Original Research

international lactation consultant association®

Journal of Human Lactation
2018, Vol. 34(1) 176–183

DOI: 10.1177/0890334417740345
journals.sagepub.com/home/jhl
SAGE

The Voices That Influence HIV-Positive Mothers' Breastfeeding Practices in an Urban, Ghanaian Society

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Abstract

Background: The World Health Organization recommends that HIV-positive mothers should breastfeed for at least 1 year. There are people in the lives of these mothers who influence their decisions.

Research aim: The aim was to explore the role of social persuasion in the decision-making processes of HIV-positive breastfeeding mothers.

Methods: A qualitative, exploratory research design was employed (N = 13). Participants were recruited from a public hospital in the Greater Accra Region of Ghana. One-on-one interviews were recorded and transcribed verbatim, and the contents of the transcripts were analyzed for emerging themes.

Results: The perspectives of spouses, health workers, counselors, and siblings about breastfeeding affect the breastfeeding practices of mothers living with HIV in Ghana. Most of the women had negative experiences with their midwives. Because of complex social and cultural influences, the opinions of spouses, health professionals, siblings, and members of the communities in which breastfeeding mothers with HIV live influence breastfeeding practices.

Conclusion: This study described HIV-positive, breastfeeding mothers' perceptions of the role played by spouses, health professionals, siblings, and the community in breastfeeding decisions and practices. Influential people in the lives of breastfeeding mothers with HIV should be involved during interventions by HIV counselors to promote breastfeeding practices.

Keywords

breastfeeding, breastfeeding initiation, breastfeeding practices, breastfeeding support, human milk, social support

Introduction

The World Health Organization (WHO, 2010) recommends that infants exposed to human immunodeficiency virus (HIV) should be breastfed exclusively for 6 months, and this should be followed by 6 months of complementary feeding. This is due to the overwhelming evidence that the rate of HIV infection transmission from mother to child through breastfeeding is tremendously reduced once the mother and infant are on antiretroviral therapy (ART; Bispo, Chikhungu, Rollins, Siegfried, & Newell, 2017; Chi et al., 2014; Chikhungu, Bispo, Rollins, Siegfried, & Newell, 2016; Govender & Coovadia, 2014; Little et al., 2017; Omondi, Ombaka, Mwau, & Ouma, 2016; Paredes, Marconi, Lockman, Abrams, & Kuhn, 2013; Schwartz et al., 2016; Townsend et al., 2014). HIV-exposed infants who are not breastfed are at an increased risk of death from malnutrition, diarrhea, and pneumonia if they are not exclusively breastfed (WHO, 2010). It then becomes a challenge because breastfeeding is also one of the main modes of transmission of HIV from mother to child. For the mother who is infected with HIV, there may be difficulty in deciding whether to breastfeed.

There were 2.1 million new HIV infections worldwide in 2015, and 150,000 were children (UNAIDS, 2016). Sub-Saharan African countries account for more than 66% of all child HIV infections (UNAIDS, 2016). Although there has been a 38% decrease in new infections in Sub-Saharan Africa, it has been estimated that nearly 400 children were infected each day in 2012 (UNAIDS, 2016). Ghana continues to make tremendous efforts to decrease the rate of HIV infection.

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Date submitted: December 10, 2016; Date accepted: October 11, 2017.

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However, a lot still needs to be done. As of 2015, 17.8 million women and 1.8 million children younger than 15 years were living with HIV, and Sub-Saharan African countries accounted for more than 60% of this figure (UNAIDS, 2016). Most of these women were of reproductive age (UNAIDS, 2016). About 19.5% of infants contracted HIV when neither the mother nor infant was on ART, according to a study in Nigeria (Anoje et al., 2012). The rate at which children are receiving ART is much slower than that of adults (WHO, 2013). A low rate of ART uptake among children has been predominantly recorded among children living with HIV in Asia and Africa due to low access to free HIV services for children (Leroy et al., 2013). Only one of three children living with HIV globally is receiving ART (WHO, 2013). In 2015, 1.1 million people worldwide died as a result of acquired immunodeficiency syndrome (AIDS)–related ailments (UNAIDS, 2016). As of 2014, 21,223 children in Ghana were living with HIV, and 1,295 of them died as a result of AIDS (UNAIDS, 2015). These figures indicate not only the magnitude of the problem but also the fact that pediatric HIV infections are numerous and worrisome (Morfaw et al., 2013). This is because human milk is the most common route through which infants contract HIV (WHO, 2010).

Some of the factors that account for this trend are the type of counseling that is received from healthcare practitioners. Health workers, who are supposed to counsel HIV-positive, breastfeeding mothers on infant-feeding guidelines, were either not current or held personal, negative beliefs about the WHO standard feeding guidelines (Kafulafula, Hutchinson, Gennaro, & Guttmacher, 2014; Shayo, Våga, Moland, Kamuzora, & Blystad, 2014; Tuthill, Chan, & Butler, 2015; Vallely et al., 2013). Spouses may also influence the infant-feeding choices of mothers living with HIV, depending on the level of disclosure between the couple. A study conducted in Nigeria found that mothers who had disclosed their HIV-positive status to their spouses were 5 times more likely to replace breastfeeding completely with formula foods (Aishat, Olufunmilayo, David, & Gidado, 2015).

The HIV-positive mother additionally may harbor fears of transmitting the virus to her child through breastfeeding (Kafulafula et al., 2014). Meanwhile, the WHO (2010) reported that a child born to a mother living with HIV has a higher chance of survival if that child is breastfed for at least the 1st year of life (WHO, 2010).

This study was situated in the philosophical underpinning of one of the constructs of the self-efficacy theory by Albert Bandura: social persuasion (Bandura, 1977). The fundamental assumption of the theory is that the confidence [to breastfeed] correlates with mastery experience, vicarious experience, psychological reaction, and social persuasion. Dennis and Faux (1999) developed the breastfeeding self-efficacy theory, which has been widely used in breastfeeding research (Aghdas, Talat, & Sepideh, 2014; Chong, Biehle, Kooiman, & Mickelson, 2016; Faridvand, Mirghafourvand, Malakouti, & Mohammad-Alizadeh-Charandabi, 2017; Glassman, McKearney, Saslaw, & Sirota, 2014; Henshaw, Fried, Siskind, Newhouse, & Cooper, 2015; Loke & Chan, 2013; Otsuka et al., 2014; Wu, Hu, McCoy, & Efird, 2014). Social persuasion refers to the influence of opinions about breastfeeding held by the people in the mother's network. The theory predicts that positive comments about breastfeeding motivate a mother to initiate breastfeeding and continue until the recommended period of 2 years or more. Likewise, negative comments will have the opposite effect. Thus, the degree of social persuasion determines maternal confidence in breastfeeding. In the Ghanaian context, it has been documented that in the northern part of the country, in-laws have great influence on the breastfeeding practices of mothers after delivery (Aborigo et al., 2012). There could be other voices that influence the breastfeeding decisions and practices of mothers living with HIV in the southern part of Ghana, which is the gap addressed by this study.

There is a paucity of literature about the roles of spouses, family members, HIV counselors, and health professionals in the breastfeeding practices of HIV-positive mothers in Ghana. In this study, we aimed to describe HIV-positive, lactating women's perceptions of the role that social persuasion plays in their breastfeeding decisions and practices.

Key Messages

- Few studies have been conducted on the influence of significant others on the breastfeeding practices of women living with human immunodeficiency virus in Ghana.
- Spouses, health workers, in-laws, and siblings are key significant others who influence the breastfeeding practices of mothers with human immunodeficiency virus in Ghana.
- Findings can be used to design policies that would involve significant others in the prevention of mother-to-child transmission.

Methods

Design

A qualitative, descriptive, exploratory design was used to answer the research aim. This design was appropriate because it allowed participants to describe their breastfeeding practices and those people who affected their choices. The conduct of the study adhered to universal ethics principles guiding social and health research (autonomy, right to privacy, confidentiality, justice, and protection from risk and harm). Data were collected after ethical clearance was obtained from the institutional review board of the Noguchi Memorial Institute for Medical Research at the University of Ghana.

Table 1. Participant Demographics (*N* =13).

Age (years)	Highest level of education	Employment	No. of children
34	Illiterate	Hairdresser	3
32	Senior high school	Caterer	3
37	Junior high school	Trader	4
32	Junior high school	Seamstress	4
30	Junior high school	Trader	2
31	Junior high school	Trader	2
35	Junior high school	Peer counselor	1
40	Junior high school	Trader	4
35	Senior high school	Seamstress	3
29	Junior high school	Trader	3
39	Illiterate	Unemployed	3
30	Junior high school	Caterer	2
32	Junior high school	Unemployed	3

Setting

The participants were drawn from one of the main public-referral hospitals, with a unit for people living with HIV, in the Greater Accra Region between November 2014 and February 2015. The women and their children were all healthy at the time of data collection. The women accessed the prevention of mother-to-child transmission (PMTCT) of HIV services at the health facility. To a large extent, people living in the Greater Accra Region are influenced by Western cultures due to urbanization. Unlike the rural areas, where breastfeeding is virtually automatic due to poverty, women in urban areas can afford infant formula, which gives them choices. Approximately 52% of all infants younger than 6 months are exclusively breastfed in Ghana (UNICEF, 2016).

Sample

A convenience sampling method was used. All eligible participants were approached, and those who were willing to take part became participants ($N = 13$). The inclusion criteria were (a) breastfeeding mothers living with HIV, (b) receiving ART in the location where this study took place, with (c) infants younger than 1 year. The demographic characteristics of participants are shown in Table 1. All mothers living with HIV who chose not to practice breastfeeding were excluded from the study. The sample size was determined by data saturation. Data were saturated on the 13th participant.

Data Collection

Data collection took place in one of the consulting rooms in the antiretroviral unit at the participants' convenience. Data were collected by the first author, who does not work at the setting of the study and had no relationship with the participants. In-depth, one-on-one interviews were conducted with a semistructured interview guide. The interview guide had open-ended questions (e.g., "Who do you consider important and influential in your life? Which of the significant people in your life influenced your decision to breastfeed as well as your breastfeeding practices? What were their perspectives about your decision to breastfeed? How did the opinions of such people affect your breastfeeding practices?"). The interview guide was pilot tested with two participants having characteristics similar to the study participants. The feedback from the pilot interviews was incorporated into the data collection instrument, which improved it. Results from the pilot study were excluded from the data. Data were collected on days when participants were scheduled to collect their medications from the antiretroviral unit of the hospital. Data collection ended after data were saturated.

Participants were given information on the study and two consent forms, approved by the institutional review board. The consent forms were given to them for at least 1 week to allow ample time to decide whether to partake in the study. After the consent forms had been completed by each participant, one was given to her to keep and the other was given to the researchers. To ensure privacy, interviews were conducted in a secluded consulting room at the hospital. Participants were informed that participation in the study was voluntary and they could withdraw at any time without consequences. Participants were identified by alpha-numeric codes, and any form of identification was removed. All data were locked in cabinets, and keys were accessible only to the research team.

Data Analysis

Data collection and transcription were done concurrently. This was followed by thematic content analysis, as described by Silverman (2016). The transcripts were read several times by the team to understand participants' perspectives. Data were coded by reading individual sentences and assigning a code (i.e., word or phrase) that correctly represented the essence of the datum that was read. The construct (social persuasion) was the major concept that had been preconceived because of the philosophical underpinning of the study. Therefore, codes that

Table 2. Data Analysis Structure With Definitions.

Code	Code definition	Major theme/definition	Subtheme/definition
Husband's comments Partner's opinions Spouse's approaches Breastfeeding beliefs of the child's father	Comments made by the husband on breastfeeding with HIV infection; beliefs of the father about his wife's breastfeeding practices	Social persuasion: *the people in the lives of breastfeeding mothers whose relationships have influence on their breastfeeding practices. The perceptions of such people on breastfeeding in the context of HIV affect the decisions of the mothers.*	Spouses: *the men who impregnated the HIV-positive mothers who participated in the study. They could be married or cohabiting.*
Sister's opinions Brother's opinions Perspectives of the infant's auntie	Perceptions of the siblings of the breastfeeding mothers who participated in the study		Siblings: *the brothers, stepbrothers, sisters, and stepsisters of the participants*
Perspectives of the nurse in the ART unit Counsel from physicians in the ART unit Physician assistant's advice Pharmacist's opinions	Advice and counsel on infant feeding in the context of HIV given to participants by counselors		Counselors: *any health workers who have been trained to counsel people living with HIV in the ART unit*
Opinions of the nurse who delivered the infant Perspectives of midwife at the postnatal clinic Midwife at the lying-in ward	Midwives' counsel and opinions about breastfeeding in the context of HIV		Midwives: *the midwives at the maternity unit who attended to the participants during the antenatal and postnatal periods*
Neighbors Church members Colleagues at the market Friends	Perceived reaction of neighbors and other members of the community to breastfeeding with HIV infection		Community members: *all the people in the locality of the participants who have different relationships with the mothers*

Note. HIV = human immunodeficiency virus; ART = antiretroviral therapy.

were suggestive of social persuasion were categorized under it. Similar codes were grouped and refined to generate themes related to social persuasion (see Table 2).

Measures to ensure credibility, transferability, dependability, and confirmability were instituted through prolonged engagement with participants, member checking findings, and triangulating data to ensure rigor. Each interview lasted between 30 and 45 min, which ensured prolonged engagement. After transcription, participants were engaged to ascertain what they had narrated earlier for member checking, and field notes were compared with transcribed data to ensure triangulation. To ensure that participants' perspectives were intact, a nurse educator who is a specialist in qualitative research was given the manuscripts to code and similar themes emerged. The research team met and agreed that the data represented the perspectives of the participants after analysis.

Results

Role of Social Persuasion

The women shared their experiences with the ways their spouses, counselors, siblings, and others reacted to their decision to breastfeed their children and how they motivated or demotivated them to continue breastfeeding.

Spouses

The participants' spouses played an important role in the mothers' decision to initiate, continue, or quit breastfeeding. Although the majority of the women revealed their HIV status to their spouses, others had not. It is fortunate that some men who were aware of their wives' status were very supportive, and they played a pivotal role in their wives' decision to breastfeed or otherwise. Two of the women said,

> He is very supportive, and he is the one who sometimes reminds me to take my medication and give the Septrin to the child. Therefore, I have the confidence to breastfeed knowing that I have my husband's support in terms of my decision to breastfeed.

> I decided from the beginning not to breastfeed the twins. But then, my husband encouraged me not to be afraid but to go ahead and breastfeed. . . . We have the same ideas, and he is very supportive.

One of the women, laughing, agreed:

> My husband is the one who has even been urging me to give the breast milk to the child, since I was a little hesitant at the beginning as to whether to breastfeed or not.

Siblings

The participants indicated that most of the siblings, especially sisters, were very supportive when it came to the issue of breastfeeding in the context of HIV, as reported below:

> My sister has been very supportive since she learned about my status. Up 'til now, it is my younger sister who calls me frequently to encourage me to continue breastfeeding all the time.
>
> At a point, through explanation, my sister told me that the people who are taking care of me here are experts, and therefore, they know what they are about. She then encouraged me to rather listen to the counselors here and do as I was told.

One of the women reported that her sister is also a nurse; therefore, her opinion about her decision to breastfeed was worthwhile. She said,

> My younger sibling is also a nurse, and she also spoke to me, and therefore, I was not afraid at all. My sister also told me to breastfeed and that there is a certain strength which the breast milk confers on the child. My sister relates to me in a very positive way. She is the one who even encouraged me to breastfeed.

Counselors

All the participants shared that their separate encounters with the trained HIV/AIDS counselors in the unit where data were collected really encouraged them to continue breastfeeding until it was time for them to stop, as illustrated below:

> When I come here, it is the counselors who show concern by asking me about the welfare of my family and my children. After asking how I am faring, they take the opportunity to counsel me and encourage me. That really helps me to continue breastfeeding 'til the stipulated time.

Similarly, some of the women said this about the role of the counselors in their ability to breastfeed:

> Hmm. Actually, I had [a] sore nipple after delivery, so I was confused and frustrated when the counselors asked me to breastfeed my child after delivery. So, I went back and explained to the counselor that I had [a] sore nipple and whether it was safe for me to breastfeed. The counselor then explained to me that the child would be given a special medication, and I would also continue taking my antiretroviral therapy while I breastfeed. That was what gave me the reassurance to continue breastfeeding.
>
> The counselors have really urged me on to continue breastfeeding.

Midwives

Participants stated that the midwives who helped them deliver their infants played both positive and negative roles in their ability to continue breastfeeding. Some of the participants shared that their midwives were hostile to them during their various encounters in the maternity unit because of their HIV-positive status. Below are statements indicating hostility from midwives:

> It was during delivery that I had a problem with discrimination. After telling the midwife that I was HIV positive, she went and called some of her colleagues to come and see a typical HIV-positive mother. I was extremely embarrassed. When her colleagues came, they asked me if I was sure that I was HIV positive, and I answered in the affirmative. They even scolded me for breastfeeding.

On the contrary, one of the women had a positive encounter with her midwives at the time of delivery. She said,

> With my first child, the midwife who took care of me was the one who encouraged me most. As of that time, I had no hope anywhere. The midwives were the ones who really encouraged me to breastfeed.

Community Members

Participants shared that the people in their communities had negative attitudes toward people living with HIV. Therefore, they were convinced that if people in the community were aware of their HIV-positive status, they would chastise them about their decision to breastfeed. To avoid being discouraged by the negative reactions from the members of their various communities, all the participants refused to inform people in their communities about their HIV-positive status, which provided peace of mind to breastfeed without discrimination, blame, or disrespect. One had this to say:

> Yes, of course. In case I tell people in the community about my HIV-positive status, they will insult me for breastfeeding my child because they would just assume that the child would surely come out as HIV positive.

One of the women shared that her husband was the one who defended her in public, saying,

> If people knew about my HIV-positive status and the fact that I am breastfeeding, they would have passed all sorts of comments about me, which wouldn't have been pleasant at all.

Another had this to say:

> As for this infection, I have not told anyone about it apart from my husband. If I go 'round telling people about it, I may never know when the person may blow my cover. The person might go about telling people about my situation. People may start pointing fingers at me about my HIV-positive status and the fact that I am insensitive to breastfeed and transmit the virus to my newborn.

Discussion

Most of the women who were interviewed were residents of areas where communal living is the standard. They lived in communal houses, which are usually called compound houses. In such areas, there is little privacy, and everyone tries to please others in order to be accepted by members of the community. Therefore, the opinions of important people in their lives about breastfeeding shaped their breastfeeding practices. The women narrated how the opinions of their spouses, siblings, counselors, midwives, and members of the community affected their willingness to breastfeed for the recommended timeframe. The opinions of spouses, family members, and health professionals described the breastfeeding practices and decisions of the participants.

Most of the women had a lot of support from their spouses, and that played a major role in their decision to breastfeed. At certain times, when the mothers felt helpless and afraid of transmitting the virus to their infants, it was their husbands who encouraged them to continue to the end. On the other hand, there was a peculiar case in which one woman reported hostility and rejection from her husband regarding her decision to breastfeed. This current finding is somewhat consistent with Morfaw and colleagues' (2013) systematic review on the role of male partners in the PMTCT of HIV. In their review, some of the women admitted facing rejection from their partners. Similarly, on the issue of refusal to disclose HIV status to male partners, researchers in other studies have reported that women hid their HIV-positive status from their partners (Colombini, Mutemwa, Kivunaga, Moore, & Mayhew, 2014). The women who enjoyed total support from their male partners expressed that they experienced little or no stress, and that helped them breastfeed successfully. The support given to the women in this present study may be due to the changing roles of men in society related to modernization and cultural infiltration. In typical Ghanaian societies, childcare is perceived to be the sole responsibility of women and the men are supposed to focus on the traditional role of providing economically for the family (Dumbaugh et al., 2014). Without modernization, it may have been difficult to get these men to go to the hospital with their wives to be counseled on the importance of being supportive of the health needs of mothers and children.

The women were more comfortable disclosing their HIV-positive status and their decision to breastfeed to their female siblings than their male siblings. All the participants who disclosed their status to their siblings did so to sisters. Those sisters were highly supportive of their infant-feeding choice of breastfeeding. The sisters kept in touch with them very often and sometimes went to the extent of reminding them to take their medication regularly. Perhaps this is due to the understanding nature of women and their female roles such as motherhood. In these situations, women may also have more of a listening ear for their siblings than their male counterparts. The close-knit nature of African society may have influenced the women's decision to inform their female siblings, since this system makes people obliged in one way or another to inform at least one close relative (Maman, Van Rooyen, & Groves, 2014).

In the present study, the counselors' level of knowledge and skill was different from previous studies that reported that health workers were not abreast with current WHO feeding guidelines (Vallely et al., 2013). A possible explanation for the attitude of health workers toward HIV-positive mothers may be their training about how to handle HIV-positive mothers. Further research is needed to understand this change.

The first point of contact with a health worker after delivery is with a midwife. Therefore, the opinions of midwives may play a significant role in women's breastfeeding practices. Researchers have found a positive impact of support and education from health professionals on successful breastfeeding (Loiselle, Semenic, Côté, Lapointe, & Gendron, 2016). It is unfortunate that most of the women reported negative encounters with their midwives during delivery. Similar to the findings reported by Chinkonde, Hem, and Sundby (2012), the participants felt rejected and judged during their stays at the hospital after delivery. A study focusing on the attitudes and practices of midwifes would provide a better understanding of this situation.

Limitations

This study included only women who did not have any form of tertiary education, and this could limit the application of the findings to highly educated breastfeeding women living with HIV. All participants in this study had breastfed for some months, and some of them may not have recalled all of their decision-making processes before commencing breastfeeding. However, the strength of this study is that it was able to gain comprehensive understanding of the issue through the inductive exploratory method.

Conclusion

HIV-positive, lactating mothers are influenced by what their siblings, midwives, and counselors say about breastfeeding. Therefore, with the consent of the breastfeeding HIV-positive mother, these close relatives can be involved in promoting best breastfeeding practices. Our findings may be used to design evidence-based policies that would involve significant others in PMTCT services.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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