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**QUALITATIVE RESEARCH ON BREASTFEEDING  
IN KIBUNGO AND GITARAMA PROVINCES  
RWANDA**

by

**Rwanda Ministry of Health  
Wellstart International**

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## ACRONYMS

BFHI	Baby Friendly Hospital Initiative
EPB	Expanded Promotion of Breastfeeding Program (Wellstart International)
MCH	Maternal and Child Health
RIM	Rwandan integrated Maternal Child Health/Family Planning Project
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development



## OVERVIEW

A qualitative study of infant feeding practices and the beliefs, attitudes, and cultural context bearing on those practices was undertaken by the Rwandan Ministry of Health in collaboration with Wellstart International's Expanded Promotion of Breastfeeding (EPB) Program during July and August of 1993. The purpose of the study was to provide a basis for developing an effective communication strategy and other program activities to promote optimal breastfeeding, as part of the U.S. Agency for International Development (USAID)-sponsored Rwandan Integrated Maternal Child Health/Family Planning (RIM) project. This report describes the rationale for conducting this research, the study design and methods, and the findings of the research and their implications for the development of a program to promote optimal breastfeeding in Rwanda.

## RATIONALE FOR QUALITATIVE RESEARCH IN RWANDA

The health benefits to the infant of exclusive breastfeeding until four to six months of age are undisputed, especially in low-income populations living under unhygienic conditions. Breastmilk provides unequalled nutrition and contains anti-bacterial and anti-viral agents which protect the infant from disease. Exclusive breastfeeding (no prelacteal/post-partum fluids, no water, milks, or foods whatsoever) for the first six months of life significantly reduces the rates of diarrheal disease and acute respiratory infections (among others), the most common killers of young children in developing countries. Mothers also benefit from breastfeeding, since it decreases the risk of post-partum hemorrhage, breast cancer, ovarian cancer and anemia. Further, breastfeeding's fertility suppression effect plays a crucial role in child spacing. In Africa, it is estimated that breastfeeding averts as many births as all modern contraceptive methods combined.

Recognizing the critical importance of breastfeeding to maternal and child health (MCH), the Rwandan Ministry of Health and Wellstart International's EPB Program carried out an assessment in April 1992 that looked at health facilities, policies, practices, and legal issues concerning infant feeding. While the assessment found that nearly all women in Rwanda breastfeed, they and their infants are not deriving the maximum health, economic and psychosocial benefits that are afforded through optimal breastfeeding practices.

The Ministry of Health of Rwanda defines optimal breastfeeding as:

- 1) Initiation of breastfeeding within one half hour of birth
- 2) Exclusive breastfeeding for six months
- 3) Frequent, on demand feeds, including night feeds
- 4) Continued breastfeeding for at least two years, with gradual rather than abrupt cessation of breastfeeding.

The assessment revealed that many mothers are supplementing breastmilk with other liquids, a practice that is not only unnecessary but potentially dangerous. In addition, many health personnel were advising mothers to begin supplemental feeding at as early as two and three months, usually in the belief that mothers had "insufficient milk." (Insufficient milk is almost always caused by insufficient suckling, and



the problem is exacerbated by giving supplementary feeds to the infant.) Further, in urban areas both mothers and health workers were supportive of the use of breastmilk substitutes.

The assessment made recommendations for activities to protect and support breastfeeding and to promote optimal infant feeding. One of the key activities recommended was qualitative research (the subject of this report), which would provide information on how and why infant feeding decisions are made, and on channels for communicating with mothers and others involved in these decisions.

## RESEARCH DESIGN AND METHODS

The study is an exploratory, ethnographic investigation of factors bearing on infant feeding practices. It is cross-sectional in design, but attempts to obtain information on recent trends in infant feeding patterns. Mothers with young infants are the main focus of this study, although grandmothers, fathers, traditional healers, and health professionals are also included in order to fully understand the context of mother-infant feeding behaviors.

The study began with a review of background documents and other relevant studies. (See Annex A for Bibliography). In the field, data collection methods were as follows:

- (1) The primary data collection method was in-depth, semi-structured interviews. A total of 106 such interviews were carried out: 73 interviews with mothers, 16 with fathers, 6 with grandmothers, and 11 with traditional healers or traditional birth attendants (TBAs).
- (2) In each commune<sup>1</sup> the maternity ward of either the hospital (urban areas) or the health center was visited and brief interviews with post-partum women were conducted. Health personnel were occasionally interviewed as well.
- (3) In order to obtain a general idea of the quantities and types of foods and liquids consumed, a subset of women were asked about their diet using a 24-hour recall form. (Note: this was not intended to be an in-depth nutritional assessment, but a means of generally assessing the adequacy of liquid intake and quantity and variety of foods consumed.)
- (4) Full-day observations of eight mothers were carried out.
- (5) Five focus groups were conducted in order to confirm reported feeding patterns and rationale for them.
- (6) Interviews were carried out with "key informants" such as Ministry of Health personnel, USAID/K officials, United Nations Children's Fund (UNICEF) officials, and others.

Emphasis was placed on talking with mothers of young infants, because exclusive breastfeeding from birth to around six months post-partum is a key breastfeeding behavior and has the most nutritional and protective effect for the infant. Approximately 40% of mothers interviewed had infants less than six months of age; 33% had infants aged 6-12 months; and most of the rest had infants ranging in age from 12-24 months. The sample included 12 mothers of children diagnosed by the health center as

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<sup>1</sup> These are administrative divisions within each of the ten prefectures.



malnourished who were sought out in an attempt to identify particular practices and problems associated with malnutrition. Most mothers were working in traditional rural agriculture, although a portion of them were working in the informal sector or were salaried workers.

The study was conducted in the two health regions where the RIM project will be active: Gitarama in the central area and Kibungo in the southeast part of the country. In each area, four communes were selected, one of which was the urban commune. Some key informants indicated that Rwanda is culturally homogeneous in spite of the existence of two major ethnic groups, the Tutsi (approximately 10%) and Hutu (approximately 90%). Some felt that north/south differences could be a source of variation. The extent to which north/south differences translate into significant variation in infant feeding practices -- and therefore the extent to which this study is nationally generalizable -- is not known. Ministry of Health discussions during Baby Friendly Hospital Initiative (BFHI) training sessions in Butare indicate that practices and acceptability of certain interventions may vary.

Nutritional surveillance data from the 1991 Ministry of Agriculture/UNICEF survey show that both Gitarama and Kibungo prefectures have high rates of childhood malnutrition. Of the ten prefectures in Rwanda, Kibungo has the second highest rate of moderate to severe malnutrition (weight for height) in children 0-5 years, with 9.4% of children falling into this category. Gitarama prefecture is closer to the national average (5.2%) for this indicator, with 5.5% of under-fives classified as moderately or severely malnourished. However, Gitarama has the second highest rate of chronic malnutrition (height for age) in children 0-5 years -- 58.5%, compared with 46.9% in Kibungo and 52.2% for the entire country. What is particularly notable about the high rate of malnutrition in Kibungo and Gitarama is the fact that these two regions produce food crops in quantities which exceed calculations for the population's nutrition needs. Kibungo, Kigali and Gitarama are the top three food producing prefectures, and combined produce enough food to meet 128% of the per capita daily caloric requirement of their residents (Ministry of Health 1989:26). One factor which at least partly explains the discrepancy between high food production and low nutritional status is the fact that a large proportion of the food grown in Gitarama and Kibungo is sold in the Kigali urban market.

## **FINDINGS**

### **Background**

About 90% of Rwandan families make a living through subsistence farming. Men are responsible for preparing the soil for cultivation, harvesting crops, and tending livestock. They are also responsible for the construction and maintenance of houses, fences and other domestic structures. Women perform the agricultural tasks of watering, weeding and related care of growing crops. They handle the marketing of food crops, while men arrange the sale of cash crops. Women also are responsible for most domestic tasks including collection of water and fuel, processing food, meal preparation, home maintenance, laundry and all child care. Children also assist with many of these duties.

Both men and women uniformly report that a good mother takes care of the health and well-being of her family and children, particularly in regard to feeding, health maintenance and sick care, while a good father provides economically for the family, ensuring resources to provide food, clothing, education, and security. Many women and men also state that a father should not waste money on alcohol, women, and other distractions.



There is generally good recognition of the important signs of health and illness. Interviewees say that a healthy child seldom gets sick, is fat, active, happy, curious and grows well. He or she is well cared for by the mother, and a father is present in the family. The unhealthy child, on the other hand, is described as one who gets sick often, is fussy, unhappy, thin, poorly fed, and tends to come from a poor family that lacks the means to provide adequate food, clothing and other basic necessities.

Breastfeeding is highly valued and respected in Rwandan culture. Maternal milk should not be discarded casually, and lactating women take care not to let any of their milk fall to the ground. This reverence for breastmilk may be related to the sacred role accorded to all kinds of milk in the culture, and particularly cow's milk. There is a local saying that "milk must be respected," and this respect is shown in ways such as keeping milk covered while carrying it.

At all levels of society breastfeeding is regarded as the method of infant feeding. Indeed, one does not "choose" whether to breastfeed; it is assumed that breastfeeding is part of having a child, and of being a woman. A local expression of good wishes to a newly-delivered mother, "*Tubahaye impundo nimwonkwe*," translates roughly into "Congratulations and may you breastfeed well."

### Program Implications

- All program decisions must consider the multiple roles of women and their heavy daily burdens (both physically and in terms of time).
- Women's concern for the well-being of the family can be used to motivate action. "Well-being" should be defined in ways that include their own well-being related to overall family well-being.
- Specific suggestions should be made as to how men can fulfill their traditional role/responsibility at low cost, i.e., providing more, basic food to women to enhance their nutritional status and child health rather than more costly medicines, milks, etc. The notion of being a provider should be expanded to include the concept of providing care and assistance in addition to being a financial provider.
- Build on the high value currently placed on breastmilk and breastfeeding to strengthen support to women breastfeeding to overcome obstacles that may be causing the abandonment of a strong, excellent, Rwandan tradition.

### **Prenatal Care/Pregnancy**

The majority of women attend ante-natal clinic at least once, and some attend two or three times. Women attend prenatal care because they believe that some problems can be averted and that it is prudent to establish a record with the health center in case delivery problems arise. Little or no advice is given to pregnant women regarding infant feeding and breastfeeding during prenatal consultations.

Almost all women think they should eat more and better during pregnancy. However, about one-half of the mothers interviewed report having eaten **less**, during at least part of their pregnancy. Reasons cited are economic constraints, as well as, in some cases, nausea associated with pregnancy.



### Program implications

- Revise norms for the prenatal visit to include a discussion of good breastfeeding initiation practices and how to maintain a good milk supply.
- Seek ways for women to maintain, and if possible increase, their food intake during pregnancy, and work with men to support this practice.

### **Delivery and Post-partum Care of the Mother**

The vast majority of women deliver at home with the assistance of a female relative (typically the mother-in-law or the mother's sister), a female neighbor, or the woman's husband. It is also not uncommon for women to deliver without assistance from anyone. Women infrequently named a traditional birth attendant (TBA), i.e., a local woman (non family member) who specializes in traditional knowledge of childbirth. Some healers are considered particularly knowledgeable about pregnancy, childbirth, and lactation, but few are reported to be devoted exclusively to these concerns. It appears that birth attendants (a term which refers to women with more experience helping mothers give birth but not necessarily to women who have received formal training) are asked to assist only if there are complications.<sup>2</sup>

Traditionally, a Rwandan mother is entitled to a period of special post-partum care where she is relieved of her normal work load and is given special foods to recuperate from childbirth. The typical duration of post-partum rest is eight days, with gradual resumption of full regular domestic and agricultural work over the following two to three weeks. The nature and duration of this care depends largely on the availability of family members to help out and the economic status of the household. The poorer the family, the more simple the food and gifts provided, and the sooner the mother must resume her usual responsibilities. The husband is expected to procure good food for the mother, while female relatives help with caring for the newborn.

The post-partum mother is given a very dilute sorghum "porridge," slightly sweetened. Interestingly, the Kinyarwanda word for sorghum beverage -- *igikoma* -- also refers to all the gifts presented to the post-partum mother, including food and material goods. Other common drinks are banana drink, sorghum drink, milk, tea, and beer. If the family can afford it, meat is provided, but more often the mother is fed plantains, beans, vegetables and other local staples. Semi-solid "soft" food is considered best for lactating women. Sweet potatoes, manioc and other "hard" foods are thought to be bad for milk production. All food and drinks should be consumed warm. Women (and Rwandan adults in general) eat very little fruit because fruits are considered food primarily for children.

Beer (commercial Primus or banana beer) is considered beneficial for milk production, and has the added benefit, women report, of dulling afterbirth pains. Sorghum beer is also commonly consumed, but is not particularly associated with lactation benefits. Not all women like beer or can afford it, so the consumption of beer is quite variable. It appears that those who do drink beer consume about one bottle

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<sup>2</sup> The Demographic and Health Survey Preliminary Report suggests a stronger tradition of TBA use, while other documents state that TBAs are not active in Rwanda. Key informants suggest that the discrepancy has to do with different definitions of TBA; they were skeptical of the existence of a strong TBA tradition or network. Further study is needed to determine the number and role of *accoucheuses* in Rwandan communities.



per day (72 centiliters or 24 ounces of 3% alcohol beer), although some drink two or three bottles. There is reluctance among lactating women to tell health professionals that they drink beer because they know alcohol consumption is discouraged by the medical community. Therefore, mothers may have been under-reporting the amount of beer consumed, especially post-partum.

In general, people do not drink water, at least in part because it is considered contaminated (it very well may be) and the cause of intestinal worms. In particular, breastfeeding women are not supposed to drink water, as it is thought to dilute the breastmilk. *Water is not forbidden like a religious taboo, but it's really not good for the [breastfeeding] mother.* Nonetheless, about half of the women report having consumed some water the previous day, generally one or two glasses.<sup>3</sup> Those who did consume water appear to be more economically disadvantaged than those who did not.

Although most women think that both quantity and quality of food are important for lactation, some women believe that it is more important to eat high quality foods, even in small quantities, in order to produce enough milk, than to increase the quantity of food intake. It appears that in actuality, diets change very little for pregnant and nursing women. *The diet of the breastfeeding woman is not really special. Women eat what they can find around here.*

General information gathered on women's diets indicates that liquid intake appears to be low, fruit and vegetable consumption is low, and starch-based foods constitute the major portion of the diet. Studies have documented significant maternal under-nutrition in Rwanda, as well as dietary inadequacy in the areas of protein and fat consumption.

#### Program implications

- Recognize that in the immediate post-partum period, most mothers cannot be reached by clinic-based personnel or a change in clinic/hospital routines. Means will have to be devised to reach women in their households.
- Family members are important audiences for post-partum messages about immediate initiation of breastfeeding and fluid and food consumption by nursing women.
- It would be useful to conduct a detailed study of total fluid consumption by nursing women to determine whether or not it is too restricted. The effect of beer consumption may need further analysis; it appears that consumption by women is low, but because of possible reluctance to report, actual amount consumed should be verified and evaluated for health and lactation impact.
- Reinforce and if possible extend the eight-day special post-partum period to encourage drinking of fluids, giving of "premium" foods, and reprise from regular duties.
- Mothers should be encouraged to include a variety of foods in their diet. Attempts should be made to encourage the consumption of fruits and vegetables, and efforts should be made to dispel the notion that "hard" foods are inappropriate for lactating mothers.

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<sup>3</sup> The opposite idea was expressed during BFHI training sessions in the southern Rwandan town of Butare, where women's group members told facilitators that drinking water was necessary to keep breast milk from coagulating in the breast. This may reflect a regional or urban variation, or possibly the ideas of women who have more education or more specific training.



- Emphasizing the importance of quantity as well as quality of food may help improve maternal diets.

### **Breastfeeding Practices**

**Initiation of breastfeeding:** Both mothers and health providers say that the neonate is put to the breast "immediately" after birth. The concept of "immediate," however, generally means within one day rather than the ideal of within one half hour of birth. Most often, the first breast feed occurs between six and twelve hours after delivery, but it is not uncommon for the first feed to take place more than a day after delivery. The first feed is usually prompted by the child crying.

Mothers recognize a difference between the early "yellow milk" (colostrum) and the later "white milk," and almost all think (correctly) that colostrum is important, nutritive and health-promoting for the newborn. A minority do not see colostrum as particularly beneficial, but no one sees it as harmful, and everyone gives it to the baby.

Mothers consider a delay of more than one or two days for milk to come in and breastfeeding to be initiated is unusually long. Some mothers report that a delay of three or more days can be caused by a difficult and painful labor, or a mother not eating properly or being relaxed enough. For example, one woman said she could not eat anything after delivery due to pain, and this was thought to delay her milk. Also, many women believe that their milk cannot come in until after they return home and have a warm bath. (Only cold baths are available in birthing facilities.)

**Prelacteal feeding:** Very few people understand that giving liquids or foods before the mother's milk comes in is not only unnecessary, but may interfere with establishment of suckling and is potentially dangerous if the feeds are unsterile. Approximately half of the mothers give water to newborns in order to "satisfy thirst" or "cleanse the digestive system." Sometimes the water is sweetened and, in a few cases, salt is also added (an adaptation of the water-sugar-salt solution widely promoted for diarrhea). The water is boiled and cooled, and administered a few drops at a time with a spoon, finger or a banana leaf. Water is given when the infant cries, which is considered a sign of hunger. After nursing is initiated, it is continued at intervals a few hours apart, and the water is continued until the mother's white milk comes in. After that time, no further water is given.

It appears that women who deliver in hospitals or health centers in Gitarama and Kibungo are less likely to give water post-partum than those who deliver at home. The delayed timing of the initial breast feed is the same, however.

Usually no other liquids are given to the newborn, regardless of place of delivery. An exception to this is in the case of illness, where infants may be administered herbal remedies.

**Exclusive breastfeeding:** Ideally, an infant should be fed breastmilk alone, with no other liquids or foods, for approximately six months. Mothers do believe that an infant can be well nourished on breastmilk alone. Almost all mothers report breastfeeding exclusively for at least three months, and most women interviewed reported doing so for four to six months. When mothers are asked about the appropriate time for introducing foods or liquids other than breastmilk, the most commonly reported age



for beginning supplementation is six months<sup>4</sup>. However, a significant minority introduce supplementary foods at two or three months. Another group introduces supplementary foods later than six months; one infant was encountered who was 15 months old and who was still exclusively breastfeeding. Even though the majority begin supplementation at approximately the correct time, the timing of introduction of supplementary foods clearly varies considerably, with a substantial number of women introducing too early and others too late. Reasons for beginning supplementation are discussed in the Supplementary Feeding section.

***Frequency and duration of breast feeds:*** Because an infant stays close to its mother and nursing often takes place while the mother continues her routine duties, it is difficult for mothers to report frequency of breast feeds. Almost all mothers report that the infant is fed "on demand." *It is the child who demands when to be fed.* The virtually universally-mentioned cue for demand, however, is "when the child cries." A few mothers report that they feed when their breasts feel full. These are not necessarily reliable cues for infant feeding.

Exclusively breastfed babies are taken to the field with the mother and carried on her back or placed in the shade while she works. Typically, a mother goes to the field between 6 and 7 a.m. and returns home between 11 a.m. and 12 noon to begin preparing the midday meal. Most mothers report nursing infants two times while in their fields. Nursing is reported to be more frequent during the afternoon when the mother is at home engaged in domestic work. Babies who have begun taking other food and/or drink may be left at home during the morning's field work if the mother has older children to look after the baby. Little is known about what infants are given to drink or eat by older children during these periods. Until a child is weaned, he or she sleeps with the mother and "nurses all night."

It appears from both interview reports and from structured observations that mothers average six feeds during the day and three at night throughout the child's first year, regardless of infant age. A total of nine feeds during a 24-hour period may suffice for children over six months of age who are receiving adequate supplementary foods, but is inadequate for the younger, exclusively breastfed infant. Younger infants need about 12 feeds per day for optimal growth.

Further, information gathered on duration indicates that the average amount of time spent at each feeding is 10 to 15 minutes, regardless of whether the child is a newborn or is seven or eight months of age. It is desirable for infants to have nursing sessions last about 20 minutes, plus at least one or two longer feeds per day. Brief feeding sessions may not allow infants to receive maximum benefit from the hind milk, which is higher in protein and fat content than the fore milk. In addition, short sessions do not permit emptying of the breast, which helps a mother keep up her milk supply. Thus, it appears that both frequency and duration of breastfeeding may be inadequate, particularly for the younger infant.

There is a term in Kinyarwanda for the practice of waiting too long between feeds (*kwonsa ikibu*). It means waiting until the evening to nurse, that is, passing a large part of the day without breastfeeding. Some interviewees note correctly that this practice is detrimental to keeping up one's milk supply.

Most women did not note any particular seasons in which it is difficult to breastfeed properly. One remarked that infants nurse more often in the dry season, when time spent working in the fields is

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<sup>4</sup> This study was conducted in August 1993, concurrently with the airing of radio messages on the importance of breastfeeding exclusively for six months. These messages may have influenced mothers' responses. See section on Communication for more information.



comparatively less than during other seasons. (This study was conducted during the dry season.) Some noted that during the rainy season people spend the most time indoors and therefore mothers tend to be more available for breastfeeding. The seasons in which mothers spend the most time in the fields are those when it rains only part of the day, and the labor-intensive cultivation work must be done. This heaviest time for agricultural work is February to April, when the soil is prepared, crops are planted, and weeding is done.

**Nursing techniques:** Babies nurse on both breasts but there is a definite preference for left breast because the infant is usually held on the mother's left hip to allow her to work with her right hand. Observations show a preponderance of time spent nursing on the left breast, and the normative practice to nurse the left side first. In the several instances where breast size differences were noted, it was the left breast that was larger in all cases.

**Variation Among Children:** Gender differences in feeding practices were explored. Some interviewees cite either girls or boys as nursing more often or more vigorously, but most state that no gender differences exist. The only gender-related belief reported on several occasions is the idea that a mother separated from her male infant for a day or so must perform a simple ritual before she can resume breastfeeding the child. People who note this seem to feel it does not represent a serious obstacle for breastfeeding.

Individual variation among children is thought to be important. Some children are reported to nurse better than others, and some accept supplementary foods more reliably. It is the child who doesn't easily accept the local staple who is at risk for inadequate supplementary feeding. In addition, since the definition of "on demand" breastfeeding is "when the child cries," infants who tend to be passive may be inadequately fed. This was illustrated in a pair of malnourished twins; the boy was fussy and only wanted the breast, so the mother took him to the field and left the compliant girl at home. At nine months, the girl was marasmic and the boy only mildly under-nourished. In general, any kind of force feeding is disapproved of; the mother accommodates the child's preferences regarding food.

#### Program implications

- Praise the practice of exclusive breastfeeding and work on keeping it to the more traditional duration of around six months.
- Although many mothers give water to the neonate, this is a short-term, ritualistic practice, and does not appear to be especially threatening to the health of the infant. However, it always carries the potential of introducing bacteria and of delaying initiation of suckling. Since only approximately 50% of mothers give water to the neonate, this practice is probably amenable to change.
- The concept of "immediate" breastfeeding after childbirth needs to be changed from "within one day" to "within one half-hour." The child should be put to the breast as soon as possible regardless of whether or not he/she is crying.
- Cues to feed should be expanded to include the concept of frequent feedings and age-specific needs of the infant, rather than breastfeeding only "when the child cries." Guidelines on the changing needs of infants over time, specifically regarding the frequency and duration of breastfeeding, need to be developed and promoted.



- To maintain breastmilk supply and adequately nourish the infant, both frequency of feeding and duration per feed using both breasts need to be increased.

### **Insufficient Milk**

There is a strong conviction among professional and lay persons alike that many women in Rwanda have insufficient milk due to poor maternal nutrition. It is in fact very rare physiologically for a woman to have insufficient milk. Milk quantity is largely a function of demand; most perceived cases of insufficient milk are due to insufficient suckling (not frequent enough or not long enough to empty the breast). Only in conditions of famine is a mother's ability to produce milk compromised.

Mothers report the signs of insufficient milk to be the baby seeming unsatisfied after nursing the usual length of time, the baby wanting to nurse more often than usual, the breasts feeling empty, or the inability to squeeze out much milk from the nipple. Mothers also associate inadequate milk quantity with maternal illness and advanced maternal age.

Mothers and health workers alike appear to be unaware that it is normal for infants between two and three months to go through a marked growth period in which their nutritional needs are increased. To meet these needs the infant nurses more often and longer. Mothers apparently are interpreting the normal signs of increased appetite during the growth spurt as cues that their milk production no longer meets the needs of their children. Further, it is normal for the breasts to feel less full at around two to three months. Mothers may be interpreting this different feeling as evidence of lack of milk.

Perhaps the primary perceived cause of insufficient milk is the belief that most women do not eat as well as they should for a lactating woman. This perception was expressed most strongly among the poorer women, who often pointed to their breasts as evidence of apparent emptiness. They perceive their diet to be deficient in both quantity and quality, but they spoke more often about not having the right kinds of foods to eat, like beans, meat and vegetables. Some cannot afford the sorghum porridge which is considered an essential dietary staple for the lactating woman. The dietary histories document that many women eat a very limited variety of foods. Most of the foods eaten are starch-based; consumption of fruit, vegetables, protein and fat is low. Consumption of liquids is also limited, and water is taken only by those too poor to afford other drinks.

Many women perceive there to be a direct, immediate link between what they eat and milk production. In other words, if they eat well on one particular day, they expect to immediately produce more milk, and vice versa. A post-partum mother will not start producing milk, it is believed, until after she has been fed properly. *If the husband does not take care of the mother and provide food after birth, the mother can have insufficient milk. The mother can become malnourished.*

About 1/4 of mothers report that they themselves have experienced the problem of insufficient milk with one or more children. The reported causes of these cases were overwhelmingly dietary in nature, with respondents citing either food quantity or quality as a problem. Other perceived causes include worries, overwork, illness and poisoning. Beliefs about appropriate solutions to the problem of insufficient milk, again, are primarily dietary in nature. Interviewees cited either better nutrition of the mother or supplementation of the child as the right course of action. No one spontaneously mentioned more frequent nursing as a remedy.



It is also believed that some women are constitutionally incapable of producing enough milk, in some cases because the women themselves were inadequately breastfed during infancy, in others because of some unusual body trauma. For example, one woman who experienced several infant deaths within the first month of life, said that her breasts had to absorb the milk each time and finally revolted and will not produce any more milk.

Another form of insufficient milk is considered to be contagious. If two women embrace and touch breasts, share straws, shake hands, or have some other form of physical contact, the one with insufficient milk can pass the malady on to the other, and then the first woman is cured. The manifestation of this type of insufficient milk is the child having split fontanelles.

Other perceived causes of insufficient milk include poverty, family conflicts, poisoning, and worry. One healer mentioned that if a woman is startled by the unanticipated arrival of someone, this can decrease her milk supply. The French term *insecurité morale* indicating stress and lack of peace of mind was often used to describe external factors leading to diminished milk supply. It was mentioned over and over again by all categories of interviewees as a key factor in a mother's ability to breastfeed successfully. It is associated with inability to provide for basic family needs (most often food), family conflicts, stress in the workplace, lack of social support, and physical exhaustion from overwork. *I was lucky. I had my kids while I was still the youngest wife and still favored.*

It is possible that for some mothers, chronic anxiety and heavy work burdens affect their ability to relax and generate the let-down reflex. This in turn may lead to the inaccurate conclusion of insufficient milk as evidenced by infants nursing longer; it may be that it is simply taking longer for the letdown reflex to occur before milk flow begins, thus, accounting for the longer nursing period. *As long as a mother has milk, it will always flow when the baby suckles.* Women do not recognize the distinction between milk availability and let-down; they believe that if milk is present in the breasts the baby's suckling will release it without fail. Thus, let-down problems may be interpreted as insufficient milk.

The crucial relationship between nursing frequency and milk supply is incompletely understood by mothers and by health workers. Although most women say that the infant who nurses more often will get more milk, there is not a clear association between increased nursing and increased milk production. It is believed that the breasts refill after being emptied, but the concept that supply can be increased with heightened demand is lacking. Moreover, a significant minority -- perhaps about 1/3 -- believe that frequent nursing *diminishes* the quantity of milk available. *The more a baby nurses, the less milk there is.* Those who do recognize the positive relationship between nursing frequency and milk production think that if the mother is underfed, even frequent nursing cannot increase milk quantity. *Even on days I eat well, I still don't have enough milk.*

Grandmothers expressed the view that times are more difficult these days and that the problem of insufficient milk was rare in their day. *In earlier times mothers had plenty of breastmilk.*

#### Program implications

- It is essential that health workers be educated about lactation, particularly with regard to breast milk production and the dangers of early supplementation.



- Mothers should receive direct advice to address perceptions of insufficient milk, and to address concerns about maternal diet, frequency/duration of feeds, and changes in breastfeeding as the infant matures.
- Mothers and health workers should be educated to understand that it is normal for an infant to be hungry and nurse frequently at two to three months of age, as the infant experiences a growth spurt. In fact, if the infant is not demanding feeding more frequently, mothers and health workers need to recognize this as a problem, and should encourage more frequent breastfeeding.

### Other Breastfeeding Problems

The perception of insufficient milk (described above) is the main problem associated with breastfeeding in the study sites. Another problem is the idea that milk can "go bad" (*lait mauvais*). In fact, maternal milk cannot "go bad;" even if the mother experiences mastitis or breast abscesses, it is her breast which is affected but not her milk.

Almost all respondents affirm that it is possible for a mother's milk to become bad, but only a minority of mothers report experiencing this themselves. The appearance of diarrhea in the nursing infant is thought to be caused by the mother's milk. The most common cause of "bad" maternal milk is thought to be pregnancy. Other perceived causes include AIDS, malaria, tuberculosis, worms and poisoning. Breast conditions such as abscesses were also mentioned as adversely affecting milk.

There are conditions that are thought to render a mother's milk temporarily unfit, such as when she walks in the sun for a long time without nursing. The breastmilk heats up and becomes "too liquid." One can still nurse an infant in this situation but the milk can give the child diarrhea. One woman who experienced this said that her milk looked like clear water.

Malaria is endemic to the region, and women report that attacks occur as often as four to six times per year. Women feel that during episodes of illness, their milk supply declines. Some link this to the fact that their appetite and desire to drink liquids is diminished when ill.

A mother with AIDS is believed to transmit the illness to her baby through breastmilk, and most respondents are of the opinion that she should not breastfeed unless the infant is born infected. Mothers indicate that even if health professionals advise women with AIDS to breastfeed, they personally would not do so. *I would probably kill myself and give the baby to my family to raise.* However, fear of AIDS does not appear to have caused widespread changes in feeding practices. *How can we know who has AIDS, anyway?*

It is believed that milk can be of poor quality due to insufficient maternal diet or illness. (In fact, quality of milk is affected by maternal nutritional status only in cases of prolonged deprivation which can result in milk somewhat low in some vitamins.) Declining health of women in general and limited access to cow's milk are cited as causing problems for breastfeeding mothers. Some mothers are thought to be inherently unable to produce milk of sufficient quality. The diagnosis of congenital milk inadequacy is usually made when a child fails to grow properly despite sufficient milk quantity, then grows better after weaning and beginning to eat other foods.



Several folk illnesses related to milk quantity and quality are identifiable and there are terms in Kinyarwanda to label various conditions. The most commonly reported folk illness is *igihuba*, a disorder of maternal milk which causes illness in the child. The disorder may decrease milk quantity, or it can cause the milk to become very watery and contaminated. In either case, the effects on the nursing infant are perceived as negative, and often include sunken fontanels. Another common folk illness that sometimes affects breastfeeding is *ifumbi*, a condition that can be manifested in a wide range of symptoms, including swollen breasts. These illnesses are treated with folk medicines usually obtained by consulting a traditional healer. Certain healers are recognized as having special expertise in problems of the breast, and are sought out for care of lactation problems.

Healers identified three behavioral taboos related to breastfeeding which were later confirmed by mothers. First, a lactating mother should not extend greetings to people she meets during the period when her baby is teething. Second, when a lactating mother's father-in-law dies, she should not breastfeed until after the deceased is buried. Third, a lactating woman should not engage in adultery.

The mother's emotional well-being is also thought to affect lactation. Family conflicts are mentioned as a common source of decreased milk supply. Often the source of marital discord is tension stemming from polygamy or the husband's consumption of alcohol. Both women and men mentioned the husband's beer drinking as a common domestic problem, because it drains the family's income and reduces money available for food.

Breastfeeding problems are largely managed within the traditional sector of health care; rarely are health professionals consulted. When a woman experiences difficulties with her milk such as altered consistency or inadequate supply, she will usually first try traditional herbal remedies that she knows or that are recommended by family or neighbors. If these fail, or if the condition worsens or is considered serious enough, she will seek out a traditional healer (*tradipracticien*) with expertise in this type of malady. There are healers known to specialize in "problems of the breast," and they are not usually traditional birth attendants.

Of eleven healers interviewed, six reported being consulted for breastfeeding problems. One healer in Gitarama widely known for his expertise in breast problems says that he has treated about 30 cases of breast illness in the past three years, including the following conditions:

- something hard in the breast
- cracked nipples
- insufficient milk: The causes identified are those discussed in the section "Insufficient Milk." Signs of this malady include small breasts that are not full with milk and sunken fontanels in the child. Treatments include an herbal medicine that must be taken with food.
- abscess, sometimes with fever: No specific cause is associated with this condition. Treatment consists of oral and topical herbal medicines, which cause the abscess to rupture. The healer does not apply direct pressure to open the abscess.
- swollen breast (*ifumbi ibyirira*)
- hard breast (*ifumbi y'ibuye*)
- milk with blood: This is caused by intestinal worms which produce acid in the stomach. If the mother does not eat properly, her milk will become streaked with traces of blood. The healer had seen one case in a woman, and another in a cow.



- yellow milk that looks like pus: If a baby does not empty the breasts after a feed and the milk stays in the breasts a long time, the milk becomes sticky and yellow. An oral herbal medicine is given to thin out the milk. One healer reports having treated five such cases in recent years.

### Program implications

- Most breastfeeding problems are due to misinformation or lack of understanding about lactation. Supportive advice by health providers should help address these problems.
- Traditional practitioners seen as credible sources of advice on breastfeeding should be considered for orientation on lactation so that they give constructive advice when consulted.
- The perception that breastmilk causes infant diarrhea must be corrected, and families given a better understanding of what causes diarrhea.
- Husbands also need to understand the implications of family conflict on a mother's ability to breastfeed and the health and well-being of their infant.

### **Supplementary Feeding**

According to grandmothers, when they had young children solid foods were not introduced until a child was around three years of age. Until then, cow's milk and juices were given. This is typical of traditional herding societies, in which animal milk and milk products make up a large portion of the diet of both adults and children. In Rwanda, population pressures have resulted in much of the former pastures being converted to agricultural fields, and most families do not own cows.

The decision to begin supplementary feeds is usually based on infant behavioral indicators rather than infant age. A common prompt to supplement is the infant seeming to remain unsatisfied after nursing the usual length of time and wanting to nurse more often than usual. Other mothers cite the developmental ability to sit alone as the time to introduce supplementary liquids.

Another important factor in determining age of supplementation is the mother's perception of her own milk sufficiency. (See section on Insufficient Milk.) *If the mother's milk is enough, the child will refuse to eat other food. If her milk is enough, the child can take only breastmilk until two years.*

The first supplements introduced are liquids: typically, sorghum drink (*bouillie de sorgo*)<sup>5</sup>, banana drink or cow's milk (if the family owns a cow). Infants younger than six months are usually supplemented with diluted cow's milk; older infants are usually given sorghum beverage or fruit juice. Sorghum drink (a mixture of sorghum flour and water) is considered an essential staple of the diet of both lactating mothers and infants and thought to be necessary for general well-being. The first supplementary drinks are fed to babies by spoon in most cases, although some mothers use bottles or training cups. Only a small number of economically advantaged mothers can afford the locally available infant formula, Guigoz, a product of the Nestle Company.

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<sup>5</sup>"*Bouillie de sorgo*" is literally translated as "sorghum porridge" but is quite dilute and more like a drink.



The introduction of semi-solid food usually occurs between six and nine months, and is linked to the child beginning to crawl. Another behavioral cue interpreted to mean that a child needs other foods is the child's own show of interest in food, when the child is observed to reach out for food being consumed by siblings or parents. *When a child starts reaching out for food from his brothers and sisters, you know it's time to begin giving him things to eat other than breastmilk.* When asked, mothers list a number of possible semi-solids foods as appropriate for infants, including mashed banana, or puree of potato, sweet potato or manioc, to which may be added beans, soy flour, ground peanuts or vegetables. However, it appears infants receive a limited number of these options on any given day.

The selection of foods depends on what is locally available and in season, and what is being cooked for the family that day. (There is some regional variation in staple foods: in Gitarama the staples are sweet potatoes and manioc; in Kibungo it is plantains.) Often, a small portion of the family meal is set aside and mashed up with cooking liquid for the baby. The child is usually fed the same number of times that the family has a meal, typically twice a day, and eats from a separate bowl. Most families cook once each day, store leftovers in a covered container, and then reheat food again later: the actual temperature to which food is reheated and the hygienic implications of giving infants foods stored and reheated in this way are not known. In addition to these meals, the baby continues to be given the sorghum drink (prepared with water) and other liquids at other times of the day, often in the early morning.

The transition to sharing the family meal occurs between nine and twelve months, and is linked developmentally with the baby learning to walk. At this point, the child sits with the other children and eats by hand out of the common serving dish. It appears that, by 12 months, virtually all children are eating the foods the rest of the family eats. Family meals are usually served around midday and early evening. In the morning everyone drinks sorghum porridge. Older infants and other children may be given snacks between meals like a banana, boiled sweet potato, or sliced papaya in season, although the frequency with which these foods are given could not be ascertained. Although fruits and vegetables are considered "children's food," few young children are given them because they hold greater value as commodities for sale, and it appears that in fact fruits and vegetables are a small part of a child's diet. Generally, the weaning diet appears to be poor.

One important belief regarding infant feeding practices is that fats and oils are not good for children. In preparing food for small children, mothers try to limit or remove as much oil as possible. They often set aside a portion of the family food for the child before adding oil, thereby missing an opportunity to increase the caloric density of the child's meal.

Just as cues from the child trigger supplementary feeding, disinterest on the part of the child in eating other foods can lead to delays in introducing solid food. It appears to be the child who refuses to eat the local staple who is at particular risk of delayed supplementary feeding, as in the case of a 15 month old girl who was fed only breastmilk because she resisted eating other foods. Early introduction of supplementary foods is a problem among some mothers, but late introduction is also a problem and is usually attributed to refusal of food by the infant.

Problems in providing appropriate weaning foods are attributed to poverty, and to a lesser extent to lack of time, fuel and potable water to prepare them.



### Program implications

- Mothers' inclination to introduce semi-solids at about six months should be commended. However, guidance on timing of supplementary feeding based on the changing needs of infants over time should be developed and advocated.
- The practice of giving diluted cow's milk, especially before the age of six months, is highly detrimental, and needs to be explicitly discouraged.
- While children do vary in their habits it is important to reinforce that the mother "knows best." Mothers need to feel confident about helping children learn to like foods. If growth faltering starts, the mother needs to feel confident that she can exert her judgment and implement advice given by health professionals. Health workers should work with mothers to enhance mothers' confidence in making decisions and implementing recommendations.
- In particular, mothers of 6-12 month old children need to be encouraged to feed their children, rather than letting the children eat by themselves.
- The importance of giving a child a variety of foods, including fruits and vegetables, as well as oils, should be emphasized. Determination of appropriate specific advice to mothers on weaning foods will require further investigation of food options as well as work with mothers in their homes to determine feasibility of making changes in weaning foods.
- More information is needed on the cooking, storage and reheating of foods for infants and possible implications for infant health and nutrition.
- Since the weaning diet is poor, it is especially important to encourage frequent breastfeeding even after supplementary foods are introduced.

### **Weaning/Cessation of Breastfeeding**

Mothers continue to breastfeed their infants during and after the transition to the family diet. The appropriate age for complete weaning is thought to be around three years, but many mothers said they would breastfeed for four or five years if they did not again become pregnant and if the child remained interested.

The most common reason for weaning is pregnancy. *It is the time between pregnancies that determines how long a woman can breastfeed.* Usually breastfeeding is abruptly terminated upon discovery of a new pregnancy, creating a nutritional and emotional shock for the young child.

The second most common reason for complete weaning is the child losing interest in breastfeeding. Other reported but less common reasons for terminating breastfeeding were illness in the mother; wanting to have another child; "bad" milk; illness in the child; child reaching an appropriate age; and the return of a mother's menstrual periods. Even women who think they have very little milk to give continue to breastfeed; a small minority of mothers reported that they had completely stopped breastfeeding because of insufficient milk.



### Program implications

- The long duration of breastfeeding should be reinforced. This does not appear to be a priority area for action.
- The problem of abrupt weaning needs to be addressed, specifically sudden cessation due to pregnancy. Mothers and health workers need to understand that milk is not "contaminated" by the mother becoming pregnant, and to consider the impact on the breastfeeding infant of abrupt weaning.

### **Feeding During Child Illness**

Beliefs and practices related to feeding sick children were explored. In general, it is believed that sick children should be fed semi-solid foods, sorghum beverage, and breastmilk. There are mixed responses regarding the question of breastfeeding children during diarrheal episodes. Some say breastmilk and other liquids should be decreased in order for the infant to drink plenty of oral rehydration solution (ORS); others say breastfeeding should be continued as usual. There is agreement that cow's milk is not good during diarrhea, and that if it must be given, one should not give fresh milk. There is a common belief that children with diarrhea should be fed hard, constipating foods like manioc and colocase roots. One woman gave her personal recipe for "diarrhea food" consisting of boiled manioc and colocase root, mashed and mixed with soybean flour. One child with diarrhea was encountered who was receiving only breastmilk and rice, a practice learned at the health center.

### Program implications

- Breastfeeding needs to be well integrated into diarrheal treatment protocols, and be promoted instead of ORS for mild cases, especially for children under six months of age. Clear messages that breastfeeding is the first line of defense need to be incorporated into the diarrheal disease program.

### **Malnourished Children**

Twelve mothers of malnourished children were sought in order to gain insight into particular conditions which may lead to this problem. It appears that a clustering of factors contribute to this problem: (1) unsatisfactory infant feeding practices, (2) medical problems of the mother or child, and (3) social problems within the family. In each case, at least two and sometimes all three factors were present. Examples of poor feeding practices are using the sensation of a full breast as the cue to feed, premature supplementation, and infrequent nursing of a passive child. Examples of medical problems are premature birth and maternal illness. Instances of social problems include family conflicts related to polygamy, death of a parent, alcohol abuse, and extreme poverty.

Three case studies of malnourished children are found in Annex B.



### Program implications

- Families with a malnourished child should be targeted for special support and counseling.
- Health workers, mothers, and fathers should learn to identify faltering of the breastfed infant and to increase duration and frequency of feeds, and take other appropriate measures to address the situation.

### **Breastfeeding and Employment**

The sample of 16 employed women included public and private sector employees, as well as those in the informal sector and self-employed tradeswomen. Female employees in the public and private sectors are legally entitled to maternity benefits such as paid leave averaging two to three months, and a one hour daily nursing break when they return to work. Those in the informal sector have no legally protected benefits; they must negotiate maternity-related privileges with their individual employers. Most respondents described the attitude of their employers toward breastfeeding as favorable.

Although the rationale for the hour nursing break is to provide mothers the opportunity to nurse their infants during the work day, most employed women do not use the time in this way. Most live too far from their place of work to make it feasible for them to travel to and from home during the day to breastfeed, so they take the extra hour either at the beginning or the end of the work day. Informants say this practice is viewed unfavorably by some employers because they think it misses the intent of the free time. While the mother is at work, the infant is fed formula, cow's milk, or foods.

Most respondents do not perceive any problems with working and breastfeeding. This means that they accept feeding of breastmilk substitutes and the scheduling difficulties that can lead to decreased milk supply. Early supplementation by those who can afford it is not considered problematic, even though unhygienic conditions, lack of access to potable water and other factors such as inadequate mixing, storage and feeding of breastmilk substitutes pose serious threats to infant health.

Child care for women with higher paying jobs in the formal sector (e.g., secretaries, school teachers, nurses) is most commonly a full-time maid (usually not a family member) who takes care of the housework and some cooking as well. Women in lower status jobs such as store clerk or waitress do not earn enough to hire a caretaker. These women either keep their babies with them at work, or have a family member or friend bring the baby to them to be nursed on the job. Informal sector employees, such as maids and tradeswomen, usually keep their infants with them, at least during the early period of exclusive breastfeeding. For lower-paid urban working women as well as rural farmers, the availability of an older child is a key factor in determining whether a mother will leave her older infant at home.

None of the mothers expresses breastmilk to leave for someone to give to the child. The idea of expressing breastmilk is considered strange and unnatural.

It is clear that, for employed women, supplementation begins earlier than for those working in traditional agriculture. However, since early supplementation is also characteristic of urban feeding patterns, and since employed mothers are more commonly found in urban areas, the extent to which being employed affects infant feeding practices over and above the effect of urban influence is not clear.

Four case studies of employed women are found in Annex C.



### Program implications

- There is a legal and cultural basis for the support and promotion of breastfeeding among working mothers, and it is important to protect breastfeeding practices from further erosion among urban, working, and other groups of mothers who believe breastmilk substitutes are acceptable as long as they are affordable. Mothers and health workers need to recognize the possible negative effects of breastmilk substitutes. Specific feasible and culturally acceptable solutions need to be devised and promoted to both employers and mothers.
- Because of strong negative feelings against expressing breastmilk, leaving expressed milk is not likely to be well received as a solution for employed breastfeeding women. Behavioral trials would be necessary to ascertain whether there is potential for overcoming feelings against breastmilk expression.

### **Breastfeeding, Sex, and Contraception**

Sexual relations are considered important for a favorable birth, because the woman is comforted and put at ease, although some mention that sexual relations during the final month of pregnancy should be avoided because the baby has descended and is in a vulnerable position. It is reported that sexual relations generally resume following the eight day recuperation period after childbirth. Some healers report a longer delay ranging from two to four weeks, and two healers said it depended on the sex of the child: four days for boys and three for girls. There do not appear to be beliefs concerning sex and lactation, although one healer stated that problems with lactation can sometimes be helped by avoidance of sexual relations.<sup>6</sup> In describing the process of lactation, many individuals mentioned the importance of maternal blood, from which they believe breastmilk to be generated.

Most respondents (about 3/4) recognize a relationship between breastfeeding and birth spacing, but breastfeeding is not intentionally practiced as a contraceptive method. Conversely, some women do wean in anticipation of trying to get pregnant. Some women say they hear that breastfeeding helps birth spacing but doubt that it is true because so many women get pregnant anyway.<sup>7</sup>

The ideal number of children is considered to be four, with the preferred spacing between children varying between two and five years, with three years the most common response. Most families, however, have a larger number of more closely spaced children because the women become pregnant sooner than desired.

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<sup>6</sup>In his book on Rwandan healing, Taylor (1992) states that many healers he interviewed perceive positive benefits for lactation of sexual intercourse during the latter part of pregnancy. Further, he states that some healers believe that the vaginal intake of semen after the traditional four to eight day rest period aids the rise of maternal milk, while others believe that the breasts consist of fat that must melt (through the heat of intercourse) in order for milk to be produced. However, none of the Rwandans involved in this study mentioned these ideas, and when these ideas were asked about, interviewees in Gitarama and Kibungo considered them odd.

<sup>7</sup> Breastfeeding in and of itself does not provide contraceptive protection, but the Lactational Amenorrhea Method (LAM) does. The LAM criteria are fulfilled if a woman is less than six months post-partum, is exclusively breastfeeding, and has not experienced the return of her menses. For many women who breastfeed frequently beyond six months post-partum, the period of protection against pregnancy is extended.



Use of modern contraceptives is low in Rwanda, and few women mention the issue of potential effects of birth control pills and other chemical contraceptives on lactation. One mother of a malnourished two year old said that after she began taking Depo Provera shots at one month post-partum, her milk production decreased. Another mother said that taking birth control pills had decreased her milk supply. Some mothers express the opinion that it depends on the constitution of the woman as to whether contraception negatively affects lactation. A family planning volunteer expressed interest in learning more about lactation so that she could provide better information to mothers about the relationship between birth control pills and breastfeeding, although she noted that no one had complained about problems with breastfeeding caused by pills. This woman was aware that "minipills" can be prescribed for lactating women. For the most part, there is little awareness that there are special considerations for the lactating mother who wishes to use hormonal or chemical contraceptives.

#### Program implications

- Parents desire birth spacing. Explaining the relationship between breastfeeding and fertility is likely to be a motivation for encouraging exclusive breastfeeding to six months.
- Currently, given the low contraceptive prevalence rate in Rwanda, breastfeeding is the main determinant of birth spacing in the country. Even small changes in duration or intensity of breastfeeding could lead to higher birth rates. Policy makers should consider the importance of supporting breastfeeding as part of their efforts to promote family planning in Rwanda.
- Service providers need specific guidelines regarding which hormonal and chemical contraceptives are appropriate for lactating women.

#### **Social Influence and Social Support: The Role of Grandmothers and Fathers**

When a woman marries, she moves into her husband's house, and her mother-in-law is often an important influence on infant feeding practices. The mother-in-law is the most common birth attendant, and also provides post-partum care to mother and infant. Most grandmothers report that they had at some point given advice on the feeding of their grandchildren. A grandmother tends to have greater influence on feeding if she lives in the same household as the child. Geographic distance diminishes the influence of grandmothers and other relatives.

Mothers do not name fathers as important sources of influence and advice on child feeding; however, fathers state that they can and do play a role in feeding decisions such as the introduction of supplementary food and weaning, and in special situations such as maternal illness. Fathers do occasionally purchase food for children, and tend to agree with women on the timing of supplementary foods. Most fathers state that breastmilk substitutes are inferior to breastmilk.

Interviewees note that family members can provide support to breastfeeding women in procuring food, helping with domestic tasks and child care, and fostering harmonious relationships within the family. Most mothers express the view that fathers could do more to support breastfeeding than they typically do. Women express a desire for greater support from their husbands in the areas of agricultural work, domestic work and child care to enable them to breastfeed more easily.

Men express very positive attitudes toward breastfeeding in general and affirm its many benefits. Most acknowledge that fathers could do more to support their wives' breastfeeding. Many cite maternal



malnutrition or illness as the most common cause of breastfeeding problems, and see the procurement of food as the most important way they can help their lactating wives. Some indicate that more could be done in the areas of domestic work and providing "peace of mind" (*la sécurité morale*). Coming home early and drinking less was noted by a number of fathers as ways that men can demonstrate such support. Most fathers agree that problems of marital discord, including those arising from polygamy, can inhibit a woman's ability to produce milk. Conversely, they feel that a good relationship (*bonne entente*) helps insure peace of mind.

#### Program implications

- Key community audiences, in addition to the women themselves, are mothers-in-law, especially for their influence in the post-partum period, and fathers for their potential support with supplying nutritious foods for their wives and with helping with chores. Men already have a base of awareness of ways they can provide support; this needs to be reinforced and translated into specific actions they can undertake.
- Men, women, and health workers wishing to assist a lactating mother and her breastfeeding infant need to understand that feeding and supporting the mother is the best way to protect both the infant and the mother.

#### **The Role of Health Professionals**

This study focuses principally on mothers and their immediate community, rather than the formal health system. However, when health centers were visited, brief discussions were often held with health personnel. Further, mothers were asked about advice given them on infant feeding by health professionals. Most mothers have some contact with health providers; although most mothers deliver at home, the vast majority do attend prenatal clinic at least once, and many return to the clinic when their child is an infant.

Mothers' reports of the information and advice given to them by health professionals show that health workers often provide misinformation on breastfeeding.<sup>8</sup> They often reinforce a mother's belief that she lacks sufficient milk to adequately breastfeed her baby, and that this problem is caused by poor maternal diet. Moreover, the advice usually given is to introduce supplementary foods such as formula (if the family can afford it), cow's milk or sorghum porridge. This advice is usually given at the time of well-baby visits when mothers take their infants for immunizations and the babies are weighed. Mothers with infants as young as two months are being advised to supplement. In some cases the health center staff are supplying commercial formula, either free of charge, for cash, or in exchange for work. Some private clinics appeal to foreign donors for infant food, citing widespread maternal malnutrition and insufficient milk.

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<sup>8</sup> This agrees with the findings of the 1992 breastfeeding assessment conducted by Wellstart, which included interviews with health providers.



The advice health workers are giving is dangerous for a number of reasons:

- (1) It worsens the problem by actually reducing the mother's milk supply. If a child is given supplementary liquids or foods, it will not nurse as often, and mother's milk supply will begin to decrease.
- (2) Whatever supplements are given will displace breastmilk intake and are certain to be nutritionally inferior to breastmilk.
- (3) The risk of introducing bacteria and disease-causing pathogens is tremendously increased.
- (4) The fertility reduction impact of frequent breastfeeding is threatened, increasing the likelihood of becoming pregnant again too soon.

Mothers are often counseled that they are producing insufficient milk because they are inadequately nourished, and are encouraged to try to improve their diets by eating more meat, beans, vegetables, cow's milk, and sorghum porridge. Since poor women do not see being able to improve their diet as a realistic possibility, they come away from the health center more concerned that they will not be able to breastfeed adequately.

It appears, unfortunately, that breastfeeding patterns were better in the past (at least in regard to the duration of exclusive breastfeeding) and that health professionals are unintentionally undermining some of the very good traditional practices.

#### Program implications

- It is imperative that health workers receive training which emphasizes the importance of exclusive breastfeeding for around six months, gives them an understanding of the principles of lactation, and enables them to deal with lactation concerns. Such training is especially urgent given that health personnel are seen as reliable and credible sources of information (see below).
- The provision of formula for infants under six months of age must be stopped (except when the mother is not present or in those extremely rare cases when a mother is truly unable to breastfeed).

#### **Communication**

The most credible source of information on breastfeeding and general child health are health professionals. Mothers have great faith in what health agents advise them to do. However, advice for breast problems is generally sought from healers.

Fathers are not turned to for advice, but do have considerable influence over whether a household has *securité morale* ("peace of mind") and can provide valuable support for the mother. Grandmothers appear to have limited influence, unless they reside in the home and take the major responsibility for child care.

Perhaps only 30-40% of residents have radios, but the reach of radio may be much beyond what radio ownership data would suggest. People may listen to a neighbor's radio, especially for programs scheduled in early evening hours, and tend to share what they hear. Information transmitted via radio appears to have a very high degree of credibility. During the month of August, 1993, the Ministry of



Health aired a number of radio spots on breastfeeding. It would be useful to conduct a brief study to determine how many people heard these and perhaps other health-related spots and what the level of recall is.

Since only about 20% of the population is literate and tends to be concentrated in the urban areas, written materials would have only a limited audience in this setting. Pictorial materials have been used successfully in a variety of health education programs, and interviewees seem to readily grasp the messages on posters addressing topics such as domestic sanitation, AIDS prevention and family planning. However, some people had trouble with pictorial interpretation; any materials developed need careful testing.

#### Program implications

- Oral communication -- counselling, radio, meetings -- should be stressed over print materials, particularly if print is unaccompanied by oral explanations.
- Conduct a brief study of breastfeeding (and perhaps other related) spots aired on the radio to ascertain their reach, what people recall of their content and, if possible, their impact on behavior.
- Health professionals should be a major focus of any breastfeeding promotion effort. It looks likely that it would be beneficial to provide basic training in lactation and breast problem management for traditional healers as well.



## SUMMARY OF BEHAVIORS

### Behaviors to be protected

- *Prenatal care:* The high proportion of mothers who seek prenatal care should be maintained, although more frequent visits could be encouraged, and more information on infant feeding given.
- *Delivery and post-partum:* The existing custom of providing special care for the post-partum mother should be reinforced and extended to include support in addition to the provision of food. The need for more than eight days of rest and, if possible, extra food and liquids should be stressed, along with the value of psychosocial support and help with domestic tasks.
- *Breastfeeding practices:* Positive social attitudes and values regarding the importance of breastfeeding in general, and exclusive breastfeeding and long-term breastfeeding in particular, should be protected. The widely shared perception that almost all women are capable of breastfeeding successfully should be reinforced.
- *Working mothers:* Employment practices that facilitate breastfeeding should be protected and expanded. The special needs of lactating women working in different sectors should be addressed, with the aim of finding flexible solutions to varied situations. Employers should be encouraged to work out solutions to individual problems.

### Behaviors To Be Modified

- *Maternal diet:* Educational messages should stress that normal diets are adequate for mothers to breastfeed, but that when possible a greater quantity and variety of foods should be consumed. The problem of reduced food intake during pregnancy specifically needs to be addressed. For lactating women, the notions that water dilutes breastmilk, that "hard" foods are detrimental to lactation, and that fruits are mainly for children should be dispelled.
- *Post-partum:* The Ministry of Health of Rwanda and others organizations' recommendation of giving the breast within one half-hour of birth should be encouraged. The idea that a newborn needs water needs to be dispelled.
- *Demand feeding:* Cues to feed should be expanded to include concepts of frequent feeding and the age-specific needs of the infant, rather than breastfeeding only "when the child cries." More exploration is needed of ways to help mothers interpret the infant's need for increased frequency of feeds at different ages.
- *Timing of supplementary feeding:* Exclusive breastfeeding should be practiced for six months, and supplementary liquids or foods should not be given much earlier or much later than that time. The causes of ill-timed supplementation need to be addressed, including ideas about insufficient milk and bad milk, and lack of knowledge about initiation of weaning.
- *Weaning diet:* The child's need for frequent, small meals that are rich in energy and nutrients should be stressed. In particular, the idea that fats are not suitable for a young child should be dispelled. (A



review of existing documents and, if necessary, a more detailed nutritional study of the weaning diet and local foods which could be promoted to improve it would be desirable.)

- *Cessation of breastfeeding:* Termination of breastfeeding should take place gradually rather than suddenly. In particular, the problem of abrupt weaning upon learning of a pregnancy needs to be addressed.



**ANNEX A**  
**BIBLIOGRAPHY**



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**ANNEX B**

**CASE STUDIES: MALNOURISHED CHILDREN**



## CASE STUDIES: MALNOURISHED CHILDREN

### Case No. 1

Married at 15, a 36 year old mother of four had a malnourished two year old boy. Her other children were aged eight, six and three. After the third child, she became pregnant at one month post-partum. Not wanting this to happen again, following the birth of her last child, she began Depo Provera shots one month after delivery, and noticed a decrease in her milk supply. Because of insufficient milk, she tried giving the baby sorghum beverage at three months, but the baby did not like it and refused the drink. She continued exclusive breastfeeding until six months, at which point her milk supply seemed clearly inadequate so she tried giving banana juice and sorghum beverage, which the infant still did not take well. At age two the boy is breastfed and eats the usual family food, which is very basic. The day we visited the boy, he had a bad ear infection and seemed miserable.

The woman is the second wife of her common law husband, who drinks heavily and often doesn't take proper care of her and the children. A few months ago she had problems with her husband and left to go live with her parents. She returned to her house in June but it was too late to plant, so beans are in very short supply. The family eats manioc and sweet potatoes, adding soybean sauce occasionally, in two meals taken around 10:00am and 7:00pm.

### Case No. 2

A 30 year old mother of nine month old twins (one male, one female) had come to the clinic to obtain measles shots for the infants. We interviewed her in a nearby school classroom. She had three other children, the oldest 12 years. At birth, both twins weight 2.8 kg; at nine months, the boy weighed 6.1 kg and the girl weighed 5.0 kg. The month before at the twins' regular well-baby visit, growth faltering was detected and the clinic personnel advised the mother to feed them sorghum beverage mixed with eggs. The mother said she lacked the money to buy eggs and sorghum flour, so she fed the infants colocase roots, which is all she could afford.

The woman and her family are extremely poor. She and her husband own very little land, and what they do have is infertile. Her husband farms land that belongs to their neighbors, which generates very little income for food procurement. The husband gives the mother 100 RF (\$.70) per week to buy food for the twins.

After giving birth, the mother had a severe case of malaria, and her husband was also sick. With both parents debilitated, there was no one to buy food and the whole family suffered. One of the older children died. From the start, there were differences between the twins that led to variable patterns of child care and feeding. The boy cried more often and demanded only the breast; he also woke up more often at night to nurse. The girl was more compliant, seldom crying or demanding the breast. At six months the mother introduced supplementary foods which the girl accepted, but the boy refused, only wanting the breast. Given these behavior differences, the mother decided to take the boy to the field with her, because she could not carry more than one child on her back while working, leaving the girl at home to be cared for by her older siblings. At eight months, a noticeable difference in the nutritional status of the twins was evident, the boy's status being clearly superior.

The woman said she does not want any more children but her husband does because he was an only child.

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### Case No. 3

A 60+ year old grandmother had taken her nine month old granddaughter to a nutritional rehabilitation center. After her daughter-in-law gave birth, the parturient woman experienced abdominal pains; the family waited eight days to see if it would pass. When the pain continued the family decided she had been poisoned, so she stopped nursing to avoid passing the poison to the baby, who they believed would surely have died. The family knew she had been poisoned because of the swelling in her feet and because there were many evil-doers in their community. Two weeks after childbirth, the mother died.

The family kept the baby alive on boiled cow's milk given by spoon five times a day and two to three times during the night. At five months the grandparents introduced sorghum beverage and banana puree, and at six months, beans and Irish potatoes. Also, since birth the grandmother has nursed the baby to give psychological comfort, and was able to relactate, but never produced enough milk to sustain the infant. This she attributed to the fact that she herself had experienced insufficient milk with her last child, now aged 16.

When the baby was two months old she was brought to the Catholic nutrition center where she was given formula distributed by Catholic Relief Services (CRS), and began to gain weight. The next month the formula had run out because CRS had discontinued its program of formula distribution. Soon after, the baby began to lose weight, and her nutritional status has steadily declined to the point where she weighs only 5.4 kg at nine months. The grandmother expressed the opinion that the reason the child has not grown properly is because she did not receive the mother's colostrum after birth.



**ANNEX C**

**CASE STUDIES: BREASTFEEDING AND EMPLOYMENT**



## CASE STUDIES: BREASTFEEDING AND EMPLOYMENT

### Case No. 1 - Public Sector Employee (Teacher)

This 28 year old mother, "Irene," was a schoolteacher who had a four month old daughter. Following her three months of maternity leave, Irene returned to work, and began supplementing with infant formula. The mother rises at 6:30am, nurses the baby, then leaves shortly afterward to make it to work by 7:30am. During the morning the housekeeper/maid gives the baby two bottles of formula. Irene is lucky enough to work close enough to home that she can return during her lunch hour and nurse the baby. She returns to work by 1:00pm, and during the afternoon the baby receives two more bottles of formula. After work, Irene breastfeeds exclusively until she leaves for work the next day. No supplementary foods have been given yet, and Irene reports having had no problems with breastfeeding so far.

### Case No. 2 - Public Sector Employee (Health Auxiliary)

This 29 year old mother, "Elizabeth," had a seven month old girl and worked as a health assistant at a clinic. She breastfed exclusively until the end of her maternity leave at two months postpartum, then tried to give the baby formula. The infant refused to take the artificial milk, so Elizabeth gave her pineapple juice, which the baby accepted. At five months, Elizabeth started giving the child sorghum beverage. The mother leaves home around 7:50am after having nursed the baby and prepared the baby's sorghum, which is kept warm in a thermos; during the morning the maid gives the sorghum beverage to the baby one time, using a cup and spoon designated for this purpose. Although public employees are entitled to an hour nursing break, this mother cannot take advantage of it, she said, because the clinic has so many patients to care for between 11:00 and 12:00, when it would be most useful for her to leave to nurse the baby. She returns home in early afternoon, after all the patients have been taken care of. Elizabeth said that because of her job, she cannot nurse the baby as often as she would like; she nurses five times during the day and three times at night. In the evening, she gives the baby a light meal of plantain and soybean sauce, and mashed ripe banana.

### Case Study No. 3 - Private Sector Employee (store clerk)

This 24 year old mother, "Odette," had an 11 month old son and worked as a store clerk. She fed the infant breastmilk exclusively until the end of her maternity leave at two months postpartum. At that time she started giving the baby formula during her absence. At seven months, she switched to canned condensed milk for the baby, and began giving sorghum beverage along with vegetable soup, mashed ripe banana and pineapple juice. At present, before leaving home at 7:25am Odette nurses the baby and prepares the infant's sorghum beverage, storing it in a thermos. During the morning the maid prepares vegetable soup and gives this along with the sorghum drink to the baby. Between 11:00 and 12:00, Odette returns home to breastfeed the baby, then returns to work until 5:00pm. During the afternoon the baby is again fed sorghum beverage. Around midday the baby also eats a light meal of Irish potatoes and vegetables. In the evening the baby eats another meal, often plantains and vegetables. Odette says she nurses the baby about ten times during the day and four times at night, and says she has had no problems with breastfeeding and has abundant milk (the accuracy of the daytime feeding frequency seemed questionable given her work schedule). Nevertheless, she thinks that working in general tends to decrease nursing frequency. She wished that mothers could take four months of maternity leave instead of two. Her employer, she says, is generally supportive of breastfeeding, but does complain when there are several breastfeeding employees at one time.



#### Case Study No. 4 - Informal Sector Employee (Barmaid)

This 23 year old mother, "Celeste," works as a server in a bar, and the job also requires being a sex worker as the demand for services arises. Her sex clients are mostly soldiers whose military post is nearby. She has a seven month old baby boy, her third child. The first two children died before the age of two months. She sought prenatal care for all three children, going for two consultations during each of her pregnancies. She knows one is supposed to go three times, but in her position she had to conceal her pregnancy as long as possible, so she waited until the second trimester to begin care. The first two children were born at home in the country and the births were attended by her mother because the hospital was too far away.

For the third child, she delivered in the hospital because she was living in town then, working as a family servant. After the delivery, her female employer took care of her at her employer's house. The baby's father is a soldier who has recognized the child as his. At the time of the birth, the father was fighting in the civil war, but on one of his leaves he came to see the baby and gave Celeste 1,000RF (\$7.00). He was subsequently injured in battle and was hospitalized at the time of the interview.

Celeste stayed at her employer's home for two months, then left because the baby was not being cared for properly and became sick. Also, there were "rumors" going around that the owner's husband was the baby's father. Desperate to find the means to support herself and her baby, Celeste took her current job and rented a small room in town, where she and the baby spend their nights. She works seven days a week, from 6:00am to 9:00pm, long, hard hours washing glasses, serving beer, and seeing clients in small rooms behind the bar. For this she is paid 3,000 RF a month (\$21.00).

Celeste keeps the baby with her at work during the day. Her employer accepts having the baby there because she already had the baby when she applied for the position. Up until now, having the baby around was not a problem because she carried him around on her back, where he spent a large part of the day sleeping. Now, however, he is getting a little large and heavy to carry around all the time, and he is at an age where he needs to crawl around more. How Celeste would manage a more ambulatory infant on the job was a source of concern to her.

The baby had been exclusively breastfed until just recently, when Celeste began giving him a little of her own food provided at work (beans and plantains). The child was fat and healthy, and Celeste said she had always had plenty of milk because she ate well at the bar and drank beer throughout the day.



**ANNEX D**  
**INSTRUMENTS**

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INTERVIEW GUIDE - MOTHERS

Demographics

Mother's age \_\_\_\_\_ (yrs.)

Child's age \_\_\_\_\_ (mos.)

Education \_\_\_\_\_ (yrs.)

Occupation \_\_\_\_\_

No. of children \_\_\_\_\_

Husband present: yes/no

I. Social Perceptions

What are the characteristics/qualities of a good mother? Why?  
What are the characteristics/qualities of a good father? Why?

Please look at this photo:

What do you think of the child?

How do you think he is fed? (Probe comments like he's fed cold or left-over food: how does it make a child look like that?)

II. Prenatal Care

Did you go to see any health care provider during your pregnancy? Why? (Probe also for traditional providers if not mentioned)

How many times did you go to see \_\_\_\_\_ during your pregnancy?

Did you change your diet in any way while you were pregnant? How?

III. Delivery/ Immediate Postpartum

Care and feeding of baby:

Where did you deliver your baby? Who assisted you?

What is given to the baby soon after birth? How soon after birth? Who advised you to give this?

Was anything else given? Why is \_\_\_\_\_ given? For how long do you give it? Why?

[If water not mentioned:] is water given? Tea? Why?

What would happen if [anything other than breastmilk] wasn't given?

Is (water, tea) given along with breastmilk or before giving breastmilk?

How soon after the baby was born did you first breastfeed him/her?

Do mothers here give babies colostrum? Why or why not?

Is there a difference between colostrum and breastmilk? What?

Care of the postpartum mother:

Did you receive special care immediately after delivery? What kind? Who provided it? For how long?

[If the husband is not mentioned ask:]

Does the husband have special responsibilities toward his wife after delivery?

How long after birth did you resume your usual domestic work?

In Rwanda does the family usually take special care of the mother right after birth? How is she taken care of? For how long?

When is the mother expected to take on her usual responsibilities? Is the mother usually ready?

What is the appropriate diet for the mother during lactation? What are the appropriate drinks?

Are there drinks which are particularly good for maternal milk? Others which are bad for maternal milk?

Probe for:

- water, beer

Previous day maternal diet:

Liquids: When? Quantity?

Water: When? Quantity?

Foods: When? Quantity?

#### IV. Current Practices

[Verify that respondent is currently breastfeeding]

**Farmers:**

[Find out about the woman's typical day]

When do you leave for the fields? Do you bring the child?

Where is the child while you work? On your back or nearby?

Does someone else accompany you to care for the baby?

How often during [period of time] does the infant nurse? How does she know when it is time for the child to breastfeed? How long is each feed? How does she know that the child has nursed long enough?

When you return to the house, what do you do? When do you nurse the child? Where is the child while you prepare food, fetch water, etc.? During the night, does the child sleep with you?

Are there seasons when it is difficult to breastfeed a child as one should?

[Try to identify all the obstacles to optimal breastfeeding]

**Employed women:**

How long did you have off for maternity leave?

What are your work hours? What days do you work?

At what time do you leave home and return from work?

Where is the baby during work hours?

--who takes care of the baby?

--how is the child fed during your absence?

(Probe for: foods, drinks, frequency, quantity, how given, by whom, how prepared)

Do you take advantage of the extra hour for breastfeeding?  
When? For how many months does she have this employment benefit?

When did she begin to give supplementary foods? What did she give?

Has she ever heard about manual extraction of breastmilk?  
What does she think of this?

Does the fact that you work pose problems for breastfeeding?  
Which ones?

Are there things which could be done to help employed women to breastfeed?

Attitude of her employer toward breastfeeding?

**Women who have not yet introduced supplementary food:**

Ask when she plans to begin giving other liquids/foods to the child? Why? [If before 6 months:] Ask if she would be able to wait until 6 months. [If no:] Why not?

**Current feeding of the child: (other than maternal milk)**

What do you give the child to eat? to drink?

--how is it given? (bottle, spoon, cup)

--how much per day?

[If cow's milk is given:] Do you have a cow?

--how many meals per day?

--does the child has his/her own dish? shares with others?

--how often each day is the baby's food prepared?

--are the leftovers reheated?

--how are the leftovers stored? covered? in the shade?

Do you give medicines to the child? Which ones? Why?

How? Quantity? For how long?

**Previous day diet for infant:**

Breastmilk: number of feeds during day? during night?

Other liquids: which ones? when? quantity?

Foods: which ones? when? quantity?

**Weaning (complete):**

Why do women stop breastfeeding a child?

[Ask when she weaned her other children and why]

What are the reasons to wean? [If not mentioned, probe:]

-- child illness, maternal illness, maternal-infant separation, pregnancy, sexual relations, cues from the child

-- When it is time to wean a child, what does the family do? What does the father do?

**Gender differences:**

Are there differences between male and female babies regarding the behavior of the parents, the family's reaction, feeding habits, etc.

**Variation between children:**

Are there children who nurse well and others who do not? [If yes:] What can the mother do in such cases?

Are there children who eat well and others who do not eat other foods well? [If yes:] In such cases, what do women around here do? Do mothers around here ever force their children to eat something? How? What do you think of this?

**V. Problems**

Have you ever had problems with breastfeeding? What kind?

--What can cause such problems? What did you do? Did you seek advice from someone?

--Do you know of other mothers who have had problems with breastfeeding? What kind? Causes? Solutions?

**Insufficient milk:**

Have you ever had insufficient milk? Cause?

[If she says that the cause is poor nutrition:] What is more important, quantity or quality of maternal diet?

--Is there something a woman can do if she thinks she doesn't have enough milk?

--Have you ever tried to increase the amount of milk you have?

--If an infant nurses often, does this affect the amount of milk? How? (Does she think that if the infants nurses a lot, the milk will be replenished or depleted?)

Does a mother's milk ever go bad? Why? How?

How do you know that the milk is bad?

--Has this ever happened to you? How did you know?

--What can cause this problem?

--What can be done about it?

**AIDS:**

Have you ever heard of AIDS?

--How is AIDS transmitted?

--If a mother has AIDS, should she breastfeed her child?

VI. Lactational Amenorrhea

How many children would you like to have?  
In your opinion, what is the ideal spacing between children?  
Can breastfeeding influence the spacing between children?  
How?

VII. Social Support

How can the family be supportive of the breastfeeding mother?  
In what ways can the father in particular show support for the breastfeeding mother?

--do most fathers here show these kinds of support? your husband? why or why not?

--are there aspects of breastfeeding that fathers do not like? why?

Can family conflicts create problems for the breastfeeding mother? How?

--Can the father do anything to help avoid or resolve these problems? What?

If a man has more than one wife, can polygamy create problems for the breastfeeding mother? How?

How could men around here be encouraged to provide support for their breastfeeding wives?

VIII. Communication

**Groups:**

Do you belong to any women's groups? Which ones?

Are there other women's groups in this area?

Are there ways in which women's groups might show support for the breastfeeding mother?

**Radio:**

Do you have a radio in your house? Does it work?

When do you listen to it?

What kinds of programs do you like?

Have you ever heard anything on the radio about infant feeding? What?

Some women around here say "Radios are the business of men."  
Do you agree?

**Credibility:**

[Identify a breastfeeding or infant feeding behavior that could be modified, and ask:]

If your husband gave you the advice to (do something different), would you be willing to do it?

If a health worker gave you the advice to (do something different), would you accept the advice?

If you heard a message on the radio encouraging (something different), could you believe it?

GUIDE D'INTERVIEW \_\_ MERES

Imyaka y'umwana \_\_\_\_\_  
Umubare w'abana afite \_\_\_\_\_  
Umulimo akora \_\_\_\_\_  
Amashuri yize? \_\_\_\_\_

Abana n'umugabo Yego / Oya  
Ubukungu 1. typique,  
2. moins que la moyenne  
3. plus que la moyenne

I. Uko yumva imibereho rusange:

Umubyeyi mwiza w'intanga rugero aba ameze ate?  
Umubyeyi mwiza se w'umugabo w'intanga rugero aba ameze ate?  
Umwana ufite ubuzima bwiza arangwa n'iki?  
(Reba iyi foto) Uyu mwana urabona afite imyaka ingahe?  
Uramutekerazaho iki? Yaba agaburirwa iki?  
( Mwereke ifoto y'umwana y'umwana wariye nabi). Uratekereza ko uyu mwana afite imyaka ingahe? Uramutekereza ho iki? baba bamugaburira iki?

II Imyifatire y'umugore utwite (Soins pr nataux)

Waba warabonanye na muganga ugitwe? Uwuhe? Ni iyihe mpamvu yatumye ujya kumureba?  
Hari undi muntu waba waba waragishije inama ugitwite? ni nde? Wari ukeneye iyihe nama?  
Ese ugitwite waryaga byinshi kurusha ubusanzwe? cg se bike kurusha ibisanzwe? cg se ntacyahindutse?

III Kubyara na nyuma yo kubyara.

Wabyariye he? Mu rugo ? cg se kwa muganga?  
Ubyara hari uwagufashije? Ni nde ?  
Bagukoreye iki nyuma yo kubyara? Bakoreye iki uruhinja?  
Wonkeje agahinja nyuma y'igihe cyingana iki kavutse? Kuki?  
Hari icyo wahaye umwana kitari amashereka umunsi wa mbere? n'iki? Hari hashize amasaha angahe avutse?  
Waba waramuhay amazi? Kuki?  
Wamuhaye amata? amashereka? Kuki?  
Wamuhaye icyayi? imiti ya Kinyarwanda? Kuki?  
Amashereka ya mbere yaba atandukaniye he na iyi iminsi ikurikiyeho? atandukaniye he?  
Waba warakorewe iki ukimara kubyara? Na nde Byamaze igihe kingana iki? ( Umugabo yaba yaba yragukoreye iki kidasanzwe ukimara kubyara? yakoze iki?)  
Watangiye gukora uturimo two mu rugo hashize igihe kingana iki?  
Gusubira ku murimo hashize igihe kingana iki ubyaye?  
Wumva umugore ukimara kubyara yagaburirwa gute? Yanywa iki? Hari ibiribwa cg ibinyobwa atagomba gufata?

IV. Pratiques actuelles

[Ibi bibazo bikulikira bibazwa umubyeyi w'umuhinzi]

(Kumenya ko yonsa koko)

Ubyuka ryari? Ese uhita wonsa umwana?

Ujya mu guhinga ryari? Utahuka ryari? Ujyana umwana? Umwana aba ari he iyo uhinga? Hari umuntu ujyana wo kugufasha umwana iyo uhinga? Umwonsa kangahe iyo muri mu murima? Umenya ute ko ashaka konka? Umwana amara igihe kingana iki yonka?

Iyo utashye ukora iki iwawe mu rugo? Umwana yonka ate iyo mugeze mu rugo? Umwana aba arihe iyo utetse? Iyo ugiye kuvoma? Iyo ukora uturimo tunuranye mu rugo?

Ese urarana n'umwana ni joro? Yonka kangahe? Yaba mu itumba cg mu ki hari bihindura ku myonkere y'umwana? Sobanura?

[Gushakisha impamvu zose zituma umubyeyi atonsa bihagije mu munsu? cg mu mezi ya ngombwa?]

Ubu hari ikindi ugaburira umwana uretse amashereka? (Kureba neza ibyo ahabwa n'ukuntu abihabwa)

-Icyo ahabwa? Agihabwa muki?

-Inshoro zingahe mu munsu

-Umwana ahabwa ifunguro ryihariye cg asangira n'abandi?

-Ategurirwa ibyo kurya inshuro zingahe munsu?

-Ese ibisigaye murabishyushya cg abirira aho?

-Ibyo mumubikira mubibika mute?

-Watangiye kumugaburira ryari? Kuki?

Ibibazo bikurikira bibazwa umugore ufite akazi k'umushara

Amasaha y'akazi yawe ni ayahe?

Ukora iminsi ingahe mu cyumweru?

Uva mu rugo ryari, ukagaruka ryari?

Mu masaha y'akazi, umwana asigara he? Asigarana na nde?

Igihe udahari umwana agaburirwa ate? Arya iki? anywa iki? ibingana iki? kangahe ? Babimuhesha iki ( agakombe, akayiko, biberu) ?

Mbere yo kujya ku kazi, umwana umuha ik? Umukorera iki kindi?

Ese umwana wawe uramwonsa ku manywa? Umwonsa ryari mu masaha y'akazi? Umwonsa inshuro zingahe ku manywa? ni jorose ?

Umwana yonka igihe kingana iki ugereraniye?

Ese kuba ujya ku kazi hari ibibazo bigutera kubyerekeye kwonsa umwana ? ni ibihe?

Watangiye kugaburira umwana angana iki?

Ese ku kazi mu gira ikiruhuko cyo kubyara? kimara igihe kingana iki?

Wigeze wumva ko hari igihe bakama umubyeyi amashereka bagashobora kuyabika umwana akayanywa nyuma? Ubitekerezaho iki? Wigeze ukoresha ubwo buryo?

Ese iyo ugiye kwonsa ukoresha wawe abibona ate? Nata kibazo bigutera?

Ese ubona hakorwa iki kugirango umubyeyi wonsa kandi akora ashobore kwonsa umwana we bihagije?

Gucutsa burundu

Ese wumva yacuka amaze igihe kingana iki? Kuki umwana acuka?

Abandi bana wabacukije ryari? Kuki?

[Natabivuga kubaza niba biterwa n'uburwayi bw'umwana, ubwa nyina, gutandukana n'umugabo, imibonano cg gutwita]

Umwana w'umuhungu n'uw'umuobwa bonka kimwe?

Iyo ubyaye umuhungu cg umukobwa umuryango ( umugabo, abandi) ubyakira kimwe?

Ese mu kwonsa no mu buryo bwose bwo kugaburira umwana hari itandukanyirizo hagati y'umwana w'umuhungu cg umukobwa?

#### V Ibibazo

Hari ibibazo wigeze ugira mubyerekeye kwonsa?

-ni ibihe? Byatewe n'iki? Wabyifashemo ute?

-hali uwo wagishije inama?

-Hari abandi babyeyi uzi bagize ibabazo byo kwonsa? Babyafashemo bate?

#### Amashereka adahagije

Hali ubwo wigeze ubura amashereka?

Byatewe n'iki?

Wumva umubyeyi yakora iki igihe yabuze amashereka?

Hali ikintu waba warigeze ukora kugirango ugire amashereka ahagije?

Waba nawe utekereza ko kwonka kenshi k'umwana gutuma amashereka yiyongera? Gute? Iyo umwana yonka cyane ubitekerezamo iki? Wumva byongera amashereka cg biyagabanya?

#### Amasheeka mabi:

Ese hari igihe amashereka aba mabi?

-Hari ubwo byigeze kukubaho?

-Umenya ute ko amashereka ari mabi?

-Ni izihe mpamvu zishobora kubitera?

-Bikubayeho ko amashereka aba mabi wabyifatamo ute?

#### SIDA

Hari icyo uzi kulli SIDA?

Iterwa n'iki? Yandura ite?

Ese umubyeyi wanduye SIDA yakwonsa?

#### VI Kwonsa no gutwita

Wumva ku bwawe wifuza kugira abana bangahe?

Kuri wowe wumva umwana yakurikizwa afite imyaka ingahe?

Ese wumva kwonsa hari isano bifitanye no kutabyara indahekana?

#### VII Inkunga rusange y'umuryango

Ni ibihe bibazo ababyeyi bakunda kugira muli aka karere?

Ababyeyi fafite utwana duta bakunze kugira iakazi kenshi?

Ubona umugabo yafasha ate umubyeyi muri iyo milimo? Ese abagabo bo muli aka karere hari icyo bafasha abagore babo? Ubona hakorwa

iki kugirango abagabo bafashe abagore babo kurushaho?  
Ese abagore ubwabo hari uburyo bafatanya?

#### VIII Gusabwira

Hari amakoraniro y'imibereho y'abaturage, ya poliki? ya Kiliziya? Hari iryo waba urimo?

#### Radiyo

Mufite radiyo hano mu rugo? irakora neza? Muyumva mwese? Ryari? Igihe kingana iki mu muni? Mukunze kwumva ikihe kiganiro kurusha ibindi?

hari ibyo waba warumvise byerekeranye n'imigaburire y'abana bato? Wumvise mo iki?

#### Uko byemerwa

Umugabo wawe aramutse agusabye gukora iki n'iki utari usanzwe ukora, wabikora?

Na hose ubisabwe n'umuganga cg umukozi wo kwa muganga, wabikora?

Ari inama se wumvise kuli radiyo wyikulikiza?

## INTERVIEW GUIDE - FATHERS

### I. Social Perceptions

What are the characteristics/qualities of a good father? Why?  
If a father has a young infant, how would he show that he is a good father?  
Is it sometimes difficult for a man to show he is a good father? Why?

What are the characteristics/qualities of a good mother? Why?

What is the ideal number of children a woman should have? Why?

### II. Perceptions of a Healthy Baby

What are the characteristics/qualities of a healthy baby? Why?

Please take a look at this photo:

How do you think this child is fed?

What kind of mother do you think he/she has?

What kind of father do you think he/she has?

### III. Breastfeeding and Weaning

What does a young baby need to grow up well? Why?

What should a one-month old baby be fed? Why?

Until what age is breastmilk alone enough for the baby? Why?

Probe:

At what age should the baby be fed liquids? What? Why?

At what age should the baby be fed solids? What? Why?

Are there other signs that indicate a baby needs solids?

How does the family decide that the baby should be fed other liquids or solids?

Does the father ever make this decision? Alone or with the mother?

Is money provided specially for this milk (or food)? By whom?

Do fathers ever decide how or what a baby should be fed?

Under what circumstances?

Do mothers ever ask fathers advice on the food of the baby?

Do mothers ever ask fathers advice on the feeding of the baby?

Weaning:

How does a family know when it is time to end breastfeeding completely?

Are there special things the family must do to prepare for weaning? What are they?

IV. Breastfeeding Problems

Are there any reasons why a woman should not breastfeed? What?

How does the father feel if a woman cannot breastfeed?

Do women here ever have difficulties breastfeeding? What are some of these difficulties?

What causes these? What can be done for these problems?

Are there things that the husband can do to help prevent or solve these problems?

V. Lactational Amenorrhea

How long after childbirth do a woman's menses return?

Probe:

Does it make a difference how long she has been breastfeeding?

Does breastfeeding have anything to do with the interval between births?

VI. Social Support

Are there ways that the family can show support for the woman who is breastfeeding? How?

Are there ways that the father in particular can show support for the woman who is breastfeeding? How?

Do most fathers here do these things? Why or why not?

Are there things about breastfeeding that fathers do not like? Why?

Can family conflicts create problems for the breastfeeding mother? How?

Can the father do anything to help prevent or solve these problems?

If a man has more than one wife, can polygamy lead to problems for the breastfeeding mother? How?

How can a man with more than one wife show support for his wife that is breastfeeding?

How could men here be encouraged to show more support for breastfeeding?

VII. Communication

Have you ever received information about child care or feeding?

Probe:

Where? On what subject? By whom?

If you have, did you find the information useful? How?

Would you like more information on child health and feeding?

What would be a good way to provide this kind of information to men like you?

Do any of you in this house have a radio?

Does it work?

When do you listen to it?

What kinds of programs do you like to listen to?

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IBIBAZO BIGENEWE ABABYEYI B'ABAGABO

Komini: \_\_\_\_\_  
Imyaka: \_\_\_\_\_  
Amashuri yize \_\_\_\_\_  
Uko atuye: Typique/haut/bas

Ubazwa \_\_\_\_\_  
Umurimo \_\_\_\_\_  
Abana afite \_\_\_\_\_  
Abana n'umugore: yego/oya

I. Uko yumva imibereho rusange:

- Kure wowe, wumva umubyeyi mwiza w'umugabo ameze ate? Kubera iki?
- Iyo umugabo afite umwana muto yerakana ate ko ari umubyeyi mwiza?
- Ese wumva bikomeye kumugabo kwerakana ko ari umubyeyi mwiza? Kuki?
- Umubyeyi mwiza w'umugore se we aba ameze ate? Kuki?
- Wumva umugore yabyara nk'abana bangahe? Kuki?
- Wumva umwana yakurikirwa afite imyaka ingahe?
- Ese iyo umugore amaze kubyara, ubusanzwe umugabo we hari icyo amukorera? Iki? Igihe kingana iki?

II. Uko yumva umwana afite ubuzima bwiza

- Ku bwawe umwana ufite ubuzima bwiza aba ameze ate? Kuki?
- Reba iyi foto. Urayibona ho iki? Uyu umwana ugereranije afite imyaka ingahe? Ni umukobwa cy ni umuhungu? Urabona yaragaburiwe neza? Ugereranije nyina ameze ate? Ababyeyi bakora iki ngo bite ku buzima bw'abana?
- Reba neza iyi foto (umwana udafite ubuzima bwiza) Urayibona ho iki? Babaza ibibazo bimwe nk'ibyo haruguru.

III Ibyerekeye kwonsa no gucutsa.

- Ni iki cya ngombwa kugirango umwana akure neza? Kubera uki?
- Umwana umaze ukwezi avutse, kuri wowe wumva yagaburirwa ate? Kuki?
- Urumva umwana yatungwa n'amashereka yonyine gusa kugeza igihe kingana iki? Kuki?

Baza neza witonze:

- Umwana mutoya batangira kumuha ibinyobwa bitari amashereka ryari? Kuki?
- Mu muryango bemeza gute ko umwana ashobora kurya nk'ibyo abandi barya? Ni nde ufata icyo kemezo? Ese ni se cyangwa se babijyamo inama na nyina?
- Ese ibyo biryo hari amafaranga y'umwihariko babitangaho? ni nde uyatanga?
- Ese hari ubwo se w'umwana ari we ufata icyemezo cy'ukuntu umwana agaburirwa? Biba byagenze gute?
- Ese hari ubwo ababyeyi ba'abagore basaba inama ku buryo bwo kugaburira abana babo? Wowe se ubwawe hari inama wigeze utanga ku buryo bwo kugaburira umwana? Watanze izihe?
- Ese wumva umubyeyi w'umugabo yakora iki kugirango yizere ko umwana we agaburirwa neza?

## INTERVIEW GUIDE - GRANDMOTHERS

### I. Social Perceptions

What are the characteristics/qualities of a good mother? Why?  
Is it sometimes difficult for a woman to show that she is a good mother? Why?

What are the characteristics/qualities of a good father? Why?  
Is it sometimes difficult for a man to show that he is a good father? Why?

What is the ideal number of children a woman should have? Why?  
What is the ideal space between children.

### II. Perceptions of a Healthy Baby

What are the characteristics/qualities of a healthy baby?  
Why?

Please take a look at this photo:

How do you think this child is fed?

What kind of mother do you think he/she has?

What kind of father do you think he/she has?

### III. Breastfeeding and Weaning

What does a young baby need to grow up well? Why?  
What should a one-month old baby be fed? Why?

Until what age is breastmilk alone enough for the baby? Why?  
Probe:

At what age should the baby be fed liquids? What? Why?

At what age should the baby be fed solids? What? Why?

Are there other signs that indicate a baby needs solids?

How does the family decide that the baby should be fed other liquids or solids?

Does the father ever make this decision? Alone or with the mother?

Is money provided specially for this milk (or food)? By whom?

Do grandmothers ever decide how or what a baby should be fed? Under what circumstances?

Do mothers ever ask grandmothers for advice on the food of the baby?

Have you yourself ever given advice about the feeding of your grandchildren? What advice?

Weaning:

How does a family know when it is time to end breastfeeding completely?

Are there special things the family must do to prepare for weaning? What are they?

Are there differences in eating patterns between boys and girls? What?

IV. Breastfeeding Problems

Are there any reasons why a woman should not breastfeed? What?

Do women here ever have difficulties breastfeeding? What are some of these difficulties?

What causes these? What can be done for these problems?

Are there things that the grandmother can do to help prevent or solve these problems?

Has either your daughter or your daughter-in-law had breastfeeding problems? What?

What caused her problems? What did she do?

In your opinion, do women today have more difficulty taking care of their children than women of your generation did? [If yes: why?]

In your opinion, do women today have more problems with breastfeeding than women in your day? [If yes: why?]

V. Social Support

Are there ways that the family can show support for the woman who is breastfeeding? How?

How can the grandmother in particular show support for the woman who is breastfeeding? How?

Do most grandmothers here do these things? Why or why not?

Can family conflicts create problems for the breastfeeding mother? How?

Can the grandmother do anything to help prevent or solve these problems?

If a man has more than one wife, can polygamy lead to problems for the breastfeeding mother? How?

How can a man with more than one wife show support for his wife that is breastfeeding?

How could men here be encouraged to show more support for breastfeeding?

VII. Communication

Have you ever received information about child care or feeding?

Probe:

Where? On what subject? By whom?

If you have, did you find the information useful? How? Would you like more information on child health and feeding?

What would be a good way to provide this kind of information to women like you?

Do any of you in this house have a radio?

Does it work?

When do you listen to it?

What kinds of programs do you like to listen to?

Social networks:

Do you belong to any women's groups or clubs? [If yes; which?]

Do you participate in social activities in the community? Which?

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- Mu muryango babwirwa niki ko igihe cyo gucutsa umwana kigeze?
- Hari mihango y'umwihariko ikorwa mu muryango mbere yo gucutsa umwana burundu? ni iyihe?
- Ese mu kugaburira umwana muto, hari bwo bitandukana hakurikijwe ko ari umuhungu cg umukobwa? byaba bitandukanira he?

#### IV Ingorane ziterwa no kwonsa.

- Ese hari hari impamvu waba uzi zabuzà umubyeyi kwonsa? Ni izihe?
- Ese umubyeyi w'umugabo abyfatamo ate iyo umugore adashobora kwonsa?
- Wowe se ubwawe hari ubwo umugore wawe yaba yaragize ingorane mu kwonsa? Wabyifashe mo uute?
- Ese muri aka karere hari abagore uzi bagize ingorane mu kwonsa? Ni izihe ngorane? Zatewe ni iki? Byagenda bite kugirango bazirwanye?
- Hari uruhare umugabo yagira by'umwihariko mu kurwanya ibibazo byerekeranye no kwonsa? Yakora iki?

#### V Inkunga rusange y'umuryango

- Hari uburyo umuryango wakwerekana rwose ko ushyigikiye umubyeyi wonsa? ni nk'ubuhe?
- Ku buryo bw'umwihariko wumva umugabo yakwerekana ate ashyigikiye umugore wonsa? Ese ubona abagabo benshi babyatabira?
- Ese mu byerekeye kwonsa hari ikintu wumva cyaba kibangamiye abagabo? Ni ikihe badakunda? Kubera iki?
- Ese impagarara mu rugo zitera ibibazo umubyeyi wonsa? Gute?
- Ese umugabo hali icyo akora kugirango ibyo bibazo bikemurwe? ni nk'iki?
- Ese umugabo ufite abagore babiri cg benshi, wumva hari inkunga yatera umugore wonsa? ni nk'iyihe?
- Kuri wowe umuntu yagira inama ki abagabo ngo barusheho gushyigikira kwonsa kw'ababyeyi?

#### VI. Uburyo bwo gushyikirana

- Ese hari inyigisho wose wunva ku byerekeye kwita ku mwana, ku mufata neza no ku mugaburira?
- Wabyumviye he? Wumvise iki? Wabwiwe nande?
- Ese wasanze izo nama zigufitiye akamaro? Gute?
- Urumva se wifuza kubona izihe nyigisho ku byerekeye ubuzima bw'abana n'imirire yabo?
- Urumva inyigisho nk'izo umuntu yazigeza ku bandi bagabo nka we akoresheje ubuhe buryo?
- Ese radiyo mutunze muri uru rugo? Irakora neza muri iyi minsi? Ese radiyo uyumva ryari? Ibiganiro (programmes) ukunda cyane ni izihe?
- Ese ubundi uyu ukitse imirimo y'ihinga cg uvuye ku kazi ukora iki? Hari indi mirimo ukorana n'abandi bagabo?
- Yaba ari iyihe? Mwaba muyikora kangaha mu cyumeru?
- Ese ukunda kujjya mu kabari gufata icupa n'abandi bagabo? Ujjayo ryari? ugeraranije unywa nk'amacupa angaha?

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## WELLSTART INTERNATIONAL

Wellstart International is a private, nonprofit organization dedicated to the promotion of healthy families through the global promotion of breastfeeding. With a tradition of building on existing resources, Wellstart works cooperatively with individuals, institutions, and governments to expand and support the expertise necessary for establishing and sustaining optimal infant feeding practices worldwide.

Wellstart has been involved in numerous global breastfeeding initiatives including the Innocenti Declaration, the World Summit for Children, and the Baby Friendly Hospital Initiative. Programs are carried out both internationally and within the United States.

### **International Programs**

Wellstart's *Lactation Management Education (LME) Program*, funded through USAID/Office of Nutrition, provides comprehensive education, with ongoing material and field support services, to multidisciplinary teams of leading health professionals. With Wellstart's assistance, an extensive network of Associates from more than 40 countries is in turn providing training and support within their own institutions and regions, as well as developing appropriate in-country model teaching, service, and resource centers.

Wellstart's *Expanded Promotion of Breastfeeding (EPB) Program*, funded through USAID/Office of Health, broadens the scope of global breastfeeding promotion by working to overcome barriers to breastfeeding at all levels (policy, institutional, community, and individual). Efforts include assistance with national assessments, policy development, social marketing including the development and testing of communication strategies and materials, and community outreach including primary care training and support group development. Additionally, program-supported research expands biomedical, social, and programmatic knowledge about breastfeeding.

### **National Programs**

Nineteen multidisciplinary teams from across the U.S. have participated in Wellstart's lactation management education programs designed specifically for the needs of domestic participants. In collaboration with universities across the country, Wellstart has developed and field-tested a comprehensive guide for the integration of lactation management education into schools of medicine, nursing and nutrition. With funding through the MCH Bureau of the U.S. Department of Health and Human Services, the NIH, and other agencies, Wellstart also provides workshops, conferences and consultation on programmatic, policy and clinical issues for healthcare professionals from a variety of settings, e.g. Public Health, WIC, Native American. At the San Diego facility, activities also include clinical and educational services for local families.

*Wellstart International is a designated World Health Organization Collaborating Center on Breastfeeding Promotion and Protection, with Particular Emphasis on Lactation Management Education.*

For information on corporate matters, the LME or National Programs, contact:

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For information about the EPB Program contact:

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**WELLSTART**  
INTERNATIONAL SM

TO: Mary Ann Anderson, Acting Chief, Health Services Division,  
G/R&D Health

FROM: Chloe O'Gara, <sup>COG</sup> Director, Expanded Promotion of Breastfeeding Program

DATE: March 7, 1994

SUBJECT: TECHNICAL REPORT

RE: Cooperative Agreement # DPE-5966-A-00-1045-00

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Enclosed are two copies of the technical report described below:

- Report title: Qualitative Research on Breastfeeding in Kibungo and Gitarama Provinces/Rwanda
- Date: January 1994
- Authors: Rwanda Ministry of Health and Wellstart International
- Country: Rwanda

If, upon reviewing this report, you determine that revisions are necessary, please send them to us within 30 days from the above date. If changes/additions or deletions are received from you or other reviewers, these will be incorporated into the report and revisions will be distributed. This report will be produced more formally and sent to a wider distribution list for use in Rwanda after any revisions are completed.

We hope you find this document useful and welcome communication about it.

Enclosures: 2 copies technical report with attachments

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