Practices and beliefs about exclusive breastfeeding by women living in Commune 5 in Cali, Colombia

LUZMILA HERNÁNDEZ, ENF, MGENF[1], MARTHA LUCÍA VÁSQUEZ, ENF, PHD[2]

SUMMARY

Objective: To describe the practices and beliefs about breastfeeding during the first 6 months after delivery, a study was completed with women living in Commune 5 in Cali, Colombia.

Methods: The methodology used for the study was ethno nursing, which facilitated inquiring about the emic perspective and identifying beneficial and risk-laden practices for the child´s health regarding feeding. Fifteen women were the key informants; this sample was determined by data saturation criteria.

Findings: Findings are presented in two parts: practices and beliefs in favor of exclusive breastfeeding and practices and beliefs that do not support exclusive breastfeeding. The prominent practices and beliefs in favor of exclusive breastfeeding are related to the mother´s bond with the child, preparation for breastfeeding during pregnancy, and family support. Among the practices and beliefs not supporting maternal breastfeeding, we must highlight the mother´s lack of confidence in her breast milk production.

Conclusions: Knowledge generated by this study may facilitate nursing care of women during pregnancy and postpartum that is congruent with their culture. To accomplish this, we identified cultural practices that should be kept and others needing modification or restructuring.

Keywords: *Exclusive breastfeeding; Beliefs; Practices.*

Creencias y prácticas sobre la lactancia materna exclusiva de mujeres residentes en Comuna 5 de Cali

RESUMEN

Objetivo: Para explorar las prácticas y creencias sobre lactancia materna durante los primeros seis meses postparto, se llevó a cabo un estudio con mujeres que habitan en la comuna 5 del municipio de Santiago de Cali, Colombia.

Metodología: La metodología utilizada fue la etnoenfermería, que facilitó indagar la perspectiva émica e identificar las prácticas beneficiosas y de riesgo para la salud del niño en cuanto a alimentación se refiere. La investigación tuvo como participantes clave 15 mujeres. La muestra se obtuvo aplicando el criterio de saturación de datos.

Hallazgos: La presentación de los resultados se organiza en dos partes: las prácticas y creencias que favorecen la lactancia materna exclusiva y las prácticas y creencias que no la favorecen. Dentro de las diversas prácticas y creencias que favorecen la lactancia materna exclusiva sobresalieron las relacionadas con el vínculo materno, la preparación durante la gestación y el acompañamiento familiar. En las prácticas y creencias que no favorecen la lactancia materna cabe resaltar la poca confianza de la madre en cuanto a su propia producción de la maternal milk.

Conclusiones: El conocimiento generado por este estudio puede contribuir a que el cuidado de enfermería que se brinda a las gestantes y puérperas sea coherente con su cultura, para lo cual se identificaron prácticas culturales que deben mantenerse y otras que deben reestructurarse o modificarse.

Palabras clave: *Lactancia materna exclusiva; Creencias; Prácticas.*

1. Assistant Professor, School of Nursing, Faculty of Health, Universidad del Valle, Cali Colombia. e-mail: luzmy1721@yahoo.es
2. Full Professor, School of Nursing, Faculty of Health, Universidad del Valle, Cali, Colombia. e-mail: maluvasq@gmail.com
Received for publication July 10, 2009 Accepted for publication March 10, 2010

Exclusive maternal breastfeeding, that is, feeding with maternal milk without adding any other solid or liquid foods during the first six months of the human being's life, is the ideal feeding method during this stage[1]. It is one of the most effective and lowest-cost measures to fortify the child's growth because it promotes brain development, protects against illnesses due to malnutrition, shields from learning and hearing difficulties; while also providing a basic component for the human being – namely, the emotional both between the mother and its offspring[2]. All these benefits are broadly recognized, but they will depend greatly on the moment breastfeeding is begun, its duration, and the age at which the child starts with the complementary diet.

To Foster awareness within the general community on the importance of breast feeding, strategies have been implemented to promote its practice world-wide. This aspect is evidenced by the documents: «Healthy People 2000» and «Healthy People 2010», whose primary objective is to increase the numbers of mothers breast feeding and the duration of this activity[3]. In 1992, the World Health Organization (WHO) and UNICEF instituted the 10 steps for successful maternal breastfeeding within the framework of the initiative: «Hospitals Friendly to Women and Infancy *(Hospitales Amigos de la Mujer y de la Infancia)*»[4].

In Colombia, the Ten-year Plan for the Promotion and Support of Maternal Breastfeeding (1998-2008), shows a general increase in the breastfeeding practice throughout the nation. In 1990, the proportion of children who had ever been breastfed was 93.4%; in 1995, it increased to 94.5%; in 2000, it was 95.5%; and in 2005, it rose to 97.1%. Nevertheless, in spite of the increase of this practice, there are still a low percentage of children with exclusive maternal breastfeeding until six months of age; from 15% in 1995 dropping to 11% in el 2000 and then in 2005, it increased to 13.5%[5].

Although in recent years the practice of exclusive breastfeeding has increased slightly in the nation, it remains far from being satisfactory. To continue promoting exclusive breastfeeding, it is important to keep in mind that health professionals and family members close to the breastfeeding mother become a decisive factor in getting this practice to be successfully developed. It is also important to know that the mere fact of being aware of the benefits of the mother's milk is not a guarantee of adequate implementation and continued practice, because this activity is determined by many biological, social, and cultural factors. Due to this, WHO experts[6] recommended since 2001, among priority research areas, the identification of biological and social obstacles within the different geographical and cultural environments to develop appropriate and effective interventions to overcome these barriers and their consequences. To contribute to the generation of this knowledge, the current research was conducted inquiring on the emic perspective of women living in Commune 5 in the city of Cali in relation to the performance of beneficial and risk practices stemming from their beliefs appertaining to maintaining or abandoning the practice of exclusive maternal breastfeeding.

REFERENCE FRAMEWORK

The current study is based on the Trans-cultural Care Theory (TCT) by Madeleine M. Leininger, whose primary goal is to furnish said care responsibly and coherently with the culture and, furthermore, reasonably adjusted to the needs, beliefs, and life styles of each of the individuals[7]. TCT permits contemplating culture as an indispensable aspect given that it enables recognizing, in each of the women participants, their beliefs and practices with respect to exclusive maternal breastfeeding. Beliefs are a very powerful force in our conduct. It is well understood that if one really believes that something can be accomplished, that *something* will be achieved; and if someone believes that something is impossible, no effort -no matter how big- will convince that person otherwise[8]. Everyone has beliefs that serve as resources and also beliefs that limit. Those beliefs can shape, influence, and even determine the quality of health and how humans take care of themselves.

Maternal breastfeeding, as a cultural practice, has been endowed with multiple meanings around which the behavioral norms are structured in the different cultures. For this reason, ethnonursing or trans-cultural nursing urges nurses to «become culturally trained»; a concept that must be understood as the possibility of acquiring knowledge on the multicultural reality and, particularly in the cultures in which the individual subject under their care is immersed, to thus be able to provide useful care that is respectful of the multicultural reality. In this sense, as we become aware of the emic perspectives of caretaking in different cultures, we will be able to

identify what type of care must be maintained, modified, or restructured[9].

METHODOLOGY

For this study, we chose ethnonursing as our methodology[10], because it permits systematically studying and classifying the beliefs and practices of the individuals to whom nursing care is being provided, just as said individuals are cognitively or subjectively known through their local language and experiences within their cultural context. The number of key participants in this study was 15 and this was obtained by applying the data saturation criterion, which -as indicated by Leininger[11] - is reached when there is redundancy in the information, where the researcher gathers the same or similar information and the participants do not offer anything different from what was previously stated.

The women participating in the study ranged from 20 to 33 years of age. Regarding the level of education, one of the women had done university studies, four had completed high school, 5 had not finished high school, and the remaining participants had been in grammar school. These were the, so-called, key participants, who were intentionally selected. The general participants were the grandmothers or aunts of the key informants and the fathers of their offspring. The information furnished by these participants served in contrasting the similarity or difference of the information given by the key participants. Prior to undertaking the field study, this research was authorized by the Human Ethics Committee of the Faculty of Health at Universidad del Valle in Cali. At the beginning of the field work, one of the researchers would explain the study to the potential key participants and indicated on the implications the study would bear for each subject in case of agreeing to participate. All the individuals contacted accepted and signed the informed consent in front of a witness with the witness undersigning. Thereafter, we gathered information through in-depth interviews via an ethnographic guide.

The interviews lasted from 60 to 90 minutes; they were conducted in the mother's natural environment, that is, in their homes and the interviews were recorded once authorization was granted. On average, three interviews were conducted for each participant – for a total of 45 interviews. The interviews were transcribed and reviewed in detail by the two researchers to guide later interviews. The analysis of the interview text was done according to the Spradley method[12]. Domains were sought after each interview and its transcription. A domain, according to Spradley, is a significance category that includes minor categories. Then, each of the domains was described with their three basic elements: the term covered or cultural domain, the terms included, and the semantic relationship, which is in charge of establishing a connection between the term included and the name of the domain. Once the domains were identified, the taxonomies were constructed. Taxonomy is a set of categories organized on the basis of a sole semantic relationship. When the taxonomies were identified, a componential analysis was done, which according to Spradley, implies the systematic search of attributes or significance components associated to cultural symbols. The componential analysis is structured through a schematic representation denominated dimensions of contrast. Lastly, from the descriptions mentioned, we discovered the themes that permitted the configuration and interpretation of the findings.

The methodological rigor or quality of the study through its qualitative character was determined via the criteria of credibility, audit ability, and transferability[13]. Hereinafter, we describe the strategies employed to guarantee the rigor of the study according to these criteria:

Credibility. To address this criterion, each of the study participants was shown the text of the domains identified after transcribing the interviews. In that sense, they were asked to indicate if what was presented in said domains represented what they had expressed during the interview. The same procedure was followed as the taxonomies and the componential analysis were identified.

Audit ability. In order to trace the findings of the study, discussions were made on the interpretations with other researchers.

Transferability. Given that this criterion implies that the results be significant for others under similar situations, it is expected that the findings of this study be applicable to other mothers in similar situations and contexts.

FINDINGS

To analyze the beliefs and practices related to exclusive maternal breastfeeding, it was necessary to

know, in the study subjects, the cultural awareness they interpret as adequate and which they apply at the moment of feeding their children. This awareness is generally learnt through oral tradition from mothers to daughters, and from mothers-in-law to daughters-in-law. It is worth highlighting that the women studied give a relevant sense to the act of «breastfeeding» their offspring, because they consider that this activity encompasses other important aspects like love, protection, and the affective bond between the mother and her child. In addition to the practices that facilitate breastfeeding, it was found that there were others that could interfere in such. Said practices are related to the fact of believing that the child remains hungry when exclusively fed with maternal milk and, hence, introduce similar practices or believing that the child will «become accustomed to the breast», by this meaning that there will be such a dependency for maternal milk to the point the child refuses to accept any other food, making it difficult to start complementary feeding and weaning. Practices conducted by the mothers in response to this belief were mostly aimed at applying bad-tasting substances on the mother's nipple.

Practices and beliefs favoring maternal breastfeeding. One of the main findings of this research has to do with how the women participants conceive maternal breastfeeding. They understand it as an act that goes beyond the biological and consider it as a natural process, which should have as essential components love, readiness during gestation, and family accompaniment in which tradition and cultural practices bear great influence, added to the support they find in health institutions.

For the mothers in this study, the transition period after the birth represents several difficult changes for the child by going from an aqueous environment, where there is a sense of protection and fusion with the mother, to a totally different environment that implies adapting to a different temperature, breathing on their own, and seeking for their nourishment. This transition period is essential for the construction of the child's physical and mental health based on the care offered by the parents. Women perceive maternal breastfeeding as the means of feeling and manifesting the love they profess for their offspring. Breastfeeding lets the mother retake the mother-child fusion from the gestational period, considered definitive and non-replaceable and which leaves an important imprint on the child's psycho-affective development. The following statement shows the transitional sense that «breastfeeding» represents for the mother:

> *«it is very important to feel oneself and the child as one person, that makes one wish to stay close to the baby all the time, bonded to the baby. Furthermore, when one is moved by love for the child, I feel it is not difficult to breastfeed, and if one knows it is the best thing for the child, I think all mothers want that, the best for their children»*

This finding confirms, in some manner, one of the many advantages of maternal breastfeeding as is the creation of a special bond between the mother and child, which will help the child be more self confident and contribute to helping the mother be more patient and perceptive. In the words of Graciela Hess[14], one of the leaders of League of Milk*(Liga de la Leche)* in México: «the breastfeeding mother produces oxytocin and prolactin, which could be called the 'hormones of love'», which is manifested in a pleasant sensation for the mother and the infant». This finding is reinforced with that indicated by the women in the study who consider that *«love is paid with love»*, meaning that if the child is fed with love, said child will be a loving individual in the future. Bowlby[15], creator of the Attachment theory, considers that children are born with a biological propensity to behave according to styles that promote closeness and contact with their maternal figure, and that this may become the basis for all their human relationships thereafter. With this in mind, one of the informants stated:

> *«One hears that breastfeeding is a form of giving love to the child and, hence, that child will also give love to oneself and to others».*

Women describe the different manners their sensations and experiences when they breastfeed their babies. The causes of greatest satisfaction they tend to highlight refer to establishing a special and intimate dialogue with the baby through smiles, stares, and caresses. Some mothers feel they have a unique and special communication capacity with the baby who has been breastfed for a long time:

«The sense of welfare is some quite inexplicable, she (the daughter) knows I feed her, she knows how to look for nourishment, she knows where to grasp. It is a special moment for the child and for the mother...» «…I felt a big sensation because of the contact with the child, whom you look at; the child looks at you, it is relaxation, peace...»

Another relevant aspect for women in keeping to breastfeeding is that they are convinced that children who are breastfed will be healthier and smarter in the future. The participants consider that this aspect is key for a mother to decide on initiating maternal breastfeeding and keeping it as exclusive until the first six months of life. One of the participants refers to it in the following manner:

«Everything one is taught during the control sessions helps one think that if this is so beneficial to the child, why don't we as mothers make the effort to give it to them (maternal milk),they say the child will be healthier and more intelligent, what mother would not want her child to be healthy and intelligent? Just by thinking of that, I think we make the decision of only breastfeeding the child».

The intellectual capacity of children who are breastfed has been a discussion appearing in scientific literature since the 1990s. Lucas *et al.*[16] published the first study related with the issue, which revealed that children who had been breastfed had intellectual coefficients between 7 and 10 points higher than those who had been fed artificial formulas.

Maternal breastfeeding during the first six months as the sole source of nourishment is considered by the participants as a difficult task, because they must face some conflicts regarding recommendations made by family members, neighbors, and health institutions. Additionally, they state that in many instances they feel confused, because everyone around them voices an opinion on what they feel is the best way to feed the baby. Due to this, the women participating in the study considered it important to prepare for the practice of breastfeeding. However, mothers comment that this preparation is not sufficiently specific and forceful, which is sometimes contradictory because the information offered to women during gestation and postnatal (puerperium) periods on the benefits of maternal milk for the child and on the difficulties that may arise during breastfeeding is not individualized. They consider that if the information were personalized it would help the mother be better prepared at home to overcome the *«challenges»* arising, considering these as doubts, uncertainties and fears during breastfeeding. The following statement illustrates this situation:

«at the clinic they tell you to breastfeed, but just the same, there at the clinic they bottle feed the baby! I think they should dedicate more time to us, teaching us how to breastfeed, and not this way, they say it in general for everyone and when you get home there are many difficulties».

Another way women are prepared for breastfeeding is through oral tradition passed on from the grandmothers, mothers, mothers-in-law, and other older family members, due most of all to life experiences in the practice of maternal breastfeeding. This knowledge is generally based on guidelines on how to carry out certain tasks of child rearing, according to normalized customs in their surroundings. In this study, the participants reported that when the child was born, they were immediately supported by an elderly woman on the care of the newborn, usually a family member like the grandmother or the mother-in-law. This aspect is more marked in primiparous mothers, because they are considered to «lack expertise» in the task of caring for a newborn, turning them into individuals with a greater degree of dependency on older women. On the particular issue, one of the mothers expressed:

«… but above all my mother is on top of it all. When it is your first baby, there is almost always a person who is experienced having babies, who guide you, who teach you to do this and the other...»

For the women in this study, the milk they offer their children must have two characteristics: adequate quantity and quality. The recommendations made by elderly women or «experts» in breastfeeding are aimed at increasing the

quantity and improving the quality of maternal milk through the intake of certain beverages or infusions considered lactiferous, which help women have the amount of milk necessary for the child to be adequately nourished; almost all these beverages have brown sugar (*panela*) as a base ingredient. Among the beverages, we found *«fennel water»* (*Foeniculum vulgare*)[17] a plant with anisette odor, which has been long used as a medicinal plant. It is known for its diuretic properties and for its effectiveness in the eradication of exogenous parasites. The fennel beverage is prepared with leaves or seeds from the plant, water, and brown sugar; it is felt that fennel – aside from increasing the production of maternal milk – has an effect on the color and consistency of such. Mothers believe that by consuming this beverage, the milk turns thick giving it improved nutritional qualities. One of the lactating women states it in the following manner:

> *«I would take fennel seeds and make a beverage in a big cooking pot; I would cook them, boiling them and would drink this water all day. You feel your breasts filling up, getting hard, and you see that with this drink the milk is different, it is thicker, I think it is better».*

Another beverage that is frequently used by the participants is *«brown sugar (panela) in water with milk, alone or with the peels of a ripe plantain or with a very ripe plantain»***.** This drink, according to participants, has an immediate effect on the production of milk. The mothers perceive that soon after drinking the beverage, their breasts fill up with milk, turning hard and thus favoring the child's ability to easily extract the milk and in greater amounts.

> *«…Yes, it does work indeed, because when I drank all that I would have a lot of milk come out; the milk increases, the breasts fill up to the tilt so you can easily feed the child, since it is all in there …»*

The lactiferous beverages indicated by the participants are well accepted among them, given that in addition to their ingredients being readily available, these permit them, as far as they are concerned, to adequately breastfeed their children.

Obstacles against exclusive maternal breastfeeding. Human feeding patterns bear great influence on the child's health and nutritional status. In this sense, exclusive maternal breastfeeding greatly benefits infants, because its qualitative and quantitative characteristics constitute the ideal diet and it should be the only diet children receive until the sixth month of life[18].

There are many factors that may lead a mother to start with substitutes for maternal milk; the history of artificial diet for children dates to past centuries. In 1794, William Moss, maternity surgeon at Liverpool, wrote[19]: «*It has been suddenly noted that artificial diet being fed to children causes colic and loosens the child's intestine, it is very difficult to furnish an adequate substitute for breastfeeding*». This shows us how humanity has for many years tried to introduce substitutes for maternal milk.

The current study found some practices and beliefs that do not favor maternal breastfeeding and, hence, contribute to the incorporation of substitutes to such. There is, for example, the belief that child fed exclusively with maternal milk remains hungry. Other relevant beliefs are the negative experience undergone by some participants at weaning and the influence of solar exposition in diminishing the production of maternal milk.

Hereinafter, we describe each of the practices and beliefs found:

The women participants who did not offer exclusive maternal breastfeeding adduced a variety of biological, social, and cultural reasons within which the insufficient production of maternal milk is underscored, the reason for the child remaining hungry. This is the aspect that most concerns them and induces them to start the child with complementary diet prior to six months of age, through formula milk or other diets like porridge or juice. As indicated by one of the participants:

> *«Since birth, I started feeding him bottled milk; the thing is that I did not produce enough milk, no matter what was done to me, I did not produce, or very Little came out and the baby was still very hungry, that makes you have to use the baby bottle; also, the baby has been fed juice and soup and he has not gotten sick, he has not suffered of anything, what else can one do if even by*

insisting one's milk cannot sustain the baby, and then you hear the baby crying… what else can you do …»

For women it is very important for the child not to manifest inconformity that can be perceived by the mothers when the baby continues weeping, in spite of having been breastfed. This is one of the most complicated aspects found by mothers in caring for their children. Some authors[20] consider that the stress generated by feeling that the child is not being fed well is often the cause of the insufficient production of milk; this is called *«transitory crisis of maternal breast-feeding»*. The situation is characterized because the child being breastfed is no longer satiated with the accustomed frequency of feedings; the mother feels that the breasts no longer fill up as they did before and the child requests breastfeeding more frequently. It is common to hear during this period mothers commenting *«the milk is gone»*; this perception brings much anxiety to the mother and no matter how many times the child is breastfed, the mother feels she is not producing the milk necessary to sustain the child. It is at this point that the mother decides to complement her «insufficient milk» with some type of baby formula.

Another prevalent belief is the idea that the mother's exposure to the sun is a determining factor that directly influences on diminishing maternal milk. The mothers say the sun can penetrate the milk in several ways: when the woman goes out to the street and the sun *«hit»* directly on her, when the maternal milk spills on the floor where it is exposed to the sun, when the brassier or a cloth soaked in milk is hung out to dry in direct sun. Through any of these forms, the child ends up*«hating»* the breast. Some women explained that because they were engaged in tasks that exposed them to the sun, they did not produce more milk inducing them to feeding their children with artificial milk. The following quote illustrates this aspect.

«One month after the baby was born, I had to start working, and given that I work on a school bus picking up children, the sun started to hit me; from that moment the milk dried up and not one more drop came out again; I would get home and would put the baby on the breast but nothing, nothing would come out. I think, then, that is was because of my exposure to the sun that no more milk came down».

Mothers consider that as the sun «hits» the milk -directly or indirectly- such starts to evaporate. The evaporation process is what ultimately makes the milk totally disappear or diminish its production. Because of this belief, when the mother does not want to continue breast-feeding the child, perhaps because the baby is too big or simply because she wants to stop doing so, she recurs to the method of drying the milk through solar exposure. One of the mothers mentions it so:

«this method was used by my grandmother and my mother, and it is done this way: take a baby diaper and soak it in milk from both breasts, the diaper must be thoroughly soaked, throw it up on the roof and leave it there, that day should be very sunny and that dries you up».

This mother's belief goes against recommendations generally made by health professionals for gestating or lactating women to expose their breasts to the sun when such have fissures or lacerations. This reveals that interventions done in some cases are not congruent with the practices and beliefs of those being cared for.

Women participants adduced that pain on the breasts as another reason for not offering exclusive maternal breastfeeding. One of the women narrates her experience as a painful episode in her life:

«it is difficult because as a woman you feel bad knowing that you were unable to breastfeed your child, but the pain you feel in your breasts is something horrible, just thinking that I was going to breastfeed would send chills down my spine, a chill from my head to my feet, that is very hard».

Women participants who did not offer exclusive maternal breastfeeding remember the process as something painful and difficult. In their story, they state that the child with such a small mouth injures their breast; furthermore, they considered that the baby's saliva ended up lacerating their breasts. These

lacerations would cause intense pain, making them feel both unfortunate and guilty for not being able to breastfeed their children. They state that in spite of having been prepared by nature to lactate their babies, these very babies injured them so that they could not offer the nourishment the baby needed at that moment; that feeling of guilt irritated them and made them feel like *«bad mothers»*. They also commented that as much as they insisted on breastfeeding, the milk would not come out and the pain was increasingly acute. The mothers assured that the most painful moment was breastfeeding the baby and not childbirth. The following testimony states how a woman perceives the dual feeling of wanting and not being able to breastfeed the baby:

«My mother-in-law and my husband supported me and would say that I could, that it was a matter of getting used to it, but every day it would get worse when I would see my breasts reddened, painful, cracked, and seeing that the baby was not getting any milk, I got desperate, my only option was to follow the recommendation made by a friend, which was to start feeding the baby bottled formula; with this decision my breasts got better, but I could not stop feeling bad for not being able to feed my child.»

This experience is determinant for breastfeeding the children that follow. Some mothers with experience in exclusively breastfeeding considered that their babies created a dependency on the breast that resulted difficult for them and for the babies; they denominated this experience as *«being stuck to the breast»*.

«I breastfed my previous daughter until she was five or six months of age, but then this became a problem, because weaning her was very difficult; I tried all means and nothing, she would only accept the breast, then this makes you be careful not to breastfeed another child so much».

Getting stuck to the breast (Entetarse) is a native term that means a baby's addiction to the maternal breast, in which the only thing the child knows to feed is to suck on the breast and when you offer another diet form, the baby rejects it. Some women see it as some type of *«vise»* and as with every *«vise»* it is difficult to break. The suffering caused by the act of «getting stuck on the breast» is experienced by both the child and the mother. The mother faces the difficult situation of knowing that although the child needs of her to survive; she in turn must refuse to breastfeed to stop the dependency or vise for the breast. The following shares what happened to one of the participants:

«is removing the dependency the child creates for the mom, it's that so much time with the baby stuck to you, you get tired and just want to get him off you, they suffer a lot, but in the end I think I am the one suffering the most now, it's that when you see them there stuck to you and they look at you as if they were saying things with their eyes so you won't take away the breast, it's hard… «

The participants consider that weaning is easier when the baby has had milk from a different source to the maternal breast prior to starting the transition to solid foods. This explains why for them it is a good idea to give the child bottled foods different from maternal milk at some time when the baby is between 3 and 4 months old or earlier if weaning is desired. This shows how the mother keeps in mind the critical stage experienced during weaning to avoid repeating it with subsequent children, and these very women later advise others on the importance of introducing the child to complementary diet early on to get the child to lose interest in the maternal breast and be ready to start another diet different from the maternal milk.

Protection against disease is primordial for the mothers during child rearing; they consider that the child is born with a weak stomach; hence, actions must be taken to protect it, strengthen it, and somehow seal the stomach to prevent future problems like diarrhea, colic, and vomit. This belief is generally transmitted at the home level, that is, through the female chain comprised of the grandmother-mother-daughter. The mothers use home preparations, which are offered to the baby on the first day home from the health institution where the baby was born. One of these beverages is what mothers call «bean tincture», which is prepared in the following manner: the beans are left in water the day before, they

are cooked without condiments until they are totally soft and with very little water or concentrated, that is they become dark red; after simmering, the baby is fed a small amount of the liquid because at such an early age the bean itself cannot be fed to the child. The mothers do not report this practice to health personnel. The following illustrates this practice:

> *«I gave my children bean tincture, and that is why they grew up healthy, I never had to take them to the clinic because of diarrhea, vomit, or any of those things; that is something you do quietly, because you can get scolded since physicians don't believe those things, then it's better to do it quietly».*

Another way of «curing» the baby's stomach is with bacon; this is cooked with a small amount of salt and given to the child to suck on. Some mothers commented that they were not too convinced with this method because they had heard that pork meat is harmful and causes allergies in the baby. The stomach is also *«cured»* by feeding the child between one and two teaspoons of whole pepper boiled in a little bit of water. According to the mothers, this preparation purges the stomach and helps the newborn to eliminate the meconium or waste substances adhered to the intestines. This method is less used because some women think it is too strong and can later cause gastritis in the baby. Bean tincture is most often used, among other reasons because the child shows pleasure in receiving it, and it is considered a food that contains vitamins and it is everything the child needs to have a strong and healthy stomach.

Implications for nursing care. Through this study, we found a series of practices and beliefs that may directly contribute to keeping to exclusive maternal breastfeeding and others that to the contrary, favor abandoning the practice. In this sense, and bearing in mind Madeleine Leninger's cultural care theory, there are practices and beliefs that would be worthwhile preserving and keeping in mind when elaborating the nursing care plan regarding the child's diet; this will permit mothers to accept the recommendations made, because they would feel identified with and sure of a type of care that agrees with their beliefs and customs.

Among the practices and beliefs that are important to maintain, the most outstanding are: tightening of the affective bond between the mother and child and the mental preparation the mother must have since the pregnancy; this preparation should have the participation of family members, friends, and healthcare professionals, who must continue furnishing support throughout the whole breastfeeding process. It is also worthwhile to preserve the practices to increase the production of maternal milk through lactiferous beverages (brown sugar water with ripe plantain skins, fennel water, malt beverages with milk, among others).

We found some practices and beliefs that should be adapted to reach benefits for mothers and their children; among these, there is the introduction of foods prior to six months of age, which could be because of the belief that the child remains hungry, or that the maternal milk dried up, or the mother wishes to prepare the child for weaning.

In light of the findings of the current study, some practices that are deemed harmful to the child's health should be restructured, like using the «purge» by feeding the child a red bean tincture or black pepper in water, or even bacon. Recommendations by international organizations consider that children should be fed exclusively maternal breast milk until six months of age; if other foods are begun before this age there is a high risk of developing allergies, infections and alterations in the gastrointestinal system[21].

CONCLUSIONS

The findings in this study reveal that feeding children exclusively with maternal milk is a task requiring lots of effort from the mother, given that it is difficult for some of them to overcome their desire of introducing another food source before the child is six months old, because she is, generally, pushed by close family members, neighbors, and even health personnel to start complementary feeding of the child. It is then considered that exclusive maternal breastfeeding depends greatly on the relationship between the mother and her surroundings, where there is influence from the beliefs and practices in her environment and culture.

The affective bond, translated as «love for the child», acts as a primary pillar and as a significant condition that motivates and triggers mothers to offer their offspring maternal breastfeeding.

In Colombia, there are practices and beliefs aimed at increasing the production of maternal milk. These practices are innocuous; removing them from the culture would possibly imply a sense on the part of the mothers of insecurity and inability in lactic production. Also, there are practices and beliefs that produce early abandoning of exclusive maternal breastfeeding, which are related to lack of confidence by the mother in sufficient production of maternal milk.

The breastfeeding mother receives information from different sources; these can be family or institutions, on what breastfeeding «should be», generating, in her, anxiety and pressure. This situation leads to devaluation of their own bodies, assuming themselves as incapable of providing nourishment for their offspring, leading them to recurring to the use of artificial milk.

In most cases, all these practices and beliefs are unknown to nursing personnel and, generally, to other health professionals, who because of this lack of awareness may be offering education or advice that could be contrary to the mother's cultural context.

Participant mothers request greater and better support from health personnel in the process of maternal breastfeeding.

Conflict of interest. None of the authors has conflicts of interest related to this study.

REFERENCES

1. Aguilar MJ. *Lactancia materna*. Madrid: Elsevier SA; 2004. p. 157-67.
2. Paricio-Talayero JM, Temboury-Molina MC. Lactancia materna: otras formas de promoción. *En: Comité de Lactancia Materna de la Asociación Española de Pediatría;* 2003. p. 141-4.
3. Dickson C. *Understanding breast-feeding*. New Jersey: Drug Store News; 2003. p.25-30.
4. Organización Mundial de la Salud, Fondo de Naciones Unidas para la Infancia. *Protección, promoción y apoyo de la lactancia natural: la función especial de los servicios de maternidad.* Declaración Conjunta OMS/UNICEF. Ginebra: OMS; 1989. p. 1.
5. PROFAMILIA. Encuesta Nacional de Demografía y Salud 2005. Bogotá: Printex Impresores; 2005. Fecha de acceso febrero 15 2008. URL disponible en: http://www.profamilia.org.co/encuestas/01encuestas/pdf_2000/
6. Organización Mundial de la Salud. *La duración óptima de la lactancia materna exclusiva. Revisión sistemática.* Comunicado de Prensa N° 7, abril 2, 2001. Febrero 15 2008 URL disponible en http://www.aeped.es/pdf-docs/duracion-lm.pdf
7. Leininger M. *Transcultural nursing: concepts, theories, research and practice.* New York: McGraw Hill Inc; 1995. p. 4.
8. Leininger M. *Cultures care diversity and universality: a theory of nursing*. New York: National League for Nursing; 1991. p. 57-95.
9. Boyle J. *Asuntos críticos en los métodos de investigación cualitativa.* Medellín: Editorial Universidad de Antioquia; 2003. p. 193-5.
10. Mariner-Tomey A, Rile-Alligow M. *Modelos y teorías en enfermería.* 5ª ed. Madrid: Mosby/Doyma; 2003. p. 507.
11. Leininger M. Transcultural nursing: perspectives: basic concepts, principles and culture care incidents. *In: Transcultural nursing*. New York: McGraw-Hill; 1995. p. 57-90.
12. Spradley J. *The ethnographic interview.* Orlando: Harcout Brace Jovanovich College Publishers; 1979. p. 93-105.
13. Castillo E, Vásquez ML. El rigor metodológico en la investigación cualitativa. *Colomb Med.* 2003; *34:* 164-7.
14. Amador L. *Lactancia materna versus leche de fórmula, relación emocional*. 2007: 64. '[fecha de acceso septiembre 17 2008]. URL disponible en: www.lalecheleague.org/Mexico.html
15. Bowlby J. *Una base segura. Aplicaciones clínicas de una teoría de apego*. Barcelona: Ediciones Paídos; 1996. p. 45-6.
16. Veliz-Gutiérrez JA. *Identificación de factores vinculados a la práctica de la lactancia materna exclusiva.* Policlínico «Hermanos Cruz». Tesis para optar por el Título de Magister en Salud Pública. Escuela Nacional de Salud Pública Cuba. 2004. p. 16.
17. Diccionario de la Lengua Española. Madrid: Espasa-Calpe SA; 2005.
18. Riverón-Corteguera R. Valor inmunológico de la leche materna. *Rev Cubana Pediatr.* 1998: *67:* 33-4
19. Helsing E, Savague F. *Guía práctica para una buena lactancia*. México, DF: Editorial Pax; 1993. p. 55-6
20. Verronen P. Breastfeeding: Reasons for living up and transient lactational crises. *J Adv Nurs.* 1982; *71:* 477-8
21. Díaz-Granado G. Más ventajas sobre lactancia. *Rev Colomb Pediatría.* 1999; *34:* 30-4.