be 45.6% in infants less than three months of age and 43.1%, 4.7% and 6.6% in those who were 4-6, 7-9 and 10 or more months of age, respectively.

The three rounds of the Rural Nutrition Survey (7) found that 93.9%, 93.3% and 94.6% of children less than two years of age were breastfeeding in the rural areas of 12 surveyed regions. Almost 88% of the children less than one year of age were also found to be getting supplementary diets at the time of the survey. In a nation-wide study which looked into the first two years of infant feeding (2), economically advantaged and educated families (Group A), poor and usually poorly educated families (Group C) and families in rural areas
(Group R) were studied. One of the places where the urban groups were studied was Addis Ababa. Ninety one percent, 97% and 100% of Groups A, C and R had breastfed the index child, respectively. The most common reason for not breastfeeding was found to be insufficient milk irrespective of the child's age.

Prevalence of breastfeeding was food to fall. steeply with increasing child age and was well maintained in urban poor and rural groups of mothers. In another study (8), three different Ethiopian Communities representing different economic and cultural situations were studied. In the studied children who have completely ceased breastfeeding the highest duration of breastfeeding (19 months or more) was found in Tigray (Northern part of Ethiopia) and no infant with breastfeeding duration of less than seven months was found in this community .

Tigray Region is a highly traditional community in Ethiopia and the authors accounted its high breastfeeding prevalence for its extremely meagre resource preventing mothers from adopting new things. In Sidamo (Southern Ethiopia), on the other hand, 32% of the children were breastfed for

19 months or more and 38% for 7-12 months. Sidamo is a cash crop area and the society is described as " open" which can " afford" to be more open because of the availability of resources. Arssi (Southern Ethiopia) children were breastfed for less than three months in 15% of the studied subjects, 27% were fed for 4-6 months and 47% for 7-12 months with only 11% fed longer than one year .People of the studied village in Arssi were found to be cattle people,
with cow's milk given a very big importance in child-feeding and, hence, early weaning was the norm. Paradoxically enough, males were found to be breastfed longer than females because of "their need for energy to become good herdsmen" .The most frequent reason given for early weaning was "...otherwise the
mother will not have children. ." .Hence, the ever increasing morbidity and mortality in the area was found to increase the need for more children further strengthening the picture of early weaning. Other reasons given for weaning included "cow milk better than human milk", and "child hurts the mother if he breast feeds any longer". A study undertaken in a rural community in the south western part of the country (9) found that 86% , 69% and 31% of infants 0-2 months, 2.1-4 months and 4.1-6 months, respectively, were given breast milk alone. It is obvious from these studies that different practices exist in the country in regards to breastfeeding. It was, therefore, deemed necessary to assess breastfeeding practices and the factors contributing to these practices in Addis Ababa where a large number of people with different socio- economic and ethnic mix reside.

The in-depth interviews were carried out (a) to learn about the policy of the Ministry of Health (MOH) regarding breastfeeding and supplementation, (b) to understand hospital practices concerning feeding of infants and children and the existence of communication activities with regard to child feeding, and (c) to identify areas to be emphasized in the focus group discussions and to help us frame the focus group guides. The focus group discussions, on the other hand, were carried out with the objectives of (a) assessing participants' attitudes, perceptions and opinions on infant feeding with particular emphasis to breastfeeding, (b) attaining greater depth of understanding about choices of the different modes of feeding and to make a preliminary determination of the importance of ethnicity in breastfeeding behaviour .

Methods

The components of the situation analysis were in-depth interview and focus group discussion.

1. In-depth Interview:

A pretested questionnaire was used to interview concerned officials in the MOH and the Ministry of Labour and Social Affairs (MOLSA); obstetricians, midwives and matrons of the three major obstetric hospitals in Addis Ababa: Tikur Anbessa Hospital (TAH), Yekatit 12 Hospital (YI2H) and Ghandi Memorial Hospital (GMH). All the three are central referral and teaching hospitals. T AH is the biggest teaching hospital in the country .GMH is the biggest obstetric hospital and its yearly deliveries are estimated at more than 2500.

2. Focus Group Discussions:

Eight focus group discussions were conducted from Sep., 1991 to January, 1992. The first group consisted of 10 women but, as it was felt that the group was too big to conduct an effective discussion, the subsequent groups sizes were reduced to 6-8 women. The groups were: two groups of low SES Amhara mothers, two groups of low SES Guragie mothers, one group of Amhara grandmothers, one group of low SES Tigre mothers, one group of low middle income Amhara working mothers and one group of high income Amhara

working mothers. The discussions mainly focused upon Arnhara, Gurage and Tigre mothers, because these are the three major ethnic groups comprising of 50% , 17% and 15% of the population of Addis Ababa, respectively (CSO, 1988). Homogeneity within the groups was maintained regarding ethnicity, monthly income, age and presence of a child less than one year of age. Fathers of children less than one year of age
were not included in the focus group discussions because of repeated failure to have them assembled resulting from their lack of interest in discussion about child feeding. Most of the approached fathers stated that they do not know or do not get involved much in child feeding, a task carried out entirely by mothers. A questionnaire was used to recruit the different groups of mothers from "Kebeles " (local government units).

The questionnaire included presence of a child less than one year old, ethnicity of mother, age of mother, and monthly income. Two health workers went from house to house each day of the focus group discussions till they found 6-9 women fulfilling the criteria of age, ethnicity, monthly income and educational status set for the focus group discussion of the day. Mothers fulfilling the set criteria were informed that the discussions were about "child feeding" and were asked for their consent to participate. The discussions were conducted in Kebele offices except the ones for the working mothers which were conducted in a diarrhoea training unit.

The discussions were chaired by the principal investigator who used pretested discussion guides. The discussion guides among the groups were similar dealing approximately with the same topics with only some changes addressing the respective groups. The discussion was recorded verbatim by two recorders, both health professionals.

The recorders were not used for fear about the reactions of the mothers. The basic areas covered in each of the sessions were health of the youngest child; necessities at birth; first breastfeeding; supplementation; problems of breastfeeding; problems of the different modes of feeding; images of babies and mother; necessities for good health; factors making a child look unhealthy and feeding modes of poor and a well-to-do mothers. To elicit information on images of babies and mothers, a photo-sort projective technique was used. This was done in the following ways.

1. Photographs of well nourished and malnourished children, below and over five months of age, were shown and respondents were asked what they think each child feeds on and why.
2. Photographs of well-to-do mothers and poor mothers were shown and respondents were asked what they think each mother in the picture would feed her child who is less than one year old and why. After each discussion, transcription was done, verbatim findings under each of the above topics were summarized. After
completion of all the eight focus group discussions a cross-group analysis was done under the above topics.

Results

1 In-depth Interview

1.1 Training and Other Activities to Promote Breastfeeding

Very little time is allotted for breastfeeding training in the curricula for physicians, nurses, health assistants and TBAs/CHAs. There are no sources of information about breastfeeding for health

professionals as the limited number of training/health education materials are targeted to the public. Short term in-service training on breast feeding are conducted irregularly by the Department of Family Health for nurses, midwives and MCH coordinators. The last training was conducted in 1988.

There is no policy of the MOH concerning breastfeeding and supplementation. The only two nongovernmental organizations (NGOs) involved in breastfeeding promotion are Catholic Relief Service (CRS), which promotes breast feeding mainly as a means of contraception and World Vision International. There is a Breast-Feeding Information Group of Ethiopia (BIG-E) under the Family Health Department of the MOH whose members are representatives of mass organizations (e.g. Women's Association, Children's Commission), different divisions/Institutions within the MOH (eg. The Ethiopian Nutrition Institute) and other ministries (MOLSA). BIG-E is not active enough in carrying out its mission and not much has been accomplished by the Group so far. The two NGOs involved in breastfeeding promotion are also not represented in BIG-E.

There are two women support groups in Addis Ababa. As these groups are handling poor and displaced women (as a result of famine and war), their main goal is income generation in order to institute self-reliance among the participating members.

Home deliveries are usually attended by. traditional birth attendants (TBAs) .TBAs are not regular care givers but are delivery specialists. They are not usually approached by formula makers' representatives and do not talk to mothers about breastfeeding.

1.2 Laws Concerning Maternity Leaves

There is a 45-day maternity leave with pay (at the time the study was undertaken) for working women approved by the MOLSA. There are no special laws and practices concerning breaks for nursing. However, a
mother can have nursing breaks with an unofficial agreement with her employer. No creche facility is available in any of the public or private sectors.

1.3 Hospital Delivery Practices

Delivery practices are almost similar in all the three hospitals. Hospital stay of vaginally delivered mothers range from 6-24 hours and that of Caesarian Section (C/S) from 7-15 days. Most vaginally delivered babies are roomed-in after 30 min. -12 hours. This delay is a result of the practice of not rooming- in babies before they get vaccinations and bathing. This has resulted in the delay in rooming-in of up to 12 hours of babies delivered vaginally at night because of" .. inadequate staffing to give vaccinations and bathing at night. .." .Babies born by CIS are mostly roomed-in after 24 hours., Babies delivered vaginally at night and those delivered by CIS are given sterile water or cow's milk/fonnula milk in addition to breast milk, depending on how the mother feels, till they are roomed-in. According to interviews with the hospitals , staff, mothers are taught in groups about breast-feeding both prenatally and right after delivery .No fliers or other learning materials are, however, given. Mothers of not roomed-in (mainly in cases where the baby is sick and is admitted to neonates' ward while the mother is still in post-delivery ward as in T AH), babies are encouraged to breast-feed every 3-4 hours. In cases where the mother is sick and is unable to breastfeed, newborns are given ccw's mild or fonnula milks with feeding bottles in GMH and YI2H and with cups in TAH. There are

no fonnula makers' representatives in any of the three hospitals and mothers are supposed to buy their own fonnulas in cases when the mother chooses to have her own formula milk rather than the hospitals' supplied milk. In YI2H, fonnula milks are provided to poor mothers free of charge. Bottles are not provided free in any of the three hospitals for home use.

Mastitis was the only absolute contraindication mentioned by interviewees in all the three hospitals and the most frequent breast-feeding problem which mothers seem to have was mentioned to be unwillingness to breast-feed on the part of specially young mothers.

If the baby has to be separated from the mother (eg. pre-eclampsia. eclampsia), the breast milk is collected and stored for the baby in GMH and YI2H, while it is collected and discarded in T AH (because of reported
"inadequacy in the number of staff to carry out such tasks. ." .But staff in all the three hospitals thought that pre-eclampsia and eclampsia are not contraindications to breastfeeding.

Contraception use is not promoted at all right after delivery in Y12H, while the pill is promoted in GMH. Mothers delivering at T AH are taught about the different contraceptive methods, and the choice is left to the mothers.

2. Focus Group Discussions

The major findings of the focus group discussions are summarized below.

2. Heath for the youngest child Low income mothers had divided opinions about the health of their youngest children: some said they were usually sick and others generally healthy. However, almost all working mothers thought that their youngest children were healthy.

Among low income mothers who said that their youngest children were healthy, most attributed their good health to the personal cleanliness of the children. '... I wash his cloth regularly and keep him clean... I think that is why he is healthy...' a low income Guragie mother . Almost all working mothers attributed their youngest child's good health to good nutrition, including breastfeeding. '...during night I give him breast milk, and at day time I feed him cow's milk with cup and spoon. I never use bottle for feeding. Probably this is why he is healthy...' a high income working mother.

2.2 Necessities at birth

Just after birth, almost all mothers interviewed, regardless of their ethnicity and socio economic status, gave water (boiled and sugar and salt added) for their newborn children. The most frequently mentioned reasons for giving water were: to prevent thirst, to prevent hunger, to replace the lost fluid, no breast milk production in the first few days. There was no woman, however, who knew the reason for adding sugar and/or salt to the water given as most of them responded by

"..that's how the water should be given..." '...even if there is breast milk initially, all newborns need water. Otherwise, their throats will be dry and they will not be able to passurine normally...' a low income Amhara mother.

'... breast milk has too much salt and if water is not given breast milk alone can induce heart bum...' a low middle class working mother .

'... the breast does not produce milk at first... so I give boiled and cooled water initially after adding a little salt and sugar...' a low income Tigrei mother . Breast milk was given by very few mothers who delivered at home initially.

'... I usually have breast milk starting from pregnancy. So, I started breastfeeding right after delivery...' a low income Guragie mother

Almost all mothers who delivered in health facilities gave breast milk initially, but started water just after they got home.

Butter was given initially by few mothers (Amharas and Gurages). Some of the reasons cited for giving butter were tradition, to get rid of 'the black substance from the gut which otherwise will give severe abdominal pain, and to soften the throat.

'... if it were in the country side I would have given butter and honey to soften the throat ...but here there is no pure and fresh butter. So what else can one give other than plain water a low SES Amhara grandmother .

Another fluid given to a newborn by very few low income mothers was camomile water . It was mainly given to prevent and treat constipation and abdominal cramp.

2.3 First breast feeding

Almost all mothers knew what colostrum (enger) is and almost all express and discard some (token) amount of the initial milk. The reason for discarding it was mainly to prevent abdomina cramp.
'... they say that enger tums into a knot in stomach and causes severe pain ...so I expressed the first part of this milk and discarded it....' a low income Gurage mother.

'-. I do not like it personally. It is very ugly. The child may vomit or may have abdominal pain If liven... after all it had stayed 1001 in the breast and is not fresh...' a low income Amhara mother.

Few 'tow income mothers and most of the working mothers did not discard the initial milk.

'... I did not express and dispose off it initially. They (health workers) advised me to live. .I took their words and gave him... and nothing happened to him...' a low income Amhara mother .

2.4 Time of initiation of breastfeeding

Most mothers started breastfeeding the day, i.e., soon after delivery .However, a few mothers did not initiate breastfeeding till the 200 -3rd day. According to all mothers, time of initiation of breastfeeding entirely depends on when the milk started. One very column reason for giving breast milk was by most low income mothers 'because health workers say so'. Many grandmothers and working mothers (high income and low-middle class) said that breast milk protects young children from diseases and increases bondage .

'...breast milk makes a child stronger and protects from illness. It helps the infant to grow well and to put on weight ...' a grandmother.

'... I feel very happy when my child sucks on my breast. When I see him sucking, I feel how much I love him...' a high class working mother .

2.5 Supplementation
Among all working mother supplementation starts at two months which corresponds to the time when women go back to work after maternity leaves. No working mother expresses her breast milk for use by the infant during working hour.

Among low income mothers there were different opinions and practices as far as age of supplementation is concerned: the earliest age of supplementation was one and a half month and the latest was seven months. Most low income mothers used diluted "Shola" milk (low fat pasteurized milk) for supplementation. Cow's milk was also used by a considerable number of low income mothers. Cereal gruel and powder milk were used by very few low income mothers. Fenugreek-water was very rarely used. Most working mothers used fresh cow's milk. Formula milk was used by few low-middle class working mothers and some high income mothers.

Reasons for supplementation among low- incomes mothers included mainly inadequacy of breast milk. Continuous crying of the baby and flabby breast were the commonly mentioned indicators for inadequate milk production.

'... my breast milk was not adequate ...(if not supplemented) the child will lose weight and will not grow well ...the breast alone cannot build bodies..' a low income Tigrie mother .

'... you can tell from the appearance of the breast that is not producing enough milk ..it looks like a dried beef...' a low income Amhara mother.

'.. I started giving additional food as I had to go to work. Otherwise I would have given him only breast milk for two years...' a low middle class working mother .

2.6 Problems of breastfeeding
Almost all mothers attributed temporary cessation of breastfeeding to illness of the child. Inflammation of the uvula referred to as 'elongation of the uvula' was the most common leading to refusal to breastfeed. Most women said that a permanent remedy for this situation is to cut the uvula, after which procedure the infant is put on melted butter for a couple of hours and breastfeeding is resumed.

Evil eye was mentioned as a cause of breastfeeding refusal in few low-income However, most low-income mothers thought that evil eye does not prevent breast feeding that child vomits immediately after feeding. They also said that a child who is on bottle-feeding is more likely to suffer from evil eye problem than one who is breasted as the milk in a bottle can be easily seen and can be affected with an evil eye.

'... since breast milk is covered it is not possible to see it when a child is sucking. However, if a feeding bottle is not covered with a piece of cloth when the child is being fed with it, the whiteness of the milk may attract evil eye...' a low income Gurigie mother .

Anther factor which some low-income mentioned as a cause for a brief cessation of breastfeeding is the mother getting tired after a heavy work or the mother staying in the sun for too long.

'... the milk in our bodies boils when we are tired and the child vomits if he takes the milk at this time. So it is good not to breastfeed a child for some hours till the milk cools down...' a low income Amhara mother .

2.7 Problems of the different modes of feeding

Almost all mothers thought that bottle feeding, if the bottle is not cleaned properly, causes diarrhoea and vomiting. Most low income mothers also think that bottle feeding exposes to evil eye. 11 was the feeling of all mothers that feeding with cups poses very few problems since it can be washed very easily. Among the problems mentioned about cup- feeding was the danger of aspiration and the difficulty and the inconvenience of the practice.

'... I am also scared to use cup. I am afraid my child will die from aspiration... Unless you yourself know how to do it and are always at home to do it, it is very risky to make other people do it.' a low-middle class working mother who bottle feeds.

2.8 Image of babies and mothers

Most low income mothers said that imported canned foods, cows milk, oranges, eggs, and potatoes make a child look healthy, regardless of the age of the child. Most grandmothers and working mothers, on the other hand thought that breastfeeding and supplementary diet at 3-4 months were necessities for good health.

'... you can tell from his looks. He feeds or balanced food such as cerelac, eggs, cows mill and potatoes...' a low-income Guragie mother.

Most low-income mothers thought that giving only breast milk makes a child look unhealthy, even in very young babies. Some low-income mothers felt that bottle-feeding (using unclean bottle) and not breastfeeding at all makes a child look unhealthy. There was no ethnic differences in these opinions.

'... his body can tell. His bones are wide, his blood is clean, his stomach is bulging and his head is big. He surely gets only breast milk...' a low income Gurigie mother said.

Most grandomothers and working mothers thought that bottle-feeding makes a child look unhealthy. Some thought that breastfeeding only for a very short time, inadequate breast milk or giving only breast milk for a long period make a child look unhealthy.

'.. He did not get breast milk. He is a bottle fed child and is fed formula with an unclean bottle' a low middle class mother said.

All mothers thought that what a poor mother feeds her child is only breast milk.

'.. the woman is so thin and looks poor. I think she gives her child breast milk only she will breastfeed for two or three years or even more. Actually till the child refuses to breastfeed...' low- income Amhara mother said.

Most low-income mothers said that the most likely foods a well-to-do mother gives to her. child, regardless of the child's age, is canned foods and other 'balanced foods' other than breast milk.

'... why should she even think of breastfeeding She has got several alternatives. She can afford to give canned foods to her baby..' a low-income Guragie mother .

'... she looks rich. She can afford to hire a baby sitter and feed her baby cerelac and other nutritious foods. The woman does not look weak also because she does not breastfeed...' a low- income Amhara mother .

Most grandmothers and working mothers, however, thought that a well- to-do mother gives her child mostly breast milk and other supplementary feeds.

'... I think she gives breast milk when she is at home and other balanced foods when she goes to work' a high-income working mother .

'.. It does not mean that she will lose weight if she breastfeeds. If she is rich enough and can afford to eat good foods herself, she could be in a good condition despite breastfeeding...' a low-income Amhara grandmother .

Discussion

Infectious diseases and malnutrition are the most important antecedents of the elevated childhood mortality in developing cow1tries. Not optimal breastfeeding seems to contribute to the diarrhoea problem which is one of the leading causes of morbidity and mortality specially in children under five years of age. There is no national policy of breast feeding in the country. Moreover, not enough emphasis has been given to breastfeeding in the medical, nursing, and health assistants school curricula. For health workers to be effective health educators, they need to have a good grasp of the knowledge, be it through basic or post basic education. Apart from the curriculum being deficient in breastfeeding, very limited workshops/ seminars have been given so far for health workers concerning breastfeeding at a national level. It is, therefore, recommended that ways be devised which help health professionals to upgrade their knowledge on breastfeeding so that they could be effective health educators.

In the in-depth interviews of staff of maternity wards, it has been indicated that free samples of formula milk are generally not given though some poor mothers "who cannot afford to be formulas" are the ones occasionally getting them. As there is an indication in our finding at free samples of formula are associated with decreasing rate of exclusive breastfeeding, this area needs a very careful consideration as poor mothers who could benefit the most from breastfeeding exclusively are the ones most affected.

Samples given to mothers have also been shown to reduce breastfeeding duration elsewhere (12). Moreover, babies delivered by caesarian section and those delivered at night vaginally are given sterile water or cow's/formula milk till they are roomed-in. In addition, no health education materials are given to mothers pre- and post-natally. Regimented breastfeeding is practised in cases where babies are not roomed-in. These practices, as they are learnt from hospitals, are liable to be carried home by mothers and practised as "correct" practices for babies: regimented feeding was thought to be superior to demand-feeding by the interviewed mothers and supplementary feeds were started as early as the first day of life. The facts that working mothers have only a 45 day maternity leave, day care facilities are absent at working places, mothers do not express their milk

for use by their infants during working hours and only a small proportion of the mothers could go home and breastfeed during working hours, sufficiently explain why mothers spending long hours outside their homes regularly have lower rates of exclusive breastfeeding. Though issues of work affecting overall breastfeeding prevalence is controversial (13), the explanation given above is plausible enough to show the effect of work on exclusive breastfeeding in the first four months of life, especially in places where maternity leaves are very short, day-care centres are virtually non existent, mothers are not officially allowed to go home and nurse their infants during working hours and expressing breast milk is not commonly practised as is the case in our study. One way of changing this trend among working mothers (since other ways may take longer period of time to institute) could be through raising their awareness about the possibility of expressing one's milk for use by the infant when mother is away.

Breast-feeding was also found to have very low image, specially among low-income mothers, as found from the photo-sort projective test: a child; who is malnourished was thought to be on breast milk alone regardless of the age of the child, poor mothers were said to give only breast milk to their babies and well to do mothers were said not to breast-feed at all. Breast milk was considered to be a feed given to babies when there are no other alternatives. One surprising fmding, though, was the fact that breastfeeding had a better image among the grandmothers and the working mothers (both low-middle class and high-income working women) than among the low-income mothers. One explanation for this can be the fact that low income women put their babies on breast milk alone for an extended period of time with probably additional low nutrient over diluted supplements (as a result of unaffordability of supplementary feeds and/or ignorance) which leads to growth faltering in the children. The growth failure might thus be attributed to breastfeeding among these low income mothers. Working mothers, on the other hand, can afford to supplement breast milk at the appropriate time and since no or very little malnutrition problem is exhibited, breastfeeding continues to have a good image among them. Grandmothers have good image of breastfeeding probably as a result of their long experience with their own children.

According to the above results, there seems to be no difference in practices, opinions and beliefs of mothers from different ethnic groups. This may be a reflection of the urban environment in which a large population of mixed ethnic and cultural behaviours live in a relatively small area. This leads to families being exposed to, and influenced by, other cultures other than their own either as a result of close neighbourly relationships or as a result of inter marriages across cultural boundaries.

In conclusion what we have found in our study were that: (1) there is no national policy on breastfeeding, (2) the medical, health assistant and nursing school curricula are deficient in all aspects of breastfeeding, (3) there is a delay in the rooming-in of evening land night time health facility delivered babies, (4) there is an introduction of non-nutritive fluids to the majority of newborns in the first three days of life, (5) there is a negative attitude towards breast feeding among poor mothers and positive attitudes in middle/high SES mothers and grandmothers, (6) there is a lack of health education on child feeding in general and on breastfeeding in particular and (7) there is a low level of knowledge of breastfeeding and supplementation among all group of mothers.

It is, therefore, recommended that:
(1) breastfeeding policy be formulated at a I national level,

(2) items on breastfeeding be added to the curricula of medical, nursing and health assistants schools,
(3) newborns, regardless of the time of their birth or type of delivery , be roomed-in soon after delivery ,
(4) health education be given regularly at antenatal, postnatal and child health clinics; posters and fliers be prepared by the responsible unit of the Ministry of Health and the mass media be effectively used to (a) increase awareness of mothers on child feeding in general and breastfeeding in particular and to (b) delay the introduction of non-nutritive fluids to young infants till at least four months of age, (5) giving free samples of formula milk be prohibited at health facilities and mothers be encouraged to initiate breastfeeding very soon after birth and l (6) day-care facilities be made available around employment areas to enable working mothers breast feed their babies long enough and/or working mothers be officially. allowed to go home and breastfeed their babies at least till their babies are four months old.

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