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**INDIGENOUS BREASTFEEDING PRACTICES AMONG LACTATING
WOMEN IN THE BUILSA NORTH DISTRICT**

BY

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DECLARATION

I, Anthony Moro declare that this thesis is the result of my own work done under supervision. I also declare that with the exception of published materials which were used in this research and duly acknowledged, this work has not been submitted in any form for a degree at any University or any tertiary institution.

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ABSTRACT

Optimal breastfeeding is the most preferred means of feeding infants most especially babies below six months of age. This ideal practice, however, has eluded some babies in certain communities in Ghana due to various traditional beliefs and practices. The Theory of Reasoned Action guided this study to explore the indigenous breastfeeding (IBF) practices among lactating women in Northern Ghana. The study employed a qualitative exploratory descriptive design. Fifteen (15) lactating mothers were purposively sampled from the Siniensi community to participate in the study. Data was obtained from the participants through individual face-to-face interviews using a semi-structured interview guide. All interviews were audio taped, transcribed verbatim and analysed using thematic content analysis. Seven major themes emerged from the data which included; beliefs about IBF practices, opinions of referent others, motivation of lactating mothers to comply with the practice, attitude towards the behaviour, subjective norms about the behaviour, intentions of lactating mothers about the behaviour and knowledge deficit about exclusive breastfeeding (EBF) practices. The findings of the study established that lactating mothers categorised their beliefs about IBF practices into beliefs before the initiation of breastfeeding (BF), beliefs during the period of BF and beliefs about experts' advice. These findings suggest that IBF practices are difficult to avoid because of cultural beliefs. Findings of this study have implications for nursing practice and future research.

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DEDICATION

I dedicate this work to my family especially my dear wife, son and mother.

ACKNOWLEDGEMENT

I thank God Almighty for guiding me and granting me good health and wisdom to undertake this research. My special thanks goes to my able and dynamic supervisors, Dr. Florence Naab and Dr. Mary Ani-Amponsah for painstakingly going through my work and making the necessary corrections and suggestions that have made this work to see the light of day. I am equally grateful to all the lecturers and staff of the School of Nursing and Midwifery, University of Ghana for their immense support throughout the programme. I also want to thank the District Director of Health Services, Sandema, and staff, the Head of Siniensi Health Centre and staff, and all the lactating mothers who volunteered as research participants in this study. I would also like to acknowledge the authors and publishers whose works were used as literature in this study. I am highly indebted to my siblings, friends and colleagues for their diverse contributions that saw me through the entire length of the study.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
BF	Breastfeeding
BM	Breastmilk
CHPS	Community-based Health Planning and Services
CS	Caesarean Section
CWC	Child Welfare Clinic
DHMT	District Health Management Team
DRC	Democratic Republic of Congo
EBF	Exclusive Breastfeeding
HC	Health Centre
HIV	Human Immunodeficiency Virus
IBF	Indigenous Breastfeeding
JHS	Junior High School
RN	Registered Nurse
SHS	Senior High School
TBA	Traditional Birth Attendant
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UNICEF	United Nations Children's Fund
WHO	World Health Organization.

CHAPTER ONE

INTRODUCTION

1.0 Background of the Study

Breastfeeding has been and is still the most preferred means of feeding infants across the globe. Empirical evidence suggests that infants who are not breastfed are exposed to increased risks of gastroenteritis, otitis media, lower respiratory tract infections, diabetes, obesity, sudden infant death syndrome, childhood leukaemia and poor neurological and cognitive development (Stuebe & Bonuck, 2011). Lactating mothers who are not breastfeeding are also vulnerable to developing type 2 diabetes, breast and ovarian cancers, and myocardial infarction (Dacosta & Gillespie, 2012; Mwini-Nyaledzigbor, Atindanbila, Abasimi, Adatara, & Annan, 2014; Stuebe & Bonuck, 2011).

According to World Health Organization [WHO] (2003), breastfeeding is the single most important means of providing food for the healthy growth and development of infants. It is universally believed that effective breastfeeding helps to promote mother-to-child bonding which generates psychological satisfaction between the mother and her infant. Additionally, breastfeeding is an integral part of the reproductive process which provides numerous health benefits to lactating mothers. Some of these benefits include; serving as a contraceptive method, a mechanism of arresting bleeding after delivery and helps in early involution of the uterus (Kramer & Kakuma, 2012). Following these benefits, WHO recommended that infants should be exclusively breastfed for the first six months of their lives to attain maximum growth, development and good health. Subsequently, to meet their daily growth nutritional requirements, infants should be given

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nutritionally adequate and ideal complementary foods while they continue to breastfeed for up to two years of age or more (Binns et al., 2004; Joel, 2013; Kramer & Kakuma, 2012; World Health Organization, 2003). This evidence based recommendation was subsequently adopted by both developed and less developed countries across the globe. However, certain societies are not able to embrace the concept fully due to certain indigenous breastfeeding (IBF) practices

A study conducted among primiparous (first time mothers) women of urban slum in Delhi, India by Subbiah and Jeganathan (2012) and Chinese-American Mothers in New York City by Lee and Brann (2015) revealed that, misconceptions and cultural taboos (indigenous practices) regarding breastfeeding (BF) are hindrances to exclusive breastfeeding (EBF). The authors discovered that initiation of BF after delivery is done days later by mothers mainly due to family rituals and interference by elderly females. According to these studies, sugar solution is given to infants as pre-lacteal feeds and rice drink offered at day 7. Other unfavourable breastfeeding practices of the people include the avoidance of colostrum (the first milk), hygiene taboos associated with the lactating mother, such as avoiding tooth brushing and bathing. Dietary restrictions after childbirth and breastfeeding their infants for just a few minutes with the belief that breastfeeding for a longer period will cause their nipples to develop sores. Lactating women are also restricted from engaging in outdoor and sexual activities for a specified period (Lee & Brann, 2015; Purdy, 2010; Subbiah & Jeganathan, 2012). These studies suggest that the message of exclusive breastfeeding has not been well received among lactating women. This implies that the campaign for EBF has to be repackaged and intensified in order to make the needed impact.

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In the Region of Peel in Canada, EBF rate at six months postpartum in 2010 was as low as 23 percent even though initiation of breastfeeding was established immediately after birth (Dacosta & Gillespie, 2012). Ethno-cultural beliefs of residents have been blamed for the low levels of exclusive breastfeeding practices as well as high levels of in-hospital formula supplementation to infants and the distribution of free formula samples at local hospitals. Similar cultural beliefs are also hindering the practice of EBF among Lebanese first time mothers (Osman, Zein, & Wick, 2009, p. 4). According to these authors, many of the lactating mothers believed in “good” or “bad” breastmilk and wanted to know the indications for it so that they will not harm their babies with their breastmilk.

Also, a study conducted among low-income women in the north-eastern region of Brazil reveals low rates of exclusive breastfeeding practices (Henry et al., 2010). In Brazil, the national average of exclusive breastfeeding is around 47.5 percent at one month and decreases drastically to 7.7 percent at 6 months (Henry et al., 2010). The cause of this trend is blamed on socio-cultural factors, and the belief of some ethnic groups that only poor women breastfeed their babies. The study noted that infant residents in the low-income communities suffer largely from malnutrition and chronic diarrhoeal diseases. This could probably be due to the early introduction of food supplements, inadequate food supplements and unhygienic practices associated with child feeding.

Studies conducted by UNICEF and WHO (2015) revealed that despite the widespread sensitization, intention and recommendations of the world scientific community of the importance of exclusive breastfeeding, only 38 percent of infants under 6 months of

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age were being exclusively breastfed. It is noted that societal habits, behaviours and standards, in addition to lack of support and encouragement to lactating mothers account for this abysmal world performance (Daglas & Antoniou, 2012).

Furthermore, anecdotal evidence establishes that though nearly all African countries have embraced the concept of exclusive breastfeeding, a good number of them are reporting national figures far below the acceptable WHO levels. In Zambia for instance, about 86 percent of newly born infants are put on EBF. This figure tips down to 46.7 percent by the time the infants are 6 months old, a situation blamed on indigenous breastfeeding practices of the people (Nchimunya, Halwindi, Allan, Hazemba, & Chimfwembe, 2015). Similar findings like the introduction of water, animal milk and herbal drinks to infants were also reported to be practising among mothers in Enugu and Yebe states of Nigeria (Ajibuah, 2013). Research evidence indicates that colostrum is not suitable for infant consumption because it is seen as dirty milk due to its yellowish colour. It is therefore expressed daily and discarded routinely for a number of days (Ajibuah, 2013; Sanusi, Leshi, & Agada, 2016). Sanusi, Leshi and Agada (2016) again revealed that 14.5% of the mothers in Enugu state introduced their infants to breastmilk within 1 hour of birth while about 75% introduced prelacteal feeds. The authors concluded that only 24.3% of lactating mothers were practising exclusive breastfeeding.

In Zimbabwean and Kenyan traditions, prelacteal feeding is a common practice. Feeds are given to newborn babies because these cultures believe that the stomach of the newborn must be first of all cleansed before the initiation of breastfeeding (Ministry of Health, Kenya, 2011; Muchacha & Mthetwa, 2015). According to these authors, some of the products used to clean the stomach are ghee (clarified butter made from the milk of a

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cow), cream, salt and sugar solutions, and warm water. In Kilifi, Kenya, lactating women do not initiate breastfeeding within the first three to seven days. This is to enable the performance of certain rituals before breastfeeding can commence (Ministry of Health, Kenya, 2011). During these first days of the infant's life, the infant is given warm water, other milk products, and light porridge. The colostrum is regarded as dirty and so is discarded. Zimbabwe's tradition demands that traditional medicine be administered to newborn babies to try and prevent the death caused by severe dehydration. This practice is also prevalent in Kenya where infants are given various kinds of herbal concoctions to treat a condition known in Kenya as 'Ndebele' which is believed to be caused by evil spells (Ministry of Health, Kenya, 2011; Muchacha & Mthetwa, 2015)

In Ghana, infant and neonatal mortality rates are established to be 41 and 29 deaths per 1000 live births respectively (Ghana Demographic and Health Survey, 2014). This same report stated that 56% of lactating mothers in Ghana initiate early breastfeeding (i.e. within an hour of birth) with 52% of them exclusively breastfeeding their infants for 6 months. Though the national percentage for EBF is relatively high, anecdotal evidence suggests regional differences. For instance, Bolgatanga Municipal Health Directorate (2011) reported that exclusive breastfeeding rate in the Municipality was as low as 0.21%. A study conducted among nursing mothers attending child welfare clinic in a regional hospital in Ghana disclosed that majority of the mothers believed their BM alone was not enough to meet the nutritional requirements of their babies (Diji et al., 2017). This made the mothers to introduce early complementary feeding. Another study done by Aborigo et al. (2012) in the Kassina Nankana East Municipality on breastfeeding revealed that lactating women have knowledge on EBF, what they lack however was the

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implementation. The study uncovered significant traditional practices that are inimical to EBF practices. Gripe water, herbal water, traditionally meaningful foods such as guinea corn flour mixed with water (yara'na) are given to infants. Colostrum from primips (first-time mothers) is often tested for bitterness by putting ants into it before infants are put to the breast (Aborigo et al., 2012). This process leads to a delay in initiating breastfeeding and thus affects exclusive breastfeeding practices. The practice of these harmful indigenous breastfeeding practices suggests that there is the need for more research in this area to assess the effects of these practices on EBF. The Theory of Reasoned Action (TRA) was used as an organising framework to explore these indigenous breastfeeding practices.

1.1 Problem Statement

The international community adopted the Sustainable Development Goals (SDGs) 2.2 and 3.2 to help end all forms of malnutrition and to reduce neonatal mortality to as low as 12 deaths per 1000 live births and under-five mortality to as low as 25 deaths per 1000 live births respectively by the year 2030 (World Health Organization, 2016). This beautiful ambition cannot be realised without appropriate infant and child feeding practices of which breastfeeding is key. Meanwhile, research findings indicate that global trends in exclusive breastfeeding rates are not increasing despite the numerous benefits it provides. In some countries, the rates are stagnating or even dropping, meanwhile sales figures of infant formula and other baby foods are gaining grounds annually (International Baby Food Action Network, 2014).

Despite all the frantic efforts being made by healthcare professionals to have the issue of subnormal BF practices address in the African sub-region, several studies in

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Kenya (Kimani-Murage et al., 2011), Zimbabwe (Desai et al., 2014), Zambia (Katepa-Bwalya et al., 2015) and Ethiopia (Adugna, 2014; Belachew, Kahsay, & Abebe, 2016; Legesse, Demena, Mesfin, & Haile, 2014; Rogers et al., 2011; Tamiru, Belachew, Loha, & Mohammed, 2012) report about the existence of subnormal BF practices. To address this subnormal BF practices, one will need to have a clearer understanding of the practice to be able to make the needed impact.

In Ghana, socio-cultural pressure on lactating mothers (Diji et al., 2017) and traditional feeding habits (Sika-bright & Oduro, 2013) such as late initiation of BF and pre-lacteal feeds have been identified to favour sub-optimal BF practices. Meanwhile, a study conducted in rural Ghana indicates that initiation of BF after the first day of an infant life is associated with a three times mortality risk in babies 2 to 28 days of age (Edmond, Kirkwood, Tawiah, & Agyei, 2008). Among the Kasem and Nankani speaking tribes in rural northern Ghana, infants to first time mothers are sometimes fed with 'herbal teas' whilst the mothers are made to undergo a cultural purification for a period of 3 to 4 days depending on the sex of the child (Aborigo et al., 2012). Similar findings were observed to be practising among the Manya and Yilo Krobo indigenes of the Eastern Region of Ghana (Otoo, Lartey, & Pérez-escamilla, 2009).

Furthermore, during the period of 2005 to 2008, while I was working in one of the Sub-districts (Wiaga sub-district) in the Builsa district now Builsa North district of the Upper East Region of Ghana as a registered nurse (RN), I encountered several IBF practices. It was a common practice for a mother to give water, cow milk, herbal preparations, and millet flour mixed with water (zunyiem) among other substances to her infant. Colostrum was expressed and discarded by most households with the reason that it

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was dirty and harmful to the baby. Despite all these practices, the researcher did not locate any research conducted on the subject in the Builsa north district in the databases used and hence the need to conduct this study.

1.2 Purpose of the Study

The purpose of this study was to explore the indigenous breastfeeding practices among lactating women in the Builsa north district.

1.3 Specific Objectives

The specific objectives of the study were to:

1. Describe the beliefs about indigenous breastfeeding practices (behaviour) among lactating women.
2. Assess the opinions of referent others and the motivation to comply with the practice
3. Describe the attitude of lactating women towards indigenous breastfeeding practices.
4. Assess the subjective norms about indigenous breastfeeding practices among lactating women.
5. Determine the intention of lactating women towards indigenous breastfeeding practices

1.4 Research Questions

1. What are the beliefs about indigenous breastfeeding practices among lactating women?
2. What are the opinions of referent others and the motivation to comply with the practice?

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3. What are the attitudes of lactating women towards indigenous breastfeeding practices?
4. What are the subjective norms of indigenous breastfeeding practices among lactating women?
5. What are the intentions of lactating women towards indigenous breastfeeding practices?

1.5 Significance of the Study

The findings of this study are significant to traditional councils and religious groups. The traditional authorities could institute bye-laws to help regulate the practice of indigenous BF among lactating mothers within their communities. The religious leaders may also use their platforms to educate nursing mothers on the importance of engaging in optimal BF practices. The District Health Management Team may find this study useful as it may help them to develop strategies that are culturally sensitive in carrying out BF campaigns/education. The study is significant as the findings may contribute to a body of knowledge in the area of indigenous BF practices and its implications may guide future research.

1.6 Operational Definitions

- Elders: The grandmothers, mothers, mothers-in-law, fathers-in-law, husbands, sisters-in-law and other older women in the community who instruct the lactating mother on how to breastfeed
- Indigenous breastfeeding practices: Beliefs and practices about breastfeeding that a group of people engage in.

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- Confinement: keeping the mother and her baby indoors for a period of 3 to 4 days. She is not allowed to go out or do any work at home during the period.

1.7 Organization of the Study

Below is how the study was organized:

Chapter One presented the introduction to the study, the problem statement, purpose, objectives and significance of the study. Chapter Two offers a review of relevant studies conducted in the area of breastfeeding which related to the research topic. Studies covering areas such as traditional breastfeeding practices, role of significant others in breastfeeding, societal norms concerning BF and lactating mothers' beliefs, attitudes and intentions about BF were reviewed. Chapter Three describes the methods used in the study. The procedure employed to recruit participants for the study and how the interviews were conducted have all been elucidated. A description of data management and analysis have been presented.

The Fourth chapter presents the findings of the study. Participants' narratives reflecting their views on indigenous BF practices are all captured in this chapter. Chapter Five discusses the findings in relation to pertinent literature on the research topic. Meanings are also drawn during the discussion by the researcher. The last chapter presents conclusion drawn from the study and implications of the knowledge generated. Recommendations based on the study findings are advanced to specific institutions to help cause a change thereby helping to improve the delivery of healthcare to lactating women.

CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

This section of the research deals with the philosophical underpinnings of the study and reviews relevant literature on indigenous breastfeeding practices. The study used the Theory of Reasoned Action (TRA) developed by Fishbein and Ajzen (1975) as a theoretical foundation to explore indigenous breastfeeding practices among lactating women. The purpose of this framework was to enable an in-depth explanation that link the concepts of the TRA to indigenous breastfeeding practices.

2.1 Theoretical Framework of the Theory of Reasoned Action

The Theory of Reasoned Action (TRA) was propounded by Martin Fishbein and Icek Ajzen as an improvement over the Information Integration Theory (Fishbein & Ajzen, 1975). It was first used to study human behaviour in 1980 by the propounders and in 1988 the theory was revised to form the Theory of Planned Behaviour. The constructs of the theory include; Beliefs about the behaviour, Evaluation of the behaviour, Attitude about the behaviour, Opinions of referent others, Motivation to comply, Subjective norm, Intention and Behaviour.

2.1.1 Beliefs and evaluation about the behaviour

According to Ajzen and Fishbein, an individual's behavioural intentions will be informed by his or her beliefs about that behaviour (indigenous breastfeeding practices). If the individual beliefs about the behaviour are positive, then the likelihood that he or she will form an intention to act is great. The opposite also holds (Ajzen & Fishbein, 1972; Fishbein & Ajzen, 1975). To liken it to this current research, if a lactating mother has positive beliefs towards indigenous breastfeeding practices she is likely to form an

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intention to practice them. On the other hand, if her beliefs are unfavourable towards indigenous breastfeeding practices then the chances to intend to practice them is minimal.

2.1.2 Attitude about the behaviour

Attitude is the first antecedent of a behavioural intention. Attitude is the individual's positive or negative belief about performing a behaviour. These beliefs are called behavioural beliefs. An individual will intend to perform a behaviour if only he evaluates it positively. Attitudes are determined by the individual's beliefs about the outcomes of performing the behaviour. If the individual evaluation of the outcome of the behaviour is positive, then his or her attitude towards the behaviour will be good and vice versa (Ajzen & Albarracin, 2007; Fishbein & Ajzen, 2005).

2.1.3 Opinions of referent others and the motivation to comply

An individual will intend to perform or carry out a particular behaviour when he/she perceives that significant or referent others think he or she should do so. When opinions of referent others disapprove of the performance of a behaviour, this decision of theirs may be obeyed or disregarded based on the individual's motivation to comply at the time. This can be determined by enquiring from respondents to judge how probable it will be, that people who are very significant to them would sanction or prohibit them from performing a given behaviour (Ajzen, 1985; Ajzen & Fishbein, 1972). Significant others might be a person's spouse, close friends, nurse, mother-in-law, father-in-law etc. Relating this to the current research, will a lactating mother be engaged in indigenous breastfeeding practices simply because she has been told by the mother-in-law to so? Or she will only do so when motivated to comply?

2.1.4 Subjective norm

Subjective norm is considered the second predictor of behavioural intention.

Subjective norms are the perceived influence of social pressure on an individual (normative beliefs) to perform or not to perform a particular behaviour. The weight of the social pressure and the individual's own motivation will determine whether he or she will be motivated enough to comply with those perceived expectations (Ajzen, 1985; Mutuli & Walingo, 2014). In this current research, the question to ask is, will a first timer (first time mother) who is mocked at by the colleagues for breastfeeding in public continue to do so or will she stop breastfeeding in public?

2.1.5 Intention

Behavioural intention is an immediate antecedent of behaviour and is defined as the perception of an individual towards the performance of a particular behaviour (Fishbein & Ajzen, 1975). The TRA is based on the assumption that human beings are rational in thinking and will always make systematic use of information available to them. The theory further states that people consider the implications of their actions before they decide to engage or not to engage in certain behaviours (Ajzen, 1985; Ajzen & Albarracin, 2007). In this sense, it means that before a lactating mother engages in any type of infant feeding she has to think through the options available to her before. Intentions are supposed to capture the motivational factors that influence a particular behaviour. They indicate how hard men and women are willing to try, of how much of an effort they are willing to exert in order to execute the target behaviour. As a general rule, the stronger the intentions to engage in a behaviour, the more likely one would strive to perform it (Ajzen, 1991; Ajzen & Fishbein, 1974).

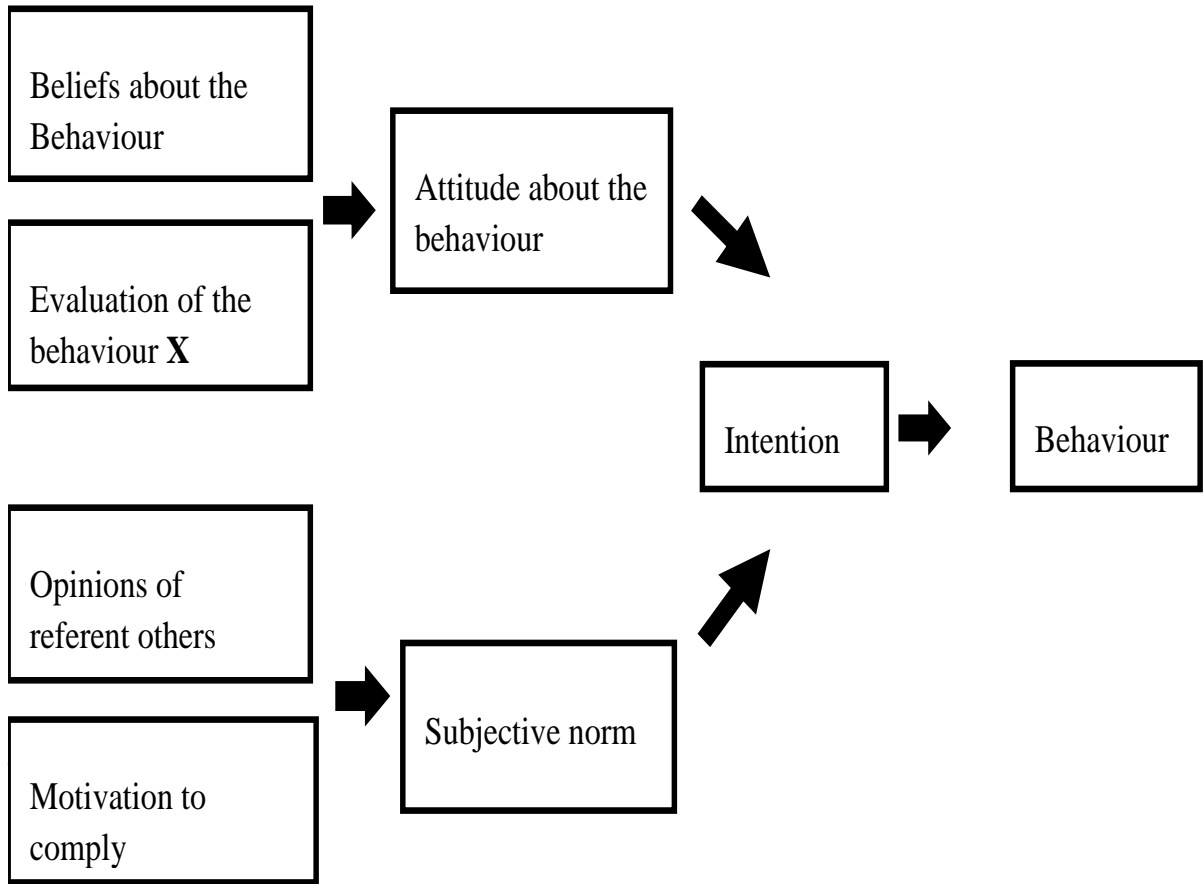
2.1.6 Behaviour

It is the ability of one to implement an intention or perceived behaviour at a particular given point in time (Ajzen, 1985; Fishbein & Ajzen, 2010). For a behaviour to be practiced, one's beliefs, attitudes and motivation to comply, and subjective norms, as well as strong behavioural intentions, will have to be considered. In this vein, to determine whether or not a lactating mother will comply with indigenous breastfeeding practices, all these factors mentioned in the theory will have to be considered. Behaviour is thus said to be the final product of the TRA.

One weakness identified in the TRA is the absence of perceived behavioural control (Ajzen, 1991). Perceived behavioural control is the degree to which a person feels that performance or non-performance of the target behaviour is not under his or her will power. People are not likely to form a strong behavioural intention to execute a behaviour if they believe that they do not have the necessary resources, skills, abilities or opportunities to do so even if they have a favourable attitude towards the behaviour and believe that referent others would endorse the behaviour. Perceived behavioural control can influence behaviour directly or indirectly through behavioural intentions (Fishbein & Ajzen, 2010; Mutuli & Walingo, 2014). To sum up, the practice of a given behaviour matches up with the individual's confidence in his or her ability to perform the behaviour in question (Ajzen, 1991).

Evaluation of the behaviour in the model was not considered as a separate entity as was done for the other constructs. This is because evaluation is presumed to be integrated into all the other constructs of the model.

Figure 1: Theory of Reasoned Action



X: Not Studied

Source: Fishbein and Ajzen (1975)

The Theory of Reasoned Action has been used with the Theory of Planned Behaviour (TPB) to predict change in health behaviours among the youth (Nisson & Earl, 2011). These two theories helped to predict the application of basic public health issues such as diet, exercise and condom use to health outcomes. The TRA was also used in a study to predict breast self-examination intention and frequency among middle and older women (Powell-Cope, Lierman, Kasprzyk, Young, & Benoliel, 1991). The TPB was not considered in this study because it did not fit well into the study. The TRA on the other

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hand, was suitable for the study because its constructs were more useful in addressing the research problem.

Lactating mothers have beliefs when it comes to how they breastfeed their babies and these beliefs lead to the formation of their attitudes towards the behaviour (IBF practices). Mothers with positive attitudes will form the intention to carry out the behaviour whilst those with negative attitudes will not form the intention to engage in indigenous BF practices. Opinions of significant others about indigenous BF practices have significant influence on how the mother will engage in the behaviour, but this will depend on the motivation level of the mother. If the mother is motivated by what her referent others are telling her, she will form the intention to practice it. Societal norms can however put pressure on the nursing mother to indulge in the behaviour whether she has evaluated it positively or not and whether she is motivated to engage in the indigenous BF practices or not. Based on these, the researcher will want to understand how beliefs and attitudes, opinions from referent others, motivation to comply, subjective norms and intentions affect IBF practices among lactating mothers.

2.2 Literature Review

2.2.1 Literature search

Relevant literature for this study was retrieved from databases such as PubMed, Science Direct, Cumulative Index for Nursing and Allied Health Literature (CINAHL), Sage and MEDLINE with Google Scholar as the search engine. Key words such as beliefs, perceptions, indigenous BF practices, breastfeeding, attitudes, Culture, subjective norms, intention and motivation were used for the search. Relevant literature written in English language from 2009 to 2018 were retrieved and used. However due to the nature

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of the topic and the depth of published information relevant to the study, some older studies were included.

2.2.2 Beliefs about indigenous breastfeeding practices (behaviour) among lactating women

Human milk is unquestionably the most ideal diet for babies. It also acts as a form of insurance cover for the child as well as the mother (Hernandez & Vasquez, 2010; United States of America Department of Human Services, 2011; Walker, 2010). Despite the plethora of evidence reported in the literature about the inexhaustible benefits of optimal BF to mother and child, babies elsewhere are being denied these lucrative benefits in the name of traditional and or cultural beliefs.

Colostrum – the ‘magic component of breast milk’/the ‘liquid gold’ is undoubtedly endowed with numerous nutrients needed for the smooth growth of the infant (Godhia & Patel, 2013; Hurley & Theil, 2011; Munblit et al., 2016). This precious substance is regrettably, expressed and discarded as it is seen as not good for the baby to feed on (Acharya & Meena, 2016; Asim, Malik, Tabassum, Haider, & Anwar, 2014; Ertem & Ergün, 2013; Steinman et al., 2010; Subbiah & Jeganathan, 2012; Thu et al., 2012). According to these authors, the elders’ belief is that colostrum is harmful and can cause diseases and other misfortunes in the newborn hence the refusal to allow the babies to suck. It is also believed to be dirty and unhealthy because of its yellowish colour (Bandyopadhyay, 2009; Ertem & Ergün, 2013). Again, colostrum is believed to be difficult to swallow and digest because of its thick nature and staleness (Asim et al., 2014; Steinman et al., 2010). Other reasons for withholding the infants from suckling the initial breastmilk (colostrum) is the fact that certain purifications needed to be done

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before the child can start to suck. While waiting for such traditional initiations to be done, pre-lacteal feeds such as sugar solution, cow milk, honey, local tea, and mustard oil are introduced to the babies to purify their system (Bandyopadhyay, 2009). According to this author, postpartum mothers in West Bengal, India, administer hot water to their babies few hours after delivery as the first feed to probably welcome them.

Among primiparous women of urban slum in Delhi, India for instance, a mother who delivers must wait for her sister-in-law to come and perform breast purification with grass soaked in raw cow's milk before she can commence breastfeeding (Subbiah & Jeganathan, 2012). This ritual, the elders believe is to make the breast milk safe for the infant. The performance of this ritual could take up to between 3 to 7 days to complete depending on the availability of the sister-in-law and the gender of the baby. This delays the initiation of breastfeeding and thus encourages pre-lacteal feeding which defeats the WHO and UNICEF recommendations that babies should be put to the breast immediately they are born (United Nations Children's Fund, 2016; World Health Organization, 2003).

Evidence in the literature also indicates that many lactating women introduce their babies to pre-lacteal feeds especially sugar water, traditional tea and honey because of their belief that the baby may be thirsty and hence needed something to quench the thirst (Subbiah & Jeganathan, 2012; Thu et al., 2012). It is also a belief among some Pakistani mothers that when the mother feeds the infant with pre-lacteal feeds she automatically transfers her innate characteristics to the newborn child (Asim et al., 2014).

Many traditional beliefs and practices favour the introduction of early complementary feeding (complementary feeding before 6 months). A qualitative study conducted among cross-section of lactating mothers at a community health centre in

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western Turkey revealed that when a lactating mother becomes pregnant the taste of her breastmilk changes and so her baby will not suck (Ertem & Ergün, 2013). The respondents also posited that when a mother breastfeed her baby for long it causes the baby's mouth to smell in future (Ertem & Ergün, 2013). Another belief and misconception is that when lactating mothers take medicines like contraceptive injections it affects their babies health (Ertem & Ergün, 2013; Thu et al., 2012). Nursing mothers whose families held the belief that women in that family could not produce adequate amounts of breastmilk to suffice the needs of their infants tend to fall on early complementary feeding without giving optimal breastfeeding a try (Osman et al., 2009). Studies conducted among postpartum mothers in India (Bandyopadhyay, 2009) and Australia (Russell et al., 2016) also revealed the introduction of early complementary feeding. Lactating mothers in Australia mentioned the need to satisfy their babies, reducing allergies in their babies and pressure from mothers-in-law as some of the factors that made them to engage in early complementary feeding.

Breastfeeding women also hold the belief that the evil eye of a menstruating woman can cause the drying up of their milk supply (Asim et al., 2014; Osman et al., 2009). These authors also discovered that breastfeeding mothers believe that when they are experiencing abdominal pains and yet go ahead to breastfeed, they will transmit the abdominal colic to their babies through the breast milk. In addition, the studies uncovered that mothers hold the perception that during the process of breastfeeding and the baby burps the mother could develop breast cancer. Another study by Hernandez and Vasquez (2010) brought to the fore that some mothers in Colombia strongly hold the belief that

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when their breast are directly exposed to the sun or when their breastmilk spills onto the floor and is exposed to the sun directly it can lead to the drying up of their breastmilk.

Furthermore, dietary intake and food restriction practices were found among Chinese, Mexican American and Vietnamese postpartum women (Gill, Reifsnider, Mann, Villarreal, & Tinkle, 2004; Koon, Peng, & Karim, 2005; Lundberg & Ngoc Thu, 2011). These studies discovered that Chinese lactating mothers used certain herbs to prepare their food and drink during their confinement period. The Chinese and Vietnamese breastfeeding women also avoided the consumption of foods considered to be ‘cold’. They were encouraged to drink and eat foods that are regarded as ‘hot’. Vegetables such as bean sprouts, cucumber, cabbage, and watercress among others were considered cold and hence was avoided from their diet. Vegetables such as string beans, mushroom, French beans and carrots were regarded as hot and were eaten by the BF women (Koon et al., 2005). Mexican American BF women on the other hand, were encouraged to drink “Liquado” a special drink prepared from fresh fruits such as bananas or melon with the addition of sugar, milk and eggs. The consumption of these foods was to help enrich their BM for their babies to suck (Gill et al., 2004, p. 46).

Another noticeable indigenous BF practice that was discovered in literature was the confinement of postnatal mothers. Studies among postnatal Chinese and Vietnamese mothers disclosed that when a woman delivers, she is not allowed to go out or do any work at home (domestic chores) for a period ranging from 30 to 90 days (Koon et al., 2005; Lundberg & Ngoc Thu, 2011). The only work this postnatal woman does is to breastfeed her baby. The Vietnamese postpartum women indicated that, the reason for the

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confinement is to avoid being exposed to wind which can cause future sicknesses such as arthritis and rheumatism in the mother.

Parashar, Singh, Kishore, and Patavegar (2015) investigated nursing mothers' knowledge about BF positioning and attachment technique and discovered that majority of the mothers had inadequate knowledge about positioning and attachment and hence were engaging in bad positioning and attachment. This resulted in some mothers experiencing sore and cracked nipples. Midwives, as part of their routine education should include positioning and attachment.

A number of research findings in Africa report about cultural beliefs, misconceptions and perceptions about colostrum (Kimani-Murage et al., 2015; Legesse, Demena, Mesfin, & Haile, 2015; Setegn, Gerbaba, & Belachew, 2011; Victor, Baines, Agho, & Dibley, 2013). For instance, it is a taboo among a section of the people in two urban slums of Nairobi and mothers of Raya Kobo district of north-eastern Ethiopia to feed their infants with colostrum since they believe it could cause wide range of sicknesses (leprosy, eye diseases, abdominal colic etc.). Some also argue that pre-lacteal feeds such as plain water, sugar or salt mixture and gripe water are given to the infants to protect them against abdominal pains (Legesse et al., 2015) and hiccup (Yotebieng, Chalachala, Labbok, & Behets, 2013). Early complementary feeding is believed to be good for baby boys, especially those whose sizes are larger than normal because the women hold the belief that breast milk only cannot meet the baby boys' nutritional demands (Yotebieng, Chalachala, Labbok, & Behets, 2013). These indigenous beliefs affect breastfeeding negatively.

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According to Wanjohi et al. (2017) children who breastfeed for longer period tend to behave foolishly in adult life. Another reason for the introduction of early complementary feeding is to make the children get used to other feeds so that when they are 6 months of age they will not have problems eating other foods. Participants of that study also indicated that when the rate of breastfeeding is reduced, it enables a child who has delayed in walking to rise up and walk. Again, it is an abomination for a lactating mother to have sex with a man who is not the baby's father. If she does, she must stop breastfeeding the baby until she is cleansed else the baby will get bad omen and grow lean and die (Kimani-Murage et al., 2015). It is a taboo to breastfeed in public else a person with 'evil eye' (witchcraft) can curse the mother to make her breast develop sores or the breastmilk to dry up completely (Kimani-Murage et al., 2015; Nchimunya et al., 2015).

Another indigenous belief of the Luo community of Kenya about breastfeeding practices is the fact that women who breastfeed must not quarrel with their husbands or other people. If they do fight, certain rituals must be performed to cleanse them before they resume breastfeeding, if not their babies will be cursed (Kimani-Murage et al., 2015; Wanjohi et al., 2017). Equally obnoxious traditional belief among mothers of Ayete, Nigeria, that militate against optimal breastfeeding practices is the introduction of pre-lacteal feeds and early complementary feeding. The nursing mothers give salt or sugar solution, plain water, herbal teas and honey to quench their babies thirst and to fortify them to grow stronger (Alade, Titiloye, Oshiname, & Arulogun, 2013; Joel, 2013; Sanusi et al., 2016).

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A hospital based study conducted in Libya to evaluate breastfeeding practices such as positioning, attachment and effective suckling uncovered poor positioning and attachment among majority of the mothers (Goyal, Banginwar, Ziyu, & Toweir, 2011). The study discovered that breast conditions such as sore and cracked nipples and mastitis were associated with poor positioning and attachment. Lactating mothers need to be educated on positioning and attachment to avoid developing these conditions during lactation.

In Ghana, a number of traditional and cultural beliefs affect the way a mother engages in breastfeeding. For example, studies conducted in Bolgatanga by Abasimi, Atindanbila, Mwini-Nyaledzigbor, Benneh, and Avane, (2014), Navrongo by Aborigo et al. (2012) and in Talensi by Boatbil, Guure, and Ayoung, (2014) revealed that first time mothers are not permitted to immediately start breastfeeding their babies until their breastmilk is traditionally tasted. It is the study participants belief that when the baby feeds on bitter or bad BM the baby will suffer from stomach pains. He or she will also not thrive well. Boatbil et al. (2014) discovered that bitter or bad BM causes malnutrition. To avoid these issues, the lactating mother BM is expressed into a calabash and black ants put into the milk and when the ants are able to come out of the milk alive then, it is an indication that the milk is wholesome and the baby can go ahead to suckle. If the ants die in the milk, it indicates that the milk is bitter, dirty and toxic for the baby's consumption. Traditional rituals are performed on the mother to purify her breastmilk before the baby is put to breast.

Another study also revealed that mothers who ate pork whiles pregnant, when they deliver they will have to prepare guinea corn flour water and put some pig hair in it

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and drink before their babies are allowed to suck the breastmilk (Abasimi et al., 2014). These same authors revealed in their research that because of fear of aspiration nursing mothers were now sceptical about the practice of 'force feeding'. Force feeding is the practice where liquid (herbal concoctions or flour water) is forced down a baby's throat to drink by blocking the baby's nostrils.

It is also a belief among the Manya and Yilo Krobo people that a lactating mother who becomes pregnant must immediately stop breastfeeding regardless of the gestation age and the age of her baby. The people of Manya and Yilo Krobo believe that the pregnant mother's breastmilk is warm and can cause diarrhoea and subsequently death to the child. It is equally a taboo among people of certain traditional areas in Ghana to allow lactating mothers to express their breastmilk and store for their babies to feed (Mogre, Dery, & Gaa, 2016). The administration of plain water and herbal concoctions to babies by lactating mothers to either cleanse their babies stomachs of dirt (meconium) or treat abdominal colic was also reported (Abasimi et al., 2014; Aborigo et al., 2012).

2.2.3 Opinions of referent others and the motivation of lactating mothers to comply

Though many expectant mothers made their minds to optimally breastfeed their babies when they are born, they tend to yield to pressure coming from referent others to give pre-lacteal feeds and subsequently continue with supplementary feeding. This obviously is against the WHO recommendation for infant and young child feeding (World Health Organization, 2003). Numerous studies have revealed that mothers whose knowledge levels about effective breastfeeding practices were low easily gave in to the practices of harmful indigenous breastfeeding. These mothers embraced the decision to discard the colostrum and to introduce pre-lacteal feeds as suggested by their

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grandmothers or elderly females in the society (Dietrich Leurer & Misskey, 2015; Prates, Schmalfuss, & Lipinski, 2015; Thet, Khaiing, Diamond-smith, Sudhinaraset, & Oo, 2016; Yadavannavar & Patil, 2011). The lactating women respected the views of these grandmothers because they regarded them as women who possessed great wisdom, knowledge and experience in the field of breastfeeding. So, mothers were motivated to comply with the advice the grandmothers gave. Equally worth noting is the fact that the lactating mothers believed in the elders to seek the welfare of their babies. For instance, when the grandmother instructs that water should be given to the infant because of the hot weather the breastfeeding mother who lacks knowledge with regards to the composition of breastmilk will quickly comply. After all, she thinks that the hot weather can cause the baby to get thirsty often.

Again, the influence of mothers and mothers-in-law and perception (self-assumption) of lactating mothers that they could not produce sufficient breastmilk to feed their babies motivated them to embrace indigenous breastfeeding practices (Acharya & Meena, 2016; Brand, Kothari, & Stark, 2011; Glassman, McKearney, Saslaw, & Sirota, 2014; Kent, Gardner, & Geddes, 2016; Robert, Coppieters, Swennen, & Dramaix, 2014). Once the mother feels helpless because milk is not coming for her baby, anything that the elders tell her to do with regards to feeding her baby she will gladly do.

Furthermore, breastfeeding women are hugely influenced by their maternal grandmothers who mostly are the primary caretakers of their babies to indulge in early complementary feeding (Negin, Coffman, Vizintin, & Raynes-Greenow, 2016). These mothers are highly motivated to give their babies breastmilk substitutes believing that the substitutes will satisfy their children hunger, maintain their babies body weights allowing

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them to grow up stronger and healthier devoid of diarrhoeal diseases, vomiting, colic abdomen and allergies (Gallegos, Vicca, & Streiner, 2015; Hernandez & Vasquez, 2010; Nuzrina, Roshita, & Basuki, 2016; Russell et al., 2016). Many lactating mothers fear to disobey the elders when it comes to traditional customs and taboos regarding breastfeeding their infants (Subbiah & Jeganathan, 2012). The mothers feared that disobedience may lead to harm of their babies. However, mothers who were well informed about breastfeeding issues were not motivated to comply with the elders decisions to discard colostrum and introduce pre-lacteal feeds (Ismail, Muda, & Bakar, 2014). These mothers rather listened to the advice and opinions of nurses and doctors to enable them exclusively breastfeed their babies. Supportive, enlightened husbands were also identified as positive enforcers on their wives to optimally breastfeed their babies (Nuzrina, Roshita, & Basuki, 2016; Rempel & Rempel, 2011).

Equally relevant significant others whose ill advice made BF mothers to switch to early supplementary feeding was some health workers (nurses and doctors) (Raffle, Ware, Borchardt, & Strickland, 2011). The authors identified that delay in milk production and or women who undergo caesarean section have their infants introduced to formula feeding by the medical staff. The missing link here is that the medical staff either by commission or omission fail to advice the mothers to quickly switch to breastfeeding when milk production is established and or when the mothers fully regain consciousness.

Also, studies conducted among Vietnamese postnatal mothers by Lundberg and Ngoc Thu (2011) and Myanmar's postnatal mothers by Sein (2013) revealed that certain activities are performed on postpartum mothers to help them expel lochia and to control postpartum haemorrhage. Myanmar's lactating mothers are given traditional medicines

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(nutmeg) to take alongside uterine massage by elderly women to facilitate the flow of lochia and lessen postpartum blood flow. Vietnamese mothers on the other hand, are given ‘hot’ foods like meat and eggs to eat to help expel the lochia, promote recovery, improve the blood and induce lactation. A systematic review conducted by Negin et al. (2016) on the influence of grandmothers on BF rates unveiled that grandmothers influence vary from study to study depending on the level of BF experience they have acquired. This presupposes that grandmothers whose attitudes and experiences were positive about BF will encourage the young ones to breastfeed. However, those who had negative BF experiences will encourage their daughters-in-law to practise mixed feeding.

Opinions of referent others concerning breastfeeding in Africa seems to dominate the individual lactating mother’s choice to feed the young one. Studies conducted across Nigeria indicate that mothers-in-law, family members from both the nuclear and extended family setups and the role of the church play pivotal roles when it comes to how an infant should be fed (Agunbiade & Ogunleye, 2012; Ekanem, Ekanem, Asuquo, & Eyo, 2012; Joel, 2013; Uchenna, 2012). The elders think they know the customs and traditions of their people about breastfeeding and so see it as a duty to guide the lactating mothers through that path. The breastfeeding mothers tend to have faith in the elders since they have gone through the breastfeeding path before and are assumed to know better. The mothers demonstrate their commitment to comply with the decisions of their elderly women by agreeing to introduce traditional teas, water and other breastfeeding substitutes to their babies as instructed. The church is also seen as a strong significant figure in the business of breastfeeding practices. According to Chiejina (2018) and Ekanem et al. (2012) lactating mothers who were Christians, were significantly practising EBF as

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against the other religions. Probably it is because the Christian religion frowns on most obnoxious indigenous practices. These same authors found in their studies that married women were more likely to practice EBF.

In Kenya, spouses of lactating mothers constitute the driving force that propel mothers to follow the numerous social and cultural beliefs about BF (Walingo & Mutuli, 2014; Wanjohi et al., 2017). Stepmothers and mothers-in-law are also influential force that dictate to BF mothers as to what to give to their babies (Yotebieng et al., 2013). They encourage mothers to start feeding their babies with porridge and other baby foods to help satisfy their hunger and allow them to grow healthy. This group think that water should be given to babies to drink alongside the breastmilk since water is essential for life. However, research evidence suggest that BM contains about 87% water (Martin, Ling, & Blackburn, 2016) and so providing water for infants to drink alongside BM may not be necessary.

Contrary to the above findings is the study by Abasimi et al. (2014) where some husbands were found to be the driving force behind their wives success in practising EBF in the Bolgatanga Municipality. Research findings by Aborigo et al. (2012) indicated that referent others (mothers, mothers-in-law and grandmothers) instructed their daughters-in-law and other young lactating mothers to administer early complementary feeds to their babies based on their (referent others) past experiences on BF. These authors also disclosed that herbal concoctions were given to lactating mothers who could not produce enough BM to drink. Some of the herbal water was used to prepare food for the nursing mothers to eat whiles some were used to massage the mother's breast to aid milk production (Aborigo et al., 2012). The stronger the influence of significant others –

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mothers-in-law, husbands, friends and community practices on BF, the greater the likelihood that mothers may comply with indigenous BF practices (Sika-bright & Oduro, 2013). However, weak influence from referent others coupled with high maternal knowledge on the benefits of optimal BF, with appropriate supportive health systems will strengthen the resistance level of mothers to give in to pre-lacteal and early supplementary feeding.

2.2.4 Attitudes and intentions of lactating women towards indigenous breastfeeding practices

Cultural and traditional beliefs and practices have significant influence on lactating mothers' attitudes and intentions to breastfeed (Kuzma, 2013; Nuzrina et al., 2016; Purdy, 2010; Senarath, Dibley, & Agho, 2010). Inadequate breastfeeding knowledge as well as customs and traditions among women sampled in Papua New Guinea greatly influenced their attitudes to indulge in indigenous BF practices. Though these women believed that breastmilk was the best option for their babies, they discarded colostrum and introduced pre-lacteal feeds and supplementary feeding (Kuzma, 2013). Poor knowledge regarding the benefits of EBF was also seen as a major factor that deprived some teenage mothers of USA from executing their intentions of practising EBF (Smith, Coley, Labbok, Cupito, & Nwokah, 2012). Positive BF experience teen mothers were inspirational to their daughters and this greatly affected their attitudes and intentions to BF their babies effectively (Chinnasami, Sundar, Kumar, Sadasivam, & Pasupathy, 2016).

Additionally, maternal knowledge, beliefs and support systems were identified as influential factors affecting BF practices (Jones, Power, Queenan, & Schulkin, 2015;

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Nuzrina et al., 2016). A study conducted among urban mothers in West Jakarta by Nuzrina et al. (2016) revealed that lactating mothers who were abreast with BF information were able to successfully breastfeed their infants. Mothers who perceived to be producing insufficient breast milk, as well as those who had associated smaller maternal breast size to low milk production units, embraced formula feeding. Those who witnessed the bitter experiences of other nursing mothers as well as their own bitter experiences in attempting to breastfeed their babies also embraced early complementary feeding (Nuzrina et al., 2016). Inappropriate breastfeeding information, maternal work, and free distribution of formula feeds at some hospitals in America affected minority African American and Asian American breastfeeding intentions (Jones et al., 2015). That study also uncovered that support systems coming from family members, friends and healthcare workers greatly made a difference in the mothers' decisions to initiate and continue with BF. Those mothers who did not receive support gave in to societal demands and fed their babies with infant formula and other breastmilk substitutes. Mothers who possessed adequate knowledge on the benefits of breastmilk to their babies, and had planned to breastfeed exclusively could not do so because of perceived insufficient milk production, maternal health problems, breast abnormalities and taboos to breastfeed in public (Eftihia, Anna, Dimitra, Vasiliki, & Maria, 2009; Hamade et al., 2014). Few respondents according to these authors had negative attitudes towards optimal BF. Some of these women had bitter experiences in the past regarding breastfeeding. Teen mothers who would not want to have their breasts sag also switch to formula feeding.

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Conversely, mothers with high self-efficacy, strong support from healthcare systems and communities formed solid intentions build on positive attitudes to breastfeed their children exclusively (Al-Akour, Khassawneh, Khader, Ababneh, & Haddad, 2010; MacKean & Spragins, 2012). Grandmothers and partners who acted as enablers to lactating mothers had negative influence on the mothers' breastfeeding intentions and attitudes. Another study conducted among 5 East and Southeast Asian countries (Philippines, Vietnam, Indonesia, Cambodia and Timor-Leste) revealed that working mothers, less educated mothers, mothers from well-to-do households, first time mothers and home delivery were factors that hindered optimal BF (Senarath et al., 2010). The study indicated that these factors were more likely to force a BF mother to abandon her well intention to exclusively breastfeed and to adopt harmful indigenous breastfeeding practices such as discarding colostrum, engaging in pre-lacteal feeds and subsequently supplementary feeding.

Moreover, attitudes and intentions among African breastfeeding mothers towards indigenous BF practices are not quite different. Literature shows that maternal awareness and knowledge about the dietary importance of breastmilk enhance positive attitudes and intentions to EBF (Adugna, 2014; Tadele, Habta, Akmel, & Deges, 2016). According to these authors, though majority of mothers in Mizan Aman town, Southwestern Ethiopia had positive attitudes towards EBF, few mothers possessed the critical ingredient (technical know-how) that was in consonance with the recommendations of WHO concerning BF duration. The authors further revealed that lack of maternal knowledge among BF mothers in Minch Zuria, Southern Ethiopia, was recognised to be responsible for the delay in initiation of BF. This gave rise to the administration of water to infants to

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purportedly clean their stomachs. A study conducted by Onah et al. (2014) in Southeast Nigeria, however, revealed that maternal awareness and knowledge per se do not significantly contribute to the practice of EBF. In that study, over 80% of mothers were aware and had knowledge on EBF. However, only a little over 30% of mothers actually practiced EBF. It is noted in that study that, mothers of high socio-economic status and delivery by Caesarean Section (CS) were factors that favoured supplementary feeding as oppose to EBF. Low maternal education was also discovered to favour early supplementary feeding (Chiejina, 2018; Onah et al., 2014). The Finding that wealthy mothers are associated with low EBF is incongruent with the finding of Ogbo, Agho, and Page (2015) that, mothers of wealthier households exclusively breastfeed their babies. Mothers who introduced their infants to breastmilk as the first feed did practised EBF (Onah et al., 2014).

Equally worth noting is the suggestion by research evidence that positive social and cultural beliefs (breastmilk is good for brain development and infant health) influence mothers intentions and attitudes towards the acceptance of EBF (Wanjohi et al., 2017). Negative cultural beliefs and practices (colostrum is dirty, fear of evil eye and no BF after extra marital affairs) were identified by the authors to favour indigenous breastfeeding practices. Support from spouses and other women, and the presence of EBF mothers in the community (Nchimunya et al., 2015), being housewives, and the availability of postnatal counselling services (Liben et al., 2016) were found to be predictors of EBF.

In Ghana, lack of understanding and poor attitudes towards exclusive breastfeeding among lactating mothers in Bolgatanga Municipality led to inappropriate

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breastfeeding practices (Atindanbila, Mwini-Nyaledzigbor, Abasimi, Benneh, & Avane, 2014). Also, the hot and windy nature of the weather in rural northern Ghana motivated some lactating mothers to administer water to their babies (Aborigo et al., 2012).

2.2.5 Subjective norms about indigenous breastfeeding practices among lactating women.

Notwithstanding having positive attitudes and intentions to breastfeed exclusively, subjective norms are capable of influencing a mother to modify her intentions. Empirical evidence states that one main difficulty of lactating mothers within the first six months is the pressure of conflicting information regarding BF (Campos, Chaoul, Carmona, Higa, & Vale, 2015; Hernandez & Vasquez, 2010; Negin et al., 2016; Thet et al., 2016; Yadavannavar & Patil, 2011; Yotebieng et al., 2013). Family members, neighbours and healthcare workers, through the influence of traditional customs and beliefs associated with BF, give the mother inconsistent information regarding how to optimally breastfeed her baby. Due to the influence of these significant others, some lactating mothers feed their babies with other liquids alongside the BM and yet claim to be practising EBF (Campos et al., 2015).

Also, a study conducted in the Democratic Republic of Congo (DRC) on infant feeding practices disclosed that 75% of healthcare workers sampled instructed nursing mothers who perceived to produce insufficient BM to supplement with formula, porridge or juice (Yotebieng et al., 2013). These conflicting pieces of information put unnecessary pressure on the mother. If the influence of those who believed in mixed feeding is the strongest, then the mother who perceives herself as having no power is likely to comply with them. However, if the mother is well informed about the benefits of EBF and

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perceived to have control she will comply with only those healthcare workers who advise her to feed her baby on only breastmilk.

Furthermore, a study conducted among Marshallese migrants in the USA revealed that breastfeeding in public attracts both verbal and non-verbal shaming (Scott, Shreve, Ayers, & Anna, 2017). This culture of restricting/prohibiting BF in public also affects African women living in Australia (Gallegos et al., 2015). This phenomenon makes the mothers uncomfortable to carry out the practice of breastfeeding their babies on demand. Once these are working mothers, it becomes a challenge to balance BF against their jobs since they could not breastfeed their babies in the open. That study also discovered that some nursing mothers consumed ‘special foods’ during lactation to help them produce sufficient BM. They also introduced their babies to water and other feeds in a bit to conserve their indigenous BF practices (Gallegos et al., 2015). The rigorous advertisements on breastmilk substitutes among Vietnamese society and the belief that pre-lacteal feeding helps to transfer the characteristics of the feeder to the baby in Pakistani culture, push some mothers to develop interest for formula milk and other baby feeds for their babies (Asim et al., 2014; Lundberg & Ngoc Thu, 2012).

Another crucial factor that has been found to coerce women to abandon optimal BF is the work place environment. For instance, Danso (2014) found in her study that professional working mothers face huge challenges with regards to EBF because of the unfavourable working environments they find themselves in. This is supported by Abasimi et al. (2014) in their study among nursing mothers in the Bolgatanga Municipality. In that study, it was revealed that nursing mothers who wanted to effectively breastfeed their babies have to stop working and take care of their babies till

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the grow before they return to work. It is probably time for the parliaments of Ghana and other African countries to take a second look at the duration of paid maternity leave.

Ghana, for instance, could extend paid maternity leave from the current 12 weeks to 6 months to enable nursing mothers exclusively breastfeed their babies.

Additionally, equally worrying subjective norms that work against Human Immunodeficiency Virus (HIV) positive mothers and their babies in Ghana is stigma and poverty. The WHO recommendation for HIV positive mothers is to either practice EBF or engage in exclusive replacement feeding (ERF) using either infant formula or animal milk (World Health Organization, 2010). A systematic review of literature among HIV positive mothers in Sub-Saharan Africa revealed that because of poverty, social pressure and local norms, many HIV positive mothers give in to the pressure of family members to practice mix feeding contrary to the WHO recommendation (Laar & Govender, 2013). Another study by Laar and Govender (2011) also revealed that fear of stigma is what pushes nursing mothers living with HIV/AIDS to engage in mixed feeding since the women do not want their family members to know of their HIV positive status.

According to Aborigo et al. (2012) when infants are having challenges in feeding household heads consult soothsayers to find out the cause and to make the necessary sacrifices to appease their ancestors. The indigenes believe that their ancestors have enormous power and can resolve any challenge they face. That is why they will prefer dealing with their ancestors first before any other thing.

2.3 Summary of Literature Review

Optimal breastfeeding is considered the most ideal way of feeding infants and young children. Colostrum, the first component of breast milk is known to be endowed

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with nutrients necessary for infant growth and welfare. This component (colostrum) is regrettably not given to babies in some traditional settings with the belief that it is harmful to infant health. Because of this, pre-lacteal feeds are given to the babies until such a time that the babies are permitted to breastfeed. In other traditional settings, indigenous breastfeeding practices such as the purification of the lactating mother's breast is done before the newborn is allowed to commence sucking.

It is observed that opinions of referent others play a major role in determining how mothers breastfeed their babies. For fear of losing their babies, mothers willingly agree to practice the prescribed indigenous breastfeeding as instructed by the elders of the community. Lactating mothers' attitudes and intentions to breastfeed are dictated by cultural and traditional beliefs regarding breastfeeding. Low knowledge level of lactating mothers about optimal breastfeeding was also identified to be responsible for the practices of indigenous breastfeeding. Mothers whose knowledge levels concerning breastfeeding was high could resist to indulge in abhorrent indigenous breastfeeding.

Inconsistent information and societal pressure on lactating mothers pushed some mothers to practice suboptimal breastfeeding. Some working mothers could not practice EBF due to short maternity leave period and also unfriendly working environment. Stigma on the part of mothers living with HIV and poverty were also identified to influence how a lactating mother feeds her baby.

Furthermore, there is a plethora of literature on BF using quantitative research approaches, however very few studies were found that explained the phenomena of IBF practices typically in the Ghanaian context.

CHAPTER THREE

METHODOLOGY

This chapter presents the steps that were followed to conduct the study. Details on the research design, study setting, target population, inclusion and exclusion criteria, sampling technique, data generation tool, data collection procedure, data management and analysis, methodological rigor and ethical consideration are presented.

3.1 Study Design

A research design is the overall plan for addressing a research question. It includes strategies for enhancing the study's integrity (Polit & Beck, 2010). This research was an exploratory descriptive qualitative study involving lactating women in the Builsa north district. This design was appropriate for the study because it offers the participants the opportunity to express themselves in an open manner as compared to closed-ended questions used in quantitative methods.

3.2 Research Setting

Builsa North District Assembly is one of the thirteen (13) Municipal and District Assemblies in the Upper East Region of Ghana. It lies between longitudes $1^{\circ} 05'$ West and $1^{\circ} 35'$ West and latitudes $10^{\circ} 20'$ North and $10^{\circ} 50'$ North. It is bounded to the North and East by the Kassena Nankana West District and Kassena Nankana East Municipal Assemblies respectively. The West and South on the other hand share boundaries with Sissala East and Builsa South District Assemblies respectively. The Builsa North District covers an estimated land area of 816.44030 km^2 and constitutes about 12.1% of the total land area of the Upper East Region. The total population of the Builsa North District according to the 2010 population and housing census was 56,477 consisting 27,792 males

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and 28,685 females (Ghana Statistical Service, 2014). For the purpose of health services, the district is divided into six sub-districts namely Sandema West, Sandema East, Wiaga, Chuchuliga, Siniensi and Kadema. The district can boast of 3 Health centres, 21 functional Community-based Health Planning and Services (CHPS) zones and one district hospital. The district hospital serves as the only referral centre for all the health centres and CHPS compounds. The hospital also caters for referrals from the Builsa south district.

The Builsa north district is located in the Guinea Savannah zone of northern Ghana. It has two main seasons - dry and wet seasons. The dry season is longer than the wet season and is characterised by severe harmattan (dry, cold and dusty winds) which commences around December and ends in February. The other half of the dry season is made up of very high temperatures starting from February to somewhere in May. Temperatures of the area could rise to as high as 42 degrees Celsius during the period with negative consequences. The wet season spans from somewhere in May and ends in September and is sometimes very erratic in nature (Azongo, Awine, Wak, Binka, & Oduro, 2012; Issaka, Buri, Tobita, Nakamura, & Owusu-Adjei, 2012). This affects food security since the inhabitants of the area are predominantly peasant farmers.

3.3 Target Population

The population from which participants were selected are lactating mothers from Siniensi sub-district. This sub-district was selected because it is one of the remote areas of the Builsa North District Assembly with very hard to reach areas making it difficult for the community members to access health care.

3.4 Inclusion Criteria

The inclusion criteria in this study were BF mothers of 18 years and above with babies aged 6 months and below who have been living in the Siniensi community for the past 2 years or more and were willing to participate in the study.

3.5 Exclusion Criteria

Lactating mothers who were residing in the Siniensi community but were not willing to participate as well as those who had some form of impaired cognition were excluded from the study. This was because they could not have provided the needed information for the study.

3.6 Sampling Technique and Sample Size

A purposive sampling technique was utilized to obtain a wide-range of views from fifteen (15) participants. The aim of purposive sampling was to enable the researcher to recruit informants who had the information needed. A good informant is one who is knowledgeable and experienced about the phenomenon under study. He or she has the ability to reflect, is available, has time to be interviewed and is willing to participate in the study (Creswell & Plano Clark, 2011; Etikan, Musa, & Alkassim, 2016; Palinkas et al., 2015)

Purposive sampling was employed for the study because it afforded the researcher the opportunity to include participants with the required experience that helped to generate rich qualitative data on the issue under exploration. The midwife of the postnatal unit of Siniensi health centre was contacted and she provided the lists and addresses of lactating mothers in the sub-district. The researcher then used this information to go round the various houses to recruit and subsequently interviewed participants who had

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babies less than 6 months of age and gave their consent to participate in the study. In all, 15 lactating mothers were recruited and interviewed. The researcher stopped interviewing at the 15th participant because he was not getting any new or additional information. In other words, the data was saturated (Fusch & Ness, 2015; O'Reilly & Parker, 2013).

3.7 Data Generation Tool

The main research instrument was a semi structured interview guide (see appendix C). Open ended questions were developed based on the constructs of the theory used and the objectives of the study. The interview guide consisted of 2 sections. Section A comprised of demographic data while the section B contained the main questions on indigenous breastfeeding practices. The interview guide was pre-tested at the Sandema district hospital and all ambiguities clarified. The results of the pre-testing were not added to the main study findings.

3.8 Data Collection Procedure

The proposal for this study was reviewed and approved by the Institutional Review Board (IRB) of Noguchi Memorial Institute for medical research (NMIMR) at the University of Ghana (see appendix A). An introductory letter from the School of Nursing and Midwifery was obtained (see appendix B) and sent to the District Director of Health Services, Sandema to obtain permission to collect the data. The researcher attended three (3) of the CWC sessions and was introduced to the lactating mothers by the Head of the Postnatal Service Unit. Mothers were approached and those who satisfied the study criteria were given information sheets to read. Those who could not read the information sheets, the purpose of the study was explained to them in their own language by the researcher. Contact numbers/house addresses were collected from participations

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who were willing to take part in the study. This information was used to crosscheck the information given by the Head of the postnatal unit to ensure that the correct addresses were obtained to make the follow up very easy. All the lactating women contacted decided to have the interviews done at the comfort of their homes. The researcher then made phone calls to those lactating mothers who had mobile phones to schedule the date and time for the interviews. Those who did not have mobile phones were also visited by the researcher to plan the date and time for the interviews. Participants who consented to be part of the study were given informed consent forms to sign. Those who could not sign were assisted to thumb print before they were interviewed. Before the interviews were conducted, permission was sought to enable the researcher tape record the interviews and take field notes. All Interviews were done in Buli language and lasted between 45minutes to 55minutes.

3.9 Data Management and Analysis

Data were transcribed verbatim to English by the researcher himself. Headphone was used to listen to the audios during the transcription process thereby preventing people around from listening to the audios. The electronic version of the transcript of each interview and the audios were stored in an identifiable folder on the researcher's laptop and a security code provided to make them inaccessible to any other person except the researcher and his supervisors. Participants of the study were identified by pseudonyms to help protect their identity. The consent form, field notes, the printed transcripts together with the tape recorder that was used for the data collection were kept in a drawer under lock and key in the researcher's home. The data will be kept for a period of 5 years and thereafter, destroyed.

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Data was analysed using thematic content analysis (Anderson, 2007). At the end of each day of interview, the researcher transcribed the recorded interview verbatim into a personal computer taking into account the field notes. To ensure accuracy of the transcripts, the researcher compared the transcripts with the audio recordings and missing links filled. The transcripts were then printed out for the supervisors to read and make inputs.

The actual analysis was done by carefully reading and re-reading through the transcripts to identify the common statements or concepts which were differentiated by assigning codes to them. These codes were sorted into sub-themes based on their similarities. Sub-themes with similar meanings were also grouped into themes. The themes were then revised repeatedly until it was suitable to present the findings according to the objectives of the study.

3.10 Methodological Rigor

Methodological rigor in qualitative research examines the extent to which findings of the study truly represent the perspective of the participants (Grove, Gray, & Burns, 2015). To enhance trustworthiness of a study, Lincoln and Guba (1985) provided 4 sets of criteria that can be used for that purpose. These include; credibility, dependability, confirmability and transferability.

Credibility: This involves the confidence in the truth of the research findings (Lincoln & Guba, 1985; Murphy & Yelder, 2010). To achieve credibility in this study, the researcher made sure he recruited participants who met the inclusion criteria. The credibility of the research was also maintained by pre-testing the interview guide which helped to modify some of the questions. Prior to conducting the interviews, the researcher

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had met the participants on two occasions to familiarize himself with them. This made the participants to feel relaxed during the day of the interview. The interview was a face-to-face encounter which enabled the researcher to do more probing and this yielded more in-depth information. Data was audio-taped and transcribed verbatim noting the tone of voice of participants. To further ensure that the study was credible, member checking was done by tracing the participants to confirm the accuracy of transcribed data and emerging themes. Finally, debriefing sessions were held with supervisors to ensure that the questioning style and interviewing skills were appropriate.

Dependability: This deals with the constancy of findings over time and over conditions (Polit & Beck, 2010). It also looks at how similar findings could be obtained when a different researcher outside the data collection and data analysis team conducts an inquiry audit of the procedures used to arrive at the findings. Dependability requires that the research process is sound, traceable and clearly documented in terms of the decisions made by the researcher (Shenton, 2004). To ensure this, the method used for data collection, analysis and interpretation were captured in the report. Also, the findings of this research were given to breastfeeding experts to peer review.

Confirmability: This refers to the extent to which other researchers can confirm that the findings of the study indeed reflected the participants' voice and not the researcher's own biases or perspectives (Polit & Beck, 2010). To ensure this, the researcher kept an audit trail comprising of field notes, audio recordings, analysis notes and coding details. A personal journal was also kept and all motivations, preferences and assumptions which were likely to influence the research process were documented.

Transferability: This refers to the ability to transfer the findings of one study to other setting with similar group of participants (Petty, Thomson, & Stew, 2012).

Transferability was ensured through thick description of the entire process of the investigation (Anney, 2014). To ensure this, the researcher gave a clear description of the procedure for selection of participants, a detailed description of the setting and the processes observed during the entire study.

3.11 Ethical Considerations

The researcher sought ethical approval from the Institutional Review Board (IRB) of Noguchi Memorial Institute for Medical Research of the University of Ghana before carrying out the study. A copy of the approval letter and an introductory letter from the School of Nursing and Midwifery were sent to the District Director of Health Services, Sandema to obtain permission before mothers were recruited for the study. Ethical principles of research involving human participants such as anonymity, respect for human dignity, beneficence and justice (Polit & Beck, 2010) were adhered to.

Anonymity: Anonymity of the mothers was maintained by excluding identifiable personal information from the interview. Pseudonyms were assigned to the participants to help protect their identity. Participants' information was stored in the researcher's personal computer and a password used to prevent access by any other person. Privacy was maintained by carrying out the interviews in the participants' home. The researcher explained to the lactating mothers that they could stop the interview anytime they felt their privacy was being invaded.

Respect for Human Dignity: Before the participants were recruited, each of them was given a consent form which also contained the general information on the study to read

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(see appendix D). Those who could not read, the general information was read and explained to them in their own language by the researcher. Participants were informed that participation was voluntary and that they have the right to withdraw from the study at any time they so wish. Those recruited were given voluntary agreement forms to sign or thumb print before interviews were conducted. The consent the participants gave also covered permission for audio recording, transcribing, note taking and finally reporting of the participants' descriptions. The participants were allowed to schedule the dates, time and to choose the venue for the interviews.

Beneficence: Participants were informed that there were no direct benefits to them by participating in the study but the findings will inform nurses and midwives about how to package their education about EBF.

Justice: Selection of participants was strictly based on the inclusion and exclusion criteria. All participants were treated equally regardless of age, religion and educational status. Participants were not coerced to talk on issues they did not want to.

CHAPTER FOUR

RESULTS/FINDINGS

This chapter presents the findings of the study. The findings are presented according to the objectives of the study and the themes generated. The characteristics of the participants are presented first.

4.1 Demographic Characteristics

The ages of the women ranged between 18 and 38 years. All participants were married and had children ranging from 1 to 7. Fourteen (14) of the participants practised the Christian religion with one (1) being a traditionalist. Four (4) of the participants had no formal education whilst five of them had primary school education. Two (2) dropped out of Junior High School (JHS) form one whilst three (3) managed to complete their JHS education. Out of the 15 participants, only one (1) was able to complete her Senior High School (SHS) education making her the participant with the highest educational qualification. On their occupational status, 8 participants were peasant farmers whilst one (1) of them was a house wife. Two (2) were petty traders whilst one (1) of them was a hairdresser. Two (2) participants were seamstresses and the last one (1) was a pupil teacher. All the participants were Builsas by tribe. See appendix E, page 136 for demographic data.

4.2 Organization of Themes

The themes of this study were organized based on the objectives of the study and the constructs of the Theory of Reason Action (TRA). In all seven (7) main themes were identified from the data. Six (6) of them were consistent with the TRA whilst one major

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theme was not consistent with the TRA. The table below shows the major themes with their corresponding sub-themes.

Table 4.1: Depicts the major themes and sub-themes

Major Themes	Sub-Themes	Codes
1. Beliefs about IBF practices	<ul style="list-style-type: none"> a) Beliefs before the initiation of BF <ul style="list-style-type: none"> - Beliefs about bitterness of BM (cleansing/purification) - Identifying good or bitter BM (dripping of BM during pregnancy & testing of first time mothers' BM) - Welcoming babies with water - Expressing colostrum out (considered "dirty") b) Beliefs during BF <ul style="list-style-type: none"> - Herbal concoctions to mother to boost BM production - Herbal concoctions to baby to treat abdominal pains/cleansing of the stomach - Nutritional beliefs about BF - Initiation of food/water to baby before 6 months - Beliefs about positioning during BF - Confinement of mother and baby c) Beliefs about experts' advice <ul style="list-style-type: none"> - Because babies faint during force feeding nurses say no more force feeding - Lack of potable water 	BELI
2. Opinions of referent others	<ul style="list-style-type: none"> a) Maintaining maternal health after delivery <ul style="list-style-type: none"> - Drinking hot water to clear lochia - 'Pomsika' (blowing ritual) b) Maintaining baby's health during BF <ul style="list-style-type: none"> - Stomach pain after BF; herbs water - Dry throat; water to 'cool' it c) Comparing BM to cow's milk d) Spousal opinions about referent others e) Opinions about BM f) Benefits of past experience 	ORO

Source: Transcribed data, 2018

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Table 4.1: Depicts the major themes and sub-themes

Major Themes	Sub-Themes	Codes
3. Motivation to comply	a) Intrinsic factors <ul style="list-style-type: none"> - Happiness - Peace of mind - Joy - Good health b) Extrinsic factors <ul style="list-style-type: none"> - Space to work/time to rest - Increase in baby body weight - Learning from other people experience - Past experience - Windy weather 	MOTI
4. Attitude of lactating women about IBF practices	a) Positive evaluation <ul style="list-style-type: none"> - Giving baby water is good - Some herbs good for BM production - Giving porridge to babies less than 6months is good - Passing on the practice to next generation b) Negative evaluation <ul style="list-style-type: none"> - Force feeding can cause aspiration c) Borderline evaluation <ul style="list-style-type: none"> - positive - bottle feeding, negative – force feeding - positive - mother and baby bonding through frequent BF, negative - heat and restriction of movement (confinement) 	ATTIT

Source: Transcribed data, 2018

Table 4.1: Depicts the major themes and sub-themes

Major Themes	Sub-Themes	Codes
5. Subjective norms about IBF practices	a) Spirituality <ul style="list-style-type: none"> - consulting soothsayers - Appeasing the gods. - Force feeding to help choose a successor for the family gods - Initiation of babies to family gods for protection b) Control over infant feeding choices c) Food taboos d) Societal pressure e) Conflicting information	SUBJN
6. Intention of lactating women about IBF practices	a) Healthcare workers influence on intention to BF b) Intentions Influenced by own experience and the elders' coaching c) Intention to give water to the child d) Intention to drink guinea corn flour water e) Intention to obey the family gods	INTENT
7. Knowledge deficit about EBF practices	Ineffective breastfeeding education by nurses	KD

Source: Transcribed data, 2018

4.3 Beliefs about Indigenous Breastfeeding (IBF) Practices

The first major theme identified in this study was lactating mothers' beliefs about IBF practices. Majority of the lactating women enumerated a lot of beliefs they hold and practice when it comes to breastfeeding (BF) a child. Their beliefs were categorised into beliefs before the initiation of BF, beliefs during BF and beliefs about experts' advice on BF.

4.3.1 Beliefs before the initiation of breastfeeding

Almost all the lactating women had some form of beliefs when it comes to breastfeeding their children. They held the belief that there are some women when they deliver, their breastmilk (BM) taste bitter and this “bitter BM” is not good for the baby to suckle, it must be purified or cleansed before allowing the baby to commence sucking else if the baby should suckle the bitter BM the baby will die. The women indicated that as part of the purification process certain potent herbs are used. Some of them even indicated that under no circumstances should a lactating mother assist her colleague lactating woman at either the bore-hole or well site to carry her water without asking to know whether that woman had the condition of “bitterness of the BM”. Three of the participants had this to say:

“When you deliver and your breastmilk is bitter and your child sucks it, you will lose your child’s life unless the elders have performed the purification rites on the BM”. (Adoma)

Yaa stated that they use herbs to perform the purification rites.

“If your BM is bitter, we have some herbs in the bush that they will normally go and get them and when they bring them to you, you will boil them and use part of the herbal water to prepare groundnut soup to drink. The remaining water will be used by an elderly woman in the house to wash your breast morning and evening for 3 to 4 days depending on the sex of the child. Whiles they are washing your breast, you too will be drinking the soup and this will purify the bitterness and when your child sucks the breastmilk it will not worry your baby” (Yaa).

Ama on the other hand indicated that a lactating mother who has experienced the issue of “bitter BM” is not supposed to assist her colleague lactating mother to carry her water.

“just as I have this my baby, any woman whose breastmilk is bitter and they have even performed the purification rites on her breast, when I meet such a woman at the bore-hole or at the well and I assist her to carry her water I will also get it and they will have to also get me the traditional medicine to purify my breast before my child can resume sucking” (Ama).

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Some of the lactating women also stated that during pregnancy it is their duty to observe their breast to help them identify whether their BM will be “good” or “bitter” for their babies to feed on when they deliver.

“Some children are there when you are pregnant with them and getting to term your BM will be leaking into your shirts. Emm, when it is leaking like that, it’s an indication that your BM is not good, it is bitter. And so when you deliver they will bring the herbalist to come and treat the BM before your baby start to suck” (Sika).

Furthermore, to identify “good” or “bitter” breastmilk, a number of the participants who delivered for the first time at home stated that their BM was traditionally tested before their babies were allowed to commence feeding on the breast. According to them, the elderly women made them to express their BM into a small calabash and they caught some black ants numbering 3 to 4 depending on the sex of the baby into the expressed BM. When the ants are able to move out of the BM, it is an indication that the BM was good and suitable for the baby to start sucking. If some of the ants should die inside the BM, it’s a sign that the BM is bitter and so must be purified before the baby can start to feed on it. Some of the participants had this to share:

“When you deliver for the first time, the elders will want to find out whether your BM is good for the baby to feed on. When I delivered I expressed my BM into the calabash they use to bath the baby and they put 4 black ants into the BM because my baby is a girl. They say when all the ants are able to move out of the BM it is an indication that my BM is good. But if one ant should die inside the BM then my BM is bad and so they will have to purify it before my baby will be allowed to suck the BM” (Akos).

Ama also disclosed that her BM was traditionally tested before her baby was put to the breast.

“When I gave birth the first time, the elders said they have to test my BM to see whether it was good for my baby to suck or not. So I expressed my breastmilk and they caught some black ants and put them into the milk. They said when the ants

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are able to swim out it is an indication that the breastmilk is good but if the ants should die inside the breastmilk, then the breastmilk is not good. In my case, all the ants were able to swim out of the BM alive” (Ama).

Another participant indicated that they welcome their newborns with water.

“Any newborn in this house is considered a visitor and must be welcomed with water. When I gave birth to this child the first thing we gave to her was water to drink. It was after that I introduced her to the BM” (Sika).

Colostrum was one of the substances the breastfeeding mothers had issues about. Some of the lactating women held the belief that colostrum is not good. They said that it is dirty milk and so not good for the baby to feed on. They then resorted to expressing it out anytime they give birth. Some participants have this to say about colostrum:

“...to me, that milk (colostrum) is not good, it’s dirty. When you deliver they will go and bring someone to come and squeeze that milk out using some herbs. Whiles that process is going on, the baby will be fed with cow’s milk until the breast purification process is over. When that milk is out, the milk that will now flow is clean” (Sika).

Were as Sika BM (colostrum) was squeezed out, Yaa on the other hand had to perform a ritual called “biisum nyuka” (milk drinking) which made her run diarrhoea to bring out the dirty BM.

“That milk, hmm, I didn’t allow my baby to feed on it. It’s dirty. When I delivered, I went and performed a ritual called biisum nyuka (milk drinking). It made me to run diarrhoea to bring out all the dirty milk. When all the dirt was out, I then started to feed my child on the good milk” (Yaa)

4.3.2 Beliefs during breastfeeding

Beliefs during breastfeeding was another sub-theme identified under beliefs about IBF practices. Participants held the notion that once a lactating mother was breastfeeding her baby, there are certain things that she needs to consider. Some of the beliefs the women expressed has to do with what they themselves can eat to boost quality BM

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production, what they can feed their babies with alongside the BM and positions to assume when breastfeeding their babies. In order to stimulate the production of quality BM for her baby to suck a participant has this to say:

“...now I use the herbs water to prepare the guinea corn flour water to drink. When I drink that flour water you will see that my breast will expand. Quality BM will quickly be produced and fill the breast and you will see that it is really true. And when my child sucks my breast he gets full and can sleep well” (Adjoa).

Another participant who believed so much in the potency of the herbs to aid her produce quality BM for her baby needs has this to say:

“There are some particular trees that we go to cut their barks and when you grind them and cook, it looks like BM. When you use it to prepare soup and eat it aids the production of quality breastmilk. When I gave birth, I asked my husband to get me those herbs which I was preparing and eating and because of that I was able to produce a lot of quality BM for my baby to suck” (Yaa).

The lactating women believed that when their babies are afflicted with abdominal pains and they administer certain herbal concoctions to them it will help to resolve those pains. It was a general belief by the majority of the participants that when babies are born they will need to take in some herbal preparations to help prevent abdominal pains and also aid in the loosening of their intestines thereby allowing the evacuation of dirt in their tummies. Two of the participants have this to say:

“...giving the herbal water to my baby is good. It helps to protect my baby from getting stomach pains. It also aids the baby’s intestines to loosen to allow the dirt in her stomach to be washed out thereby making the baby to be healthy” (Serwaah).

“When my child was always stretching herself and crying, my sister-in-law said it was the baby’s intestines that were loosening that is why she was doing that. I then went and bought some herbs known as elephant’s intestines from the market which I boiled and was giving to the child to drink to help loosen her intestines so that all the dirt in her stomach could come out” (Adjoa).

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Nutritional beliefs about BF were also articulated by some of the breastfeeding mothers. Some of them stated that when they use “asuwaka” (bitter leaves) to prepare soup and eat, it helps to clean their BM of any impurities. Their belief is anchored on the bitter nature of the bitter leaves. According to them, the bitter leaves has the properties to clean any unwholesome BM thereby making it wholesome for their babies to suckle. They again stated that eating the bitter leaves helps them to produce adequate BM for their babies to feed on. This is what one woman has to say:

“When I eat bitter leaves it makes my BM fine. If there are any impurities in your BM the bitter leaves will help to clean the dirt out. Because of its bitterness, it has that property of cleansing so it cleans the BM of any dirt. This makes the BM to be clean and also to flow plenty for the child to suck” (Adoma).

Majority of the participants also belief in early initiation of water and food to their babies. They indicated that waiting for a child to reach 6 months as the nurses have been telling them before he or she is introduced to water and food is not a good thing. This is what Adjoa has to say:

“I have seen someone’s child who they didn’t give water to him to drink when he was born until 6 months. The child grew so fast, very well but anytime the child has fever he drinks a lot of water. He drinks almost every second and I think that is a worry. Seeing this, why won’t I give water to my baby to start drinking early?” (Adjoa)

Another lactating mother described her ordeal with her baby when the baby was barely two weeks old. She resorted to gripe water and it worked like magic for her.

“When I delivered my baby, within a week or so she started crying and stretching herself because her stomach was paining her and I was always struggling with her during the night, so I obtained permission from my husband and my mother-in-law to buy gripe water for her. They agreed and I bought the gripe water for her and the stomach pains stopped. Had it not been the gripe water I don’t know what would’ve happened to my baby by now” (Serwaah).

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Abena too has this to say about initiating early feeds to her baby as against what the community health nurses have been teaching her:

“The community health nurses say we should wait for the child to reach 6 months before we introduce her to water and food. But I think you shouldn’t wait till 6 months before you give the child food. You can start giving the baby light porridge when she is around 3 months so that by the time she will be 6 months she can now eat fine” (Abena).

A participant also indicated that they have a belief in their house that unless a child is able to reach out for a cup or a bowl and sends it to the mouth that child will never be given water to drink nor food to eat regardless of the age of the child.

“...if your child is even 2yrs and yet has not reached out for a bowl or a cup to send to her mouth she will not drink anything nor eat anything. You will have to continue to feed her with only the BM. But if you think that they are lying and you want to test the system and see, you may end up losing your child” (Ampoma).

Some of the beliefs expressed by the participants have to do with positioning of babies during breastfeeding. The participants held the belief that if you are fond of laying down for your baby to suck your breastmilk and some BM flows into the baby’s ears it can cause some sickness.

“When you always lay down to breastfeed your baby and your BM flows into your baby’s ears it will cause sore in your baby’s ear and water will be coming out of it. You can see even children who are grown are having this sickness. When you see them, you will notice that dirty smelly water is always coming out of their ears and this is because their mothers didn’t know and were always laying down for their children to suck” (Adjoa).

Another belief that was expressed by all the participants is the confinement of newly delivered baby and the mother. The mothers noted that as part of their tradition, when a woman delivers depending on the sex of the baby she will be made to remain indoors for 3 to 4 days. During this period, she does not do anything. Even to come out of the room is a taboo for her. If she decides to come out before the necessary rites are performed and

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she meets any of those who perform that rite, she may either suffer severe headache or die.

“Agreeing to remain indoors for the required number of days will help you to avoid breaking the taboo and hence saving yourself from either getting that severe headache or dying. ...but once you are indoors with your baby all the time she too will be sucking all the time. This may help the baby to grow fast. The baby will get to know you early” (Akua).

4.3.3 Beliefs about experts’ advice.

The last sub-theme identified under beliefs about IBF practices was the belief of participants about experts (nurses and midwives) advice. Some of the participants believed that because some babies do faint during “tugilika” (force feeding) with the herbal water that is why the nurses are discouraging its practice and rather advocating for EBF.

“When our mothers force our children to drink herbs water through tugilika (force feeding), there are times that they will force feed the baby and the baby will faint. The force feeding of the child with the herbal concoctions also makes the baby’s tummy to protrude. That is what I think is the reason why the nurses say we shouldn’t give water to our babies to drink until they are 6 months” (Akos).

Other participants are of the view that because most of them do not have potable drinking water at their homes the nurses do not want them to give unclean water to their babies to drink so that the babies will not fall sick. Other than that, there is no reason why water should not be given to a baby to drink.

“The reason why I think the nurses are saying that we shouldn’t give water to our children when we deliver is that some people have no clean water at their homes to give to their children. So to prevent our babies from getting sick because of unclean drinking water the nurses say we shouldn’t give them water before 6 months. That is what I think, and that is why I give voltic mineral water to my baby to drink” (Adjoa)

4.4 Opinions of Referent Others

Referent others such as mother and fathers-in-law, mothers, husbands, sisters and sisters-in-law, peers and other older women living within the community play pivotal roles when it comes to breastfeeding the young ones. They are more or less the ones who determine how a lactating mother should breastfeed her baby. This group of people (referent others) make sure they hand down the traditions of the community and their individual experiences about BF to any newly delivered woman they encounter. Most at times they impose their likes about BF on the innocent young mothers. Mothers who do not want to hurt the feelings of these people are compelled to succumb to do whatever they demand should be done. Several sub-themes emerged from this major theme. Some of them are; maintaining maternal health after delivery, maintaining baby's health during BF, comparing BM to cow's milk and spousal opinions about referent others among others.

4.4.1 Maintaining maternal health after delivery

Referent others place high premium on lactating mothers' health. They believe that a healthy mother will ensure a healthy baby. For this reason, the moment the woman delivers, the elders will heat water for her to drink. The elders will encourage her to continue to drink hot water to aid her have all the lochia flow out. The referent others believe that if the newly delivered mother does not drink enough hot water her lochia will be retained and this can make her abdomen to remain big as if she is still pregnant thereby jeopardising her health. Two of the participants had this to say:

“When I gave birth to my baby, the old women in my house told me to be drinking hot water all the time so that the retained fluid (lochia) in my stomach could melt and come out. They said if I don't drink the hot water and the fluid doesn't flow

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out, my stomach will still remain big as if I'm pregnant and it will affect my health and I may not be able to breastfeed my baby properly. That was why I have to drink the hot water for about a month” (Abena).

“They always say that when you deliver and drink the hot water, all the bad water (lochia) in your stomach will melt and come out so that you will not become a sick person. You need to be strong to enable you breastfeed your baby. Which was why when I delivered my baby I was drinking the hot water all the time” (Akos).

Referent others are also of the opinion that every newly delivered mother should not make attempt to go out until the traditional rite called “pomsika” (blowing) is performed. “Pomsika” (blowing) is an initiation rite performed to welcome a newborn baby into the family lineage. According to them, if this rite is not performed and the mother goes out to meet the person who does it, the mother may die. Akua has this to say:

“The elderly people in our house told me that if they have not yet performed the pomsika and yet I go out to meet the person who does it, it will affect my health. Hmm! They even said I may die. This is the reason why when I gave birth I stayed indoors for the 3 days without coming out” (Akua).

4.4.2 Maintaining baby's health during breastfeeding

As the elderly women are working around the clock to ensure that lactating mothers' health is intact, they equally give same attention to the babies. They believe that some babies after sucking the BM usually have abdominal pains and to curb that they give some herbal concoctions to the babies to drink.

“The old women said that when they give my baby the herbal concoctions to drink it helps. That is what they said. They said if the child finish sucking the BM and his stomach is paining him and they give him those herbs it will stop the pains so that he can be free to continue to suck the BM well, well” (Asantewaa).

Another opinion of the referent others has to do with babies' throats getting dry after continuous crying. The elders stated that when a baby cries for some time his throat gets dry and so water must be given to 'cool' the throat.

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“Our mothers said when the child cries like that her throat gets dry and so they have to give her water to “cool” the throat. That is the reason why they have been giving my child the herbal water morning and evening to drink” (Abena).

4.4.3 Comparing breastmilk to cow’s milk

Some of the participants indicated that their mothers and mothers-in-law compare human BM to that of cow’s milk. To them, a lactating mother’s BM is just like cow’s milk and since a cow’s milk causes frequent thirst same applies to human milk. They are therefore advised to always give water to their children to drink after they have breastfed them. This is what Adjoa was told by her mother-in-law:

“My mother-in-law told me that my breastmilk is just like cow’s milk and since cow milk can cause thirst after eating it so it is with my BM. She then told me to always give my child water to drink after I have breastfed her. I noticed that anytime my child is crying and I offer her the BM and she refuses to suck and yet still crying, when I give her water to drink she will stop crying. This made me believe that it is true that the BM causes the child to feel thirsty and will need to drink water after sucking” (Adjoa).

Another participant also has this to say:

“When I delivered my baby, my mother told me that the BM that the child is sucking is like cow’s milk. She said that when you eat cow’s milk you will be feeling thirsty frequently. For this reason, the child will need to be given water to drink from time to time” (Ama).

4.4.4 Spousal opinions about referent others

Some husbands expressed their unbelief in some of the IBF practices. Those husbands think that some of the beliefs and practices are not beneficial enough to warrant practicing. They therefore will always discourage their wives from engaging in them.

This is what Afia has to say about her husband:

“Anytime my mother brings home some herbs for me to boil and feed my baby with them and I inform my husband, he will tell me not to do it because the herbs are not good for the baby and that those their beliefs are not true” (Afia).

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Adoma also has this to say about her husband:

“My husband doesn’t believe in those IBF things. He will always tell me not to do them. He says they are not true and so not necessary to do them. He will usually ask, how can something enter into a woman’s breastmilk and make it bad for the baby? These are ancient practises which he doesn’t think it is necessary to practise” (Adoma).

4.4.5 Opinion about breastmilk

A number of participants also reported that their mothers-in-law and sometimes their grandmas have been telling them about bad BM. According to the referent others, there are some women when they give birth, their breastmilk is not good for their babies to suck unless something is done about it before. Mothers who ignore the warnings of their elders and go ahead to breastfeed their babies with that bad BM are risking their babies’ lives. Those babies who feed on the bad BM find it difficult to thrive well. Two of the participants have this to share:

“The old women in my house have been saying that when a woman BM is not good and the child sucks it, the child will run diarrhoea and will look miserable. They also said that sometimes you can see some things coming out of the breast like pus and they will have to express them out. During pregnancy, your breastmilk may be flowing out on its own too. All these things they say are indications that your BM is not good” (Afrakomaa)

Ama indicated that her mother-in-law told her that a woman with bad BM cannot breastfeed her baby to get full unless her breast is purified.

“My mother-in-law told me that if a woman breastmilk is not good, her child can suckle and suckle the breast which she will think the child should be full or satisfied and doing well but that will not be the case. The issue can only be resolved when the old people go to collect the traditional medicine to come and purify the woman’s breast to make the BM good for the child to suck” (Ama).

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4.4.6 Valuable past experience

Majority of the participants reported that their mothers and other older women in their community believed in the indigenous BF practices so much so that when you complain to them about some aspects of the practice they do not even mind you. Some of them will even go ahead to share with you their experiences about how those practices contributed to the care and nurturing of their kids. Below is what three participants had to share:

“According to the old women in my house, they have done these IBF things for quite a long time and have seen the benefits. That is why they said I should also do them” (Abena).

Afia also stated that:

“The elders say they fed their children with the herbal water and did those other things to their children and it was helpful that is why they want us to do them too. They will say that if it wasn't good they wouldn't have been telling us to practise that” (Afia).

Adoma on her part revealed that:

“They always say that when they delivered you they never refused to welcome you with water and so how can they deny this your baby of water” (Adoma).

4.5 Motivation to Comply

Another major theme that emerged from the data was the motivation of lactating mothers to comply with their referent others. Majority of the participants explained that once they were introduced by their mothers and mothers-in-law to some of the IBF practices and after careful analysis of the practices they decided to give it a try. Two sub-themes emerged from this major theme; intrinsic and extrinsic factors.

4.5.1 Intrinsic factors

Under intrinsic factors, when lactating mothers were asked why they agreed to engage in the practice of IBF, a sizeable number of them indicated that they derive some inner satisfaction from adhering to those practices. Terms such as happiness, joy, peace of mind and good health were what emerged from the lactating mothers' interactions.

Participants Abena and Yaa could not hide their happiness and have this to say:

“What motivates me to practice these IBF things is that, as I went and had my bad BM purified it has helped me and my child a lot. Now my child could get enough good BM to suck and because of that she doesn't cry like she used to and now I can rest small. That is what makes me happy to engage in the IBF things” (Abena).

Yaa on her part disclosed that:

“As for me, I'm looking for good health for my baby and so those who delivered me when they tell me something to do in connection with my child's feeding I agree to it because I know they mean well for me and my child. See how my child is happily playing it's because of those things that I do that makes her healthy like that. I'm very happy for her. This is what motivates me every day to practise those our traditional beliefs that has something to do with feeding and caring for my baby” (Yaa).

Another participant also explained that since she has agreed to obey the elders to practise the indigenous breastfeeding practices, she has never been disappointed. In fact, she has no regrets at all. According to her, she did all the things she was told to do by her mother-in-law and the other elderly women in the house when she gave birth to all her children. To her, it's because of her love for her children that is what motivates her to practise all the things the elderly women instruct her to do. According to her, when she does them, it gives her peace of mind.

“I love my child. As I sit right now if it is not because of this my child what hope will I have? It is because of my child's life that is why I agreed to do those their practices. But as I'm doing them I can say the practice is beneficial. I practised

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those things when I gave birth to my other 6 children and it has been so helpful. Why won't I continue with this current baby? As I do them, I have my peace of mind because there are no problems with my child" (Esi).

Two other participants could not hide their joy but to express it out. One of them indicated that she was more than willing to eat anything if only it will lead to the benefit of her child.

"So if it is for me to eat those foods for my child to benefit, I think I'm glad to do them. If I have to eat something to help make my BM nice for my baby to suck and be healthy that one gives me joy and I'm more than willing to do it" (Asantewaa).

The other lactating mother also has this to say:

'What gives me joy in this whole thing is that as I decided to do the IBF things my aunty tells me to do for the sake of my baby, my baby is healthy. Even though she is about 3 weeks old, she hasn't encountered any health problem yet and this gives me joy" (Serwaah).

Another intrinsic factor that was mentioned by the participants has to do with the health of both their babies and themselves. A number of them indicated that since they agreed to practise those indigenous BF practices they and their babies have been enjoying good health and that has been the motivating factor to them. Yaa and Esi have this to say:

"You see, when I didn't have a baby or when I wasn't pregnant nobody told me to do any of those things. I was never told to eat this or drink that. But now that I have someone (a child) that is why they are now teaching me what to do so that we (my baby and I) can be healthy. If we were not in good health by now we would have been laying in the room" (Yaa).

Esi indicated that:

"...but since I have been drinking those their herbal concoctions and the hot guinea corn flour water anytime I give birth and also feeding my children with those herbal concoctions, I haven't had a miscarriage before or something bad happening to me or any of my children. This child is just about 4 months but you can see how she is healthy and playing. If you refuse to obey the elders to do those things and you lose your child what will you do? As for me, I will practise them as long as it makes me and my baby healthy" (Esi).

4.5.2 Extrinsic factors

Several extrinsic factors motivated majority of the participants to indulge in IBF practices. This was made clear by the sorts of expressions they used during the personal interviews. Whiles some were motivated to practice those IBF practices because it affords them the space to do their work, increases their children weight and helps their children to get enough BM to suck. Others too were engaged in the practice because of their own and other people past experiences. The nature of the weather was also identified to be an influencing factor to those who engaged in the practices of IBF. Amoakowaa and Sika indicated that they were motivated to engage in the IBF practices because it affords them time and space to either do their work or to rest.

“Anytime my child is force fed with those herbs, she sleeps fine allowing me to do my work” (Amoakowaa).

Sika on her part was motivated to feed her baby with herbal concoctions because it makes her baby not to suck her breast too much.

“When my baby drinks these herbal concoctions, it makes her not to suck the BM too much. She could just suck small and be satisfied and when you lay her down she will be sleeping giving you the mother time to rest” (Sika).

Other lactating mothers were motivated to practise the IBF practices because it aids them to produce ample quality BM for their children to suck. This made their children to gain and maintain normal body weights. Two of the participants have this to share:

“When I gave birth to my baby, at a point when I pick her to suck the BM she will suck just small and stop and will be crying and this made her loss weight. When I complained to the old ladies, they told me the things that I should eat to improve my BM production. When I started to eat those things they taught me, within 3 days my child began to suck very well and there was no more problem with her at all. After that, when I went for the next weighing the nurses praised me that I have done well because my child’s weight was going up. Now I prepare the guinea

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corn flour water all the time to drink, I cook and eat the bitter leaves and I don't eat cold foods as I was educated by the old ladies" (Afrakomaa)

Adjoa also had this to share:

"...since I haven't started drinking those herbal preparations they claim aids BM production before I went for my child's weighing and now knows his weight, let me get those herbs and start drinking them for my baby to be sucking so that next weighing day I will compare the weight to see whether those herbs are really good for BM production. When I did that and went for the next weighing session, my child's weight increased proper and since then I have been drinking those herbal water for my child to suck" (Adjoa)

A participant explained that her source of motivation to start giving her baby food came from what she saw happened to a colleague's child. She indicated that:

"When you wait till the child gets to the 6th month and you give her food she will not eat. So that is why I have started giving her the porridge small, small so that she can be used to it and when she is 6 months eating will no more be a problem. I know a certain woman who waited for her child to be 6 months before she started to give food to the child, come and see, this boy will not want any food to enter into his mouth. He is always sucking and sucking the mother all the time even though he is above a year" (Abena).

It was also refreshing to note that majority of the participants engaged in the practice of those indigenous BF things because of what they experienced themselves in the past.

Three of the lactating mothers recounted their past experiences.

"When I gave birth to my first child, I told the old ladies in our house that I wasn't going to give my baby anything to drink or eat apart from the BM because the nurses said I shouldn't give my baby any herbal water to drink. I nearly lost my child's life. One day he got up and started crying and crying and when we sent him to the native doctor and when they gave him water he drunk and drunk the water like something. That was where we saw the child getting back to life. Because of this experience how will I say that I will not give this child water to drink? What if I do that and lose her life what will I do? That is the reason why we don't practice the nurses' teachings of not giving water. But when we finish bathing the child we force to feed her with the herbs water" (Esi)

A participant narrated her experience when she decided to go against what she was taught by the elders.

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“When I delivered this child, I was told not to chew fresh maize but I didn’t listen. One day they harvested some maize and roasted some and I took just a few grains that night my child didn’t sleep. She was just stretching and crying and turning like that. This made me to believe that it is true when you chew fresh maize and your baby suckles your BM it will worry her. After that experience, I have vowed that I will never chew fresh maize anytime I’m BF a baby” (Adjoa).

Ampoma stated that she gives her babies gripe water to treat their stomach colic.

“When I gave birth to the child before this child, anytime his stomach was paining him I buy gripe water for him to drink and the stomach pains will stop. When I gave birth to this my child, at a point her stomach too was paining her and she was always crying and stretching herself, I bought the gripe water again and was pouring it to her to drink and it stopped. I will buy it for her if she should start getting stomach pains again” (Ampoma)

Another motivating factor that pushed many of the lactating women to hold tight to the practice of indigenous BF stuff was the unfavourable nature of the weather. This is what

Sika and Afrakomaa had to share:

“Hmmm! With this windy weather how can you say you will not give your child water to drink? Our weather here is always hot and sometimes windy. This can make even an adult to feel thirsty very often and so I can’t say I will not give my child water to drink. The BM too is like cow’s milk that we eat. If you eat cow’s milk it gives you a lot of thirst. That is why I agreed with my mother-in-law to give my baby water to drink often” (Sika).

Afrakomaa added that;

“You will have to feed her with BM and also make sure you give her water to drink. That is what I have been doing since I gave birth to her. You see how the wind is blowing everywhere like this, it makes the child’s throat dry quickly and this gives her thirst. So you need to give her water to drink from time to time. When I don’t give this my child water to drink for some time she will just be crying and when you give her water she will stop. Because of that I don’t joke with my child’s water at all” (Afrakomaa).

4.6 Attitude of Lactating Women towards Indigenous Breastfeeding Practices

Another major theme that came from the thematic analysis of the data was the attitude of lactating women towards indigenous breastfeeding practices. Under this

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theme, it was realised that some of the participants had positive attitudes towards IBF practices whilst others had negative attitudes about the indigenous practices of breastfeeding. It is however worth noting that what the women evaluated to be positive were those practices that they think were good and of the best interest of their babies and themselves. They then practised those ones voluntarily. Any of the IBF practices that the lactating mothers disapproved of were evaluated negatively. Those BF women who were positive about the IBF practices willingly engaged in the practice. Those that held negative attitudes about the IBF practices were unwilling to practice it. Three sub-themes were identified under this main theme. They were; positive evaluation, negative evaluation and borderline evaluation.

4.6.1 Positive attitudes towards indigenous breastfeeding practices

Majority of the participants held positive views about indigenous breastfeeding practices. They totally agree with the elders to practice them. According to these participants, they think there are a lot of benefits that they will reap in practising the indigenous breastfeeding practices. Some of them expressed that, they have confidence in their mothers and mothers-in-law to seek their interest and so did not think that they could be deceived to do something that will harm either their babies or themselves. Some of the participants think that giving water to their babies alongside the BM was the best thing to do.

“The main thing that I practice right now that I’m convince it’s good for my child is the giving of water to my child. With the water, I have faith that it is proper that I give to my child. Because as a human being you can’t say that she shouldn’t drink water” (Adjoa).

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Another participant had this to share:

“You have to feed your baby with BM and also make sure you give her water to drink. You see how the wind is blowing everywhere like this, it makes the child’s throat dry quickly and this gives her thirst. So you need to be giving her water to drink from time to time” (Afrakomaa).

Sika also stated that:

“Once they have taught me to get some herbs and boil for the child to drink in addition to the BM, anytime her stomach is worrying her and she cries for say a day or two I always look for those herbs to prepare them for my baby to be drinking” (Sika).

Some participants also indicated that they agreed with the elders to consume the herbs to help them produce adequate BM for their babies to suck. This was because they could not produce enough BM the first and second day after delivery. This is what a participant has to share:

“There are other herbs in the forest like kognamuning (a traditional herb) that they can get for you to cook and eat for four days and after that you stop. Your BM will now be flowing for the child to suck and nothing will worry her” (Akos).

Majority of the mothers were of the view that giving porridge and other light diets to their children less than 6 months was ok. They think the BM alone is not sufficient. This is how participants Amoakowaa and Esi put it:

“...before she is up to the 6th month, say from the 3rd month onwards you can start to prepare porridge for her. Or you can get some kenkey (a local Ghanaian dish) and mash it for her to be drinking. You can start doing this until she can now eat well” (Amoakowaa).

“Even though she is 3 months, when I woke up this morning I prepared some small porridge for her. When you give her the porridge to take and she gets full she doesn’t disturb. She can now suck the breastmilk later. In the afternoon I will prepare some again for her to take and when she is ok she plays, laughing” (Esi).

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Those participants that hold very positive views about IBF practices, indicated that they will teach the younger generation about the practice so that the practice can continue.

This is a participant view.

“It is people who taught our mothers about these breastfeeding practices and they too are now teaching us. You see these children that I have, if they grow I will also teach them what my mother taught me so that they too can take care of their children well” (Yaa).

4.6.2 Negative attitudes towards indigenous breastfeeding practices

Some of the participants evaluated some of the IBF practices as bad and so did not want to practise them. They think that some of the practices were irrelevant in this contemporary era. One of such participants was appalled with the way the older women carried out with their “tugilika” (force feeding) thing.

“This tugilika (force feeding) is not good at all. When they want to do it, they will put the baby down on their laps, with force they will close the child’s nose and then pour the herbs water into the child’s mouth to swallow. You have close the baby’s nostrils and yet you want him to swallow. How can she swallow? You will see that the child will be struggling. She wants to breathe then something enters her throat. She wants to breathe then something enters her throat. This can cause the child to even faint” (Adjoa).

Another lactating woman who also did not share in the wisdom of the elderly women about forcing babies to drink herbal concoctions has this to share:

“When my baby was about a month old, one day she got up and started crying and stretching her legs and the old ladies said her stomach was paining her that is why she was behaving like that. They then went and dug some chiwiaksa (herbs) from the forest. They boiled them and wanted to force and feed the baby with it but I refused because I didn’t believe in those things. Besides, I was afraid my child may faint in the process. I then asked my husband to buy me gripe water which he did and I started giving that one to the baby and later she stopped crying” (Afia)

A participant who made up her mind to practice EBF has to resort to lies to help her push her agenda through. She whispered (mother-in-law just came in) that, lies is the tool she

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has been using to outsmart her mother-in-law not to force and feed her baby with those herbal concoctions.

“I wanted to practise what the nurses having been teaching us whenever we go for weighing but my mother-in-law will not agree. So anytime she asks me whether I have forced the baby to drink the herbs water I will often lie to her that I have given him already so that she will not complain and say things that are not good to me” (Akua).

4.6.3 Borderline evaluation

A number of the participants’ responses about their attitude towards IBF practices can be grouped under borderline evaluation. These mothers were not out rightly against the practice of IBF. They rather had problems with some aspects of some of the practices and wished the authorities (elders) could agree to modify those ones. For instance, some of the participants had no problems with their children drinking herbal concoctions. Their problem has to do with the mode of administration of the herbs water (i.e. the force feeding). Those mothers who had a little say about how their babies should be fed suggested to use feeding bottles to feed their babies with the herbal waters. Others too sit their babies up and try to feed them with the herbal water. Afrakomaa and Serwaah, both had this to say:

“I think that it’s not good to force a little child like my baby to drink herbs water. The way they do it self can make the child to aspirate and die. Have you seen them do it before? It’s horrible! That is way I suggested to the old ladies that I will buy a feeding bottle so that when we prepare the herbs water we pour it inside the feeding bottle for the child to be drinking anytime she is feeling thirsty” (Serwaah).

“For me I don’t force to feed my baby with the herbs water. I think forcing a person to take water is wrong. What I do is that, I sit my baby up and put the water to the mouth and if she wants the water she will drink but if she doesn’t want she will not drink” (Afrakomaa).

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Many of the participants also seem to have mixed feelings about the traditional practice where a newly delivered mother is made to stay indoors for a number of days depending on the sex of the baby. This group of participants see some aspects of the practice as good. They also see other aspects of the practice as unfriendly. This is what some participants had to share:

“I think that this indoors thing they make us go through has its own good and bad parts. During that period, you the mother don’t do anything. You are just with your baby all the time for her to be sucking the breastmilk. The only time you are separated from your baby is when you’re to bathe or free yourself. On the feeding aspect, I think that it is a good practice because it gives you the opportunity to be able to breastfeed your baby very well. The aspect I don’t like is this: during that period, you don’t get the chance to come out for air to blow you even small. Sometimes the room will be hot and yet you have to be there like that” (Abena).

This is how Akos also put it:

“To me, this practice of being indoors for some time has its own positives and negatives. During that time, you the pokei (lactating mother) don’t do anything. You are always with your baby and so she sucks all the time unless she is sleeping or they are bathing her. This makes you to become use to your baby and I think that is good. But sometimes the room will be very hot and yet you can’t go out for fresh air. You will be inside the room like a prisoner” (Akos).

4.7 Subjective Norms about Indigenous Breastfeeding Practices

Many of the participants reported that the community has several beliefs and practices about breastfeeding that a lactating mother has to adhere to. Some of these beliefs may either have to be executed by the lactating mothers themselves or by other people within the community. For a lactating woman to agree to practice a particular belief will depend on the weight of the pressure being exerted on her to practice. Most of the participants also considered the bearing of the beliefs on their babies as well as themselves before agreeing to practice them. Participants who seem powerless could not help it but to agree to practice whatever that the society has put forward. Several sub-

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themes were identified under this major theme. They include; spirituality, control over infant feeding choices, food taboos, societal pressure, conflicting information and testing of first time mothers BM.

4.7.1 Spirituality

Majority of the women explained that the societal norms which members of the community hold dear to their chest and practice have spiritual connotations attached to them. They believed that there are unseen forces who protect the lactating mothers and their babies from harm. These forces perform the critical role of helping mothers to produce adequate BM to feed their babies. The spiritual beliefs the society practice are centred on those activities that will promote safe breastfeeding of the babies, protection of the newly born and to aid landlords to choose successors for the family gods. A participant indicated that when she delivered, her BM was not flowing and her people have to consult a soothsayer to aid them remedy the situation.

“When I gave birth, the old men went out to consult a soothsayer because my BM wasn’t coming for the baby to feed. When they consulted the soothsayer it was found that some things have covered the holes in my breast where the milk will pass to come out. So I have to go and perform some rituals at a certain herbalist house. After that ritual, my BM started to flow and my baby could now get enough milk to suck” (Abena).

Other participants also stated that in their custom it is a taboo to practise wet nursing.

Ampoma, one of the lactating mothers indicated that under no circumstance should her baby be allowed to suckle a different woman’s breast. She added that when that happens, the gods will have to be appeased before she can take back her child.

“As I was sitting with the other breastfeeding mother when you came, if my child had grabbed her breast in attempt to suck, she will have to take custody of my child and I will keep her baby. We will then have to go to the shrine for the shrine’s keeper to pour some libation to appease the gods before my child can be

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returned to me and she too can take back her baby. If this is not done and I take back my child and she sucks my BM it is believed that she will die” (Ampoma).

Some of the spiritual beliefs and practices of the society concerning feeding of infants were in the area of “tugilika” (force feeding) and initiation of babies to family gods for protection. Some of the participants stated that force feeding was a means of helping landlords to choose successors for the family gods. Esi and Ama had this to say:

“Our practice is that when a woman gives birth the new born will have to be fed with herbs through tugilika (force feeding). If they are doing this force feeding thing and any child should faint during the process, it means the gods of the family have not chosen that child. That child can’t inherit the gods in future. But those babies that will not faint are those chosen by the family gods” (Esi).

“In our house when you give birth, after they had bathed the baby in the morning they will go and put the baby in a separate room (the family gods’ room) and fetch some herbal concoctions and put by the baby. The baby will be there for the whole day so that the family gods will be feeding and protecting her. In the evening they will go and get the baby and come and bath her and after that they will now give the baby back to the mother to feed. The baby only sucks the mother’s BM in the night. This will continue until the baby can crawl. That is the initiation process” (Ama).

4.7.2 Control over infant feeding choices

Majority of the participants who initially did not make their minds to engage in IBF practices lamented that they have to practice it by force. In the participants’ traditional setting, issues bordering on how a baby is cared for does not solely lie in the purview of the mother but rather the elderly women who are living in the house. Sometimes, even older ladies who are staying outside the home of the lactating mother have some amount of influence on how she should feed her baby. This was made clear when majority of the participants put out expressions like; “I don’t have much say”, “I couldn’t resist” and so for.

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“I don’t have much say on what they give to my baby to eat or drink. It’s my mother-in-law who decides that. When I complain about the way she is forcing the baby to drink those herbal concoctions, she will tell me that she has been doing it not today. So anytime she finishes bathing the baby she will fetch the herbs water and force the child to drink” (Amoakowaa).

Ama also lamented that:

“Hmm! I couldn’t resist what the grandmothers were doing to my baby. They were those bathing the baby and so I couldn’t tell them not to give water to the child or not to force the child to drink the boiled herbs water. If I had resisted, they could have become angry with me and leave the child for me which I couldn’t bath her myself because she was small” (Ama).

Another lactating mother also stated her reason why she couldn’t adhere to the feeding practices the nurses taught her to do when she gives birth.

“The reason why I couldn’t practice what the nurses told me to do when I deliver was that, I’m not the one who baths the child. It is the elderly women who bath her and after that they give her the herbs water to drink. When you talk they will insult you. But when they give her the water to drink, after that I don’t give her again” (Abena).

When a participant was asked why she was feeding her baby with herbal concoctions, this is what she has to say:

“Hmmm! immediately I gave birth to my baby, the old ladies went and gathered some herbs and brought to the house. They prepared them and anytime the finish bathing the baby they will fetch some and feed the baby. They also asked me to always fetch some for the baby to drink. All this happened without my consent. When I tried to tell them that the baby was too small to start drinking those herbs come and see! They insulted me and said a whole lot of things about me” (Afia).

4.7.3 Food taboos

One of the cardinal things that ran through all the participants’ responses was the issue of food taboos. All the participants made mentioned of one or two foods substances that they were told by the elderly women in their homes not to eat after they have put to bed. The reason that was assigned to the prohibition of the lactating women from eating

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those foods was that if the breastfeeding mothers go ahead to eat those foods and their babies suckles their BM it will affect their babies' health. Adjoa, Afia and Afrakomaa had this to share:

“The elders told me not to eat certain foods as a lactating mother. According to them, I shouldn't eat bambara beans or chew fresh corn else if I do and my child sucks my breastmilk it will tighten my child's ribs and she will find it difficult to breath. Honey too I shouldn't eat else it will block the child's nostrils and she will find it difficult to breathe. As at now I don't eat those things” (Adjoa).

Afia indicated that:

“We have some foods when you eat them it affects your breastmilk. For example, the elders said if I drink very cold water or eat cold tuozaafi (TZ) or chew fresh groundnut and my baby sucks my BM he will vomit. They said the cold water will make my BM to become cold and when my baby sucks the BM he will be vomiting it. For these reasons I have stopped eating such foods” (Afia).

Afrakomaa on her part stated that:

“The old women said if I eat bambara beans it will enter into my BM and when my child sucks my BM she will experience chest congestion and will not be able to breathe well. Also, ebony fruits, mangoes, and shea fruits, they say I shouldn't eat them. They said if I eat shea fruits or mangoes my child will run diarrhoea. She will be passing stools frequently. And all this will bring her problems. It is the same with fresh corn. They say if I chew fresh corn and my child sucks the breastmilk she will also experience chest congestion and this will interfere with her breathing” (Afrakomaa).

4.7.4 Societal pressure

Societal pressure was one of the major issues that majority of the participants had to grapple with when it came to how they were to feed their babies. Lactating mothers who were not comfortable with some aspects of the IBF practices that were being practised in their area and decided that they were not going to do them faced a lot of bushing from both their peers and the elderly women. It was not uncommon for expressions such as “you don't respect”, “you are stubborn”, “you are a witch”, “you will

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be held responsible” etc. to be used on those women who didn’t what to agree to all that was being thrown at them. Adoma and Sika had this to say:

“.....if my house women talk about it outside and my peers hear that I have refused to do some of the IBF practices, they will be saying that I don’t respect that is why they are teaching me and I refuse to listen. So now that I don’t listen, what if something happens to my child what will I do? They will say that they are all practising what their mothers-in-law are telling them to do so anytime they are teaching me I should listen” (Adoma).

“When my peers went and performed the BM rituals and I refused to do it, anytime the old ladies see me outside they will be talking and insulting me that I’m stubborn. Hmmm! my own mother told me that if I get a problem with my baby I should carry him to my husband so that the two of us will deal with it. I shouldn’t tell them” (Sika).

Some of the lactating mothers could not resist the pressure that was coming from the referent others to practice the IBF stuff and hence have to give in.

“When I told the old ladies in my house I wanted to do EBF, they were not happy about me. Anybody who hears it will be insulting me. Even my own mother complained bitterly about my refusal to listen to her to her colleagues. When I am going for Child Welfare Clinic (CWC) the women who have heard that I have refused to engage in the IBF practices will always be complaining about my attitude. This pushed me to start doing some of their things” (Afia).

Yaa on her part disclosed that she was threatened by the old women in her house and that made her to engage in the practice.

“The elderly women in my house threatened me that if I refuse to agree to do the things they are telling me to do for myself and my baby and anything happens to my baby, I will be held responsible. This made fear to enter me and I have to agree to practice their things” (Yaa).

A participant stated that when she delivered her baby the old ladies in her house were always on her to administer herbal concoctions to her child. Initially, she resisted it and the old women started bushing her with unpalatable words so she took a strategy. The

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strategy was to always deceive them that she is giving their herbal water to the baby to drink.

“Hmmm! If I had told the old ladies that I will not give the herbal concoctions to my baby, they will say that I don’t respect, and if anything happens to the child, they will blame me. They will say that they told me what to do and I refused. That is why I often deceive them that I have giving the herbal concoctions to the baby to avoid any unfair accusations” (Akua).

Another participant also stated that the fear of being branded as a witch made her to give in to the demand to practice some of the IBF things.

“If you deliver and refuse to practice their traditional things and in case your baby falls sick or dies, they will blame you for the death of the baby since you have refused their advice. They will say that you are a witch that is why you have bewitched your own child if not when they advised you to do those things to help you produce quality BM for your child to suck you refused. So you know the cause of death of your child” (Serwaah).

4.7.5 Conflicting information

Majority of the participants indicated that they had a lot of conflicting information coming from the nurses and also from their referent others about what they can give to their babies to take. According to the lactating mothers, when they visit the health centre (HC) the nurses will tell them not to give anything to their babies to take apart from the BM. When they come home, their mothers and mothers-in-law too will be telling them to give either water or herbal concoctions to their children to drink. This at times makes them confuse. Two of such mothers had this to share:

“When I gave birth, I was told by the nurses not to give anything to my baby apart from BM until she is 6 months else she will be having stomach pains and may run diarrhoea. But one day my baby got up and was stretching herself and crying non-stop and the elders told me that it was her stomach that was paining her that is why she was behaving like that. They told me that if they give her some herbal preparations to drink it will stop. I was confused because I didn’t know who to believe. But finally they gave the herbal water to the child to drink and she stopped crying” (Serwaah).

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Adjoa on her part indicated that:

“When I was pregnant anytime I attend antenatal clinic (ANC), the midwife will tell me that when I give birth I shouldn’t give water to my baby to drink. So I asked her why? And she said that there is water in the BM and that water is better for the child than the water I will give. When I delivered my child and came home, the elders also said I should give the child water to drink, I asked them too, to find out why, because the nurses said I shouldn’t give the child water. They too responded that my BM that the child is sucking is like cow’s milk. And that when you eat cow’s milk you will be thirsty. Truly speaking I have eaten cow’s milk before and know how it causes you to feel thirsty after eaten it. Now, if you were in my shoes which of these people will you believe? I decided to buy voltic mineral water to give to my baby to drink anytime she is feeling thirsty” (Adjoa).

4.8 Intentions of Lactating Women about Indigenous Breastfeeding Practices

The women reported their intentions about indigenous BF practices in different ways. They reported health workers influence on intentions to breastfeed, intentions influenced by their own experiences and elders coaching and intentions about giving water to their babies. Other intentions such as, mother intention to drink guinea corn flour water and the intention to obey their family gods were identified. Majority of the participants had strong intentions to practice some of the IBF practices. According to most of the mothers, they have gone through some of the IBF practices before and can attest that the practices are helpful. Those who had given birth for the first time were also more likely to follow what the nurses and the midwives have been teaching them to do.

4.8.1 Health workers influence on intention to breastfeed

Some of the participants, especially the first time mothers, stated that they had wanted to practice the things the nurses taught them to do. They were not ready to give anything to their children to drink or eat unless their children were up to 6 months of age. They however were unable to execute their intentions because their significant others did not permit them the chance to do so. Two of such participants had this to say:

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“When I was pregnant, I was always saying to myself that when I deliver my baby I will take very good care of her so that she will grow fine. Anytime I went to the HC for antenatal care, the nurses will teach me that giving herbal water, plain water and porridge to the baby before she is 6 months wasn’t good. So my intention was to follow what the nurses were teaching me. But when I gave birth and came home, anytime the old ladies in my house bath the child, they will force and feed her with some herbs water. When I told them the nurses said I shouldn’t let the baby drink water now, they told me that then I should take my baby to the nurses for them to bathe her” (Abena).

“During the time I was pregnant, I was always attending ANC services and the midwives who took care of me educated me that when I give birth I shouldn’t allow my mother-in-law and other women deceive me to feed my baby with herbs and other things. The midwives told me that giving those things to my child before she is 6 months will cause the child not to grow well. I then decided that when I deliver my baby, I will practice EBF to see how it will help my child to grow well” (Afia).

4.8.2 Intentions influenced by own experience and elders coaching

Lactating mothers who were nursing children for the second or more times indicated that they had gone through some of the IBF practices before and have seen the benefits. This group of nursing mothers had their minds already made up to engage in the IBF practices. According to them, whatever that the elderly women will be teaching them will be additional information which is only meant to enhance their knowledge. Adoma had this to share:

“Since I have delivered before I knew some of our traditional breastfeeding practices so my intention was that I will continue to do those things for my baby and myself. And if the elders teach me other breastfeeding things I will do them so that it will help my child to be healthy and grow well” (Adoma).

Ampoma also had this to say:

“Since I fed my other children with the herbs water and also gave them porridge and soups to eat when they were about 3 months and it helped them, I planned to continue same with this girl. My mother-in-law has also been telling me what to eat to be able to produce enough BM for my baby to suck. Foods like; the soup prepared with the herbs water, bitter leaves and the guinea corn flour water. I’m

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eating all of them. Even before I delivered this child I knew that was what I will be doing for myself and my baby” (Ampoma).

4.8.3 Intentions about giving water to the child

When a number of the participants were asked about their intentions about breastfeeding and care of their babies, they indicated that they were going to continue with their traditions and customs. Their intentions were to continue to tow the lines of their grandmas and mothers - how they brought them up. Afrakomaa indicated that:

“My plan was that when I give birth, I will get some of the herbs from the bush which I will boil and pour the water into a feeding bottle for my baby to be drinking. That was what I intended to do when I deliver. As I’m feeding my baby with those herbal water you can see she is looking healthy” (Afrakomaa).

Another participant also had this to say:

“My intention is that when my child is 2 months onwards I will start to give her the herbal water to drink so that she will not get stomach pains and can grow well” (Serwaah).

4.8.4 Mothers intention to drink guinea corn flour water

Majority of the lactating mothers had the intention of drinking the guinea corn flour water when they deliver their babies. It was their desire to produce adequate BM for their babies to feed on and so when they were told by the elderly women that drinking guinea corn flour water helps to produce enough quality BM, the lactating mothers didn’t hesitate to buy into the idea. This is how two of the mothers expressed their intent:

“During the time I was pregnant and getting to term, I fried plenty of guinea corn so that when I deliver I will mill it and be preparing the zunyiem (flour water) to drink to help me produce enough BM for my child to feed on” (Akos).

“When I was pregnant I planned that when I deliver I will be drinking the zunyiem (flour water) and eating the bitter leaves and the herbs soup so that my baby can get enough BM to suck and grow fine” (Abena).

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4.8.5 Intention to obey the family gods

Some of the lactating women had family gods who play several roles when it comes to nurturing of the kids. Some of these gods acted as protectors of the babies whilst others were responsible for ensuring that the lactating women produce ample quality BM for the babies to feed on. Those women who had these types of gods in their homes made their minds to obey fully whatever they will be told to do to keep their babies well and fit. This is what Esi stated:

“I planned that when I deliver and my child is fine I will not do anything on my own that will go against our BM god. If they want to send us (mother and baby) to the god to perform those rites that will help my breastmilk to come plenty and thick for my baby to suck, I will gladly agree to go so that this child too will survive and add to the other children” (Esi).

Another lactating mother also stated that for her to do anything that will guarantee the safety and health of her child she was more than willing to do it.

“We have some family gods so whenever a woman in our house delivers, after the baby is bathed in the morning the old ladies will take the baby to the room in which the gods are and leave her there for the gods to be feeding and protecting her throughout the day. So before I gave birth my intention was to comply with all that the old people will say the gods say I should do. It’s the life of my child that matters to me and so I will do whatever the gods say I should do if only that will make my child to be healthy” (Ama).

4.9 Knowledge Deficit about Exclusive Breastfeeding Practices

Knowledge deficit about EBF practices among majority of the participants was the only theme that was not consistent with the model used for the study, it emerged from the data. Majority of the participants had inadequate knowledge and other misconceptions about EBF practices. Though most of them admitted being educated by the nurses and other health care staff on optimal BF, their responses on how they breastfeed their children were not in line with the WHO recommendations for EBF. Ineffective health

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education by nurses on optimal BF practices was identified as being the cause of the problem.

4.9.1 Ineffective breastfeeding education by nurses

The statements of a number of the lactating mothers revealed that either the message from the nurses about EBF to them was not clear or, they find it difficult doing away with some of their traditional practices on breastfeeding. Even though majority of the women could memorize some of the things they have been taught by the midwives during their antenatal clinic (ANC) days and also what they teach them anytime they go for child welfare clinic (CWC) services, they seem not to implement that. This is what one participant has to say:

“The health workers say the child shouldn’t be given anything to drink or eat until she is 6 months except the BM. But when we bath her in the morning we give some herbal water to her to drink and also in the afternoon and evening. We give her herbal water to drink 3 times in a day” (Afrakomaa).

Three of the participants who seem to misconstrue the education given to them by the nurses about optimal BF had these to share:

“The nurses say I shouldn’t give food to my baby because of that I give her only water to drink after she has sucked the BM. I’m waiting to start giving her porridge when she is around 4 months” (Abena).

Ama also stated that:

“The nurses taught us that when we deliver we should allow our babies to feed on only the breastmilk for 6 months. So I feed my baby with only BM.... We only give her water morning and evening after bathing her to kill her thirst (Ama).

Asantewaa on her part disclosed that:

“The health workers say that we should allow the children to get to 6 months then they can now start to drink water and eat food. But I don’t know about the ‘white man’s food’ like lactogen and co. Those ones I think you can give to him to eat but as for our local foods you can’t give him to eat now” (Asantewaa).

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One lactating mother who seems not to agree completely with the breastfeeding information given to her by the health workers had this to say:

“The proper way to feed my child is that, because she is less than 6 months, it is the BM and water that you need to be given to her. When you are pregnant and you go for ANC, the nurses will tell you that you shouldn't give your child water when you deliver but I think this is not right. The child needs water too” (Adjoa).

4.10 Summary of Findings

The findings of the study showed that the study participants were between the ages of 18 – 38 years. With the exception of one mother who managed to complete her SHS education, majority of the lactating women either did not have any formal education or were dropouts. Three of the mothers were JHS leavers. The mothers were all married and had children ranging from one to seven. Apart from one woman who was a traditionalist, the rest of the mothers were Christians. Majority of the mothers were peasant farmers.

The study revealed that all the lactating women have either practised or heard of some beliefs about indigenous breastfeeding practices. Some of these beliefs were; beliefs about bitterness or bad BM, beliefs regarding colostrum, beliefs about the potency of herbal concoctions, beliefs about confinement of mother and baby among others.

It was also discovered in the current study findings that opinions of referent others played a major role in influencing some nursing mothers to practise the indigenous BF practices. Examples of some of these referent others who were instrumental in the act of indigenous BF were the mothers-in-law, mothers, husbands, sisters-in-law, colleagues and other elderly women in the community.

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Majority of the lactating women were motivated to comply with the practice because they think it was good for them and their babies. Most of them expressed that when they agreed to engage in the practice, it gave them peace of mind, happiness, the space to do their work/rest, kept them and their babies healthy among other benefits.

Furthermore, the findings of the study revealed that while majority of the lactating mothers evaluated the practice as positive, few of them evaluated it as negative. A third group could not classify the practices as solely being positive or negative. This third group had mixed feelings about the practice. They saw some useful as well as negative aspects in the indigenous BF practices.

Societal pressures were yet another major finding that emerged. The lactating mothers reported of certain mandatory traditional practices that are performed when a woman gives birth in their community to aid her to conduct a successful breastfeeding. Some of these practices were food taboos, consulting soothsayers, invitation of gods to come and aid BM production, testing of first time mothers' BM among others.

Another remarkable finding of the study was that, while majority of the participants had intended to engage in the indigenous BF practices some few ones had the intention to feed their babies according to how the nurses taught them. Those who had previously practised the indigenous BF practices and were comfortable with the system, planned of administering herbal water to their babies and also to obey their BM god.

The study also established that most of the lactating mothers lacked sufficient knowledge on EBF practices. Even those who seemed to memorize what the nurses have been teaching them were not practising same. Some findings of the current study portray ineffective BF education by the nurses and midwives as the cause of this phenomenon.

CHAPTER FIVE

DISCUSSIONS OF FINDINGS

This chapter discusses the findings of the study. The discussion is organized according to the main themes as presented in chapter four.

5.1 Demographic Characteristics of Participants

The lactating mothers who participated in the study were women within the reproductive age bracket. They were within 18 – 38 years' age group. Society expects that women within this age group (18 – 38 years) who are not in school should get married and have children. This is exactly what these participants did. It was also not surprising to realise that the participants were within this age bracket. According to Ghana Statistical Service (2014), more women are within this age group in the Builsa north district. All the participants were married and had children ranging from 1 to 7. The reason why the lactating women were all married could possibly be because of the way unmarried women with children are viewed within the northern communities. In the northern part of Ghana, any woman who gives birth without marrying is considered as a promiscuous woman. Even though all the participants were married, they were all involved in indigenous BF practices contrary to the findings of (Ekanem et al., 2012).

Findings from the study indicate that majority of the participants (14 = 93%) were practising the Christian religion while 7% of the lactating women were traditionalists. This maybe the case because Ghana is largely dominated by the Christian religion (Ghana Statistical Service, 2014). In this current study, being a Christian was not seen playing any key role in determining how a mother breastfeeds her child. This is contrary to evidence posited by Chiejina (2018) and Ekanem, Ekanem, Asuquo, and Eyo (2012)

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who seem to suggest that nursing mothers who are predominantly Christians were more likely to shun indigenous BF practices and embrace EBF.

The educational background of participants comprised of no formal education, primary education and junior and senior high education. It maybe arguably right to state that because of the low levels of education of the participants, they engaged in poor BF practices. Once the mothers did not appreciate the value of EBF due to their low levels of education it was easier for their significant others to convince them to engage in indigenous BF practices as reported in previous studies (Chiejina, 2018; Onah et al., 2014).

None of the lactating women were in any formal employment that demanded fixed time schedules. Majority (8) of them were peasant farmers. One cannot therefore use maternal employment of the participants to form the basis for their engagement in indigenous BF practices. Their issue was not about time but rather tradition which seems difficult to abrogate.

5.2 Beliefs about Indigenous Breastfeeding Practices

Traditional beliefs and practices surrounding breastfeeding were highly prevalent among the participants. Majority of the lactating mothers saw the practice of indigenous BF as being part of their tradition and hence did not have any problems indulging in it. Findings from the study categorized the lactating women indigenous BF practices into three namely; beliefs observed before the initiation of BF, beliefs during the period of BF and lastly beliefs they associate with what experts teach them. No finding was cited in literature to have categorized lactating women beliefs about indigenous breastfeeding practices into these categories. This probably suggests that beliefs and practices about BF

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practices are not uniformed and must be handled as such. The multiplicity of culture and traditions across boundaries is amply articulated in this study.

The lactating mothers described the beliefs they observed before initiating their babies to their breastmilk as very important. This is because, they believe it has a direct impact on the lives of their babies. Majority of participants especially those who gave birth for the first time believed in the harmful nature of “bitter” or “bad” BM as supported by a Lebanese study (Osman et al., 2009). The bitter BM is believed to cause abdominal pains to the babies when they suckle it, because of that any woman who delivers for the first time must have her BM traditionally tested before her baby is put to the breast. Several studies in Ghana also discovered that such bitter or bad BM is established through traditional way of testing (Abasimi, Atindanbila, Mwini-Nyaledzigbor, Benneh, & Avane, 2014; Aborigo et al., 2012; Boatbil, Guure, & Ayoung, 2014). This practice is most likely to be one of the reasons for the introduction of pre-lacteal feeds among majority of the breastfeeding mothers studied. Once the breastfeeding women are waiting to have their BM tested, and once their babies are crying in hunger, they will definitely have to give the babies something to drink to sustain them. The waiting period becomes even longer when the ants put into the BM die inside the BM indicating bad BM. In such instances, more time may be needed to gather the items for the purification rites.

Another surest way of detecting “bad” or “bitter” BM according to the lactating women was that, during pregnancy any pregnant woman whose breast leaks BM into her dress is an indication that her BM will be “bitter” or “bad” when she delivers. So immediately these women give birth, their BM will have to be purified before their

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babies are allowed to commence breastfeeding. This purification process involved the use of herbal water to wash the breast morning and evening for a period of three to four days depending on the sex of the baby as also reported by Subbiah and Jeganathan, (2012).

While all this is being done, the baby will be fed on cow's milk and herbal concoctions.

It was also discovered in the current study that many of the lactating mothers expressed and discarded the colostrum part of their BM whether it was traditionally tested bitter or not. They considered it to be dirty and harmful and hence did not think it was good for their babies to feed on it. This belief about colostrum being dirty and harmful is consistent with several studies conducted both in Ghana (Aborigo et al., 2012) and abroad (Acharya & Meena, 2016; Asim, Malik, Tabassum, Haider, & Anwar, 2014; Bandyopadhyay, 2009; Ertem & Ergün, 2013). This practice of discarding the colostrum part of the breastmilk favours the introduction of pre-lacteal feeds. It is imperative that nursing mothers are made aware of the enormous benefits colostrum has for the babies.

Similarly, before majority of the lactating mothers introduced their babies to their BM, water was given first to the babies to drink as a form of welcoming them to the house and the world since they regard every newborn as a visitor. This current finding is similar to a study conducted among rural West Bengal postpartum mothers of India where hot water is the first thing mothers give to their babies before starting them with their BM (Bandyopadhyay, 2009). This ritual is probably being practised in Ghana because in the Ghanaian context, any person that visits your home must first of all be given water to drink as a sign of welcoming that person to your home. This indigenous practice exemplifies our Ghanaian hospitality. The practice is even more pronounced in the northern part of Ghana where the research was conducted.

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Another cardinal finding of this study is the beliefs lactating mothers have during the period of breastfeeding. Participants of the study expressed that after they had established breastfeeding they have to adhere to strict dietary practices to be able to continue to produce enough quality BM for their babies to suckle. Some stated the use of herbal concoctions to prepare soup and other foods described as “zunyiem” (guinea corn flour water) and similarly described as “yara’na” (Aborigo et al., 2012, p. 6) and “liquado” (Gill et al., 2004, p. 46). They also used “asuwaka” (bitter leaves) to prepare soup to eat. All these foods were eaten by the lactating mothers to help enrich their BM for their babies to suck and grow well. The lactating mothers avoided the eating of cold foods such as “tuozaafi” (TZ) and drinks because they hold the belief that when they eat those cold things it will make their BM to be cold and when their babies suckle the cold BM the babies will vomit. Similar to the findings of the present study, is the Chinese practice where postpartum women avoided eating cold foods (Koon et al., 2005). Mothers, after they have painfully gone through the period of pregnancy and enduring labour pains will do anything to keep their babies healthy.

The current study also discovered that majority of the participants administered herbal concoctions to their babies to either cleanse their babies’ stomachs of dirt (meconium) or treat abdominal pains as also reported by Aborigo et al. (2012). Some also were of the view that their babies needed to be given water to drink alongside the BM because they believe that human BM is like cow’s milk and can cause thirst in the babies. Many of the lactating women also introduced their babies to food as early as 3 months as similarly reported in Australia (Bandyopadhyay, 2009; Russell et al., 2016). The nursing mothers gave water and food to their babies probably because of the hot and windy

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weather conditions that prevail in the study setting. The lactating mothers think that the BM alone was not enough to suffice the growing needs of their children.

Confining postpartum mothers for three to four days was yet another belief the women practised. Similar findings among postnatal Chinese and Vietnamese mothers were reported (Koon et al., 2005; Lundberg & Ngoc Thu, 2011). However, the number of days Chinese and Vietnamese mothers were confined was longer than the days found in the present study. The participants in this present study indicated that before they ended the confinement period, a traditional rite called “pomsika” (blowing) was performed. This practice is healthy because it helps mother and baby bonding. It also affords the lactating mother opportunity to rest and recover from the stress of child birth. Some of the nursing mothers believed that improper positioning and attachment during breastfeeding can cause ear infection. Whereas improper positioning is believed to cause ear infection in this study, other studies elsewhere reported improper positioning and attachment to cause cracked nipples, mastitis and sore nipples (Goyal, Banginwar, Ziyu, & Toweir, 2011; Parashar, Singh, Kishore, & Patavegar, 2015).

Participants also articulated the beliefs they have about experts (nurses and doctors) advice on some indigenous BF practices. Some of the nursing mothers expressed that because of the dangers associated with some indigenous BF practices such as “tugilika” (force feeding) where herbal concoctions are forced down the throats of babies, nurses are discouraging them from practising it. Their concern is that the practice can cause aspiration and possible death of the baby. Fear of aspiration and death was also the main concern raised in a study conducted by Abasimi et al. (2014) among nursing mothers in the Bolgatanga Municipality regarding force feeding. This practice makes the

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infants drink a lot of water instead of BM. But once the baby's tummy is full of water he or she may not be able to suck enough BM and this can deprive the baby of the essential nutrients meant for growth and development. A participant also stated that she believes that because some of the mothers do not have good drinking water at their homes for their babies to drink, that could be the reason why the nurses are advocating that they should not give water to their babies until they are six months of age. Just as this assertion could be valid, whether forcing the baby to drink clean water or unwholesome water will still impede the baby's capacity to suck enough BM and this will invariably affect the amount of nutrients the baby will obtain from the BM.

5.3 Opinions of Referent Others

Referent others such as mothers and mothers-in-law, grandmothers, sisters-in-law, husbands, peers and other elderly women within the society all have a say when it comes to the feeding and care of postnatal mothers and their babies. These people place high premium on the maintenance of both the lactating mother and her baby's health. This is the reason why immediately the pregnant woman delivers her baby; the elders will start to prepare hot water for the postnatal mother to drink to help in the free flow of the "bad water" (lochia). Studies among Vietnamese and Myanmar's postpartum women revealed similar practices (Lundberg & Ngoc Thu, 2011; Sein, 2013). However, unlike the mothers in this study who drunk hot water to aid in the evacuation of the lochia, the Myanmar's mothers consume traditional medicines (nutmeg) and engaged in uterine massage to facilitate the flow of lochia. Vietnamese postnatal mothers are provided with special diets described as 'hot' foods like meat and eggs to eat to help expel the lochia.

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The general belief about lochia among the participants is that it is putrid and therefore must come out of the lactating mother else it can cause sicknesses in her.

The participants of this study also revealed that their babies were given plain water, herbal concoctions and gripe water by their grandmothers to drink to “cool” their throats and to treat or prevent abdominal colic. This finding agrees with that of Abasimi et al. (2014) and Aborigo et al. (2012) where plain water and herbal concoctions were administered to babies. The indigenous Ghanaian man or woman believes in the potency of their herbs to take care of all manner of ailments, and once babies cannot talk to tell their parents why they are crying, it is hoped that giving plain water and the herbs will help to take care of all the baby’s health problems.

Spousal opinions about referent others were also reported in the study. The study found that some enlighten husbands did not agree with the practice of some indigenous BF practices and therefore discouraged their wives from engaging in them. This finding is supported by the studies of Rempel and Rempel, (2011), Abasimi et al. (2014) and Nuzrina, Roshita, and Basuki, (2016) where it was disclosed that husbands were the driving force behind their wives success in practising effective BF. Other studies conducted in Kenya presented the contrary (Walingo & Mutuli, 2014; Wanjohi et al., 2017). In those studies, husbands’ opinions favoured indigenous BF practices. Also, In Kinshasa, Congo, husbands encouraged their wives to add both formula and porridge to the BM for their children less than six months of age (Yotebieng et al., 2013). To achieve universal acceptance in optimal BF practices, policy makers must adopt the husband support strategy to encourage male partners to support their wives in breastfeeding their

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babies. Notwithstanding this suggestion, other referent others such as mothers and grandmothers must not be left out in the campaign against sub-normal BF practices.

Several significant others such as mothers-in-law, grandmothers and other older women have expressed their opinions about breastmilk indicating that mothers whose BM is not good is not suitable for the babies to suck unless the breastmilk is purified. The finding suggests that if the babies suckle the bad or unwholesome BM they will experience diarrhoea and look miserable. Similar to this finding is the results reported in a study conducted by Aborigo et al. (2012) in the Kassina-Nankana district of the Upper East Region of northern Ghana on infant nutrition. Considering the amount of power these elderly women have within the community, it will be more challenging for a young lactating mother to ignore these opinions and go ahead to breastfeed her baby exclusively. Breastfeeding campaigners should consider inquiring the views of these elders in their BF education.

The study also discovered that some referent others (mothers and grandmothers) advocate for the administration of pre-lacteal feeds (water and herbal concoctions) to infants instead of the colostrum. These people instruct young mothers about infant feeding based on the experience they have acquired over the years as mothers. This study is consistent with that of Aborigo et al. (2012) and Negin, Coffman, Vizintin, and Raynes-Greenow, (2016) studies which saw grandmothers and mothers-in-law putting to work their indigenous BF experiences in infant care. This kind of knowledge and experience exhibited by the referent others is detrimental to the welfare of babies since it denies them the benefits of the 'liquid gold' (colostrum). This experience is rooted in their traditions and hence has no empirical backing. To achieve the Sustainable

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Development Goals 2:2 and 3:2 (World Health Organization, 2016), more efforts need to be put into educating all concerned in the care and nurturing of babies.

5.4 Motivation to Comply with Referent Others

The study found that lactating mothers' motivation to comply with referent others was based on two distinct factors. The intrinsic and extrinsic factors. Intrinsically, the lactating mothers were motivated to practise the indigenous BF practices because it gave them happiness, peace of mind, joy and good health. The nursing mothers reported being happy and feeling good when their babies seemed to be doing well as they introduced them to all kinds of pre-lacteal feeds and early complementary feeding. Some of them also expressed their joy for being able to produce enough BM for their babies to suck after they had followed some of the dietary prescriptions. Almost all the lactating mothers indicated that they were highly motivated to comply with the traditional BF practices because of the health of their babies and themselves. These findings are supported by Gallegos, Vicca, and Streiner, (2015), Nuzrina et al. (2016) and Russell et al. (2016) who also discovered that nursing mothers were motivated to engage in traditional BF practices because of the joy, happiness and the good health that it brings to them and their babies. As long as referent others like mothers and grandmothers continue to advocate based on the benefits about indigenous BF practices to young lactating mothers the practice will continue to persist regardless of the latent harmful effects these practices may have on the children.

Extrinsically, nursing mothers who supported force feeding reported that anytime their babies are force fed, they get satisfied and sleep, giving the mothers the opportunity to rest adequately. Mothers who engaged in early supplementary feeding also reported

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that the practice helped to increase their babies' weight. This present finding is consistent with the findings of (Gallegos et al., 2015; Russell et al., 2016). In those studies, pre-lacteal feeds to infants was viewed to be very beneficial since mothers were able to feed their babies to be full and thereby increasing the babies' weight. Nursing mothers could equally breastfeed their babies to get full and maintain healthy body weights if the right education is given to them. Breastmilk has all the nutrients in their right proportions and is best for the babies than formula or any other baby feeds.

Again, it was discovered from the present study that lactating mothers were motivated to engage in indigenous BF practices because of what they learnt from other mothers and their own experiences. This current finding is supported by a study conducted among urban mothers in West Jakarta, that lactating mothers practised sub-optimal BF because of the bitter experiences of other nursing mothers and their own bitter experience in attempting to practise optimal BF (Nuzrina et al., 2016). These unfortunate experiences of the lactating mothers in the present study could have come about as a result of improper education about how to breastfeed exclusively and lack of BF support. The unfriendly dry nature of the weather in the study area was also found to be a motivation factor to BF mothers to engage in indigenous BF practices. This finding resonates with that of Aborigo et al. (2012), Joel, (2013) and Thet, Khaiing, Diamond-smith, Sudhinaraset, and Oo, (2016) who disclosed that hot weather was among some of the factors that made nursing mothers to give water to their babies before six months. The weather at the research setting is most of the time very hot coupled with the harmattan winds. It is therefore not surprising that lactating mothers feel obliged to give water to

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their babies to drink. This notwithstanding, the BM is reported to contain a lot of water that can take care of the baby's water needs.

5.5 Attitudes of Lactating Women about Indigenous Breastfeeding Practices

The feelings and thoughts of the lactating mothers predict their actions. This study revealed three predictive factors that influenced the lactating mothers' attitudes towards indigenous BF practices. According to the findings, participants evaluated the behaviour as positive, negative and borderline. Those who were in support of the indigenous BF practices saw the behaviour as positive. Those who did not support the practice saw it as negative and those who supported some aspects of the behaviour described it as borderline. No study was found to have classified mothers' attitudes about indigenous BF into these categories.

Positively, majority of the lactating mothers believed in the administration of water and herbal concoctions to babies, usage of certain herbs for BM production, giving porridge to babies less than 6 months and lastly passing down the behaviour to their girl child to continue when they grow. Many of the participants stated that they were convinced that giving water and herbal concoctions to their babies to drink alongside the BM was the best practice. The mothers argued that, the babies are also human beings and therefore must drink water. Similar finding was found in Yotebieng, Chalachala, Labbok, and Behets, (2013) where many of the nursing mothers felt that water should be given to babies alongside the BM. Many of the participants in this current study see BM as only food and so after they have fed their babies with it, they need to give them water to drink to aid digestion. But, research evidence establishes that about 87% of human BM is water (Martin et al., 2016) and so there is no need to give water to the babies to drink alongside

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the BM. This belief that babies need to drink water after being breastfed could only be found in the participants traditional belief systems. It has no empirical support and needs to be defused by effective well-co-ordinated breastfeeding campaigns.

According to Aborigo et al. (2012) lactating mothers who could not produce BM for their infants to feed on were given some herbal concoctions to drink. Some of the concoctions were used to prepare food to eat while some were used to massage the breast and this facilitated the production of plenty BM. Similarly, this current study also found the use of “kognamuning” (a traditional herb) to boost BM production. But the question here is, how much of these concoctions must one drink before the BM begins to flow? It is normal for a lactating mother to have scanty BM flow on the first and second day postpartum. Generally, enough BM begins to flow starting from the third day and so drinking herbs to aid BM production may need to be thoroughly investigated to ascertain the validity of the claim. Wanjohi et al. (2017) discovered in their study that nursing mothers have the perception that when they do not commence the feeding of their babies with solid food early enough and waited for the babies to reach six months before they give them food, they will not eat. This finding was evidently articulated in the current study. It may not be entirely true that if babies are exclusively breastfed for six months they will not agree to eat solid foods thereafter. Probably, it maybe the amount and rate at which the child will eat the food that will be affected, but that will improve with time. Many of the lactating mothers were very positive with the behaviour (indigenous BF practices) that they indicated passing it onto their girl child to continue in future. This is a significant finding that needs to be examined critically if the campaign to conquer sub-optimal BF is to be won.

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Some of the study participants who evaluated the practice of indigenous BF practices as negative viewed the practice of “tugulika” (force feeding) as undesirable. This group of participants are of the view that force feeding could cause the baby to aspirate and probably die from it. A study by Abasimi et al. (2014) revealed that some participants were not comfortable with force feeding because they think that the practice can cause death. This view by the participants about the practice of force feeding could be as a result of the nature and manner the practice is carried out. Force feeding is the practice where liquids (herbal concoctions or flour water) is forced down a baby’s throat to drink by blocking the baby’s nostrils.

Many of the participants had mixed feelings about the practice of indigenous BF. They evaluated the behaviour (indigenous BF practices) as borderline. That is; not entirely useful or useless. These lactating women stated that some aspects of the practice is good while other aspects are bad and should not be practised. Majority of mothers were against force feeding and not the giving of herbal concoctions to their babies. The thinking of these nursing mothers suggest that they have not yet understood the concept of EBF. Much education is therefore required to help these mothers detach themselves from the native way of breastfeeding and to embrace EBF based on its proven benefits.

Other lactating mothers seem to like the confinement practice they are made to go through when they give birth. They however suggested that little space and time be given to them to always come out to enjoy fresh air before going back to the room. This practice of confining a newly delivered mother indoors for 3 to 4 days depending on the sex of the baby becomes precarious during the dry season where the weather is always hot. During the dry season, temperatures of northern Ghana where the study was

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conducted could rise to as high as 42 degrees Celsius. Maybe the practice could be made friendlier by modifying it to make way for postpartum mothers to always come out of the room for some 5 - 15minutes to have a feel of fresh air before going back.

5.6 Subjective Norms about Indigenous Breastfeeding Practices.

Societal norms such as beliefs and practices operating within one's environment may influence her to behave in a certain manner. Many societal beliefs were identified in this study to have influenced the lactating mothers in the way they carried out the care and breastfeeding of their babies. These are beliefs about spirituality, control over infant feeding choices, food taboos, societal pressure and conflicting information.

Majority of the lactating women reported that when it comes to child rearing, there are a lot of traditional and spiritual matters that the elderly males must attend to. Consulting soothsayers and appeasing the gods are among some of the spiritual matters. According to Aborigo et al. (2012) family heads consult soothsayers to find out why babies are not breastfeeding well and to make the necessary sacrifices to appease the gods. The current study also found that many households engage in force feeding of their babies to help them choose successors for the family gods. Others too have a custom where they have to initiate all newborns to the family gods for protection. Mostly, it is the family heads (old men) who superintend over such spiritual matters and under no circumstance should a young lactating mother refuse to obey them. The fear is that, if you fail to obey them you may lose your baby. Education about optimal BF practices should include these family heads.

This study also discovered that control over infant feeding choices are in the hands of mothers-in-law and grandmas. This finding is supported by Aborigo et al.

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(2012), Thet et al. (2016) and Yadavannavar & Patil, (2011) who revealed in their respective studies that mothers-in-law and grandmothers exercised autonomy over infant feeding choices. In most African countries and in the Ghanaian culture in particular, husband mothers live with their sons and their daughters-in-law and since most of these old ladies indulged in indigenous BF practices during their days, they still think that their daughters-in-law should also do same. Health workers especially nurses need to give equal attention to these elderly women when they are embarking on EBF campaigns.

Another subjective norm that surfaced in this study was the restriction of newly delivered mothers from eating certain foods. This was to help conserve their babies' health. Similar findings were cited in Lundberg and Ngoc Thu, (2011, p. 734) and Sein, (2013, p. 1259) where postpartum mothers were prohibited from eating certain foods considered to be "cool". These studies cited both the mother and her baby's health as the reason for the food taboos unlike the current finding where only the baby's health was the reason for the mother not to eat such foods. The belief that anything the nursing mother eats goes direct into her BM and the fact that the people associate certain foods to certain conditions maybe what is influencing this belief. It is therefore prudent that health experts formulate workable educational programmes to help disabuse the community members of this belief to allow lactating mothers to eat all the local foods available to help them stay healthy and breastfeed their babies well.

Equally important finding of this study is societal pressure on lactating mothers about how they should breastfeed their babies. Lactating mothers who did not want to engage in indigenous BF practices reported being put under intense pressure from both their peers and the elderly women in the community to practise it. This finding is

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consistent with the studies of Gallegos et al. (2015), Laar and Govender, (2013) and Russell et al. (2016) where social pressure was found to be among the many factors that made lactating mothers unable to practice optimal BF. The dictates of society is a powerful tool that can do or undo a behaviour. Optimal BF as a behaviour may not be achieved if society does not embrace it. It is therefore significant to note that for the negative indigenous BF practices to be faced off from the study setting, everybody must be brought on board by way of education.

Some (7) study participants also complained receiving conflicting information from both the healthcare workers and that of their mothers-in-law and other elderly women within the community regarding how to breastfeed their babies. A study conducted among postpartum mothers in western Kenya by Walingo and Mutuli, (2014) supported this finding. Also, Yotebieng et al. (2013) disclosed in their study that 73% of healthcare workers who were interviewed on their knowledge levels about optimal BF practices stated that lactating mothers who think their BM was insufficient for their infants to suck can augment with either formula, porridge or juice. If this concern of the lactating mothers is not addressed it has the propensity of discouraging them from striving to practice effective BF and the battle against sub-optimal BF practices will be lost.

5.7 Intention of Lactating Women about Indigenous Breastfeeding Practices

The findings of the study indicated that majority of the participants had several and different plans with regards to how they wanted to breastfeed their babies. Some of their intentions were either influenced by healthcare workers' teachings or their own experiences and that of the elders. Several of the lactating mothers who had planned to

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engage in EBF practices as they were educated to do so by the midwives and the nurses could not put their plans to action because of the influence of their significant others. Aborigo et al. (2012) revealed similar findings in their study. Once the young lactating mother continues to stay in the environment where optimal BF practices is not the norm, it becomes difficult for her to stand up in the presence of the elderly to say that she wants to feed her baby differently. Her plan can only be achieved if all the stakeholders are sensitized to embrace the new feeding concept (optimal BF)

On the contrary, other participants disclosed that they had intended to continue with their indigenous BF practices since the practice had helped them when they were nursing their previous children. According to these lactating mothers, their past experiences with the indigenous BF practice was favourable and so they are encouraged to continue with the practice. This decision of nursing mothers who enjoy practising the traditional way of BF is supported by their mothers-in-law who encourage them to augment their BM to benefit their babies as reported by Nuzrina et al. (2016). Probably, because some of the effects of subnormal BF practices is manifested in later life in the children, lactating mothers do not have any idea about it. It will take a lot of hard work from the healthcare workers to inculcate this into the nursing mothers.

Findings of the study revealed that many of the lactating mothers indicated their intentions to continue to administer water to their babies to drink regardless of the age of the babies. The participants also stated their intentions to continue to prepare the guinea corn flour water to drink during their lactating period to help keep their traditions alive. Gallegos et al. (2015) also found in their study among African women living in Australia observing dietary prescriptions during lactation and introducing water and food to their

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babies within the first week of life in a bit to conserve their traditional BF practices.

Traditions really die hard as they say. It takes a lot of efforts and time to be able to re-orient people's minds. To be able to win the battle against all the traditional BF practices that are inimical to optimal BF, re-strategizing the current baby friendly campaign with specific focus on targeted populations in areas where indigenous BF practices are deeply entrenched is needed.

It was also identified in the findings of this study that lactating mothers whose belief is in the BF gods had the intention to continue to abide by all the rules and regulations of such gods. According to these nursing mothers, it is the health of their babies that matters most to them. It may not be surprising to hear this from the lactating mothers because carrying a pregnancy for nine months coupled with such distressing labour pains to bring forth the baby will make anybody do anything to see to it that the baby survives. Maybe healthcare workers may need to evaluate this practice to identify the harmful aspects of the practice to concentrate their education on. This requires behavioural change communication to make the needed impact.

5.8 Knowledge Deficit about Exclusive Breastfeeding Practices

Majority of the participants exhibited gross understanding of the practice of EBF. Their responses on how they breastfeed their infants demonstrated lack of understanding of the concept of optimal BF even though some of them were able to mention correctly some of the things the nurses taught them. It is evident from the findings that some of the participants knew what they were taught concerning EBF, what they lack however, is the implementation of those principles. This finding agrees with Aborigo et al. (2012) who revealed in their study that lactating mothers have optimal BF knowledge but lacked the

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motivation to implement it. According to Atindanbila, Mwini-Nyaledzigbor, Abasimi, Benneh and Avane, (2014) lactating mothers who purported to be practising EBF in the Bolgatanga Municipality were providing water to their babies to drink in addition to the BM. The findings of these authors also discovered that some mothers intended to exceed the six months' duration for EBF as stipulated by WHO with the reason that the practice was good. Others too were BF their babies only three times in a day meanwhile they also indicated that they were doing EBF.

Another study by Campos, Chaoul, Carmona, Higa, and Vale, (2015) found that nursing mothers who claimed to be practising EBF were also feeding their babies with other liquids. This misunderstanding of the concept of EBF as demonstrated by the participants in this study could be as a result of ineffective BF education by nurses and midwives. Their understanding and practice of what they term EBF might have been shaped by their traditional BF practices. More education on EBF practices to lactating women is therefore needed to help them grasp the concept very well and to also be able to implement it to the latter.

In summary, the discussion covered beliefs about indigenous BF practices, opinions of referent others and motivation to comply, attitudes of lactating women about indigenous BF practices, subjective norms about indigenous BF practices, intentions of lactating women about indigenous BF practices and lastly knowledge deficit among lactating mothers about EBF. All the themes except knowledge deficit were consistent with the Theory of Reasoned Action which was used to organise the study.

CHAPTER SIX

SUMMARY OF THE STUDY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of the study, the implications of the findings to nursing practice and nursing research. Limitations of the study are looked at and conclusion made. Lastly, recommendations based on the implications of the findings are outlined.

6.1 Summary of the Study

Breastfeeding the infant solely on BM for the first six months of the infant's life is considered essential for proper growth and development. However, indigenous BF practices of the people of the Builsa north district supports the augmentation of BM with other liquids during this crucial period of the child's life. This study therefore explored the indigenous BF practices among lactating women in the Builsa north district using the Theory of Reasoned Action as an organising framework. The objectives of the study were formulated using the constructs of this theory. An exploratory descriptive qualitative design with a purposive sampling technique was used to engage fifteen lactating mothers who met the inclusion criteria. The study was conducted at Siniensi sub-district, Sandema. Data gathering commenced after ethical approval was obtained from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana. The interview guide was pre-tested at Sandema hospital to refine the questions and fit it into the context of the study. Lactating mothers who agreed to participate in the study were informed about the study and guided to sign/thumb print a

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consent form before they were interviewed. All interviews were audio-taped and transcribed verbatim. Data collection was concurrent with analysis using thematic content analysis

The study disclosed that lactating mothers had certain beliefs when it comes to BF their babies. These beliefs were categorised into beliefs before the initiation of BF, beliefs during BF and beliefs about experts' advice. The participants believed that before a baby was allowed to start BF, the BM has to be traditionally tested to ensure that it was wholesome. The consumption of certain foods was linked to the production of BM. Mothers also believed in the potency of certain herbal preparations to prevent or treat abdominal pain in their babies.

Referent others such as mothers-in-law, grandmothers and husbands were also identified to have strong influence on lactating mothers when it comes to BF. Lactating mothers who were motivated to comply with their referent others were convinced that what their referent others were telling them was good. Participants of the study evaluated their attitudes towards indigenous BF as positive, negative and borderline.

Societal pressure on lactating mothers to indulge in indigenous BF practices was also discovered. Majority of the nursing mothers practised some of the indigenous BF practices not on their own volition. It was society that dictated to them what to do and what not to do. Participants revealed that their intentions to practise indigenous BF practices were influenced by their past experiences and the teachings of the elderly women. Those who had negative intentions towards the practice were informed by the education of healthcare workers.

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It was also found that many of the lactating mothers had no adequate knowledge about EBF. This could be the possible reason why majority of the lactating mothers employed indigenous breastfeeding practices to breastfeed their babies. This theme was inconsistent with the theory of reasoned action.

6.2 Implications

The findings of the study had implications for nursing practice and nursing research.

6.2.1 Nursing practice

The study findings revealed inadequate knowledge about EBF among the participants. To tackle this issue (knowledge deficit), lactating mothers need to be educated on the benefits of optimal BF as well as the dangers associated with unhealthy breastfeeding practices. Mothers may need to be educated about effective BF on one-on-one basis accompanied with practical sessions to help them obtain the skills needed to practice the act at home. Significant others such as mothers-in-law, grandmothers, husbands and a host of others will need to be sensitized on the benefits of EBF and engaged in supportive measures for BF mothers and pregnant women. These people were identified in the study findings to control the lactating mothers on how they should breastfeed and care for their babies. Periodic in-service training sessions for nurses and midwives on BF will help perfect their skills to enable them deliver culturally appropriate and timely BF education to mothers and will-be mothers. Again, skills obtained from the in-service training will empower nurses and midwives to fashion out well calculated educational programmes that will target the deep seated traditions associated with BF.

6.2.2 Future research

The findings of the study disclosed that indigenous practices affect optimal BF among lactating women in the Builsa north district, Ghana. However, Ghana is made up of so many cultures with diverse beliefs and practices. Therefore, understanding these beliefs and practices regarding optimal BF is important. Furthermore, research among significant others (mothers, mothers-in-law and grandmothers etc.) of lactating mothers is required to broaden the understanding of these indigenous BF practices and the control over pregnant women and young mothers. Again, it is recommended that research be conducted on the composition of BM among lactating mothers who reside in hot weather conditions to identify the percentage of water in the BM. Knowledge from these studies may guide nurses and midwives to adopt strategies that will be more culturally sensitive and acceptable in educating members of the various communities on optimal BF practices.

6.3 Limitations

Despite the useful information this study has unearthed about indigenous BF practices, the study was not without limitations. Fifteen (15) lactating mothers were recruited for the study, thus, generalisation of the findings should be done with circumspection. Findings of the study however, can be transferred to similar contexts since the demographic data and the setting have been appropriately described, but with caution due to the variations in the study population. Also, data were translated from the local language to English. For statements that do not have exact meanings in English language, efforts were made to use the nearest expression to explain them. The limitation of the study to only lactating mothers without the involvement of mothers and mothers-

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in-law made the findings a one sided story. However, lactating mothers who were staying with their mothers or mothers-in-law and had knowledge on the phenomenon of the study were recruited for the study.

6.4 Conclusion

This study explored the indigenous BF practices among lactating women in the Builsa north district using the Theory of Reasoned Action as an organizing framework. It was found that indigenous BF practices are common among lactating mothers in the Builsa north district. Even though most of the practices were detrimental to the health of the lactating mothers and their babies, it was difficult for lactating mothers to avoid the practice because of the influence of their significant others on them to engage in the practice. These findings suggest that lactating mothers and their significant others need to be educated on the dangers of subnormal BF and the benefits of EBF. Therefore, these findings have implications for nursing practice and further research.

6.5 Recommendations

Based on the findings of this study, the following recommendations are made to the Ministry of Health, Ghana, and the District Health Management Team (DHMT), Sandema.

6.5.1 Ministry of Health, Ghana

The Ministry of Health should ensure that:

1. They collaborate with the Ministry of Gender, Children and Social Protection to have women sensitized on the need for optimal breastfeeding.
2. They collaborate with the Ministry of Chieftaincy, Arts and Culture to have all chiefs and queen mothers sensitized on breastfeeding. These chiefs and queen

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mothers will in turn sensitize their community members about the need to allow lactating mothers engage in optimal BF.

3. The current curriculum for training nurses and midwives be reviewed to include traditional BF practices in healthcare teaching. This will equip the nursing and midwifery students with knowledge about IBF practices which will assist them to engage in appropriate BF teachings when they complete their programmes of study.

6.5.2 District Health Management Team (DHMT), Sandema

The DHMT is under the Ghana Health Service. The DHMT should:

1. Ensure that all nurses and midwives under the district catchment area are trained on breastfeeding. Continuous in-service training sessions for nurses and midwives in the district should be organized to update their knowledge on optimal BF.
2. Routine home visits by community health nurses and midwives should be made compulsory. These visits should be scheduled in such a way that mothers, mothers-in-law, husbands, landlords and grandmothers are part of the education that is given to the lactating mothers during these visits.
3. Provide breastfeeding manuals to be used by all nurses and midwives in the district to educate nursing mothers.
4. Periodically organise community durbars in the various sub-districts to sensitize community members on the need to embrace EBF.
5. Ensure that monthly returns on EBF practices are prepared by the various sub-districts and sent to the district health office. These returns must be perused immediately and support giving to sub-districts that are not performing well.

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6. Organise periodic BF training sessions for traditional birth attendance (TBAs) and traditional healers who will in turn educate their clients on the need to practise EBF.
7. Nurses and midwives at the ANC departments should designate one day in a month for BF training session. Pregnant women immediate significant others should be encouraged to accompany the pregnant woman to these sessions.

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Appendix A: Ethical Clearance

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979 *A Constituent of the College of Health Sciences*
University of Ghana

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INSTITUTIONAL REVIEW BOARD



Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

13th November, 2017

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 036/17-18

IORG 0000908

On 13th November, 2017, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Indigenous breastfeeding practices among lactating women in the Builsa North District**

PRINCIPAL INVESTIGATOR : **Anthony Moro M.Phil Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 12th November, 2018. You are to submit annual reports for continuing review.

Signature of Chair:

Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

Appendix B: Introductory Letter



UNIVERSITY OF GHANA
SCHOOL OF NURSING

SONM/F.11

December 19, 2017

Ref. No.:

The District Health Director
Buisa North District
Sandema.

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Anthony Moro, M.Phil Year II student of the School of Nursing, University of Ghana, Legon. As part of the M.Phil programme, he is conducting a research on "**Indigenous Breastfeeding Practices among Lactating Women in the Buisa North District.**" Your outfit has been chosen as her data collection outlet.

I would be grateful if you could kindly offer him the necessary assistance needed to enable him collect data for his thesis.

Thank you.

Yours faithfully,

Dr. Florence Naab
SUPERVISOR

COLLEGE OF HEALTH SCIENCES

P.O. Box LG 43, Legon, Accra, Ghana.
• **Tel:** +233 (0) 302 513 250 / 0289 531 213 • **Email:** son@chs.ug.edu.gh • **Website:** www.nursing.ug.edu.gh

Appendix C: Interview Guide

INTERVIEW GUIDE

Research Topic: Indigenous breastfeeding practices among lactating women in the Builsa North District.

Researcher: Anthony Moro (MPhil Nursing Student)

Address: School of Nursing and Midwifery, University of Ghana, Legon.

Tel: 0244028784

The questions are asked based on the constructs of the THEORY OF REASONED ACTION

SECTION A: Demographic data

Pseudonym/Code No:

Age:

Educational Level:

Marital Status:

Single ()

Married ()

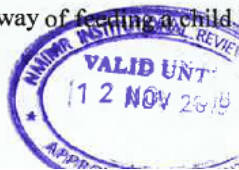
Widow ()

Beliefs about the behaviour (Indigenous Breastfeeding Practices)

1. How old is your child?
2. How long did it take you to start breastfeeding your baby after birth? Why that long?
3. How many times do you breastfeed your baby in a day? Any reason for that number of times?
4. What are some of the beliefs regarding how you should feed your child?
5. Why do you practice those beliefs?

Attitude towards the behaviour

1. Is the practice of indigenous breastfeeding wide spread in this community?
2. What do you think is the proper way of feeding a child below 6 months?



INDIGENOUS BREASTFEEDING PRACTICES

Opinions of Referent Others

1. How difficult was it to you to decide to breastfeed your baby?
2. Who takes decision regarding how you should feed your baby?
3. Are there any consequences to you if you refused to obey them?
4. What are those consequences?
5. What is normally done in this community when a woman delivers?

Motivation to Comply

1. What motivates you to engage in indigenous breastfeeding practices?
2. What demotivates you from indulging in indigenous breastfeeding practices?

Subjective Norm

1. Do you feel like you are being pushed to feed your child the way you are doing now?
2. Who is pushing you?
3. Why do you think those people want you to feed your child that way?
4. What will happen if you do not breastfeed the way you are being pushed to do it?

Intention

1. What was your plan towards the feeding and care of your baby?
2. Has that plan changed? If yes, why? And if no why?
3. If you were left on your own how will you breastfeed your baby?

Behaviour

1. How do you feed your baby now?
2. What are some of the substances that you gave/are still giving to your baby?
3. Any reason for giving your child those substances?
4. Have you heard of EBF? If yes, what is it about? why are you not practicing it?
5. Where do you get breastfeeding information from?



Appendix D: Consent Form

CONSENT FORM

Title: Indigenous breastfeeding practices among lactating women in the Builsa North District of Ghana.

Principal Investigator: Anthony Moro (MPhil Nursing Student)

Address: School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Legon, P. O. Box LG43, Legon.

General Information about Research

The purpose of this study is to understand your cultural and or traditional ways of breastfeeding your baby. If you live in Siniensi and you are breastfeeding your baby who is less than 6 months you are qualified to be part of this study. You are therefore invited to part take in this discussion in an interview with the researcher. In this interview, you will be required to share your experiences about how you breastfeed your baby. This interview will last for about 45minutes. Before you are interviewed, you will be required to sign or thumbprint to indicate your agreement to participate. A conducive time and venue will be arranged for the interview based on your preference. The interview will be audio recorded. However, your name and address will not be needed in this interview.

Possible Risks and Discomforts

You will not be hurt or harmed by providing information on how you breastfeed your baby. However, you are not obliged to answer any question you are not comfortable with.

Possible Benefits

There are no direct benefits from this study but the information you give will be used to plan an educational package for other women.



INDIGENOUS BREASTFEEDING PRACTICES

Confidentiality

No information given by you will be made accessible to other parties except the researcher and his supervisors. Your real name will be represented by a pseudonym or false name to ensure anonymity. Additionally, the laptop on which your information is kept will be protected by a password. All information stored in hard copies will be kept in a cabinet and locked in the supervisor's office. This cabinet can only be accessed by the researcher and his supervisors. These documents will be destroyed after 5 years. Before the interview session starts, you will be required to sign 2 consent forms, one will be kept by you and the other by the researcher. Findings of the study could be published or presented at conferences but once again, your identity will be protected.

Compensation

You will be served with a snack (coke and meet pie) after the interview session to acknowledge your time and effort.

Voluntary Participation and Right to Leave the Research

Taking part in this study is voluntary. You can withdraw from the study at any time. You do not need to give any reason for your decision to withdraw and this will not affect you in anyway.

Termination of Participation by the Researcher

The researcher will terminate your participation in the study if you refuse to sign the consent form. Your participation will also be terminated if you are found to give inconsistent information or if you are found to be in a confused state.



INDIGENOUS BREASTFEEDING PRACTICES

Contacts for Additional Information

In case of answers to pertinent questions about the study contact the researcher Anthony Moro on 0244028784 or his supervisor Dr Florence Naab on 0204522332

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh



INDIGENOUS BREASTFEEDING PRACTICES

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title *(Indigenous breastfeeding practices among lactating women in the Builsa North District)* has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent



INDIGENOUS BREASTFEEDING PRACTICES

Appendix E: General Profile of Participants

Pseudonyms	Age	Marital status	No. of children	Current child's age (months/weeks)	Religion	Educational background	Language	Occupation
Abena	18	Married	1	5	Christian	No formal education	Buli	Farming
Adjoa	24	Married	2	2	Christian	SSS	Buli	Pupil teacher
Adoma	20	Married	3	4	Christian	Primary 6	Buli	Farming
Afia	21	Married	1	3	Christian	JHS	Buli	Petty trader
Afrakomaa	26	Married	4	4	Christian	JHS	Buli	Farming
Akos	21	Married	2	4	Christian	JHS	Buli	Farming
Akua	38	Married	4	3 weeks	Traditiona -list	Primary 6	Buli	Seamstress
Ama	24	Married	3	3	Christian	Primary 2	Buli	Farming
Amoakowaa	23	Married	2	2	Christian	No formal education	Buli	Farming
Ampoma	27	Married	5	3	Christian	Primary 3	Buli	Farming
Asantewaa	28	Married	3	3	Christian	JSS 1	Buli	Hairdresser
Esi	37	Married	7	3	Christian	No formal education	Buli	House wife
Serwaah	25	Married	3	2 weeks	Christian	No formal education	Buli	Seamstress
Sika	22	Married	4	2	Christian	JHS 1	Buli	Farming
Yaa	30	Married	4	4	Christian	Primary 5	Buli	Petty trader

Appendix F: Codes and Descriptions

Table 4.3 Codes and their Descriptions

CODES	DESCRIPTION
BELI	Beliefs
ORO	Opinions of Referent Others
MOTI	Motivation
ATTIT	Attitudes
SUBJN	Subjective Norms
INTENT	Intentions
KD	Knowledge Deficit