Traditional Beliefs and Practices towards Infant Care and Associated Health Impacts: A study in Finoteselam, west Gojjam

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Abstract

Maintaining sound health and wellbeing is the prime concern of parenting everywhere. But the real health situation of infants in Finoteselam is one among the worst in the country. Morbidity and injury remain high in this age group due to the inappropriate and less quality care provided to infants. This study was designed to understand infant care beliefs and practices that have an impact on health in Finoteselam. Cultural beliefs and practices associated to feeding, health management, psychosocial care, and hygiene care have an extensive impact on this regard.

The study employed qualitative method. It was conducted using an interview data of 40 lactating mothers (whose surviving baby aged between 41 day and 12 month) and 6 voluntary health workers in addition to focus group results with heterogeneous group of participants (elderly women, TBAs, herbalists and faith healers) from both urban and rural kebeles of Finoteselam. The collected data through interviews and FGDs from February 08 to March22 was thematically analyzed.

The result of analysis showed that a number of infant care related beliefs and practices affect infant health in Finoteselam both in urban and rural kebeles. While some of them have no known destructive effect, others are found to be dangerous to health. Health damaging beliefs and practices include those which restrict exclusive breastfeeding (beliefs such as breast milk insufficiency, fear of abdominal pain and thirst on babies in feeding sole breastmilk) , behaviors of feeding infants with less nutritious food items, beliefs which delay or hasten the timing in the introduction of complementary foods, behaviors that endanger personal, domestic and environmental hygiene (such as open defecation and urination, absence of water treatment at home, lack of frequent hand washing and bathing) , customs which result in misconstruction of the causes of infant health problems (beliefs on supernatural and spiritual forces) and diseases specific beliefs that initiate unfitting or delayed care seeking.

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List of Acronym and Abbreviations

ANC	Anti Natal Care
BBS	Bangladesh Bureau of Statistics
CSA	Central Statistical Agency
DBURCO	Debre Birhan University Research Coordinating Office
EDHS	Ethiopian Demographic and Health Survey
ETB	Ethiopian Birr
FGDs	Focus Group Discussions
FSAU	Food Security Analysis Unit
HIV/AIDS	Human Immuno-deficiency Virus
IFPRI	International Food Policy Research Institute
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practice
MoH	Ministry of Health
NCT	National Childbirth Trust
NCTPE	National Committee on Traditional Practices of Ethiopia
ORS	Oral Rehydration Solutions
PNC	Post Natal Care
SCN	Ethiopia- Save the Children Norway-Ethiopia
TBAs	Traditional Birth Attendants
USAID	United States Agency for International Development
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Public Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Chapter One

Introduction

1.1. Background of the Study

Infant care is a common undertaking since the existence of mankind on earth. Every nation, irrespective of the nature of social organization and its level of development, has some form of handling its future generation.

However, much of infant/child care behavior is indigenous to cultures, and even to households and individuals i.e. there is a considerable variation in the way different cultures handle the care of their infants. For example, there is a great deal of variation across cultures in ways of feeding, sleeping and responding to feelings of child discomfort with a shared objective of the preserving and maintaining the health and wellbeing of the infant/child (Liamputtong 2007).

From a sociological point of view, infant care is a socially constructed practice. Thus, similar to other human behaviors, it is influenced by cultural beliefs. Due to traditional beliefs, few of the world's infants are actually fed according to Global Infant and Young Child Feeding recommendations (World Health Organization, WHO 2003) and foods or fluids other than breastmilk are commonly introduced in the early infanthood period in most of sub-Saharan countries (Thairu 2006).

Nonetheless, the above stated practices result in health risks to infants in different ways. For instance, traditional practices such as initiating supplementary foods prior to six month of the baby's age are known to led diarrhea and lose of appetite on infants (WHO 2003).

In addition, poor hygiene care behaviors manifested in the traditional way of home construction and management affect infant health by carrying disease causing vectors. The African way of building houses does not protect in any way against mosquito invasion where the victims are mainly infants/children. Houses are built with thatch and mud with openings that mosquitoes easily enter through. It is a common practice for houses to store water in pots and other containers after rainfall. These encourage the breed of mosquitoes around houses. Not uncommonly, vegetations are grown around homes in a typical rural Nigerian society. These also encourage the breed of mosquitoes (Augustine 2007).

Furthermore, traditional management of infant health exists in different communities but it often brings no preventive or therapeutic significances. Instead, it damages infants' health. For instance, among most ethnic groups of Eritrea, the belief that the uvula can swell to block the throat or rupture to cause death of infant leads the practice of cutting the uvula during infancy which in most cases results in excessive bleeding and trauma on the infant (United Nations Fund for Public Activities /United Nations Children's Fund, UNFPA/UNICEF 1996).

In general, some of the traditional infant care practices could interrupt and or complicate the disease status of children to the point of death or disability. They could also deplete or limit the available family resources, thereby limiting the capacity of families to pay for proper biomedical interventions. In addition, traditional beliefs and practices could breed social stigma, especially beliefs in 'devil child' which could lead to negligence and improper treatment of an otherwise malnourished child (Mwangome 2010).

The above situation indicates that the impact of traditional beliefs and practices is pervasive in all aspects of infant care in the country. The conduct of infant care practices in the study area (Finoteselam) is therefore not immune to the stated beliefs. In other words, a variety of well-established traditional beliefs, taboos and superstitions associated with infant care prevail in the area as it belongs to a culture-rich, under-developed nation. Yet, little is known about the effect such beliefs and taboos have on infant health and survival.

The purpose this study is therefore to highlight the variety of cultural beliefs and discuss how these can influence infant care practices after the end of postnatal seclusion. It also sought to clarify how these care practices may potentially impact infant health in the study area. The study is expected to form the basis for health practitioners' understanding of local beliefs so as to provide a culturally meaningful health care.

1.2. Statement of the Problem

The health status of infants in Ethiopia is one among the worst in the world. A study conducted by United Nations Development Program, UNDP (2004) revealed that one out of ten under one year child had long-term health problems while more than one-third had experienced an illness in the last 24 hours before the study.

Despite some improvements in health care and child survival, critical threats to infant health exist today. The common infanthood illnesses in the country include diarrhea, malaria, and acute respiratory infection (Central Statistics Agency, CSA 2011).

Though it is not well documented, the role of traditional beliefs and practices in the above condition is vital. Thus, understanding cultural beliefs and practices relating to infant care is important for the successful delivery of health messages and health services which promote the quality of infant care (Abel *et al.* 2001). This is particularly important in the case of Finoteselam where inappropriate care-giving has resulted serious health risks to un-estimated large number of infants.

Available studies o n infant care within the Ethiopian context mostly came from psychology and health sciences which include; *Dagnew and Damena (1990)*, *Desalegn (2005)*, *Mihret (2007)*, *kelemu (2010)*, *SCN-Ethiopia (2011)* and *Bekele (2009)*.

Dagnew and Damena (1990) discovered harmful traditional ways of managing health in Ethiopia that seriously affect the health of under one children and contribute for the transmission of HIV/AIDS. Particularly in Northwest parts of the country practices such as uvulectomy, milk teeth extraction, and eyelid incision are regulated by a set of beliefs. While uvulectomy is presumed to prevent suffocation during pharyngitis in babies, eyelid incision is supposed to prevent conjunctivitis. On the other hand milk teeth extraction is

perceived as useful treatment for diarrhea. Although many infants/children survive these ill advised procedures and their complications, the considerable damage done to some of the children makes these procedures serious health hazards.

Mihret (2007) on his part discovered inappropriate feeding in the early infanthood among the Sidama where infants are fed juices of amensa (herb) after a month or even sometimes a week to clear their stomach because of the belief that if the infant does not drink "amensa", it will fall sick and will not have immunity from disease.

As regards hygiene, Kelemu (2006) founded that people in Awi zone of Amhara region take field defecation as a tradition. However, this has served as a source of diarrhea for infants in the locality.

Moreover, it has been discovered regarding psycho social care that traditional beliefs on "devil child" or "mingi" resulted in (physical and emotional) neglect of infants and young children among communities of South Omo River in Ethiopia (Save the Children Norway-Ethiopia, SCN-Ethiopia 2011).

An overview of the previously outlined studies indicated that they mostly did not briefly outline the role of traditional beliefs and practices on infant care even when they do part of them fail to create a link between the mode of infant care/treatment and associated health outcomes. Besides, they fail to comprehensively address the basic components of infant care. They rather concentrate on a single component of care. Giving these gaps, the study at hand examines the health impact of a range of maternal infant care practices with an embedded consideration of local beliefs.

1.3. Objectives of the study

1.3.1 General objective

The overall objective of this study was to identify local infant care beliefs and behaviors in Finoteselam and the impact they have on infant health.

1.3.2. Specific objectives

The study was specifically aimed

- To identify the health impact of current traditional beliefs and practices associated with infant feeding in the study area
- To find out the health impact of local beliefs and practices related to psycho-social care of the infant
- To assess the health impact of existing traditional beliefs in infant hygiene
- To describe the health impact of traditional infant health management practices
- To see the rural-urban variation in the health implication of infant care associated beliefs and practices

1.4. Scope of Study

The study focused on infant care practices that are carried out by individual mothers in Finoteselam. Thus, care practices such as; infant feeding, hygiene, psycho-social and health care were treated in relation to the international infant care guidelines. The health effects of such customary infant care practices were explored. Due to financial and time constraints, the study was restricted to five kebeles of Finoteselam. Within each Kebele only those mothers with infants between the age range of 41 day and one year were accounted.

1.5. Operational Definitions of Basic Terms

Infant: In this study the word infant refers a baby with the age of less than twelve months/one year.

Health: is a state of complete physical, mental, and emotional well-being. This definition emphasizes the importance of being more than disease free, and recognizes that a healthy body depends upon a healthy environment and a stable mind.

Infant/child care: refers to the provision in the household and the community, of time, attention and support to meet the physical, emotional and social needs of the growing child. It involves the act of attending the infant's immunization, treatment, hygiene, feeding and emotional safety.

Exclusive breastfeeding: when the infant receives only breast milk without any additional food or drink, not even water, on demand – that is as often as the child wants, day and night, with no use of bottles, teats or pacifiers

Complementary Feeding: an introduction of foods or liquids other than breastmilk along with continued breastfeeding in the period after six month of infant's age.

Psycho-social care: refers to the provision of affection and warmth, responsivity to the child, and encouragement of autonomy of learning.

Hygiene Care: cleanliness of the baby, caregivers, home and surrounding environment to promote health.

Tradition: a set of habits, legends and statements which are transferred from generation to generation by oral or practical ways

Beliefs: are defined as subjective feelings about the validity of an idea or set of facts.

Chapter Two

Review of Related Literature

2.1. What is Infant Care and what are Its Principal Components?

Infant/child care is defined by different scholars and organizations. International Conference on Nutrition, ICN (1992) defined it in terms of the provision in the household and the community of time, attention and support to meet the physical, mental, and social needs of the growing child and other household members. On the other hand, Engle (1992) described infant care as a complex of behaviors such as breast feeding, diagnosing illnesses, determining when a child is ready for supplementary feeding, stimulating language and other cognitive capacities and providing emotional support.

According to Engle (1992), six principal components of infant care are incorporated from the early period of pregnancy up to post-weaning time. These include (1) care for pregnant and lactating women, such as providing appropriate rest time or increased food intake; (2) breast-feeding and feeding of very young children; (3) psychosocial stimulation of children and support for their development; (4) food preparation and food storage behaviors; (5) hygiene behaviors; and (6) care for children during illness, including diagnosis of illness and health-seeking behaviors.

Nandan (2011) also adopted the above six components in the study of child care in urban slums of Agra (India). But the International Food Policy Research Institute, IFPRI (1997) categorized Infant care behaviors into four i.e. feeding behaviors, health and hygiene-related behaviors, psychosocial care of the child, and maternal care and social support systems.

The components of care included in this study are based on condensed adaptation of the above sketches. Thus, child/infant care encompasses child feeding, emotional support, health management and responses that promote a safe environment (hygiene) for the child. This is done by taking in to account the age range of index infants included in the study (between 41 day and 1 year). In other words, care components which go back to the period of pregnancy or go ahead to consider care after the end of infanthood (after one year from birth) are not accounted.

2.2. An Overview of Infant Care Practices and Associated Beliefs

As a cultural undertaking, infant care is affected by a set of local beliefs and practices. Some cultural practices have stood the test of time and have positive values, while others may be harmless, uncertain or harmful (Augustin 2007). For instance, the long birth interval in African societies accompanied by breast-feeding which continued into the second or third year of the child's life enhances chances of child survival where the post-weaning diet was low in protein (LeVine 1994).

In addition, a traditional bab y massage in the pacific highlands is considered a preventive and therapeutic measure. It is carried out 'to strengthen the baby' and is believed to prevent infectious diseases in the newborn. It is also believed to treat conditions like rashes and breathing problems in young infants (Abel *et al.* 2001). Similarly, there are very useful child care practices like prolonged duration of breastfeeding and sleeping arrangements among the Borena of Ethiopia, where the baby slept with his mother for an extended period of time, that have a positive contribution to their socialization (Melkamu 2006).

However, there are other damaging superstititious beliefs and traditional practices performed on infants/children. For instance, among the Hamar, Dassenech and Nyangatom tribes of southern Ethiopia children considered "mingi", babies with the top teeth before the bottom teeth, are viewed as cursed and are believed to beckon an evil spirit into the village with every breath they make. Hence, mothers are not allowed to breastfeed them because of the belief that they themselves become "mingi". In the same way those who are born without wedlock have to be abandoned, casted in to the remote area or killed otherwise a bad luck will come (SCN-Ethiopia 2011).

2.3. Infant Feeding Beliefs and Practices

Cultural construction of infant feeding has many facets. It addresses vital questions such as what kind of foods are appropriate, who should (or should not) feed the baby, what are the expectations for the baby's growth etc. (Valsiner 2000). Infant feeding issues treated in this paper are breastfeeding and complementary feeding.

2.3.1. Breastfeeding Practices and Associated Traditional Beliefs

World Health Organization's report on the evidence for *a Ten Steps to Successful Breastfeeding* in 1998 comprises directives to early initiation of breastfeeding, exclusive breastfeeding for first six months of life, safe complementary feeding as well as on demand breastfeeding while breast feeding continues for up to 2 years of age or beyond (WHO 1998). However, inappropriate breastfeeding still exists all over the world. No more than 35% of infants worldwide are exclusively breastfed during the first four months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate and unsafe (WHO 2003).

Breastfeeding is declining in almost all parts of the world despite its nutritional and immunological benefits. There is also an obvious trend towards decreasing breastfeeding throughout the under developed counties of the world especially in urban areas. Socio-economic development, rapid urbanization and participation of women in work force have all been cited as possible causes for this trend (UNICEF 1996).

Besides the above maternal socio-economic conditions that limit breastfeeding coverage, traditional beliefs about shortage of breast milk supply are still negatively affecting its duration. In Eritrea the amount of breast milk is believed to decrease with the increase of workload and movement and that breast milk increases with rest. Particularly among the Ugana, there is a belief that having male babies decrease mother's milk because males venture outside the home and female babies increase mother's milk because they remain close to the home(UNFPA/UNICEF 1996).

The consequence of the above decreasing trends of breastfeeding coverage and duration is expanded health risks to infants. The major risks associated to these are infectious diseases. Every day, between 3000-4000 infants die in developing world from diarrhea and acute respiratory infections because they are given inadequate amount of breastmilk. Infants who are not breastfed have a six fold greater risk of dying from infectious diseases (WHO 2006).

2.3.2. Complementary Feeding

Choices that mothers make including when to initiate solid and liquid foods other than breast milk have a bearing on the nutritional and health status of children particularly in the early years of life. However, their choice of practicing appropriate complementary feeding is regulated by culture. In every setting, there are cultural norms

for when and how infants should receive foods and drinks in addition to breastmilk (Dettwyler and Fishman 1992).

There is a wide variation within a culture or a group in the timing, type, and amount of supplemental feeds and in beliefs about the appropriate styles of feeding. But each culture/group has a set of generalized rules for feeding infants and for meeting their developmental milestones. Although these cultural norms are dynamic, they are passed down through subsequent generations and retain at least some traditional features. Certain cultural norms surrounding infant feeding hamper mothers' efforts to implement practices that would decrease the risk for infant infection (Varga 2008).

Erroneous application of complementary foods remains dominant in some areas. For instance, Thairu (2006) stated that in sub-Saharan Africa mixed feeding (introduction of solid, semi-solid or soft food in addition to breast milk before 6 month) is the traditional pattern of infant feeding due to the belief on inadequacy of breast milk for sustaining infant. It is common to give infants other substances to drink within the first days of life. After breastfeeding is initiated, infants are typically supplemented with foods and liquids well before they are six months of age.

Research among diverse ethnic groups in Eritrea also showed that among 49.7% of the respondents, supplementary feeding begins at five to six months of age .The types of supplementary food mentioned in rank order include porridge, tea, milk, ***injera***, eggs, rice and biscuits. The stated reasons for giving supplementary foods at this early time were better child development, inadequate breast milk and need to protect the child from illness and hunger (UNFPA/UNICEF 1996). In the same way, several custom based and child related justifications were discovered in Nigeria which include lactation problems,

child refusal of breast milk, the perception that babies becoming addicted to breast milk or continued to be hungry after suckling from a breast (Agunbiade and Ogunleye 2012).

Norms also regulate what is to be given to the infant and what is not. In a Pakistani community; various nutritious foods are not given to the infant in the mistaken belief that they would cause illness. Furthermore, some families believe that some Hot or Cold foods are not healthy. Foods like meat, eggs etc are considered as hot food that could cause allergy, and other problems; and foods like rice and citrus fruits are considered cold foods that hold characteristics of causing flu and pneumonia (Hirani 2008).

Similar to the above, among the pastoralists of Gedo and Bakool in Somalia, it was found that animal organs (liver, kidney, and heart) are not consumed by children. It is believed that children are unable to digest these foods, causing a delay in the development of verbal or speech skills in children. This is then likely to lead to deafness (*Dhagol)* in children if they are fed on these foods. The same belief for consumption of organ meat by children is also held by the urban communities in most parts of Southern Somalia (FSAU 2007).

2.4. Psycho-social care

Psycho-social care is an active mother-child bond and has a direct effect on child health and growth. The mother's sensitivity toward her child, as indicated by attentiveness and responsiveness, provides the child love and affection (IFPRA 1997). Infants develop a great deal of attachment for their mother especially because of feeding. The feeding experience of an infant especially when it is breast of the mother involves a lot of touching, cradling and carrying. The infant gets comfort both from the feeding as well as touching and carrying. Thus such an association is bound to foster the attachment

of the infant with the mother. But by no means the attachment is one directional. The mother too feels very much attached to the infant because of the touching, cradling and caring (Musen, Conger, and Kagan 1980).

Improving the quality of psychosocial care and interaction increases the child's mental ability of malnourished children more than would be possible with nutrient supplementation alone. In addition, there is also a beneficial effect on physical growth and development of children by improving the quality of psychosocial care and interactions (Chavez *et al.* 1971).

On the contrary, nutritional and psychosocial deficits during the first year of life can result in lifelong impairment and disability because this time is critical periods in which brain and physical growth are most active. For example, separating infant from mother may cause emotional harm to the child or disrupt the mother-infant bond .This in turn has adverse consequences for infant's mental and physical health (Booth *et al.* 2002).

Sever emotional neglect in early childhood can result in damaging effects. Without stimulation and proper care, children can lose the capacity to form any meaningful relationships even though such degrees of neglect do not happen frequently. Problems that result from this situation can range from mild interpersonal discomfort to profound social and emotional problems. Neglected children can also be at risk of many physical problems, including failure to thrive, severe diaper rash and other skin infections, recurrent and persistent minor infections, malnourishment, and impaired brain development (Desalegn 2005).

Despite the above fact, many families in Pakistan believe that the child should not be cuddled otherwise the baby would become a demanding child. Therefore, based on that

belief, in few Pakistani sub-cultures babies are encouraged to sleep unattended in a quiet, dark room for long hours to keep them calm. This belief and practice not only causes a delay in feeding but also detaches the child from their immediate caregiver and decreases caregiver-child interaction. Furthermore, such practices effect the child's growth and development (Hirani 2008).

The Nyansengo mother (in kenya) also does not act very affectionately toward her infant, although other care takers may do so. It is rare to see a mother kissing, cuddling, hugging or cooing at her infant. The mother nurses the child mechanically and only occasionally takes it from the nurse when unprovoked by its crying. The Nyansongo infant is loosely wrapped in a thin store, cotton cloth due to the belief that the bodies of infants are excessively warm and must become hardened through exposure to cold (Levine 1994).

Abel *et al.* (2oo1) stated that although there are some differences among ethnic groups of Newzealand, there was a consensus that for its healthy development, the baby needs to be loved and wanted. Likewise, in Baganda (Rural Uganda) infants are smiled to frequently by care takers as well as other adults, are given to other adults to be hold, are encouraged to sit in various social events where they engage with lots of people which pertains them to nurtures them a higher social development during their first year of life (Kilbride and Kilbride 1983). In contrast, infants/children in Sidama are not attended every time they cry depending on the perceived cause of cry (may be due to their bad nature) as it is believed to spoil them and they grow up difficult. Parents fear that infants will be spoiled if they are soothed every time they cry (Mihret 2007).

Male and female infants are not accorded an equal amount of love and affection in some communities. Anthropological and other evidence shows the existing gender prioritization in infant care. Miller (1981) has collected evidence from thirty one ethnographic studies from several regions in India and studies indicate gender differentiation in feeding practices and caretaker bias against female children in breastfeeding, weaning, supplementation practices, and in apportionment of quality foods such as milk, butter, snacks and sweets.

2.5. Infant Health Care

Infant care includes a variety of actions aimed at maintaining good health and reducing exposure to disease and illness among infants (Liamputtong 2007). Shared and learned values, beliefs, norms and ways of life of a particular society are believed to guide their health and illness behaviors and how care is provided (Helman 2001). Among the basic elements of infant health care is therefore an effort to identify emerged health problems and apply protective solution as well as preventive mechanisms for potential health risks.

2.5.1. Custom Based Construction and Identification of Infant Illness

Throughout human history societies have had particular perceptions of health and disease rooted in their own culture which have led to a plurality of practices for disease prevention and cure UNESCO (1996). Helman (2001) suggested that people attribute causes of illness to factors within individuals themselves (e.g., bad habits or negative emotional states), factors within the natural environment (e.g., pollution and germs); factors associated with others or the social world (e.g., interpersonal stress, medical

facilities, and actions of others), and supernatural factors including God, destiny, and indigenous beliefs such as witchcraft.

In different communities infants are perceived to be vulnerable to natural forces such as bad human intent and evil spirits. For instance, in rural Karnataka the mother and child are thought to be physically and psychologically vulnerable to illnesses of natural and supernatural origin. They may be affected by 'drishti' (evil eye), or possessed by spirits and afflicted with illnesses such as 'bheeti shanke' (literally meaning terror and superstition) (Kesterton and Cleland 2009). L ikewise, in Somalia all types of infant illnesses which are not well understood including strong malaria are believed to be caused by the evil eye (FSAU, 2007).

Other beliefs of illness causation also exist in other areas. For example, among communities in New Zealand there is a belief that infant poor health or even death could be caused directly by such behaviors as parental infidelity, violence, inattention, and deviation from traditional practices (e.g. eating prohibited foods in pregnancy, not providing the baby with the protection of bed sharing, or not following correct naming protocols) (Abel *et al.* 2001).

In Eritrea, the belief that measles is a disease brought by 'fairies'(magicians),is common among Tigre, Saho, and Kunama peoples,and is followed by keeping the child afflicted by measles indoors clothed in clean warm clothes, with no exposure to sunlight for up to 40 days, preparing coffee, pop corn, sweets, etc. in room (UNFPA/UNICEF, 1996). Likewise, in rural Zimbabwe diarrhea in an infant was sometimes thought to be caused by contaminated breastmilk from a mother who had become pregnant again. For this reason, if a breastfeeding infant had diarrhea, and if the infant's mother was pregnant

again, the mother would respond to the disease by stopping breastfeeding, and by using an herbal home remedy (Cominsky *et al.* 1993).

Customary identification of infant illnesses or danger signs also prevails in different cultures. In Ghana, most mothers mentioned high body temperature, diarrhea, refusal to suckle, excessive crying and 'Asram'(a sickness that attacks children under one month old or in the womb, caused in numerous personalistic ways; for instance by seeing the breasts or stomach of the pregnant woman, or a pregnant woman walking past a house with Asram medicine in it) as perceived danger signs in newborns (Bahl *et al.* 2005).

2.5.2. Custom Based Treatment of Infant Illness and Its Health Impacts

Traditionally prescribed ways of coping with infection exists in every culture. These are ways that populations without immunization or antibiotics have to fight the risks of life threatening infections at the most vulnerable period in the human life span (LeVine 1994).

Among the Ethiopian Nuer, a leech massage of the body part is believed to remove a foreign object that supposedly is causing health problem, where a leech is spirit possessor (Hall 1998). Similarly in Nigeria giving massage was linked to the importance attributed to the baby's physical and psychological characteristics in terms of beauty, strength, or fearlessness (Abel *et al.* 2001). In addition, treatment of the evil eye through faeces of elephant, hooves of donkey, hyena's skin, garlic and *Ubuore* leaves among the Somali is believed to clear the child's brain (FSAU 2007).

While many of these and other traditional medical practices have helped people struggle against various types of illnesses and manage ordeals of pregnancy and child delivery, a number of practices have proved to be harmful and detrimental to the people's

health, particularly women and infants (Beser *et al.*2010). Unexpected health danger is associated with certain customary ways of health preventing and treating illness. Several traditional infant care practices which vary with culture may cause infections. For example, branding the gums using a hot iron or nail is believed to stop the side effects of teething among infants suffer. But they may develop diarrhea, vomiting and fever due to the natural teething process (UNFPA/UNICEF 1996).

In general, not all cultural elements are motivating people in to modern health care seeking for childhood illnesses. Rather, there are elements constraining care seeking and result in complicated health problems. If children do not receive the proper immunizations, prescribed medications, necessary surgeries, or other interventions due to the influence of tradition, there can be serious consequences, such as impaired brain development or poor physical health.

2.6. Hygiene Care

Various hygiene beliefs exist in some groups that have to do with child health. For example, cold water bathing was believed in Britain and Ireland to cure various ailments and make sick children stronger, a practice that was referred to as 'the cold water cure' (Durie 2006).

There are also common personal, household and environmental hygiene practices affecting infant health. For instance, household conditions like overcrowding and poor ventilation encourage the spread of infection, and both dampness and poor indoor air quality, resulting from open fires or poorly vented stoves (Awasthi *et al.*1996). Global burden of diseases caused by poor hygiene practices has recently been estimated with various disease outcomes, particularly diarrheal disease. The main problem is increased

susceptibility to water-borne diseases such as diarrhea and dysentery, water-washed diseases such as trachoma and scabies, water-based diseases such as Bilharzia, and water-related insect vectors including malaria (UNICEF 2007).

Diarrheal disease is directly related to the quality of water and sanitation services, as well as behaviors that are embodied in various sanitation and hygiene practices. Thus, occurrence of diarrhea can be treated as an indicator of hygiene and sanitation conditions (IFPRA 1997). Children are the most victimized groups from the bad consequences of unhygienic conditions. Nearly 5500 children die every day from disease caused by contaminated food and water (WHO 2004).

2.7. Infant Care in Ethiopia

2.7.1. Infant Feeding

In Ethiopia, infants are the most vulnerable groups among inadequately fed sections of the population. In order to alter this condition, a National Strategy for Infant and Young Child Feeding was developed which provides detailed feeding recommendations and guidelines. Consequently, a National Nutrition Strategy was developed in 2005-06, and a National Nutrition Program for implementing this strategy on a national scale was introduced in July 2008 (MoH 2010).

Despite the above efforts, a wide range of non-optimal infant feeding practices were documented. For example, though breastfeeding is nearly universal in the country (98%), the proportion of exclusive breastfeeding up to six months is less than optimal recommendation i.e. only 52% of infants under six month are exclusively breastfed which continues on average, for 2.3 months (CSA 2011).

The practice of mothers giving water or tea to their children in addition to the breast milk was common (Alive and Thrive Ethiopia, 2010). At 6-8 months of age, 9% of infants received plain water in addition to breastmilk, 6% consumed water based liquids, and 20 % consumed cow milk. As a result, sub-optimal feeding is estimated to cause eighteen percent of infant deaths accounting for the loss of over fifty thousand infant lives every year this varies minimally across the regions (CSA 2005).

In addition, throughout the country complementary foods are often not timely, nutritionally inadequate and unsafe. Only 4% of breastfed children were properly fed in accordance with the IYCF recommendation i.e. given timely, adequate and safe complementary foods (CSA 2011). Moreover, there are misconceptions during the time of infant illness that affect complementary feeding habits. These include the belief that children cannot digest meat or other animal products, that children will choke on thick porridges, that extra food when a child is sick will contribute to illness, that children will refuse to eat during or after sickness, and that bottle feeding is more sanitary than using cups or hands to feed (Alive and Thrive-Ethiopia 2010).

2.7.2. Psycho-social Care

In Ethiopia where factors like socio-economic problems, divorce and death of parents due to HIV/AIDS and other related problems prevail there is a possibility that the infant-mother relationship gets weakened (Gadisa, 2006). For instance, in rural and very poor households of Ethiopia, the proportion of one-year-olds being cared for by non-family members or siblings younger than five is higher [due to maternal work load and the consequent shortage of time for child supervision] than for urban and less poor

households (UNDP 2004). This has deprived rural and poor family infants of the essential love and warmth from mothers.

Apart from the influence of the above socio-economic factors, cultural beliefs and practices also highly impact the strength of health building maternal-child bond. For example, the traditional practice of maternal-infant co-sleeping among the Borena (Ethiopia) for an extended period of time (Melkamu 2006) provides love and warmth to the infant. In addition, such sleeping arrangement helps babies to feel safe and protected as well as feed when they want at the night time (Dosnajh and Ghuman 1997).

In certain areas of the country there is also gender prioritization in care giving. For instance, among the Sidama some mothers preferred boys because male children always stay around their parents even if they get married and because they contribute to the family and help fathers in the farm (Mihret 2007).

2.7.3. Infant Health Care

In Ethiopia infants are at high risk of communicable diseases that are intertwined in one way or another with cultural factors. In 2004, 22.15% of under one year infants had diarrhea, 23.28% had fever (malaria) and 20.1% experienced cough (CSA 2004). The prevalence of childhood disease is higher in rural and very poor households, which also have more limited access to medical help. By contrast, injuries to children appear to be more common among poor households in urban areas (UNDP 2004).

There are measures taken by the government to combat such infectious diseases up on children, first and foremost, the routine immunization services are worth mentioning that are provided to children under one year of age for the six preventable childhood diseases (tuberculosis, poliomyelitis, tetanus, diphtheria, pertussis , measles and tetanus toxoid).

However, low awareness on child immunization among mothers and distorted beliefs resulted in a restricted coverage of immunization. Only 13.9%of infants less than one year were fully immunized in 2004 (CSA 2004). One in every five children had not received vaccinations against BCG and measles, and 25% of the households reported the death of a child under age five (UNDP 2004).

Miss information about immunization is amongst the most serious traits to the success of immunization program. Some examples of rumors are; 'vaccines are contraceptives to population or to limit the size of certain ethnic group' 'Vaccines are contaminated by HIV' and 'Children are dying in receiving vaccines' (DBURCO 2010).

The treatment of childhood illness through a formal health care setting is lower in Ethiopia. 58% of children under the age of five who were reported to have health problems have not consulted for treatment (CSA 2005).

The vast majority of Ethiopia's population lives in rural areas where the health care coverage is low and existing public sector resources are being stretched to the illness. Due to this and other long lived cultural and economic reasons, significant portion of the population resorts to local healers, herbalists and other alternative sources of health care system (Kebede *et al.* 2006).

The treatment of infanthood illnesses and injuries is conducted according to people's customary construction of diseases. Ethiopians attribute causes of health problems to either personality or natural agents and treatment is therefore, believed to be the reflection of these causes (Binyam 2011). The traditional treatment in Ethiopia consists of the use of herbs, cupping, bleeding, cauterization, steam bath, spiritual healing, holy

water, bone setting, and minor surgical process (Wilsen and Wolde 1979 cited in Adane 2010).

2.7.4. Infant Hygiene Care

The government of Ethiopia has been undertaking health extension program having 16 health packages including water, sanitation and hygiene. In line with this Ethiopia Ministry of health has introduced new sanitation and hygiene strategy. The strategy has been tried in Amhara region and it brought significant improvement in sanitation and hygiene practices. Eventually, the approach is shifted from the production and distribution of latrine slabs to social marketing. Hence, increasing community knowledge and understanding of sanitation and its linkages to health created demand for improved services and resulted in behavior changes (WHO/UNICEF 2006).

Despite the above efforts, sanitation and hygiene is still affected by shortage of pure water and traditional beliefs about cleanliness. Seventy-two percent of households use an unprotected water source for their drinking water, and rural households are more than three times more likely to use an unprotected source than urban households (80% versus 24%). Access to sanitation facilities is even more limited: 88% of households do not have access to any type of sanitation facility (toilet or any type of latrine). Ninety-six percent of rural households lack access, but even 50% of urban households do not have access to adequate sanitation (MoH 2002).

Apart from shortage of water and sanitary services, it is well documented that maternal child care and hygiene practices have impacts on the occurrence of diarrhea in children. For instance, some people in Awi zone (Amhara region) conceive an open defecation is a tradition in the locality and others in the same setting believe that

accumulation of human fasces close to their dwellings is unacceptable for fear of bad smell and transgression of bad spirits (Kelemu 2010).

Due to the above mentioned and others customary unhygienic practices, more than 250,000 children die every year from sanitation and hygiene related diseases. 60% of the overall disease burden is related to poor sanitation and hygiene (Child Survival Partnership 2004).

2.8. The Conceptual Frame work of the study

In order to depict the link between the current infant care beliefs and associated health outcomes, UNICEF's extended model of care is applied. The model incorporates multi-level factors that endanger infant health in one way or another. It also tries to address the basic components of infant care that have to do with health including infant feeding, psycho-social care, hygiene care and health care.

Infant health is affected by various factors located from individual to societal level. First and foremost, the maternal behavior of care coupled with adequate food intake and environmental hygiene is the core issue that directly affects health. However, each of these are not immune to local socio-economic systems. Rather, they are embedded in cultural contexts and are regulated by a set of traditional beliefs which sometimes promote and sometimes restrain infant health. They are also determined by a bundle of resources including economic/food resources, maternal/personal resources and health resources. Access to such scarce or valuable resources on the other hand is intermediated by availability within the locality.

At the most general level factors such as overarching values and beliefs on infant care, unavailability of part-time jobs, Poverty and gender roles determine the amount

and quality of care provided to infants by affecting maternal power of accessing the previously mentioned resources.

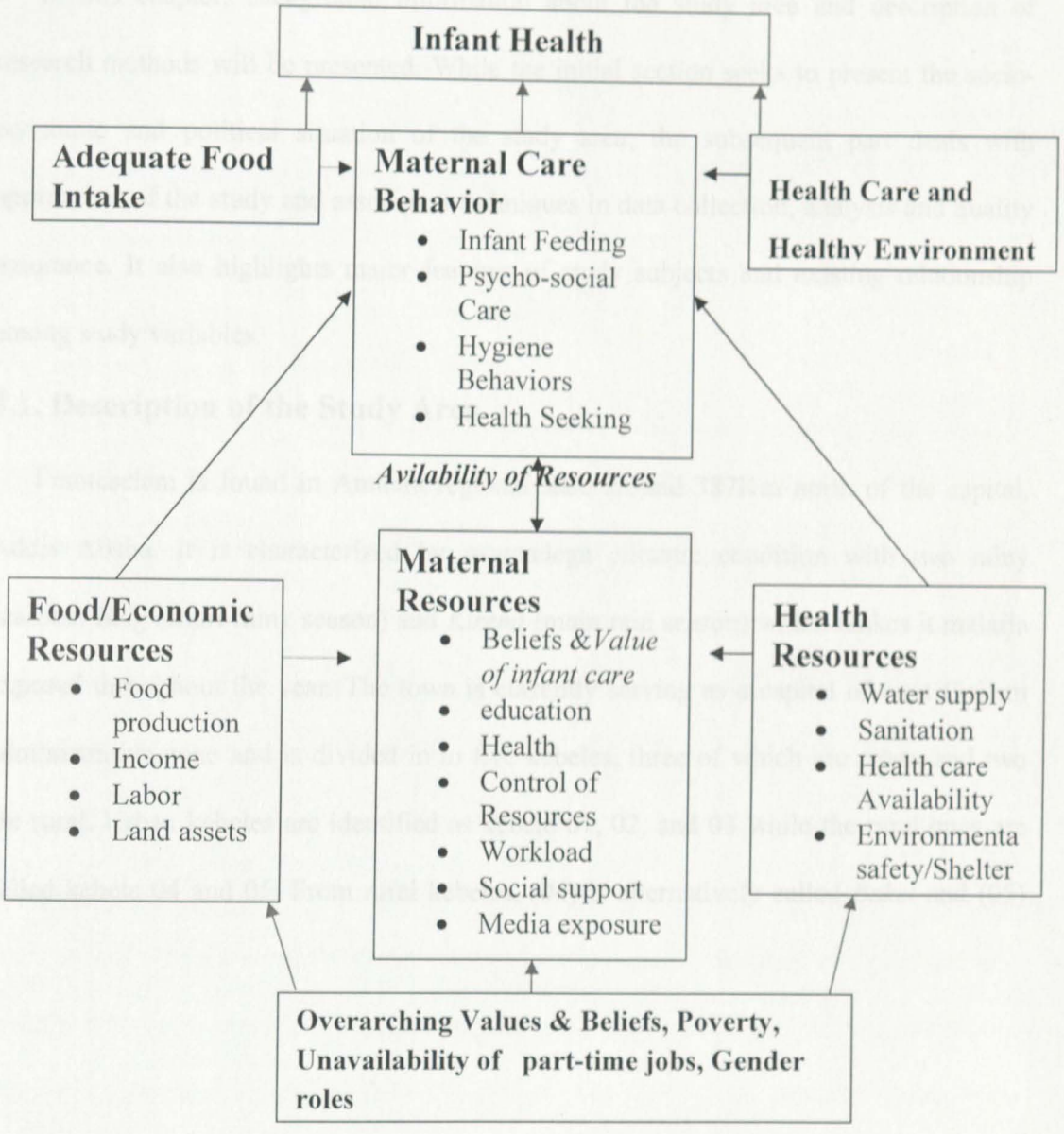

Fig. 3, UNICEF's Extended Model of Care (Engle et al., 1996)

Chapter Three

Research Methods

In this chapter, background information about the study area and description of research methods will be presented. While the initial section seeks to present the socio-economic and political situation of the study area, the subsequent part deals with approaches of the study and associated techniques in data collection, analysis and quality assurance. It also highlights major features of study subjects and existing relationship among study variables.

3.1. Description of the Study Area

Finoteselam is found in Amhara regional state around 387Km north of the capital, Addis Ababa. It is characterized by woynadega climatic condition with two rainy seasons: *Belg* (short rainy season) and *Kiremt* (main rain season) which makes it malaria exposed throughout the year. The town is currently serving as a capital of west Gojjam administrative zone and is divided in to five kebeles, three of which are urban and two are rural. Urban kebeles are identified as kebele 01, 02, and 03 while the rural ones are called kebele 04 and 05. From rural kebeles, (04) is alternatively called *Bakel* and (05)

shembequma.

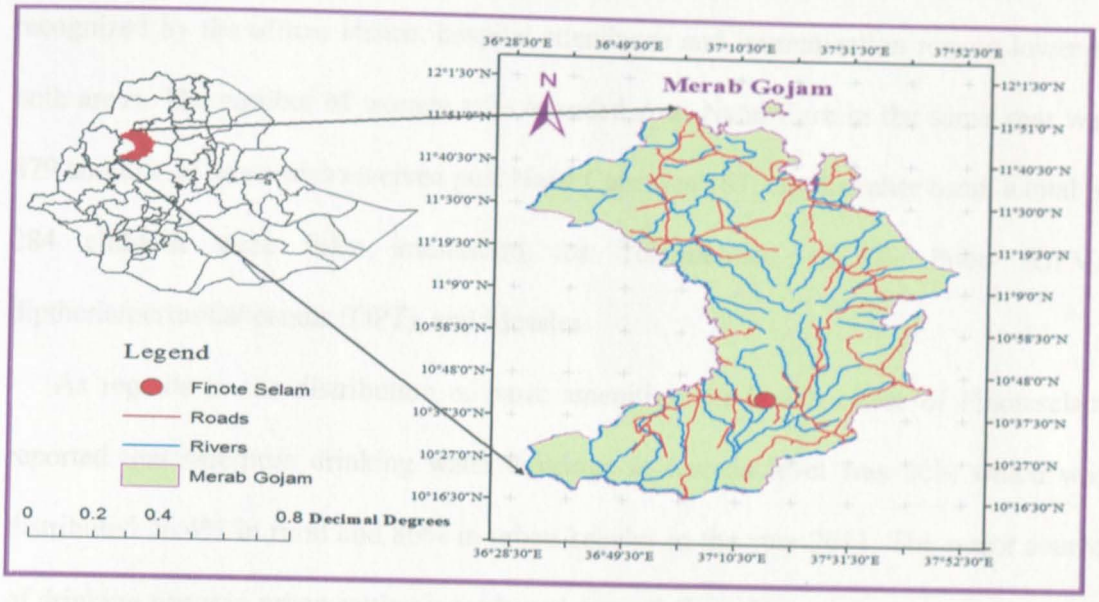

Fig. 2, Location Map of the study Area (Finoteselam) Taken from Ethio-GIS, 2007

According to the Zonal health office, there are 9522 women of reproductive age (15-49 year) including lactating mothers in all kebeles. From these 1296 are currently pregnant. In addition, there are 1191 infants aged less than one year. The health status of infants and young children is lower in the area with the situation in rural kebeles is especially worse. The common childhood/infanthood infections include common cold, pneumonia, measles, diarrhea and malaria.

The town has a total of five health institutions (one public hospital one, public health center and three medium level clinics) rendering ANC and PNC services in government and private sectors. Besides these, there are ten low level private clinics, two governmental rural health posts, two pharmacies and four drug vendors in the community. According to Finoteselam health office, in 2012 basic health education was given to 9389 residents as a result most of rural and 1377 of urban households have fulfilled minimum health packages respectively. But the households in both urban and

rural settings do not consistently implement the packages after being certified and recognized by the office. Hence, hospital attendance and immunization remain lower in both areas. The number of women who attended Anti Natal Care in the same year was 879 and that of those who received post Natal Care was 167. On the other hand, a total of 284 children were fully immunized for Tuberculosis, (BCG), Polio (OPV), diptheria/pertussis/tetanus (DPT), and Measles.

As regards to the distribution of basic amenities, the health office of Finoteselam reported that safe/pure drinking water coverage at woreda level was 66% which was distributed 26.4% in rural and 86% in urban kebeles in the year 2011. The major source of drinking water in urban setting is tap/piped water followed by protected well. However in the rural settings unprotected well/spring and rivers/streams are main sources of drinking water.

When we see the housing condition, there were 7745 housing units in three urban kebeles in 2007 and 25 of these were impoverished, the remaining were conventional, most of which have single rooms made of wood and mud and covered with corrugated iron on the top (CSA 2007). The number of impoverished housing units is high in urban setting where Personal hygiene is suffered from shortage of water, latrine problems and overcrowding. The town also has seven public toilets and one slaughtering institution with a more or less good drainage. But still there is shortage of garbage collecting containers and rubbish transport vehicles/cart.

The socio-economic situation of the study area is characterized by a number of traditional co-operative institutions like *Idir* (funeral association) and *mahber* (includes both religion based and non-religious associations) as well as fast growing investment

and newly emerging job opportunities for the active labor force. While urban residents engage in economic activities such as petty trade, service delivery and craft industry, the majority in two rural kebeles involve in farm and other agricultural activities.

Currently, women are highly involving in the labor force though gender based division of labor both at the household and community level is prevalent in the area. Thus, traditionally the primary care giver of children is the mother. Therefore, in the case of working mother caregivers for infants/children include the grandmother, siblings and household maid. It is only when infants are believed to be fairly strong (at around 4 months of age), and when the mother engage in activity that make holding or carrying impossible that the involvement of other care givers is allowed. Those who involve should be entitled according to custom (mostly siblings, kinswomen and housemaid) because of the evil eye beliefs that gazes of strangers may harm the baby.

Though there is no any study conducted on infant care in this particular area to describe the health impacts of traditional beliefs and practices, a number of newborn/infant care beliefs are apparently observed from early pregnancy to later weaning periods. Hence, the motive behind selection of the study area includes the observed expansion and diverse health impacts of existing traditional infant care beliefs and practices in Finoteselam. In addition my familiarity and deep interest to conduct research with mothers of this area were also the rationales for choosing the site.

3.2. Research Approach

Community based cross-sectional study was conducted to assess the health impact of infant care beliefs and practices. The data was collected using qualitative techniques from February 8 to March 22. Qualitative study was preferred to better understand the

cultural meanings and ways of infant care, and associated health impacts among infants born to mothers in Finoteselam who have settled within a specific cultural context. Qualitative methods enable to generate detail and in-depth information from the perspective of the actors involved, rather than explaining it from the outside (Encyclopedia of Leadership, 2004). Thus, it sought to provide an in-depth understanding of beliefs, perceptions and behavior of infant care from the point of view of the people being studied (lactating mothers).

The subjects of the study were individual lactating women in Finoteselam whose last born baby aged less than one year. The rationale behind the selection of this age range is to indicate the need for re-orienting program attention to this group as much of efforts to implement child survival programs in the area did not provide the required emphasis for this group though the degree of vulnerability to health risks is higher with in this age cohort.

3.3. Participants of the Study

The study was based on the participation of lactating mothers because mothers play a leading role in the health of the family. In the study a total of 67 respondents were addressed from five kebeles in Finoteselam namely, kebele 01, 02, 03, 04 and 05. 04 and 05 are rural kebeles and are called bakel and Shembequma respectively. It constituted 40 lactating mothers and 27 participants from diverse groups i.e. elderly women (9), TBAs (3), herbalists (6), faith healers (3) and modern health care providers (6). While lactating mothers were chosen from each kebele by the assistance of respective health extension workers, other group of participants including elderly women, TBAs, herbalists, and faith

healers were identified by the help of knowledgeable persons in the community (local leaders).

In the selection of participants from lactating mothers, eligibility criteria include residing in Finoteselam, having an infant aged between 41 day and one year, and having voluntary outlook to participate in the study. Likewise, the selection of community health workers, faith healers, herbalists, TBAs, and elderly women was made based on their residence within the area and interest to participate in the study.

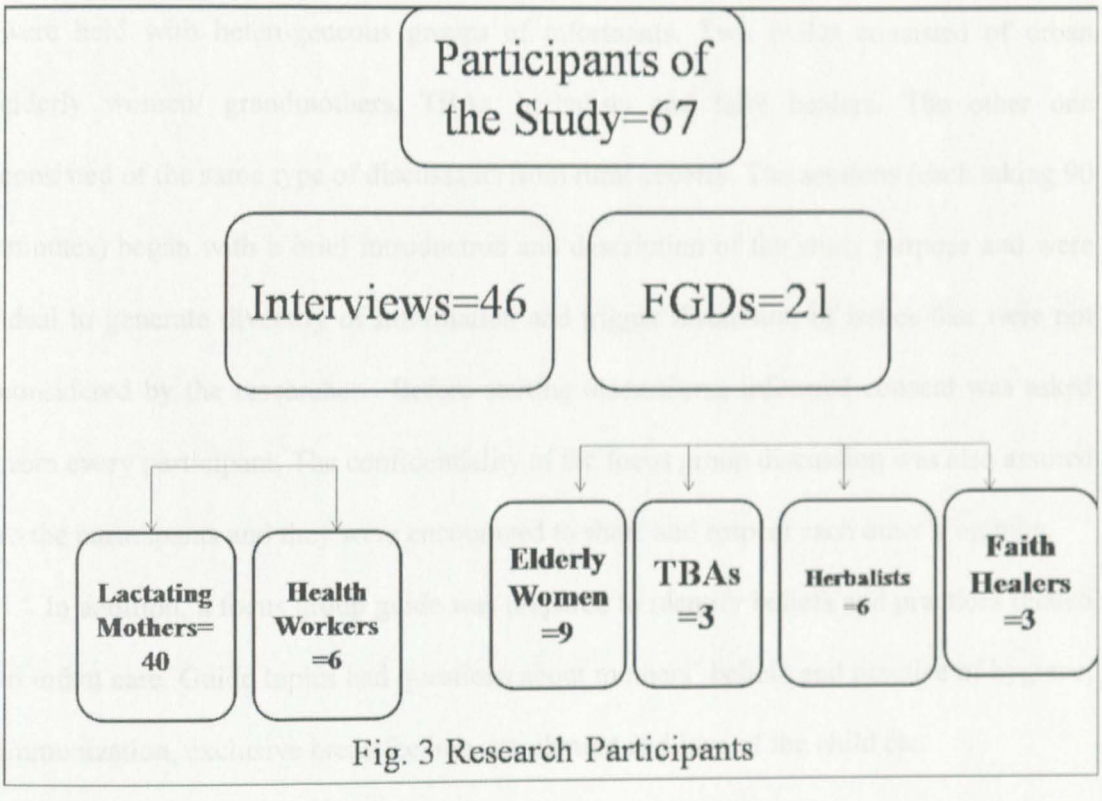

Fig. 3 Research Participants

3.4. Data Collection instruments

Interviews, Focus Group Discussions and partial observation were employed to collect data about traditional infant care beliefs which together took one and half month (from February 8 to March 22, 2013). After verbal consent was obtained from the above

mentioned group of people, eligible participants were approached in separate settings. All interviews were conducted in Amharic at respondents' homes and in the health care setting (for selected health workers) which lasted between 45 and 60 minutes. The total number of subjects participated in the interview was 46 which consisted of forty lactating mothers and six volunteer health workers. In case of both groups, a separate interview guide was developed to facilitate the discussion and the questions were revised based on feedback during initial interviews.

Besides the interview, three separate FGD sessions each having seven participants were held with heterogeneous groups of informants. Two FGDs consisted of urban elderly women/ grandmothers, TBAs, herbalists and faith healers. The other one consisted of the same type of discussants from rural kebeles. The sessions (each taking 90 minutes) began with a brief introduction and description of the study purpose and were ideal to generate diversity of information and trigger discussion of issues that were not considered by the researcher. Before starting discussions, informed consent was asked from every participant. The confidentiality of the focus group discussion was also assured to the participants and they were encouraged to share and respect each other's opinion.

In addition, a focus group guide was prepared to identify beliefs and practices related to infant care. Guide topics had questions about mothers' beliefs and practice of hygiene, immunization, exclusive breastfeeding, attachment and love of the child etc.

3.5. Data Quality assurance

The quality of the collected data depends on the genuenty of subjects in expressing their ideas this again depends on the trust they have on the investigator. Giving this fact, trust was fostered through a friendly approach of subjects and a clear explanation of study

objectives. Apart from these, notes were taken during both interviews and focus group discussions in order to assure the quality of the data.

3.6. Data Analysis

The collected data was thematically analyzed by categorizing similar ideas into groups. Interview and FGD results were analyzed in to four key themes (infantfeeding, psycho-social care, health care and hygiene care). Once the main themes were generated they were revised and manually assigned in to different sections. The socio-demographic and economic characteristics of mothers and the influence of the surrounding social environment were taken in to account in analyzing the interview data. The description was done by integrating the results from both the interviews and FGDs.

3.7. Ethical Consideration

The proposal was submitted to the Department of Sociology at Addis Ababa University. Then, based on the research protocol, permission was obtained from the concerned body. Before interviews/FGDs were conducted a formal authorization letter was obtained from the Department and this was presented to officials of various concerned organs as well as to individual participants and an informed consent was requested from respondents. Moreover, it was made clear to participants that no personal identifiers would be used on data collection for the sake of their confidentiality.

Chapter Four

Data Analysis

In this chapter description of study subjects from different groups including lactating mothers, health workers, TBAs, herbalists, elderly women and faith healers and their beliefs and practices about infant care will be presented based on the data collected through interviews ,FGDs and partial observation. While the first two groups engaged in personal/face-to-face interviews, the remaining took part in FGDs. In sum 67 persons engaged both in FGDs and interviews and the result was thematically analyzed. The analysis was done with respect to the four main themes which have to do with infant health. These are infant feeding, psycho- social care, and hygiene care and health management.

4.1. Description of Study Subjects

In this study, a total of 40 lactating mothers whose children aged less than 12 months were interviewed from both urban and rural kebeles. The collected data revealed that the age of mothers ranged from 15 and 39years at the time of the study. More than half (21) of them were in the age range of 20-24 years and only four lactating mothers fall in the age group of 15- 19 years. At some point during their reproductive lives, almost a quarter (9) of them had experienced the death of at least one child due to illness or injury. Thirty-five lactating mothers were orthodox Christians by religion and four were Muslims while one was Protestant. A ll except 4 mothers were married through a formal wedlock process.

As regard to the socio-economic variables such as education, occupation, income, household condition, family size, health care utilization and child related characteristics, there exists a marked difference among rural and urban lactating mothers. For instance the educational status of study subjects showed that 12 out of 40 mothers, most of which were from rural setting, had never been in formal schooling. From these, 3 had non-formal schooling and they can read and write. On the other hand, 20 of mothers completed primary and secondary education and only 8 have attended more than secondary education. In both lower and higher educational levels, a lot of educated lactating mothers were found to be urban residents.

The educational level of partners (husbands) was also different among urban and rural settings. 17 lactating mothers, most of them are urban dwellers, expressed that their husbands attended primary or secondary education, 13 others attended more than secondary levels but 5 had no any formal schooling. In cases of secondary and more educational levels urban partners were dominant. The rest five mothers had no their husbands (partners) with them during the study because they lost them by death and separation.

The highest educational record of other family members (substitute caregivers such as siblings, house maids and relatives who are currently residing in the same roof), was also found to be variable where 11 had members who attended tertiary education, 14 had members with primary or secondary educational background. The rest had member(s) with no any form of education (3) or had no members other than a marriage partner (12).

When we see employment of subjects, 27 of them, mostly rural lactating mothers, were house wives by occupation, the remaining were on some form of full-time paid

private or governmental employment. The monthly family income of study participants ranged from ETB-300 to ETB-3500. The number of mothers who belong to the lower income group (≤ETB-750) was greater than those in the middle (750-2500 ETB) and higher income category>2500ETB). The reported monthly family income was relatively higher for lactating mothers in urban kebeles than rural ones.

Data on the household condition of respondents revealed that there were 22 mothers who own muddy houses that were mostly covered with corrugated iron and other eight own huts constructed from wood and thatch. But eight of the total mothers in urban kebeles dwell in rented homes of the former kind. The remaining had no possession of houses in their own and were living together with or independently of their relatives. The housing condition in urban kebeles was mostly characterized by separated rooms but not in much of rural kebeles. Some living squatters were unclean and impoverished that lack basic amenities as a result residents particularly infants, were exposed for ill effect of environment. Generally, most families in the study were nuclear type holding a maximum of nine and a minimum of two members .In sum, 26 of the families had less than four family members and the rest had four and above members.

Concerning health care service utilization, majority of rural lactating mothers had no any antenatal or postnatal care and they delivered their last child outside health facilities mainly at home attended either by TBAs or kins-women including grandmothers. Nearly half of urban lactating mothers have attended ANC services including hospital based delivery but few had post natal attendance. G enerally, service utilization was better among urban lactating mothers than rural ones due to the influence of traditional beliefs and other challenges that will be stated in the subsequent sections.

When we see infant-related characteristics, 16 lactating mothers both from rural and urban kebeles have male infant and 24 have female babies. From the total number of 40 infants, one was born preterm and two others were born twins. The age of infants under the study was designed to be within the range of 41days up to 151 weeks. Hence,12 of them were under 6 month, the remaining were between six month and one year.

Besides lactating mothers, 27 respondents from health workers (6), TBAs (3) elderly women (9) herbalists (6) and faith healers (3) were involved. Except community health workers (selected medical practitioners and health extension experts), participants had less/no formal education and were pre-occupied with some form of traditional belief or practice in the provision of care to infants. Yet they were highly influential at both household and community levels. They are respected members for their old aged life experience and advices particularly in identification and treatment of infanthood illness in customized and cost efficient way.

4.2. Traditional Infant Care Beliefs and Practices in Finoteselam

4.2.1. Infant Feeding

Infant feeding includes those aspects as initiating complementary foods timely (at six month after birth), giving breast milk exclusively, applying breastfeeding frequently as well as implementing it on-demand. Each of these practices were found motivated by beliefs and were closely related to infant health status.

4.2.1.1. Breastfeeding Practice and Its Perceived Role on Infant Health

Breastfeeding is globally recommended to be conducted by every mother (except those with HIV infection) since the early time of birth to the age of two years in order to protect and promote infant health. Accordingly, all women (both rural and urban)

participated in the study including lactating mothers, grandmothers and TBAs were keen to breastfeed their babies because of the perceived physical and health benefits of breastmilk for their baby. Among benefits mostly mentioned was nutritional ideality. During the interview one of the lactating mothers stated that "There is no food that is ideal to the baby than a mother's milk because it is God who prepared it in a right quality in a way that makes the baby strong and healthy".

The above explanation indicates that informants had beliefs on sacredness of breastfeeding practice and its spiritual benefits for babies' physique and health. This belief helped to maintain it across generations both in urban and rural setting. Besides, "its spirituality", perceptions of breastfeeding as a cultural undertaking or a normative expectation of being a mother was also discovered during interviews and FGDS in both settings.

The community health extension workers on their part had asserted during the interview that breastfeeding promotes the secretion of breastmilk, strengthens the bond between the baby and the mother and enables the mother provide love and warmth, it is convenient and cost efficient. They also expressed that they are doing their best in transferring health promoting messages to lactating mothers in the area such as the practice of exclusive breastfeeding for six months after birth but their efforts are often hindered by certain beliefs.

Interviews with both urban and rural lactating mothers similarly exposed that it was common to give infants other liquids and solid foods like water, cows' milk, soup, gruel, injera and butter before the age of six month. The common traditional beliefs reported in both rural and urban setting that hinder exclusive breastfeeding include beliefs on

breastmilk insufficiency, fear of thirst, dehydration and stomach pain up on the baby who is fed breastmilk exclusively. In relation to breastmilk insufficiency, one of the lactating mothers from rural kebele (Bakel) goes on to say that "the baby continued to cry after having a feeding from my breast that is due to the hunger from insufficient milk secretion."

Due to the stated beliefs such as fear of thirst and dehydration, only few lactating mothers (mostly urban and educated mothers) whose child aged above six months had exclusively breastfed their infants since birth to the time of interview. Even part of them have reported exclusively breastfeeding their children for only three months.

Failure to practice exclusive breastfeeding had a health impact on babies as manifested in the reported health status of non-exclusively breastfed infants who showed repeated abdominal pain and loss of appetite. Lactating mothers particularly in rural kebeles mentioned that most of them were not practicing exclusive breastfeeding and they have their infants experienced with frequent diarrhea, colics and low food intake. The selected health practitioners in the local clinic also affirm that "sick babies in this area who are caught with more than one illness at the same time are those did not exclusively breastfed."

Contrary to the lower coverage of exclusive breastfeeding, on-demand breastfeeding was found to be a predominant activity in both urban and rural kebeles of Finoteselam. This was because of the influence of strong cultural norms which motivate on-demand breastfeeding. FGDs with elderly women, herbalists, TBAs, faith healers in both rural and urban kebeles showed that "a mother should breastfeed her baby every time as part of her responsibility."

Though seasonal farming and outside home employment created some problem for rural mothers, particularly during peak periods of weeding and harvesting, most housewives were physically available to breastfeed their babies on-demand in the first six months after delivery. The same was true for housewives in three urban kebeles. In other words, rural and urban housewives breastfeed their babies frequently where the spacing between feedings decreases as babies start taking other foods. But lactating mothers employed in organizations or private businesses scheduled breastfeeding to their baby as they conduct breastfeeding when they get breaks from work.

In general, mothers who practiced on-demand and frequent breastfeeding expressed that their babies were stronger and healthier than few who were put to a schedule.

4.2.1.2. Complementary Feeding

Inappropriate complementary feeding practices are major contributory factors to poor health status among infants in finoteselam. As stated in the Global Strategy for Infant and Young Child Feeding, the quality of complementary foods depend on three vital elements i.e. timeliness, adequacy and safety. *Timely* means that they are introduced when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding (exactly at six month of age); *adequacy* on the other hand, means that they provide sufficient energy, protein and micronutrients to meet a growing child's nutritional needs. In addition, *safety* indicates the way in which foods are hygienically stored and prepared, and fed with clean hands using clean utensils and not bottles and teats (WHO, 2003).

Despite the above recommendations, complementary foods were not introduced exactly at six months of age in both rural and urban kebeles. Interviews with lactating mothers communicated that they initiated complementary foods early because they

believe that "it reduces the frequency of infant crying, that it allows the mother to return back to her work and that it saves the infant from hunger and thirst." Opposite to those introduced earlier than six month, there were lactating mothers who apply complementary foods late, at the age of 8-10 months, because they believe that infants are not able to swallow solid foods at the age prior to this.

Besides the stated beliefs, FGDs with elderly women, herbalists, TBAs and faith healers indicated that food shortage has restrained lactating mothers with low family income from timely application of complementary foods both in urban and rural setting. But the condition was more pronounced among rural ones. One of lactating mother from low income family of shembequma(rural kebele) stated that "our family is not food secured and no more complementary food applied at six month of infant's age as it was a bad season."

With respect to the adequacy of complementary foods, it was recommended to apply nutrient rich foods (such as milk, egg, legumes, and vegetables) as well as diversified food staffs. But interviews explored that the reality in the study area was not the way it is recommended. There was very little diversity in diets throughout five kebeles because maternal awareness on the benefits of nutritional diversity and constituents of balanced diets was very low.

Those lactating mothers who introduced complementary foods were asked about the types of food they regularly give to their infants and they mentioned porridge, injera, shiro (Stew prepared from flour of roasted beans or peas), beso (food prepared from flour of roasted barley, with hot water; a thick version is prepared with salt and butter), firfir (mixture of injera prepared in a tomato sauce), chibto (food prepared from freshly baked

unleavened bread by making it into a fist shape),qita (unleavened bread prepared from maize/barley), Kinche (boiled cracked wheat cereal), gruel, cow's milk and water.

Lactating mothers were also asked about the ingredients from which the above stated foods are prepared and they replied that much of items were prepared from less nutritious maize, teff and sorghum. The interviewed lactating mothers justified their infant feeding choices (those described above) in terms of adherence to the norms and customs of their community. They select foods on the basis of their availability at the household level, their cultural acceptability, and their cost than their nutritional value. Although some families in rural kebeles owned land to cultivate nutritious food crops such as millet, green vegetables and bean, most of them have no habit of feeding such important items. Lactating mothers believe that uncooked vegetables are sources of amoeba and stomach pain and should not be given for a baby. As a result, they prefer less nutrient holding foods such as chibto, firfir, gruel and porridge.

Relatively speaking, babies in urban kebeles were better fed than their rural counterparts. For example, a part of urban infants sometimes receive nutrient rich commercial milk, cow's milk, vegetables, fruits, and cereals. But, the stated traditional beliefs penetrated the urban sphere and still regulate maternal feeding behavior along tradional way. Hence, the maternal behavior of applying these nutrient rich items remains to be an occasional/irregular feeding pattern.

When we see another aspect of adequacy i.e. the frequency of feeding, it is recommended (in the Global Strategy) to feed a child aged 6 to 8 months, two to three times per day and a child aged 9 to 11 months, three to four times a day. Yet, lactating mothers feed their babies only every six hour during the day, with spacing between

feedings decreases as babies get older. This is because meal frequency was usually tied to adult patterns of eating even less while in fact, young babies need to eat more often. As for the rural kebeles no fixed schedule was known in feeding complementary items.

With regard to keeping the safety of complementary foods, traditional beliefs and practices appeared to be hindering particularly in rural kebeles leaving several infants at risk of infectious diseases like diarrhea. The detail will be presented together with hygiene care explanations.

All the above aspects of complementary feeding (timeliness, adequacy and safety) are dependent on maternal attachment to traditional foods, their socio-economic features, and health care attendance. For instance, an introduction of complementary foods on the right time and quality varies with respect to mothers' level of education and economic power. Lower educated and uneducated rural lactating mothers had no sufficient knowledge of balanced diets and the time of application. They were also inclined to traditional ways of feeding. One of them in rural setting voiced that "to keep infants healthy, feeding traditionally adapted meals is vital than commercial ones."

Lower income mothers both in urban and rural areas, on the other hand, mostly postponed the application of complementary foods due to inability to access food. But the collected data revealed that economy was not the only thing that matters on-time introduction of nutrient enriched items. Rather, lack of awareness on what and when to feed infants added to the traditional attachment of mothers with the low-nutrient items put a pressure on this regard.

Regarding the role of maternal health care attendance on feeding, lactating mothers who had no higher education, ANC and PNC attendance and media exposure did not

know the timing in the beginning of complementary foods. They were more influenced by health damaging prescriptions given by elderly women, mostly grandmothers and mother in-laws. During the focus group discussion with rural participants (TBAs, herbalists, faith healers and elderly women /grandmothers) one of the grandmothers made clear that "It is only hunger and thirst that harms an infant. Otherwise, feeding customary food items is all enough for the baby because of the demonstrated effect on my babies' health so far".

Coming to the impact of maternal health on feeding, interviewed lactating mothers in both rural and urban areas frequently mentioned that avoidance of breast-feeding during their illness was prevalent in complicated situations but no reported avoidance of breastmilk for the sickness of infants.

The health impact of the above inappropriate feeding styles was founded to be widened that those who introduced complementary foods earlier than six month have their children confronted with lack of appetite and abdominal pain. In addition, mothers who were traditionally attached to less nutritious foods had their infants caught mostly with diseases like diarrhea and malaria because of weakened body immune system.

4.2.2. Psycho-social Care

Lactating mothers in the study area claimed that they were actually practicing closer attendance and psycho-social care of their own index infants. Interviews with both rural and urban mothers yield an information that adherence to the established cultural norms was the major rational in so doing. Tradition promotes the provision of extended physical and emotional support to infants. So babies are never left alone, day or night; there is always someone (mostly the mother) in charge who is close enough to respond to its

needs. According to the focus group discussants from urban and rural kebeles, lactating mothers are expected to be available near enough to the infant whenever they are not working in the office or in the field to provide continual care i.e. to attend to his/her needs, to hold the baby, protect it from harm, to feed, to bathe, to co-sleep, play and interact with the baby.

A partial observation of maternal-infant relation also confirmed the above finding from interviews, where mothers especially housewives were seen talking to and playing with their baby. Likewise, plays were believed to refresh the baby and enable him/her to learn important words and gestures as well as to divert infants' attention during cry.

All lactating mothers in the study, irrespective of their residence, contend that regular eye contact enables them to identify emotions of their baby and respond accordingly. Lactating mothers who perceived (through observation of signals) their infants as passive, fussy and ill were less likely to interact affectively (expressed in terms of regular kissing, and playing) than those who view them as active, demanding and healthy. This had brought a difference in the emotional health of children. Sensitively responded babies were reported to develop strong feeling of security and attachment to the mother .They were observed to cling themselves with their mothers continuously and were happy as well as better consuming ones.

According to the customary undertaking lactating mothers and other caregivers regularly motivate infants to sit, stand or walk on their own at different occasions within the first year of life. It is also common to initiate them to vocalize/imitate simple words and speeches so as to help them develop language skills faster. Lactating mothers

particularly in urban areas believed that such training provides the baby a sense of autonomy, joy and physical strength.

Similar to the above condition, co-sleeping was also a common normative undertaking in both urban and rural kebeles that was viewed as a way of rendering breastmilk as per the need of the baby. It was also viewed as important mechanism for lactating mothers to act affectionately by applying behaviors such as hugging, kissing, patting, whispering, and speaking.

Besides, regular kissing and body massage were considered significant in strengthening, and activating the baby. Furthermore, cuddling/carrying was believed a source of comfort/protection and warmth for the baby. These all were practiced in both urban and rural kebeles so as to build the baby physically and psychologically. This in turn helps babies to reduce the widened probability of falling ill from tradition driven health damaging practices.

Fig.4, the customary way of carrying infants by lactating mothers in Finoteselam

In order to identify the role of maternal social support on the quality of psycho-social care, lactating mothers were asked if they had adequate social support from their support networks and they identified various groups as sources of support. The foremost ones for the majority were husbands, grandmothers, mother-in-laws and herbalists. Identified illiterate and less educated support sources were found diffusing health threatening beliefs and practices in rural kebeles. But it was not an all damaging one as strong social support satisfied the emotional and social needs of lactating mothers which in its turn motivate them to act affectionately toward their babies and extend love and warmth to the babies.

Interviews with urban and rural lactating mothers also revealed that every mother in the area has to do her best to calm a crying baby particularly at night because cries at this time are believed to summon a devil. Hence, they were responsive to infants' needs by recognizing discomfort signals (crying and murmuring) or danger signs which is accompanied by taking appropriate measures like feeding during hunger, changing the diaper (nappy) when the baby shows physical unrest, massaging the baby or making him/her sleep when s/he manifests weakness and passiveness.

The need for close attendance and responsiveness to infant's needs was mentioned by the discussants from urban kebeles (a group consisting of TBAs, herbalists and elderly women) in such a way

> *A lactating mother should not separate her baby from her sight even for a while as likift (malovent spirit) or meqechet (injury) may happen to the baby. She also has to soothe a crying baby through various mechanisms such as plays which divert its attention, breastfeeding him/her or by (Ishururu) holding him/her and moving here and there, for the baby might have hunger for discomfort.*

From this statement, we can understand the local belief that babies remain unattended will be attacked by an evil spirit. This belief motivated the physical proximity and regular eye contact between mothers and their babies in the area which in turn supports the baby emotionally.

A focus group discussion with the same group of discussants from rural kebeles furnished a more or less similar outcome with the above. It conveyed that mothers have

to consider their baby all the time (when going to the market or field). Ignoring or neglecting a baby is undermined. Thus, any injury/illness happened to a baby results in gossip and ostracization against the mother for her failure of being attentive to him. This type of care is deeply rooted in the local culture.

In general, the role of maternal socio-demographic characteristics and residence were not significant in the provision of love and warmth to the baby. There was no difference among educated and uneducated as well as rural and urban lactating mothers in psycho-social care of the infant.

Nonetheless, economy plays an indirect role in affecting emotional care of the infant. A part of lower income lactating mothers in both rural and urban kebeles preferred to work outside home so as to supplement their family income. During the interview they explained that they were unable to adequately supplement their babies emotionally because of their separation/physical unavailability to their baby for a long time during the day. FGDs with both urban participants also similarly exposed the challenge lactating mothers face in providing consistent love and warmth to their babies due to interruption especially when the work atmosphere became unsatisfying to them. The situation was discovered to be worse in the absence of substitute caregiver who is closer and active enough.

In expressing the effect of poor psycho-social care on infant health, rural and urban lactating mothers jointly reported in interviews that less supervised infants exhibit insecurity and ambivalence as well as refusal to consume food which endangered their health status. On the other hand, infants who received regular supervision in terms of frequent breastfeeding, massage, eye contact, kissing and co-sleeping were less

susceptible to injury and illness. They showed good appetite, happiness and attachment to mothers. They were also "better protected from evil spirit and ***buda***".

4.2.3. Infant Health Care

Infant care includes a variety of actions aimed at maintaining good health and reducing exposure to disease and illness among infants. Among these, earlier recognition of danger signs and illness symptoms, taking preventive measures and seeking culturally competent care during the occurrence of health threat are integral issues.

4.2.3.1. Recognition of Danger Signs and Construction of Illness causation

Respondents in both rural kebeles were asked to identify the culturally perceived causes of common infanthood illnesses and the ways of recognizing them. Lactating mothers replied that they recognized common childhood illnesses in their locality (diarrhea, common cold, ***mich***, ***brd***, malaria, abdominal pain and pneumonia) by signals observed up on infants which by and large include depression, persistent crying, irritability, food refusal, weakness (***mezal***), sleeplessness, vomit, rash, body swelling, fever (***tikusat***), short and interrupted breathing. Lactating mothers reported that their children had experienced one or more episode(s) of such illnesses.

Interviewed health workers similarly disclosed that though the threat of infectious disease to infant survival had recently been lessened in the area, respiratory disorders coupled with fever remained major threats to infant health in the study area.

Coming to the commonly believed causes of the above health problems, bad weather and poor hygiene were repeatedly noted by lactating mothers and other focus group discussants in urban areas. These groups of participants believed that excess sun light is a source of ***mich*** (sunstroke), leading to skin disease. ***Yemata tsehay*** (sun's ray

immediately before it sets) is also believed to cause stroke. A blowing wind, "bad air", on the other hand is thought to cause ***brd*** causing cough and fatigue. Lactating mothers also stressed the role of poor hygiene and dirt intake in such a way that "Infants take everything they hold with their hands in to their mouth, sometimes they swallow/suck dirt materials including their own unclean fingers when they are not attended. The dirt object that they swallow or suck leads to diarrhea."

From the above statement one can understand that urban lactating mothers have better awareness of the causes of diarrhea. The interview results with health workers also furnished that much of diarrhea exposed babies are not exclusively breastfed. Rather they are often fed with contaminated food as their mothers had no adequate storage facilities.

Moreover, attribution to evil spirits was discovered in rural kebeles. "The effect of ***ganel*** (devil), ***zar*** and witche was important in spiritual illnesses." ***Zar*** is a form of spirit possession treated by a traditional healer through negotiating with the alien spirit and giving gifts to the possessed patient. For instance, if a child remains incapable of sitting properly on its own starting from the 4th month of age, it will be interpreted as malice caused either by a spirit or witchcraft with an evil interest to harm the baby. Similarly, if it acts violently and shows disturbance, it will be attributed to the effect of an evil eye.

In general, distorted construction of disease causation often exist in the community as observed in maternal attribution of sickness arising out of hunger and lack of hygiene to spiritual factors. A fever manifested on the baby following vaccination was also sometimes considered the cause of malaria. Besides, Knowledge on immediate and long-term effects of certain diseases was also scanty or missing among younger mothers in both urban and rural districts. For instance, stomach pain and diarrhea are not seen to lead

extreme health complication in rural settings since they are common in most infants. One of the mother stated that "*an infant and stomach pain are inseparable.*" This has served as a restraining factor for taking appropriate medication.

4.2.3.2. Prevention of Illness

Participants both in urban and rural kebeles were asked about the customary ways of infanthood illness prevention. They replied that they depend on intensive breastfeeding, and infant vaccination. Hence, everyone has breastfed its baby while only parts of them vaccinate infants. However, interviews with health workers exposed the fact that exclusive breastfeeding and full vaccinations were very low in both urban and rural kebeles due to the belief that vaccines bring infertility and exclusive breastfeeding results in thirst up on the baby. Findings from the FGDs also indicated that some mothers, particularly in rural area, did not believe in taking children for immunization because of their belief that vaccines cause fever to their babies.

Besides, disease specific beliefs motivate rural people to adopt risky "preventive mechanisms." For instance a belief on the polluted/spoiled nature of blood which circulates through the vessels around babies' face motivates people in both rural kebeles to adopt eye lid incision so as to prevent future headache and eye illness on infants. The process is usually done through sharp and unclean materials that create infections which hamper infant survival or wellbeing. Though not widespread, similar cases of complication arising from ovulectomy were also founded during the interview with lactating mothers in one of the rural kebeles called shembequma. It was performed on the view to prevent the perceived danger that will be posed if it grows larger. They believe it will be a source of tonsils to infants and needs to be avoided at early age.

In addition to the above local preventive mechanism, there was the act of keeping infants out of the sight of strangers during breastfeeding taken by lactating mothers in rural locations. It was also common to attach ***hirz*** (herbs like ***Tinadam*** (rutaceae) bundled with a written text inside a piece of bid, prepared by a witch or supposedly religious men) to the infant's body on the belief that it would avert evil eye. Furthermore, the act of co-sleeping with a baby while putting an iron bar underneath the bed on the belief to avoid evil spirit was usual in the rural settings.

4.2.3.3. Treatment of Illness

During interviews, selected health practitioners in the district hospital conveyed that health care use for infant illness/injury in Finoteselam was dependent upon the mother's sensitivity to and awareness of the infant's physical and emotional state. Urban lactating mothers who attended anti-natal and post-natal care and well educated ones were more sensitive to illness symptoms (such as fever, short breath, and cough) and visit modern health centers as they learned the long-term effects of an illness or injury. They were also the ones who adequately treat slight illnesses by applying their own knowledge together with customary/normative medical prescriptions. But the multitude others did not have very deep knowledge of treating illness even though they had traditionally identified it. Consultation of elderly religious men, herbalists, witches and TBAs was common in such cases after a solution was sought within the family.

Lactating mothers whose baby had ever got illness in both urban and rural areas reported that they initially attempted home remedies and when the illness persisted, they consulted herbalists. Only in severe diseases or emergency cases, they immediately visited health facility. Among interviewed lactating mothers, majority had complaints of

infant diarrhea and common cold. However, very few took a baby with diarrhea or cough to a formal health facility. They rather employ local treatments like applying food based liquids/juices and steaming the baby through a smoke of ***Tunjut*** (kind of plant). Even, no treatment was often sought because diarrhea and cold were recognized to be common and short existing.

Similarly, treating infants with abdominal pain normatively involves the use of spices such as ***Tikur Azmud*** (black seed) and ***Feto*** *(brassicaceae) together* with water and ***Injera Firfir*** *in* both rural and urban kebeles. Massage of stomach was also applied by TBAs and lactating mothers to minimize the pain. In addition, treating fever initially involves showering or holy water sprinkling followed by steaming with a boiled ***Damakese***. Furthermore, steam bathing with ***Damakese*** and body massaging were performed to treat ***Mich*** *(strock) and* ***Meqechet*** (body injury) respectively. While the former was made within the household, the latter was referred to traditional physiotherapists locally called ***Wogesha*** and TBAs who apply smooth massaging techniques using butter as lubricant. Apart from conditions of injury, baby massage was also used every time on the belief to strengthen joints and limbs of the baby.

Another form of treatment in the community was spiritual healing. It was performed by applying "holy water", reading verses from "holy" books, regular praying and animal slaughtering for healing purpose as per the order of traditional "healers" (religious men, witch, spirit possessors...). The reason for reliance of mothers on such indigenous healing systems was found to be their understandings of health and illness within traditional paradigms based on supernatural interventions that are mediated by traditional practices.

For instance one of the mothers disclosed the reason for her adherence to traditional healing in such a way;

> *When my baby started vomiting every time she consumes a meal, I gave her feto(brassicaceae) but the illness persisted longer with manifest complications and I came to suspect that some kind of bad spirit (likift) has touched her and I resorted to religious healing by taking her to holy water at Wogagualesa(located in the outskirt of the town).*

In the study area, evil eye (***buda***), as an illness was also treated in two main ways either by forcing the suspected person (a person believed to harm the baby through the extreme power of his eye) to take over his/her mischief on the attacked infant or by burning a plastic and holding the infant to inhale the smoke.

A thorough analysis of the previously mentioned health status of infants showed that rural infants were reported to have repeated sickness of one or more sort than urban ones. They were also mostly taken to traditional healing centers (places of herbal medicine, spiritual treatment and healing of personal effects like witch and evil eye) than modern health care centers such as hospitals or clinics.

Personal/face to face interviews with lactating mothers conveyed various reasons for preferring traditional health care. From these, the influence of maternal social networks (mostly partners, elderly women and herbalists) was the most cited reason followed by maternal belief that "common infant illnesses warrant local remedies as modern health care is not adequate to handle all type of illn esses." Besides, inabilit y of affording

payments for diagnosis and treatment in clinics and hospital was noted as driving factor for maternal reliance on traditional health care.

When we see the outcome of traditional treatment, only a part of seekers got some form of improvement from their effort to treat health defects within the traditionally set mechanisms. The remaining had never seen positive changes; rather a part of them faced complications in various ways. For instance, five out of eleven who relied on herbal medicine for infant illness (stomach ache and diarrhea) got complications in terms of swelling and fever. Other four have witnessed neither improvement nor complication of illness. The remaining two reported improvements in health at least for a short period of time.

In addition to the above, treatment of evil eye and *likifi* was sought by rural lactating mothers; the reported outcome for this measure was some form cure or improvement in infant health at best and unchanged health condition at worst. Conversely, no positive solution was achieved for witch effect by complaints who resorted to another witch.

In general, those who inclined to traditional treatment did not seek prompt care from modern health institutions and did not often obtain a lasting solution to the health problems of their children, rather they face complications. A better result from adherence to traditional care was mostly seen for illnesses related to evil eye and *likifi* than environmentally originated once.

4.2.4. Hygiene Care

Interviews, FGDs and observation on the existing hygiene care of infants in rural and urban kebeles showed that people adopt unhygienic practices causing several water and air borne diseases to infants. Interviews with urban lactating mothers revealed that villagers urinate in open fields or home yards despite the presence of community latrines,

as one has to pay for using it while in rural ones they defecate in the bushes around homes. Observations also communicated that in most rural and partly in some urban households infants were similarly held to excrete near the home which often was left uncleaned. Even toddlers were not mostly trained toileting through potties because potties are not common in the area.

Besides the above, no well organized solid waste management was observed in both urban and rural villages. Focus group discussions with urban participants indicated that solid waste was thrown in to the streets and within compounds that could be spread by animals, rain water and wind because garbage collection was irregular. As observations in to rural villages showed, the situation in rural kebeles was found to be worse where wastes including animals' dung is stored or distributed near home to breed malaria. Above all, some lower income rural mothers also viewed safe hygienic practices as a rich people's affair.

The consequence of the above unhygienic conditions around the homes and villages was diarrhea, cough, common cold and malaria among infants as stated by health extension workers. One of them elaborated that "Every time we teach them (mothers) to isolate solid waste from liquid one, they do it in their respective homes for a while (during the period of training). Unfortunately, they abandon it after they become graduated in extension packages."

From the above statement we can see that mothers are not able to practice the way they were trained because of the lingering influence of traditional outlooks up on them and their lack of power to decide up on household affairs. This has exposed under one children for pollution and associated sicknesses.

Regarding personal and household hygiene, observations and FGDs disclosed that in cases of non-separated rooms, mostly in rural kebeles, household untidiness posed health problems in babies because smokes from stoves affect their respiration which led to cough and interrupted breathing (pneumonia).

As regards access and usage of water, unlike urban lactating mothers, mothers in rural kebeles reported that access to safe water for domestic use was of major challenge to them. As a result, they rely on water from less protected sources such as wells and springs. Although there was an effort by local officials and health workers to treat water at the source, treatment at home either by boiling it or by adding purifying substances on it before giving it to infant was not known by most of rural mothers. In the aforementioned areas, there is an expanded tradition of drinking unclear water on the belief that it will not bring any danger. In the interviews one of the rural lactating mothers disclosed a local saying that *"kehod kegeba hulum tena new"*, which is to mean, all that reaches/enters a stomach keeps health.

In both urban and rural settings an observation on the way of using water demonstrated that the method of drawing water from a container is by damping a cup in to a pot and pulling it out. This mode of water usage appeared to be polluting to the entire water in the pot which resulted in diarrhea. Interviews also revealed that it was common to preserve "holy water" for longer time. Usually, the water gets polluted through exchanging weather and smokes of the fire. Hence, water pollution remained health threat to babies in both settings.

When we see the safety of food during preparation and storage, rural lactating mothers reported that they use plain water and ashes to wash utensils. Women in urban

areas on the other hand use soap and detergents for the same purpose. Lactating mothers in urban areas also stated that they usually wash their hands and hands of their infant before feeding the baby, after return from toilet or garbage disposal but not the case among mothers in rural kebeles.

Although it was globally recommended to serve infants fresh meals, interviews with urban mothers revealed that infants of working mothers did not receive fresh meals. In the same fashion, leftover foods are stored for later feeding. Yet, long hour storage in the absence of refrigerator spoils the food. The situation in rural kebeles is further aggravated by the interference of domestic animals like cat, hen and dog in polluting food and water prepared for the baby. These together have contributed the common infanthood illness.

Observations and Interview results confirmed that in both rural and urban kebeles regular sweeping of the house is a normative practice of mothers in every morning. But infants get polluted while crawling on the ground, giving the construction nature of most houses (having muddy wall and floor). This is precipitated by the common practice of leaving infants crawl on the floor after the age of six month on the view that they will be

as they struggle to walk and hold things.

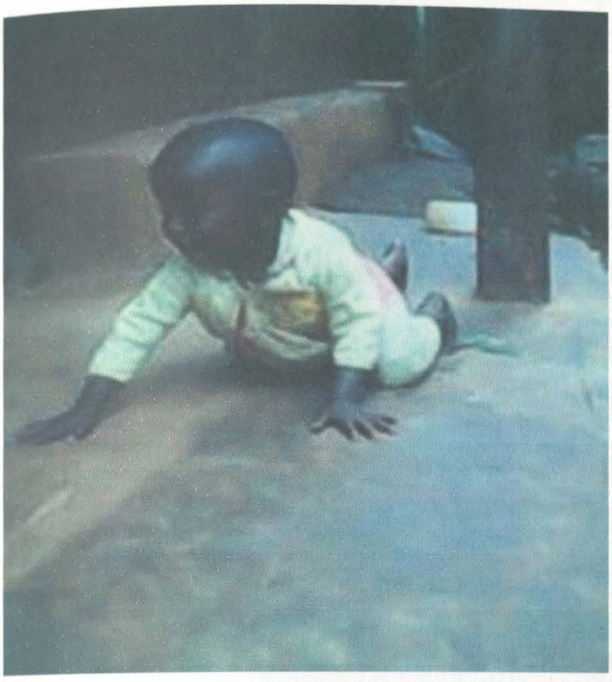

Fig.5, a baby crawling on the ground in the urban household

In rural kebeles infants are bathed regularly in summer and less frequently in winter. Every time infants are bathed, it is common to dress them with a washed cloth and nappies. However, the customary way of bathing was by laying/putting the baby in a dish called *safa* (if it is too young and unable to sit) or in the ground and pressing him/her down and pouring water over his/her head and continuing down to the whole body using soap. The latter mode of bathing is not safe enough to clean babies as it allows part of the body to remain dirt.

Lactating mothers in both urban and rural kebeles were also asked about their own personal hygiene because this has a direct impact on the health of the child. Accordingly, urban lactating mothers replied that they clean their own body and clothes twice a week but rural mothers clean only once a week. Apart from these, breast care was noted under

personal hygiene of mothers. Concerning this, interviews delivered that urban mothers keep their breast dry and clean in all circumstances but not rural ones.

In line with the above, interviews with health workers revealed that rural lactating mothers are not keeping proper personal hygiene including breast safety because of work load and the consequent time shortage. The situation of poor mothers was even worse as they have no substitute clothes to wear when the other gets dirt. This unhygienic behavior is aggravating child infection in the area.

Generally, unsafe hygiene practices of mothers, neighborhoods and the general community have resulted in health risk factors to babies and other members in terms food, water and air pollution. The common diseases followed were infectious diseases like diarrhea, acute respiratory infection and malaria.

4.2.5 Gender Issues in Infant Care

In Finoteselam babies are believed to be gifts of God and are highly valued. But gender preferences were founded in certain aspects of care. Interviews with lactating mothers revealed that, although male children are highly demanded, there was no major sex based differentiation in care of babies with in the household. Nevertheless, due to the influence of local customs on lactating mothers in both rural and urban areas, they breastfed males longer than girls to make them strong. Besides, health extension workers contend that male partners/husbands are proud of male babies because of the patrilineal cultural influence in the community and invest a lot of family income in caring boys. One of the health extension workers expressed the situation saying

I know a husband in this kebele (02) who refused to buy a cloth for his own female baby on account of her sex while she was suffering from dirt and discomfort. Neither he assists his wife in attending the needs of that baby nor he spend money except in cases of illness.

In terms of psycho-social care, observations communicated that there were cases of male baby prioritization which was manifested through the frequency and persistence of holding, kissing, breastfeeding, speaking to and playing with the baby. There was also a marked difference in the degree of maternal responsiveness during the time of infant distress, cry and food refusal. Mothers were not similarly/equally sensitive in such situations for male and female babies. They rather were found less sensitive to the later. For instance, no adequate response was extended to female babies even if they manifest discomfort signals such as cry.

Unlike in urban kebeles, rural kebeles manifested sex preference in health seeking for infanthood illness. Interviewees from rural lactating mothers reported that due to influence of their support networks such as grandmothers and elderly women, they seek varying treatments for similar sicknesses of male and female babies; males were taken to modern health care setting but females were treated within the household settings or in other traditional healing places.

With respect to hygiene care, no exaggerated differentiation reported based on gender. But FGDs revealed that babies had to be bathed more frequently than girls .One of the elderly women voiced during the discussion "Girls are settled but boys want to reach to

and touch every object at their surrounding as a result they get dirt frequently and they have to be bathed more often."

These all shows the existing segregation of female babies even though the reported morbidity in the area was not significantly varied between the sexes.

Chapter Five

Discussion and Conclusion

5.1. Discussion

In the following section a detailed discussion of findings is made by integrating factors at various levels in order to capture the effect of socio-cultural, economic, and political environment on infants' health. Since mothers are only one among a multitude of actors in care provision, it is vital to see the wider structural elements that put a pressure on delivery of quality infant care. Thus the study goes beyond a description of maternal characteristics or behaviors to focus the complex association/interaction of socio-cultural, economic, and political environment.

5.1.1. Responsible Factors for Health Threatening Forms of Infant Care

An excessive infant morbidity is partly interpretable to early exposure of children to inadequate nutrition, frequent infection, and inappropriate caring practices (Social Initiatives Group, SIG 1996). In the section below, detailed description of these and other aspects of infant care exposing to any health problem will be made based on the findings of interviews and FGDs.

5.1.1.1. Factors at Individual Level

Besides the probable impact of other factors influencing infant morbidity and mortality, the role of infant care practices in the study area cannot be ignored. At individual level maternal Personal beliefs and skill factors influence how individual mothers care for their infant. Mothers not equipped with sufficient knowledge about child care and using traditional child care methods may cause harm to their children's health

and even cause handicaps in their children. Mothers' attitudes towards health, health behaviors, education level and practices during illnesses of their children also play an important role in child health (Platin and Khorshid 1994). Perceptions also guide parental decisions concerning the child (e.g. whether to seek medical or psychological help for the child or not) (Mantymaa *et al.*2006).

Corresponding to the above statement, the study findings uncovered the wider beliefs/perceptions among rural mothers that "vegetables will bring health problems like abdominal pain" were major restraining factors for the behavior of mothers in feeding such items to their babies even they had access. This has robed babies of nutrient full foods and reduced the illness résistance capacity of their body.

Apart from feeding, maternal perceptions/beliefs also affected psycho-social care. Mothers who perceived their infants as passive ,fussy and ill were less likely to interact affectively(expressed in terms of regular kissing, and playing) than those who view them as active, demanding and healthy. This hampers the emotional health of aforementioned infants.

In addition, the health beliefs/perceptions of individual lactating mothers were important in their preferences of available health care systems (traditional and modern) for the treatment of child illness. In the study area mothers prefer care systems depending on the perceived nature of illness. A study by Bahl *et al.* (2005) discovered that people in Ghana don't believe their newborns can be treated at the health facilities for the condition they call "Asram", an illness believed to have personalistic origin (such as evil eye ,witch). They would rather treat their newborns with traditional medicine from the herbalist.

Lactating mothers take their infants to clinics/hospital only when they perceive the occurrence of complicated child health conditions. As a result, the use of modern health care was considered as a last option. Maternal perception of the causes of infant illness was another essential factor for seeking modern treatment. Some lactating mothers in rural kebeles associate problems like failure to develop speech early to the action of "God" or evil spirits. Such attribution of infant illness to spiritual causes often led to fatalism (acceptance of the disease without question and not seeking help for it).

Apart from maternal personal beliefs, maternal socio-economic and demographic characteristics have a dominant effect in infant care. Among the characteristics, maternal age, education, occupation, media exposure, health situation and health care attendance were associated with the quality of care that determines infant health. In addition marked differences exist based on the origin of mothers (rural/urban). But a study among Turkish mothers by Beser (2010) contradicts this finding while insisting that there was no significant difference between traditional child care practices and maternal education, income, family type, origin and residence.

Age Factor: the study revealed that in Finoteselam, younger mothers were less likely to rely on traditional ways of caring their infant. They hold stronger positive beliefs on personal and domestic hygiene, as well as immunization. Contrary to this, it is asserted that children who are born to mothers whose age at delivery is 20 and above (non-youngsters) have higher level of vaccination coverage (CSA 2005). Despite their relative distance from traditional infant care, young mothers were found to be the ones who breastfed less frequently and provide inadequate psycho-social support than their elder counterparts. Consistently, Dennis (2002) founded that adolescent (young) mothers

breastfeed their babies less often, initiate solid foods sooner, and feed their children less nutritious foods than older mothers.

The health impact of all these risky practices was generally found to be acute respiratory infection

Education: infants of mothers with lower/no education were at a higher risk of inappropriate care because the decisions to feed, to seek health care and to keep hygiene were related with this factor. Interview results discovered that mothers who attended below secondary levels were restricted in their utilization of available health care services and better health promoting behaviors .This is consistent with the finding of previous study in Accra that poor maternal schooling was a main constraint for child feeding, health seeking and hygiene practices (Margaret *et al.* 2006).

Lower educated mothers did not appear to practice proper hygiene which led infectious diseases. They also did not breastfed their infants exclusively. In the study, much of infants who get hygiene related illnesses (diarrhea and stomach pain) frequently were infants whose mothers had less or no education. This is interpretable partly to the failure in exclusive breastfeeding and proper hygiene.

Less educated and illiterate lactating mothers were also found to be exposed for damaging beliefs and practices. Among mothers who hold the belief that "immunization is infected with virus", majority were uneducated rural elders. Likewise, nearly all of the participants who practiced child uvuletomy were less educated at best and uneducated at worst. In line with this a study in Debrebirhan founded that misconceptions exist among the uneducated which include 'Vaccines are contaminated by HIV' and 'children are dying in receiving vaccines' (DURCO 2010).

Media Exposure: lower knowledge of maternal child health services has predisposed rural mothers, TBAs and herbalist in holding erroneous traditional beliefs/perceptions on the efficacy of services. This was primarily because of their limited exposure to media. They often believed that vaccines create fever on the baby. They also took the infant in to the nearby health facility for treatment after s/he gets complications.

Health Care Attendance: The findings of the study revealed that only a quarter of the total mothers had fully attended both ANC and PNC services. Mothers who did not attend such services were found to be less aware of immunization, safe food preparation and storage, family planning, balanced diet, and danger sign identification, personal and household hygiene. A study by Haromaya University (2012) confirmed that mothers who followed ANC were 2.8 times more likely to practice timely complementary feeding than those who did not. Likewise, WHO(1998) pointed out that appropriate hospital practices (including ANC and PNC attendance) are important in positively influencing breastfeeding and optimal infant care activities.

Similar to uneducated and less educated participants, Lactating mothers with low/no health care attendance were found to be exposed for traditional beliefs that are irrelevant at best and health threatening at worst. Participants with no/lower attendance believe that the baby will adopt sickness from other patients if taken to the health facility or it will be exposed for an evil eye. The existence of evil eye beliefs was also discovered in previous studies among the Somali where infants were made to stay secluded and hidden even after the end of seclusion period for five months on the view to keep them from various environmental hazards including "evil eyes" of strangers (Hamer and Hamer 1971). From

this we can see that failure to have good hospital practice indirectly results in health risks to infants.

Maternal Health: UNICEF (1994) pointed out that the social isolation of women, coupled with the lack of extended family networks in urban areas, is thought to have negative effects on the mental health of women, which, in turn, is likely to reduce the quality of child care, even when the mother is physically present. Likewise, more recent work has found that mothers with depressive symptoms, at two and four months postpartum, had reduced odds of continuing to breastfeed, playing with the infant, and talking to the infant. It is also reported that mothers with higher depressive symptoms have increased odds of engaging in less than optimal newborn/infant feeding practices (McLearn *et al.* 2006).

Consistent with the above studies, the findings of this research showed that maternal illness and corresponding beliefs adversely influence their ability to care infants. Sick mothers in both rural and urban kebeles did not frequently breastfeed their babies on the belief that the breast does not secrete adequate milk giving the poor nutritional intake of the mother. They did not interact with babies affectionately or respond to babies' needs. The situation was found worse in cases where a substitute caregiver was not available. In general, inappropriate infant feeding, pollution from unhygienic conditions and the consequent infant illness were interpretable to a compromised infant-mother relationship resulting from sick or depressed mothers.

Occupation: It is well recognized that continuous physical contact between the care giver and the baby forms attachment/bond which supports the psycho-social needs of the baby. In other words, the timing and duration of maternal-infant interaction determines the quality of psycho-social care provided (Gadisa 2006). However, the duration of interaction was limited by maternal decision to take a job outside home both in urban and

rural settings of Finoteselam. Although the majority of lactating mothers were housewives by occupation, there were others who take occupations in the public sphere (including farm activities). Working mothers in both urban and rural kebeles reported the challenge in providing emotional support to their babies. They also faced problem in practicing on-demand breastfeeding as a result they were forced to schedule breastfeeding. Contrary to this a study in Accra disclosed lack of association between maternal working patterns and child care giving practices (Margaret *et al.* 2000). Infants of working mothers were also mostly found to receive non-fresh meals. Rather, they get a food prepared and stored for a long hour .This sometimes got spoiled and harmed health.

5.1.1.2. Factors at Inter-personal (Relationship) Level

Much of infant care giving behavior occurs along with inter-personal interactions so the role of the mother's immediate environment (level of social support) was discovered to be vital in the provision of health determining care to infants. Social Initiatives Group (2006) founded that social support structures available for the mother have been found to be facilitative for successful child rearing practices. Formal structures like women's groups, community networks, mothers' committees or informal networks of friends and family members motivate mothers to adopt desired health behaviors, provide psychological support to overcome familial constraints that impede certain practices, help in caring for her child, accompany her to health facilities to seek care, and transfer knowledge about appropriate child caring practices.

The findings of this study partially coincide with what has been suggested by Social Initiatives Group in the above paragraph. The findings confirm both the positive and negative effect of social support in infant care. Thus, maternal responses to

advice/commands from partner, family, relatives, traditional birth attendants, neighbors, herbalists and elderly women were found contributory and damaging to infant health depending on the person involved as a source of support.

Partner: In Finoteselam, both in urban and rural kebeles a male partner is the main decision maker on health issues of family members. Thus, in the presence of a partner, decisions regarding maternal infant care, especially in terms of feeding and health care seeking, are left to the partner. In cases where the husband was illiterate or less educated, there existed a diffusion of destructive ideas and beliefs in to the mother.

A part of lactating mothers in rural setting who did not use immunization and family planning services mentioned that their partners were not supportive of the services. Mothers were asked about the views of their husbands in these regards. Repeatedly noted responses in this regard were beliefs that both vaccines and family planning services are future fertility barriers. In support of this finding of a study by Warren (2010) asserted that men's beliefs may prohibit any care seeking (to infant illness). Likewise a study among Nepalese children posited that the most important factor in immunization is parents' beliefs, attitudes, and perception of vaccines (Prislin *et al.* 1998).

Family (Relatives): multiple characteristics of the family are important determinants of proper infant care. Specifically an optimal complementary feeding depends on accurate information and skilled support from the family, community and health care system. Bentley *et al.* (1999) asserted that a woman's home and family environment can affect her views regarding how and what she feeds her infant. For instance, it has a significant influence on the decision to breastfeed and the timing of introduction of solid foods. Within the home, various conditions may encourage or constrain her ability to breastfeed. For

example, when large, extended families live together, sometimes, extended families may provide support for the mother, allowing her to breastfeed her infant (Thairu 2006) while, at other times, family members may encourage the mother to introduce other foods and liquids to the infant's diet in response to infant crying or failure to gain weight (Bentley *et al.* 1999).

The finding of this study is consistent with the above where the influence of family members (mostly partners) by dictating the manner and timing of infant feeding was wide. The influence also came from extended family members in both of the rural kebeles. But in three urban kebeles of Finoteselam married couples (partners) mostly have a nuclear family set up i.e. they live in their own separated homesteads. So the amount of social support from members of their extended family was low and they do not mostly take prescriptions on the day to day infant care activity from extended family.

The result of analysis showed that nuclear family mothers were relatively less subjected to traditional beliefs and practices associated to infant care. Likewise, in New Zealand, Pakeha parents, who mostly lived in nuclear family situations, received less advice and support from their extended families than Pacific and most Maori parents. Rather, most of them (particularly older ones) relied on their husband/partner as their primary source of emotional and practical support and on professionals and friends for advice and other support (Abel *et al.* 2001).

The role of elder siblings in the family was critical in infant care both in urban and rural kebeles of the study area; they were highly supportive of the mother in cases of maternal work engagement. But they appeared to be less powerful in influencing the maternal behavior of infant care such as hygiene, vaccination and medical treatment. This

was because of little power/autonomy of decision accorded to them at home. Yet, less/uneducated younger siblings and housemaids often reported to apply risky ways of care (such as ignoring the baby) on their own. Particularly, the latter (housemaids) were mostly not responsive to crying babies.

In addition to family members, kin networks/relatives like mother's sisters were also identified as support agents particularly in rural kebeles of the study area. Corresponding to this, it was founded that in a society like Sidama where kinship relations are very strong the role of rearing the child goes beyond parents; other members of the community also play their role in the community. Thus the dominant values and attributes of the society that children are expected to uphold are determined not only by parents but also by other members of the community like relatives and neighbors(Mihret 2007).

Likewise, most women in rural area identified their in-laws as part of infant care support networks. Hence they took care of small children, while mothers worked in the household and in the field. In-laws were found in providing persistent advises and prescriptions on matters of care. Since, there was respect of in-laws in the local custom, a part of recently married mothers adhere to sub-optimal ways of care. For instance, they received advices on feeding ghee/butter for babies in the first two months of age on the view to make them fatter and healthy yet the consequence of this was diarrhea.

Elderly women: Younger mothers were mostly challenged by the physical, emotional, and cognitive demands of their infants and they rely on the experiences of old women. Elderly women who were inclined to traditional beliefs and practices in the community greatly influence young mothers in recommending all sorts of herbs and other folk mechanisms (such as attaching hirz on infant's body) in either treating sick infants or

protecting them from becoming ill. A study by Bentley *et al.* (1999) confirm this while asserting that mothers are particularly susceptible to prescriptive advice from older women such as the infant's grandmother or traditional birth attendants.

Though family economic condition and food availability affected the maternal feeding behavior, the traditional attachment of lactating mothers and their social networks particularly, elderly women, highly matter. Foods were not adequate and safe in lower income households, mothers usually fed their babies similar items such as soup/grip injera ,shiro ,firfir and chibto made of sorgum and teff. Thus, economy was not the only factor in sub-optimal infant feeding in both rural and urban kebeles. In line with this it is asserted that child care capacity (particularly in terms of feeding) depends, to some extent, on both food availability in the household and access of the household to food items. It is, however, largely a function of (traditional) practices and behaviors, which are not necessarily a function of resources (IFPRA 1997).

TBAS: Traditional birth attendants have a chief role in orchestrating infant care particularly in rural kebeles. Their role did not stop in the process of child delivery. Rather they were called by members of the family in state of emergency/danger on the baby such as *meqechet* (special injury). They employ massages and other techniques in reducing the pain associated with the injury and other illnesses such as stomach pain. They are easily accessible than health workers. Although trained TBAs function as important contact persons for primary aid, others had transmitted outdated beliefs which trivialize maternal efforts to seek competent care from modern health facilities.

Herbalists and Faith Healers: These people are known for their preparation of traditional medicine. They are mostly knowledgeable and experienced in the treatment of

reported childhood and other illnesses. They are trusted sources of healing for the local people both in urban and rural areas. As a result people resort to such traditional medical practitioners. Congruent to this, it is made clear that remedies from traditional healers are often preferred because of cultural and religious beliefs (Warren 2010). Both herbalists and faith healers are used as references for advice when infants show disturbances and diseases symptoms. Nonetheless, they appear to falsely construct the causes of illness and spread such erroneous ideas of constructing illness causation and treatment to lactating mothers. For instance, herbalists in rural and urban kebeles prescribe a mixture of herbs for abdominal pain believing that it will induce diarrhea so as to bring the causatic agent out, its dosage is however not accurately balanced. This resulted long term effects like physical weakness, loss of appetite and illness to babies of advised mothers.

Friends: In Finoteselam mother's colleagues, mostly lactating mothers involved in delivering health messages that were both contributory and harmful. However, young mothers mostly model their friends which have no adequate knowledge on infant needs at various stages of development, so that they adopt practices which negate babies' needs. For instance younger mothers in both rural and urban centers disclosed that they were not able to know why their babies cry after sucking breastmilk in the period before beginning complementary foods and continue to introduce liquids by modeling their respective friends.

Neighbors: being a neighbor to someone has a wider meaning to people in the study area. It involves sharing ideas and articles in common irrespective of religious, ethnical and linguistic differences in the day to day interaction among members. It also mean that sharing certain household activities as well as good and bad fortunes together that befall

on individuals. Accordingly, mothers exchange ideas and comments as regards the manner of handling infants. In the process, risky traditional beliefs and practices are transferred from neighbors. The practice of eye lid incision on the belief to protect ***ayn maz*** (an eye disease) was reported to be a usual undertaking to which mothers in rural neighborhoods were socialized. But its negative impact was assured in the reports of health workers in leading infections.

Generally speaking, infants whose mothers had been strongly supported by less/uneducated elderly women, mother-in-laws, and traditional herbalists did not seek prompt health care from clinics and other modern health institutions for the common infanthood illnesses. In other words, mothers who have wider inter-personal relation were exposed for health threatening practical recommendations emanating from traditional beliefs in the locality.

5.1.1.3. Factors at Community Level

At the community level established norms and values were found significantly impacting infant care behavior of mothers. In Finoteselam, children were highly valued and the care of children was also considered an esteemed and holy undertaking. Mothers who were in a position of rearing babies were given respect and appreciation. But there was higher social expectation associated with their position. For instance, they were expected to be available aside the baby to seriously attend him and respond to its needs. It was culturally vested to co-sleep and play with the infant in the local community. This implies that the local culture promotes frequent physical contact and the corresponding psycho-social support to the baby for its importance on emotional health. A study conductedby Dosnajh and Ghuman (1997) congruently discovered that nearly all Asian

mothers sleep with their babies on the same bed. Such sleeping arrangement helps babies to feel safe and protected as well as feed when they want at the night time.

In addition, cultural attitudes and norms are recognized as important determinant factors of infant and child feeding behavior (Craig *et al.* 2008). In this regard, breastfeeding and complementary feeding were found to be affected by the wider culture in Finoteselam. Breastfeeding was normatively binding up on every mother. It was viewed as ideal and natural for the baby. Therefore all informants were found practicing breastfeeding except very few sick mothers. In a study among the Somali, it is discovered that breastfeeding was considered to have more importance to the infant much more than a way of getting nutritious food (Hammer and Hammer 1971). In another study Mihret (2007) founded that Sidama mothers believe that breastmilk gives the baby strength and make it healthy both physically and mentally.

In the study area, there is no such scheduling prescription for breastfeeding enshrined in the culture. Most housewives breastfed every hour, others breastfed every time the infant cries. But working mothers mostly scheduled thrice a day due to the associated inconvenience/physical separation. In all cases the frequency decreases as the baby grows older. Likewise, the Sidama mothers breastfed in different situations than using a permanent schedule i.e. when the baby cries, when the mother gets break, whenever infant wakes up from sleep, whenever the infant is hungry (Mihret 2007).

As regards the time of initiating foods in Finoteselam, in cases when the infant received complementary foods, it was done at an early time (before six month) among some of infants and later in others. An early introduction was due to the cultural belief on breastmilk insufficiency. Similar beliefs also exist in other cultures. In Nigeria, it was

widely believed that breastmilk has neither sufficient water nor sustenance for babies, especially from three months and above (USAID 2011). On a similar fashion among the Somali there was related belief that breastfeeding make the child feel hot, causing fever. The baby therefore needs to be supplemented with water to cool down (FSAU 2007).

The traditional attachment of mothers to the long existed feeding practices in the study area also found to affect the amount of food diversity and nutritional content they apply to their babies. In both urban and rural settings, foods were selected on the basis of their availability at the household level, their cultural acceptability, and their cost than their nutritional value. Mothers, especially older ones oriented themselves to less nutrient cereals (mostly maize and sorghum) in preparation of infant diets than fruits and vegetables. Food items were also similar in kind than being diversified in most cases. Thus economy was not the only factor in infant feeding.

In line with the above, it is recognized that child care (particularly in terms of feeding) capacity depends, to some extent, on both food availability in the household and access of the household to food items. However, it is largely a function of (traditional) practices and behaviors, which are not necessarily a function of resources (IFPRA 1997). Even studies in Ghana went on to contend that child feeding practices were not associated with household food availability, income or wealth (Margaret *et al.* 2000).

The frequency of feeding was another aspect of infant feeding regulated by cultural norms. In rural kebeles of Finoteselam, no fixed schedule of complementary feeding was reported. In agreement to this, LeVine (1994) discovered that there are no feeding schedules among the Gussi community of Kenya: the mother nurses whenever the infant cries and does not try to anticipate his hunger. Unlike the rural ones, urban lactating

mothers regularly feed their under one babies two times a day on average with the spacing between feedings decreases as the baby grows. This was because of the interplay between adult and infant feeding styles within the community.

The traditional health related beliefs, values and practices of the community, that the mother and her child belongs constitute the primary determinants that directly determine maternal behaviors for child health and nutrition outcomes (Social Initiatives Group 2006).

Congruent to what has been stated in the above paragraph, culturally held views about infant illness are determinant forces for non-formal treatment of illness in the study area. Culturally portrayed image of health in the community was significant in forming a boundary between healthy and unhealthy infant. Accordingly, a healthy infant was one who appeared happy, strong, active, responsive and well-consuming. On the contrary, ill baby was unhappy, irritable, weak, passive/less demanding and less-consuming. When an infant shows some characteristics mentioned in the latter category coupled with specific symptoms of disease (such as coughing), mothers recognize the occurrence of health risks. Based on the nature of symptoms, they attribute a causatic agent.

There were three different community constructions of illness causation in Finoteselam up on which care seeking preferences depend. These include attribution to natural (biological or environmental agents), interpersonal (evil eye) and supernatural (evil spiritual and zar) factors. The common infanthood diseases under the first category include diarrhea, malaria and stomach pain. Those illnesses fall in the second category include (*buda* and *metet/asmat*), and those fitting the last category on the other hand were *likift* and being fussy. Findings illustrate that illnesses in the second and third category

(evil eye, witch effect etc.) are treated in traditional ways. In addition, findings indicate that the initial response to an illness or complication mirrors the community perception of its cause.

Consistent to what is described above, it is founded that some mothers in southern nation, nationalities and peoples of Ethiopia believe that if the illness of the baby is related to the 'evil eye', they must go to the traditional healer first (Warren 2010). Correspondingly, Hirani (2008) noted that health problems like ambiguous genitalia, seizures, communicable diseases and jaundice are viewed as the influence of 'Witch crafts'. Because of those beliefs systems, many people do not prefer allopathic healing systems or health care settings for proper management and treatment; rather they adopt folk sector or transpersonal healers for treatment purposes.

Care seeking for infant illness in Finoteselam was diversified, following a general pattern i.e. both traditional and modern. Correspondingly there is the same trend among the Somal (FSAU 2007). But, certain childhood illnesses (such as colics) were not worthy of treatment according to the established norms as they were considered normal occurrences at a specific stages of infants' life. In line with this Augustine (2007) exposed the belief in Nigeria that every child has to experience one or two episodes of diarrhea as a sign of survival with no necessity to seek medical care for it.

With respect to hygiene, the study identified various ways in which local practices result in water and environmental pollution. For instance, the common ways of drawing water is by inserting the cup in to the water containing pot which is exposed for contamination. People in the rural areas also use open fields for defecation. In line with this a study in rural villages of India uncovered that villagers are averse to the idea of

latrines due to the misbelief that the latrines are meant for city dwellers where they lack open fields. They are often ignorant about the ill effects of improper disposal of human excreta which may result in water, food, soil contamination, favor the breeding of mosquitoes and flies. The consequence of the above unhygienic practices was consistent occurrence of diarrhea and other infectious diseases including trachoma among infants.

Besides, there were gender roles that specify the position of men and women. Accordingly, women are allocated with the task of carrying children. In addition, they were required to contribute to the family income in most poor households. This has resulted in un/less supervised baby. The study findings indicate that adequate infant feeding and emotional support was a challenge to most of working mothers as they were fail to practice on-demand breastfeeding and conduct affectionate interaction due to physical separation.

In elaborating the effect of physical separation, UNICEF (1996) posited that Nepali women especially in rural areas, are often working away from home, so that many women breast feed only two or three times a day. But contradictory findings highlighting lack of association between maternal working patterns and child care giving practices were discovered from other studies (Margaret et al. 2000).

Gender based differentiation in infant care was also another normative (cultural) issue that affect the health of female babies in communities of Finoteselam. This was consistently stated in the previous studies where there existed an observed gender bias in childcare in almost all families of agra community in India (Nandan 2011). Likewise, national data displayed that out of the total number of children with health problems boys receive better health services that girls for acute respiratory infection and diarrhea. While

19% of boys were taken to health facilities for acute respiratory infections, only 15% of girls were taken to health facilities for the same health problem (CSA 2005).

In general, the findings of this study revealed that due to the combined effect of the previously mentioned normative beliefs and practices at the community level, infants (especially female babies and those belong to working and rural lactating mothers) remain less supervised or mal-treated in diverse ways, to the extent of getting health problems such as diarrhea and other infections.

5.1.1.4. Factors at Societal (Systemic) Level

Societal contexts can inhibit healthy choices (Mattila *et al.* 2000). These include the values, customs, laws, socio-cultural and economic and political factors that influence experiences and interactions at lower levels of the environment (Social Initiatives Group 2006).

Overarching values like feeding priorities are integral elements of the social contexts that determine infant health. With this regard a socially valued practice of breastfeeding in the country served as an impetus for the predominance of breastfeeding practice in the study area. Nationally, it was estimated that ninety-eight percent of mothers breastfed their babies at least for some time after birth (CSA 2011) which was similar to the case of Finoteselam where breastfeeding coverage was 98%.

The study identified poverty as the principal social factor affecting infant care quality as observed in all dimensions. ***First***, it resulted in lack of food or lack of variety of foods which forced some mothers to rely on inappropriate feeding such as failure on timely introduction of complementary foods. Mothers in lower income family (less than ETB-1000 per month) do not apply complementary foods immediately at six month of infant's

age due to food shortage in the house. On the contrary, a study conducted by Haromaya University (2012) discovered that lower income mothers (having a monthly family income between ETB-999 and ETB 1000-1999) were three times more likely to practice complementary feeding compared to better income mothers (those with a monthly family income of ETB-4000 and above).

Second, poverty resulted in lack of capacity to seek modern health care for infant illness among some mothers which required them to resort to traditional and home treatment. In line with this it is made clear that remedies from traditional healers are often preferred because of financial barriers and other reasons (Warren 2010).

Third, the impact of poverty on hygiene care was founded in such a way that there was great discrepancy in accessibility of safe water and sanitation by wealth or family income in urban kebeles of the study area. While half of study participants access traditional toilets, it was only few who had quality latrines in their homes; and other reasonable proportions of the community, most of which are poor, had no toilets at all. Lack of sanitation and hygiene instruments among poor families (having income ETB<1000) resulted in vulnerability to dirty environmental conditions that affect health.

Furthermore, living conditions (particularly in rural kebeles) where water and electricity are inadequate were also found notorious for infanthood illness like diarrhea. The absence of helpful equipments like refrigerator and safe water container still increased the probability of illnesses due to water and food contamination both in rural and urban settings of Finoteselam.

Congruent to the above, a study by Margaret *et al.* (2000) discovered that hygiene index was positively associated with various household characteristics, namely, the

quality of housing and asset index, the expenditure quintile and the availability of services such as waste disposal, toilet facilities and water source. Similarly, a study in Awi zone of Amhara region elaborated that even when women are educated and make an effort to clean infant, home and compound properly, resource constraints prove impossible to overcome in some cases. Thus, a variation in hygiene standards between households was also related to the socioeconomic status and the educational level of the mother (Kelemu 2010).

Fourth, the impact of poverty on appropriate psycho-social care was also founded paramount though it was not direct one. In the study majority of lactating mothers, including those in the rural kebeles, opted to seek job outside home due to the existence of economic pressure. However, this situation resulted in lower supervision and psycho-social support to infants as stated above.

Besides poverty, other societal conditions identified in affecting maternal infant care include rigid gender roles, violence, rural-urban migration and absence of part time jobs. These all were discovered as contributory for infant health problem in Finoteselam.

Coming to gender roles, maternal specialization in reproductive activities including child care is important for the wellbeing of the babies themselves. This is because mothers have unsubstitutable role in child rearing. A comparative study among three nutritionally differed groups of children in Bangladesh confirmed this fact in its finding that children cared by their mothers received greater amount of care (IFPRA 1996). However, rigid gender roles designate the task of infant care solely to the mother in addition to other household tasks .This work burden had limited their time to seek appropriate health care for the baby early in the occurrence of symptoms.

When we come to the impact of violence which was dominant in both urban and rural households of Finoteselam, conflicts among household members (particularly those between husband and wife) seriously impacted infant health by compromising maternal-infant bond and emotional attachment and by reducing the amount of time devoted for supervision .It also resulted medical neglect in some cases.

The other social factor identified in the study in influencing the quality of maternal infant care was migration. Partners (husbands) provide a particularly important source of emotional or informational support to the mother but the expanding rural-urban migration of male partners rob mothers of appropriate social support which in turn put a pressure of their provision of adequate care to their children.

Finally, absence of part time jobs fitting women in the area was a worth mentioning factor for restricted infant care quality. Although new job opportunities are being expanded, there is no wider opportunity of part-time job engagement in Finoteselam. As a result lower income mothers were forced to rely on full term engagement that did not allow better care.

5.2. Conclusion

The purpose of this study was to highlight the impact of traditional infant care beliefs and practices on health in Finoteselam. A complement of interviews, focus group discussions and partial observations were employed to gather the necessary data on four principal aspects of care which include infant feeding, hygiene care, psycho-social care and health management. The findings from the analysis of the collected data revealed that infant health and survival depends on the quality of care given to them. It was also discovered that there was a wider gap in maternal adherence to infant care strategies that have been recommended to reduce the likelihood of infant health problems in the first year of life including exclusive breastfeeding, appropriate complementary feeding, proper hygiene maintaining, and full infant vaccination.

The above stated gap was not limited to the implementation of preventive measures; rather it was also apparent in the failure to practice recommended infant health promoting and recuperating strategies like psycho-social care and competent medical intervention at the right time. This was primarily because of the long existed traditional beliefs and practices. Various traditional beliefs and practices of infant care have contributed to health problems by hindering the aforementioned dimensions of care directly or indirectly. The common health problems in the study area include diarrhea, cough, malaria, common cold, and pneumonia.

The study treated infant health risks at various levels by giving emphasis to traditional beliefs and practices in four components of care. Socio-cultural and economic conditions in which individual mothers operate influence their behavior of appropriate

care. Poverty, violence, rural-urban migration and lack of part time jobs were basic social factors identified in the area with their direct and indirect implication on infant health.

The role of poverty was multifaceted and embedded in all components of care. For instance, lack of water and latrine created a problem in hygiene for poor households. In addition lack of finance to afford variety foods among lower income mothers (mothers whose monthly family income is below EBR-1000) resulted in untimely introduction of complementary foods. It also forced them to apply similar items all the time.

Violence at home and rural-urban migration were also found in hampering the amount and quality of psycho-social care provided to infants as they have an impact on maternal social support. Moreover, lack of part time employment compelled mothers to engage in full term occupations. These in turn affected quality of care as they were not suitable for conducting responsive care.

At the community level, the effect of established cultural norms and rules on infant care is significant. Being a culturally constructed phenomena, infant care influenced by a wide range of cultural values, beliefs, and practices associated with infant health and wellbeing. Cultural factors were found to be deeply involved in the whole life, like in matters of nutrition, immunization, personal, domestic and environmental hygiene, family planning, seeking early medical care. Local beliefs about breastfeeding in Finoteselam correspond well with international infant feeding recommendations (in terms of coverage, and frequency). Mothers viewed breastfeeding as normal behavior and as a way to maintain good health to their babies. It was also a common practice to on-demand breastfeeding. But there was a failure in exclusive breastfeeding as most mothers initiate

exclusive breastfeeding early and then introduced complementary foods in the period prior to months.

Culturally set strategies of dealing with common health problems were use of herbal medicine, faith healing and traditional physiotherapy. Care seeking was found to be variable with the perceived cause of the infant illnesses. Attributing infant health problems to supernatural forces and/or to evil eye has been a part of the belief system in the community. Thus, traditional health care was sought for problems considered to be supernatural. Although traditional treatment served as alternative sources of health care in access deficit conditions, often it resulted in health dangers to infants partly because of erroneous construction of illness causation in the community. The study founded several cases of illness complication due to inappropriate introduction of folk medication. Mothers who followed tradition were also less likely to seek care in clinics and hospital setting in the initial emergence of infant health problem.

As regards the role of cultural factors in hygiene and psycho social care, the common way of drawing and using drinking water led contamination in most cases. Infants and children are made to defecate near home. Yet better practices have been performed which motivate mothers to emotionally support the baby. Acts of co-sleeping, responding to a crying baby, frequent breastfeeding, play making with a baby etc. were embedded in the culture boosting emotional health.

At the intermediary level the model paid attention to the function of social support lactating mothers received from their social networks. Dual effects of social support were discovered depending on the actor identified. In the study area, many children experienced some form of health problem while their mother had social support from kin

networks. The condition is due to the influence of support networks, particularly husbands and grandmothers in prescribing unsafe ways of infant care.

Finally, at the lower most individual level, maternal personal beliefs, her health, age, education, employment/occupation, media exposure, and family income have a direct implication on the quality of infant care in the study area which in turn affected the health status of infants. It is founded that older participants tended to have less schooling as a result they do not have awareness that, vaccines are preventive mechanisms, nor did they believe on its effectiveness. They are also the ones who mostly apply supplementary foods before the age of six month. Conversely, mothers whose educational level is higher (secondary and above) were found to practice exclusive breastfeeding in the first six month of life. They are also observed to keep the personal and environmental hygiene of the infant as it is manifested in washing the baby frequently and cleaning the surface where the infant lies.

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Appendix A

Addis Ababa University

School of Graduate Studies

Department of Sociology

Information Sheet

I am a post graduate student of Sociology at Addis Ababa University. Currently I am conducting on "Traditional Infant care Beliefs and Practices and associated Health Impacts in Finoteselam" . A total 67 participants from various groups including lactating mothers,TBAs, elderly women, herbalists, faith healers and health workers in the town will be recruited to take part in the FGDs and interviews. In both FGDs and interviews, the information collected will be coded and no name will be recorded in order to protect your identity. I assure that there is no possible risk associated with participating in this study except the time spent for responding to the questionnaire.

Participation in this research is completely voluntary. Once you are involved in the interviews or FGDs, you can choose not to answer any question which does not fit your interest. In addition, you can choose to withdraw from the research for any satisfying reason at anytime. However, your wishes are considered as much as possible to avoid withdrawal. In general, your participation is vital for the success of this research, so you are kindly invited to take part. I would very much appreciate your participation.

Mebratu Alifnur: Investigator

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Thank you!!

Addis Ababa University

School of Graduate Studies

Department of Sociology

Topic: Traditional Infant Care Beliefs and Practices and Associated Health Impacts in Finoteselam

Interview Guide

Section One: Interview Questions for lactating mothers

1.1. Socio-economic Characteristics

<table>
<tr><td rowspan="2">Age of the interviewee (mother)
Level of mother's Education
Hospital Attendance(ANC & PNC)
Employment status
If you are employed, illustrate your occupation
If you are employed? Specify your engagement (part time/full time)
Media Exposure
Ethnicity
Religion
Marital status</td><td>Infant Related Characteristics</td></tr>
<tr><td>Condition of the Baby at birth normal/preterm or twin
Birth Order
Baby's Age
Sex of Baby</td></tr>
<tr><td rowspan="2">Characteristics of the family</td><td>Characteristics of the Husband/partner</td></tr>
<tr><td>Educational level of the husband
Occupation of a partner or husband
Media Exposure</td></tr>
<tr><td rowspan="2">Size of the family
Nature of the family(1.nuclear 2.extended)
Annual Family Income from all sources</td><td>List the major Sources of your (physical or ideal)support in infant care</td></tr>
<tr><td>Characteristics of social support networks
Educational level
Media Exposure</td></tr>
</table>

Section Two. Questions Related to Infant Care

2.1.Infant feeding

1. In this community, do women prefer breastfeeding to artificial feeding? Why?
2. Do you think that breastfeeding is important? Give your reason
3. Do you practice breastfeeding?
4. Is there any normatively set schedule of breastfeeding in this locality?
5. How much times you breastfeed your baby within a day?
6. Customarily, after what period of time do people in this area apply any food other than breastmilk?
7. Do people in this locality believe that supplementary feeding before six month is relevant for child's health? Yes/no If yes ,specify the reason
8. Did you start supplementing your baby with meals other than breastmilk?
9. If so, at what age of the infant is solid food introduced? Why?
10. Have you experienced a mother in this area who did not immediately start applying complementary foods to her baby in the period following six month of age? If so why?
11. What about you ,if you were delayed to start complementary foods immediately after six month, state the reason.
12. Customarily, what kind of complementary foods are recommended to be given to a child? Why?
13. What kind of complementary food you give to a child? Why?
    - Commercial food
    - Home prepared food items
    - Both alternatively
14. Why do you prefer such items?
15. Customarily, how often is a baby fed within a day?

16. How many times within a day do you feed your baby?
17. What do you think is the best food for children?
18. According to the beliefs of the community, are there items that must not to be given infants? Why?
19. Do you refrain from giving certain food items? If so what?
20. What food items that you give to your baby on a regular basis? Why do you prefer this?

2.2.Psycho-social Care

1. What is the value given to children in this community?

1. Are there any accepted and unaccepted children in this community?
2. How do you express your sense/feeling to have this (the index baby) infant at hand?
3. How much do you think a mother should attach herself with the baby? Why?
4. Would you list activities you undertake to support your baby's psycho-social health?
5. Is it common in this area for a mother to sleep with her baby? If so why?
6. Do you co-sleep with your baby in the first year?
7. How frequent do you carry/cuddle your infant?
8. Customarily how frequent do a mother have to observe the infant's overall situation? What is the reason for such frequency?
9. How frequent do you observe the infant's overall situation?
10. Is massage of the baby applied in this community? If so what is its perceived benefit?
11. Do you apply massage of the infant's body? Why

12. Do you frequently speak to or interact with your baby?
13. Do you apply regular plays with the baby?
14. Do you train your baby how to sit, stand and move on his/her own?
15. What do you think is the cause of persistent cry?
16. What do you do when the baby cries?
17. Do you believe a baby have to be attended every time s/he cry?why?

2.3.Infant Health Care

1. Normatively, what are the characteristics of a healthy child?
2. What about sick one?
3. Have you ever heard of babies who got sick in your village/community? What did they got sick in?
4. What are common health problem of children in this area?
5. Normatively what is believed to be the cause of major childhood illnesses?
6. What do people in this area do when their baby fall ill or face any health defects?
7. Did your baby ever faced any health problem(s) so far?
8. What do you do when your child fail ill?
9. If you do something to cure, why do you prefer to do so?
10. What was the result from your action up on the health of the baby?
11. Have you heard about maternal Child Health services?
12. Have you ever visited health facilities for MCH services?
13. If you ever visited any modern health facility, can you tell me any information you have received from staff of local hospitals or health stations about child health care?

14. If you ever visited any modern health facility, what initiated you to do so? If not what was the reason for not going to health facilities.
15. Does the information given by health service providers fit to your traditional beliefs about infant health care?
16. If it was different, in what ways it differed?
17. Which one you trust more and rely on from modern and traditional health care?
18. If you rely on both, can you illustrate specific situations when to follow your traditional practices, and when to adopt modern health care services?
19. Has there ever been a time when someone from your village/community has gone to modern health care facilities and experienced any health problem either on the mother or on the child in subsequent periods? Describe what happened. Why do you think this happened?
20. Do members of your community believe that infants are susceptible to illness than any section of the society? Yes/no
21. Do you also believe that babies are more susceptible? If yes, how they are supposed to be exposed?
22. What preventive measures are customarily suggested to stay away from susceptibility?

2.4.Infant Hygiene Care

1. Customarily what involves a hygienic baby?
2. Do people in this community prioritize child cleanliness?
3. Do you believe infant hygiene maintenance is a prior undertaking of infant care?
4. Customarily, how often the baby is bathed? What is the rational behind this

frequency?

5. How often do you bath your baby?
6. Do you wash baby's clothes rapidly?
7. Is it customary to clean hands before touching the baby in this community?
8. Do you clean your hands before touching the infant?
9. Do people in this locality treat water before giving to the baby for drink?
10. Do you need to do anything to the water before giving it to the child? What?
11. How is drinking water drilled from a container in your home?
12. Do you conserve a "holy water"? If so for how long?
13. Do you feed your baby fresh foods?
14. What do you do the leftover food/drink?
15. Is it a normal undertaking in this community to wash household utensils regularly?
16. How frequent do you wash household utensils in your home?
17. How frequent you clean your house?
18. Is it a normal practice in this community to separate solid and liquid waste each other?
19. Do you separate solid and liquid waste each other every time?

3.Questions about Non-maternal characteristics which have to do with the quality of infant care

3.1. Household and Neighborhood Condition

1. Residential site/Kebele?
2. Do you have a permanent house?

3. Is the house you are living in belongs to you? Yes/no
4. If no elaborate as to whom it belongs?
5. Do you have other fixed holdings? yes/no If yes, specify…
6. Do the house has partitions? If so how many?
7. The wall of your current residential home/shelter is made of---? Cement, Mud ,stone, Clay bricks, wood, others
8. The ground/floor of your house/shelter is made of--? Ceramic/marble tiles, Cement, Mud, plastic tiles, others
9. The roof of your home is made of- ? Corrugated iron, concrete cement, thatch, plastic, wood, bamboo ,others
10. The Ceiling of your home is made of fabrics, cement, bamboos, polythene sheet, wood planks, has no ceiling, others
11. Does your household have the following items?

- Electricity
- Radio
- Refrigerator
- Television
- Tape water
- Telephone/mobile phone
- Other major ones

12. What is the main source of drinking water for members of your household?
13. What type of toilet facilities does your house have?

- Traditional pit toilet
- Ventilated improved pit latrine
- No facility / bush / field
- Others, specify

14. Do you have a safe discharge/disposal for liquid and solid waste in your compound?

If so describe how do you manage waste in your compound?

3.2. Involvement of Other people in Infant care and Gender issues in care

2. In the community, who is responsible for looking after infants? Why?
3. Who communicates a socially appropriate form of infant care to you?
4. In your village/community do people usually prefer to have boy or girl children? If so, what is the reason?
5. Have you ever heard any story about people choosing to abandon a baby, if the child is not the preferred sex? If so, describe what happened?
6. Should mothers prioritize one of the sexes (male /female) in dressing, feeding… in care giving in the context of your community?
7. Are there good/bad practices relating the care of infants in this area?
8. What are the challenges in infant care?

Thank you for cooperation in answering my questions.

Addis Ababa University

School of Graduate Studies

Department of Sociology

Topic: Traditional Infant Care Beliefs and Practices and Associated Health Impacts in Finoteselam

Section II: Questions For Health workers

Sex

Qualification/Field of Specialization

Rank/job title

Year of Experience

1. Please tell me what services does your organization provide for ANC and PNC attendants?
2. What are the prevalent health problems affecting infants in this area?
3. What is the cause of the above health problems?
4. Do parents frequently bring their children to the facility? Why
5. What is the status of immunization services in this area? what do you think is so?
6. What looks like infant care practice in this area?
7. Are there good practices relating the care of infants in this area?
8. Do you think babies are receiving appropriate food? What about in other aspects of care?
9. Are there traditional beliefs and practices in this area concerning infant care? Describe if there.
10. Is there any sickness or health problem in relation to traditional belief & practice?
11. Are there traditional beliefs of local people that challenge you in your provision of services?

Thank you for cooperation in answering my questions.

Appendix B

FGD Guide Questions

Infant Feeding

1. Should infant formula be emphasized than breast milk?
2. What is the matter in feeding infant with breast milk exclusively until six month of age?
3. Shall food item other than breast milk be applied for the better health of infants with the age of less than six month? Why?
4. When should complementary foods be applied? Why?
5. Normatively how frequent are babies fed within a day?
6. Normatively, which items shall be given and which should not to infants? Why?
7. Is there a daily schedule for breastfeeding a baby in this locality?
8. Are there gender based differentiations in feeding in this community?

Psycho-Social Care

1. Should a mother and her baby take adequate rest?
2. Does tradition allow co-sleeping of mothers and their infant in this area?
3. What about body physical contact such as kissing?
4. What about continuous eye contact?
5. What about organizing plays and talks with them?
6. If a baby cries what should a mother do?
7. Should it be soothed?
8. What is the cause of persistent cry?

9. Are infants in this area trained how to sit, stand and move on their own? If so when do they are expected to acquire each of the skills?
10. Should a boy baby be treated and cared differently than its girl counterpart? Why?
11. Are mothers equally responsive to male and female babies?
12. Normatively which sex is more preferable? Why?
13. Do they act affectionately to both on equal scaling?
14. How can working women Rear their children?
15. Shall there be any person who supports the mother in care of the infant during the first year of birth period?
16. Who should be allowed to support mothers in caring the baby in early time following post partum period?
17. What is the role of other family members in caring for the infant?
18. What is the involvement of elderly and respected community members in communicating the socially appropriate form of infant care?
19. What are major factors affecting proper care of infants ?
20. Which beliefs and Practices of infant care shall be encouraged in order to promote infants' health? Why?
21. Which beliefs and practices of infant care shall be discouraged because they have health risks to the infant? Why

Health Care

1. Which children are considered unhealthy and which are healthy?
2. What are the common health problems of infants in this Area?
3. Are the above health problems related to the way babies are cared? If so how?

4. What are home remedies mostly performed in search of cure from illness?
5. When do mothers use baby massage?
6. How can mothers identify the illness of their babies?
7. Who is referred first for treatment of a health problem up on infants in this area?
8. Is it heat or cold that more endangers the health of an infant in this area? What measures shall be taken by mothers to protect infants?
9. Which treatment should mothers rely on for prevention and management of their baby? Modern health services or otherwise? why
10. Should mothers go to modern health facilities in getting treatment of infanthood illnesses?
11. If so when shall she go? why?
12. Should male and female babies be taken to hospital/clinic for illness alike?
13. Are modern vaccines and immunization services ideal for preventing illness?
14. Are infants believed to be vulnerable to supernatural forces/or evil intents of strangers particularly during the first year of life after birth?
15. If the said forces attacked a baby, what shall be done to avoid the negative impacts?

Hygiene Care

1. How a drinking water is normally be drilled from a container?
2. Shall a drinking water be treated before given to a baby?
3. Should a "holy water" be conserved for a long period of time? How?
4. Are babies in this area receiving fresh foods every time?
5. Are household implements regularly washed and kept dry?

6. Is it a problem for babies to defecate everywhere?
7. Is it a problem for adults to urinate/defecate outside?
8. Shall people separate solid and liquid waste each other?
9. Should hands be washed before touching the baby? when else?
10. Customarily, at what interval should the mother bathe her baby per a week?
11. Is there any hygiene care differentiation made based on sex?