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CULTURE & BREASTFEEDING SERIES



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**BREASTFEEDING IN UGANDA:
BELIEFS AND PRACTICES
REPORT OF QUALITATIVE RESEARCH**

by

**Nutrition Division / Uganda Ministry of Health
Child Health and Development Center / Makerere University
Wellstart International**

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ACRONYMS

CHDC	Child Health and Development Center
DHS	Demographic and Health Survey
MOH	Ministry of Health
NGO	non-governmental organization
RC	Resistance Committee
TBA	traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
Wellstart EPB	Wellstart Expanded Promotion of Breastfeeding Program



EXECUTIVE SUMMARY

INTRODUCTION

The Uganda Ministry of Health is interested in developing programs to address nutritional and growth problems identified by the Demographic and Health Survey(s) (DHS) as well as other studies. To this end, the need for an in-depth understanding of infant feeding practices and their determinants was identified as a means of pinpointing detrimental behaviors and beliefs and developing social marketing strategies for overcoming them. This is a report of a qualitative study of breastfeeding and early weaning practices conducted between March and May 1993.

The study was conducted by the Ministry of Health, the Child Health and Development Center (CHDC), and Wellstart International's Expanded Promotion of Breastfeeding Program (EPB), with funding from the U.S. Agency for International Development (USAID). Five sites representing potentially different infant feeding patterns were included: the capital city of Kampala, plus the districts of Apac, Luwero, Mbarara, and Mbale. Information was gathered principally through focus group discussions and interviews with key informants. The group of primary interest was mothers of children under one year of age, although focus groups with fathers and grandmothers were also held.

SUMMARY OF FINDINGS

Breastfeeding is positively regarded in Uganda and overall, there are many good breastfeeding practices. Women expect to breastfeed, and nearly all women do initiate breastfeeding. Mothers believe that a very young infant can be well nourished on breastmilk alone. Feeding bottles are not commonly used, except among urban wage-earning women. Duration of breastfeeding is also good: the great majority of children are given breastmilk throughout their first year of life.

Nonetheless, there are other practices which detract from the benefits that optimal breastfeeding brings. The key breastfeeding behavior which brings maximum health benefits to both mother and child is *exclusive* breastfeeding for around six months -- with no other food or liquid before this time. Other important components of optimal infant feeding are the initiation of breastfeeding within one hour of birth; frequent, on-demand feeds, including night feeds; and the introduction of nutritious weaning foods by the time the child is six months of age. However, one finds in Uganda the following practices which need to be addressed:

- Giving prelacteal feeds (water or other liquids or foods to the neonate) is nearly universal outside of the Northern district of Apac.
- The timing of the first breastfeed after birth is sometimes delayed for one to two days.
- In Apac and some communities in Luwero, colostrum is considered harmful and is discarded.
- Mothers do believe that an infant can be well nourished on breastmilk alone; however, the duration of exclusive breastfeeding is often not long enough. It appears that health providers recommend supplementation at three months, and that further, mothers feel that they don't have enough milk after that time to continue exclusive breastfeeding.
- There is, however, tremendous variation in age at which supplementation begins. Early supplementation is a problem, but late supplementation is also a problem, with some children still exclusively breastfeeding at one year of age.



- There are some indications that frequency and duration of feeds may not be sufficient, although this would have to be confirmed by careful observational study.
- The fact that more frequent suckling produces *more* milk is not understood. Many mothers believe that frequent suckling depletes the milk supply. Therefore, when mothers feel their milk supply to be diminishing, they give supplements, which cause their infants to suckle less frequently, thereby resulting in a further diminution in milk supply.
- There is a common belief that breastmilk can spoil and that such milk is not suitable for consumption. In these cases the child is prematurely and abruptly weaned.
- Breastfeeding is stopped abruptly when the mother learns she is again pregnant, thereby causing a nutritional and emotional shock to the child.

SUMMARY OF PROGRAM IMPLICATIONS

It appears that traditional practices may have been closer to the ideal than current ones. For example, grandmothers indicate that they breastfed exclusively for a longer period of time than mothers do now. Since some detrimental practices may not yet be firmly entrenched, if action is taken now, it may be possible to reverse them with relative ease. Since breastfeeding is an established part of Ugandan culture, general slogans along the lines of "Breast is Best" will have little impact. What is needed are messages designed to overcome the specific feeding behaviors and beliefs, using culturally acceptable means of doing so. This report delineates the cultural barriers as well as opportunities for improving infant feeding.

Because of the rural nature of Uganda's populace, the limited reach of mass media, and low levels of literacy, any communication strategy developed will have to be largely community-based. People are anxious to talk and learn about health issues. Men are surprisingly interested in issues of child health and feeding, as well as family planning, and may be willing to assume a greater role in these areas if included in educational efforts and given specific suggestions as to what actions they can take. There are community structures in place which show promise as vehicles for a communication program. However, it is essential that the community component be accompanied by training of health providers at the district and community level. They need to have and know how to communicate correct infant feeding information, and know how to handle breastfeeding problems. The advice given by medical personnel is influential, and the misinformation given to mothers is a contributing factor in the decline of the period of exclusive breastfeeding.



BREASTFEEDING IN UGANDA: BELIEFS AND PRACTICES

I. INTRODUCTION

BACKGROUND

The 1989 Uganda Demographic and Health Survey¹ found that 45% of children under five years old are chronically malnourished or stunted. The study also showed that growth faltering begins in early infancy, between three and five months of age. This situation would not occur if infants were optimally breastfed. In August and September 1992, MotherCare and Wellstart International's Expanded Promotion of Breastfeeding Program (Wellstart EPB) worked with the Ministry of Health (MOH) to assess the institutional, policy, legal, and health care framework for breastfeeding in Uganda. Both the assessment and the subsequent Child Nutrition and Growth Promotion Plan identified the need to document infant feeding practices and gain a better understanding of the beliefs and other socio-cultural factors that influence them.

In response to this need, Wellstart EPB, in collaboration with the Nutrition Division of the Ministry of Health and the Child Health Development Center (CHDC) of Makerere University, conducted the field work for the qualitative research between March and May 1993. The research team consisted of Mrs. Louise Sserunjogi, a nutritionist from the CHDC in Kampala, Dr. Adwoa Steel (Wellstart EPB consultant), Dr. Carol Baume (Wellstart EPB Technical Advisor), and health workers recruited as research assistants from hospitals and the local District Medical Offices.

This is a report of the findings of the qualitative research. It is anticipated that the findings will be used to develop communication and training programs to promote optimal breastfeeding practices and ultimately improve the nutritional status of infants.

THE CRITICAL IMPORTANCE OF OPTIMAL BREASTFEEDING

The health benefits to the infant of exclusive breastfeeding for up to six months are undisputed, especially in low-income populations living in 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 critical role in child spacing. In Africa, it is estimated that breastfeeding averts as many births as all modern contraceptive methods combined.

It is known that nearly all Ugandan mothers do breastfeed. However, unless optimal breastfeeding is practiced, the benefits of breastfeeding are diminished. Optimal breastfeeding is defined as:

¹ Uganda Demographic and Health Survey, 1988/89. The Ministry of Health, Entebbe, Uganda and Institute for Resource Development/Macro Systems, Inc., Columbia Maryland. October 1989.



- Initiation of breastfeeding within one hour of birth;
- Frequent, on-demand feeding (including night feeds);
- Exclusive breastfeeding for around six months;
- Continuation of breastfeeding for at least one year;
- Supplementation of breastmilk with appropriate weaning foods by the time the infant has reached six months of age.

II. RESEARCH OBJECTIVES AND METHODOLOGY

OBJECTIVES

The objectives of the research were to:

- Document current breastfeeding and weaning practices of Ugandan mothers and identify any regional variations in these practices;
- Gain an understanding of local cultural factors that influence infant feeding;
- Identify communication factors to take into account when developing a promotional strategy.

The results of the research are intended to be used as a basis for developing an effective communication strategy and other program activities to promote optimal breastfeeding practices.

SELECTION OF STUDY SAMPLE

Breastfeeding practices vary considerably in Uganda, with supplementation beginning very early in some areas and very late in others. Because of wide variation in beliefs and practices, it was important to sample from different cultural groups likely to represent those variations. Five areas exemplifying those groups were selected for study: the capital city of Kampala, plus the districts of Luwero in the central area, Mbarara in the southwest, Mbale in the east, and Apac in the north. Kampala was included to represent the largest urbanized area of the country. Within each district, the District Medical Officer helped select the specific communities to be included in the study. The selection was made to include primary ethnic groups, the predominant occupations (farming or cattle-raising), the presence or absence of a health facility. Of the 32 selected communities visited for the study, most were rural since 90% of Ugandans live in the rural area. One urban community was visited in each district.

Mothers of infants under one year of age were the main focus of the study, although a smaller number of fathers and grandmothers were also included to determine their ideas regarding infant feeding and their role in influencing feeding decisions. Only a small number of health providers were interviewed, since the breastfeeding assessment had already concentrated on medical personnel. Information on the feeding recommendations of health personnel was obtained via mother's reports. Thirty-four (34) groups of mothers, 16 groups of fathers, and 15 groups of grandmothers in 32 communities participated in the focus group discussions in four districts plus the Kampala area.



METHODS

The primary methods used were focus group discussions and interviews with individuals with key informants. In addition, some projective techniques were used as well as informal observations of breastfeeding mothers.

Focus group discussions were conducted to gain information through guided discussions with small groups of mothers, of grandmothers, and of fathers. Usually one group of mothers plus one group of either fathers or grandmothers was interviewed in each community. (Copies of the focus group guides are found in Appendix II). A moderator guided each session while another person took notes and audio-taped the session. A transcription of the tape was later made and combined with the notes to obtain a more complete record of the discussion session.

In many of the groups, projective techniques were also used. Photographs of healthy and malnourished babies and mothers of different socio-economic levels were used to elicit concepts of ideal and problematic feeding, characteristics of health and illness, and ideas about the characteristics and feeding practices of wealthy and poor mothers.

Individual interviews were conducted with a long-term resident in some of the communities. The interviews were designed to obtain information on the socio-economic aspects of the communities. Many of the key informants -- men and women -- were members of the local village governing body, the Resistance Council. The informants were mostly farmers, but also included a teacher, a religious leader and a storekeeper.

Observations during the limited period of the visit, which typically lasted three to four hours, provided additional perceptions about the community and the focus group participants.

Because of different regional language needs, it was not possible to use the same team of research assistants for the duration of the field work, and new research assistants had to be recruited for each district.

Table 1 shows the selected districts and the communities visited in them. The ethnic composition of the discussion groups and their predominant occupation are also shown.



TABLE 1A: LUWERO DISTRICT

LOCATION	DISCUSSION GROUP COMPOSITION	PREDOMINANT ETHNIC GROUP	PREDOMINANT OCCUPATION	COMMENT
Kikube	Mothers Fathers Grandmothers	Baganda	Farmers	Rural
Nsozibirye	Mothers Fathers	Baganda	Farmers	Rural
Wobulenzi	Mothers	Mixed	Farmers	Small town
Kalirokatono	Mothers Grandmothers	Baganda	Farmers	Rural
Kamira	Mothers Mothers	Mixed, incl. foreign born	Farmers & cattle farmers (minority)	Rural, War Widows Project site
Kabunyata	Mothers Fathers	Baganda	Farmers & cattle farmers	Rural
Kasalizi- Kyawakata	Mothers	Baganda	Farmers	Rural
Kikaraganga	Mothers Fathers	Mixed	Farmers	Rural
Ngoma	Mothers Grandmothers	Mixed	Cattle farmers & traders	Rural, reportedly no farming

**TABLE 1B: MBARARA DISTRICT**

LOCATION	DISCUSSION GROUP COMPOSITION	PREDOMINANT ETHNIC GROUP	PREDOMINANT OCCUPATION	COMMENT
Mbarara	Mothers	Banyankole	Housewives & police clerks	Urban, pretest
Ndajia	Mothers Fathers	Banyankole	Farmers	Rural
Rwoho	Mothers Fathers Grandmothers	Banyankole	Farmers	Rural, very infrequent transportation
Nyakashashara	Mothers Mothers	Banyankole	Cattle farmers & few crop farmers	Rural
Kyakabunga	Mothers	Banyankole	Cattle farmers & few crop farmers	Rural
Nyakasharara	Mothers Fathers	Banyankole	Cattle farmers & some crop farmers	Rural
Kiruhura	Mothers	Banyankole	Cattle farmers & some crop farmers	Rural
Nyakitunda	Mothers Grandmothers	Bakiga	Farmers	Rural, Mountainous



TABLE 1C: MBALE DISTRICT

LOCATION	DISCUSSION GROUP COMPOSITION	PREDOMINANT ETHNIC GROUP	PREDOMINANT OCCUPATION	COMMENT
Mbale Town	Mothers	Bagishu	Housewives	Urban, pretest
Mbale Town	Grandmothers	Itesot	Housewives	Peri-urban, displaced former cattle farmers
Namataba	Mothers	Itesot	Housewives & farmers	Peri-urban, displaced former cattle farmers
Namakv:ekwe	Mothers	Bagishu, Itesot Badama	School teachers & social workers	Urban
Bumbo	Mothers Fathers Grandmothers	Bagishu	Farmers	Rural, close to Kenya border
Bubulo	Mothers Fathers Grandmothers	Bagishu	Farmers & Traders	Rural, close to Kenya border
Bunasitiwa	Mothers Fathers	Bagishu	Farmers	Rural, mountainous
Buwalasi	Mothers Fathers Grandmothers	Bagishu	Farmers	Rural, mountainous
Wanale	Mothers Fathers Grandmothers	Bagishu	Farmers	Rural, mountainous
Banambutye	Mothers Grandmothers	Bagishu, Iteso, Karamoja, Bagwere	Farmers	Rural, former cattle farmers

**TABLE 1D: APAC DISTRICT**

LOCATION	DISCUSSION GROUP COMPOSITION	PREDOMINANT ETHNIC GROUP	PREDOMINANT OCCUPATION	COMMENT
Iwai	Mothers Fathers Grandmothers	Langi	Farmers	Rural, scattered population, few cattle herds left
Kwania	Mothers Fathers Grandmothers	Langi	Farmers & fishermen	Rural
Bamola	Mothers Fathers Grandmothers	Langi	Farmers	Rural, food scarcity
Afura	Mothers Fathers Grandmothers	Langi, Banyoro Baluuli	Fishermen	Rural

TABLE 1E: KAMPALA AREA

LOCATION	FOCUS GROUP COMPOSITION	PREDOMINANT ETHNIC GROUP	OCCUPATION	COMMENT
Kyebando-Kampala	Mothers	???	Housewives	Peri-urban, pretest
Luzira	Mothers	???	Factory workers	Urban



III. FINDINGS

SOCIO-ECONOMIC CONTEXT

Uganda is 90% rural. Most communities are reachable only by dirt roads, and households tend to be scattered over wide areas. Most homes are constructed out of mud and roofed by thatch or tin. Most houses are not visible from the road and residents often have to walk long distances to social gatherings or for services. Dotting the country roads are "trading centers" consisting of a cluster of houses and shops. The trading centers host market days and offer manufactured goods and supplies.

In the rural areas the major occupations are crop-farming and cattle-raising. Communities are predominantly agricultural or pastoral; a few are both.

Farming families raise cash through the sale of surplus food crops. The main food crops in the south are banana, maize, millet, sorghum, peanuts, beans, peas, sweet potatoes, cassava, and soya. In Apac District in the north the reported food crops are cassava and millet. The main crops raised for cash include coffee, cotton, tobacco and soybean. Goats, chickens, pigs are raised by families usually for sale or for special occasions. For small producers, the surplus food is sold usually by men in the markets and at the roadside.

In traditionally pastoral areas (in all four districts), residents said that cattle populations have been greatly reduced through wars, disease, and, in some areas, through cattle-rustling by people from neighboring districts who invade and take away the cattle. In some areas of Apac and Mbale Districts, people no longer keep cattle and now concentrate on farming. The situation is reportedly so serious in some areas such as Bunambutye (in Mbale District) that there are "home guards" seen everywhere ready to fight any would-be invaders. The Itesots in Namataba (peri-urban Mbale town) were former cattle-keepers driven from their home in the neighboring Kumi and Soroti by cattle-rustlers and civil unrest. The result of these changes is that some of these people whose diet used to be mostly milk ("*a child of ten may never have tasted any other food*"), have had to change their eating habits and learn to grow and/or buy, and eat other foods.

There are on-going efforts to extend health care to the rural areas, but health facilities are currently thinly spread over the rural communities. A few of the rural communities visited had fixed health facilities, some private, providing maternal and child health care. Many are served by mobile services providing immunization and simple curative care, others had no facilities. Child growth monitoring is not offered in the communities. Unfortunately, poor transportation is a constraint to using a facility even when located in a nearby community, especially for a woman in labor.

Primary schools are accessible to most of the communities, and parents believe it important to send their children to school. However, judging from the level of education of the young parents who participated in the discussion groups, many, especially the women, do not finish the seven years of primary school.

The National Resistance Movement Government has organized a hierarchy of Resistance Committees (RCs). These committees constitute the political governing bodies found in every community and at every administrative level from village to the national government (the National Resistance Council). The council meets regularly to identify local problems and solutions, to settle disputes, and also to act as a channel for disseminating information to the community.



SOCIAL PERCEPTIONS

Perceptions of a healthy baby

Mothers recognize many of the signs of a healthy baby, which, they say, is strong, looks well-fed, eats well, is heavy when lifted, sleeps well and is not often sick. Few, however, mentioned *steady* weight gain per se as a sign of good health.

While families with sufficient money and food are expected to have better-fed children, both men and women said those resources were insufficient without the correct knowledge of how best to feed and care for a child. One mother said, "*a mother may have the food but lack the knowledge and understanding of how to prepare it for a baby*" and another said of a healthy-looking baby, "*even if her parents are poor they have been educated on how to take care of the child.*" A child may become malnourished because both parents are "ignorant" or negligent. The general belief is that good infant feeding consists of successful breastfeeding and adequate supplementary feeding when appropriate.

A home with loving, caring, knowledgeable parents who cooperate with each other and plan together is most likely to produce a healthy baby. Parents repeatedly declare that a healthy, well-nourished child is also more likely to come from a home where family planning (or proper child spacing) is practiced. All discussion groups mentioned a "good sleeping place" as being important for good health. A child should sleep on a good clean bed which is free of bugs and should be well-covered at night. His general environment should also be clean.

Good health in the mother, beginning from the prenatal period, contributes to good health in the baby. "*A baby can only be healthy when the mother was healthy during pregnancy,*" a grandmother said. All respondents, both men and women, consider breastfeeding to be important, even crucial, to the welfare of the baby. A baby who is not breastfed is likely to become malnourished. It is the duty of a responsible mother to breastfeed. However, it is the general opinion in all groups that if a mother has the resources and knowledge to use substitutes well, the baby can thrive. For example, the baby of an educated, well-off mother can thrive very well even if the mother has to work and is unavailable to breastfeed frequently, because she is able to offer appropriate alternatives.

Perceptions of ill-health in infants

Everyone recognizes severe malnutrition and many mothers are able to identify kwashiorkor from a photo. The causes, they say, are poor feeding, short birth intervals, weaning (whether abrupt or not, that is "*when the baby is no longer breastfeeding*"), poor general care by both mother and father, poor hygiene, worms, poverty, or being an orphan. Many explain poor feeding as eating cold or left-over food,² having a monotonous non-nutritious diet (such as "*cold hard cassava and beans only,*" a father in Apac said), being insufficiently breastfed, or not drinking enough cow's milk, and eating contaminated food.

A mother's pregnancy can cause malnutrition in the youngest child. This is due to spoilage of the breastmilk, abrupt weaning which is necessitated by the pregnancy, and "heat from the pregnancy" which

² Key informants said that mothers generally cook twice a day -- in the afternoon and evening -- and left-over food is eaten in the morning. In spite of this general pattern, there was general disdain for left-over food.



adversely affects the child. Indeed some respondents explained that mothers sometimes discover that they are pregnant because they notice that the baby "changes" and his/her health deteriorates.

Too many, or closely-spaced children contribute to malnutrition in the child and ill health in the mother. A father: "*if a woman gets pregnant soon, the child looks like that because of abrupt weaning and neglect,*" commenting on a photo of a malnourished child.

In Mbarara District, especially, women stressed that a father's poor treatment of the mother might lead to ill-health in the child. A child may be malnourished because the father "*maltreats the mother, makes her sleep outside so she cannot care for the baby,*" or "*the father mistreats the mother, she does not eat well, and has insufficient breastmilk.*"

Ideal number of children

To most men and women, a couple should have only as many children as the family can afford. They believe the current harsh economic situation in the country calls for limiting the number of children in a family. For most, four to six children are ideal and "affordable." A poor family could have as few as three and a rich one more than 10 if desired. One man said "*I have 11 and I cannot afford their care.*" A few say that the number of children a woman has is in God's hands. Some fathers point out that because of the high death rate it is desirable to have many children to insure that some would survive; others counter that having fewer children means better care and a higher chance of survival.

Only Apac fathers and displaced peri-urban immigrant mothers from Teso regard having many children as a source of farm labor. Some Apac fathers also want to ensure that enough children survive to maintain the "prestige" of the family and clan. In contrast to the men, Apac women said that having few children is preferable because food yields are low these days, and besides most husbands are drunks who leave all the farm work to the wives.

Gender roles

A good mother is one who performs well her traditional roles as a care-giver and a home-maker. She breastfeeds her babies, cooks good food for the family, and is clean. "*Good clean habits prevent infection,*" a father said. She is respectful and hospitable to neighbors, and disciplines and teaches the children good behavior. A good mother is hardworking (mentioned more often in male than female groups) and she grows enough food for the family. She is quick to seek treatment for the children when they are sick and is herself healthy.

The predominant view is that a mother who is herself healthy and eats well is better able to breastfeed successfully. "*She is well-fed herself so can breastfeed well*" and "*she is healthy so she will not transmit any diseases through her breastmilk.*" A good mother then, "*eats well so she will be able to breastfeed.*" Thus most, though not all, see a thin mother as being unlikely to have enough breastmilk to breastfeed successfully.

Women often linked the health and well-being of a mother and her children to the behavior of husbands. Men are generally free to marry more than one woman, but once a woman gets married, after the man pays a substantial dowry to the woman's parents, she goes to live in "his" house, and farms on "his" land. She has few other options -- she may not even be welcome back in her parents' home should she decide to leave her marriage.



All agree that a good father is one who cares for his wife and children and provides for their needs. He has a job and makes sure that a home has all the necessities of daily life, such as water, salt, and supplementary food for the baby when necessary. *"He feeds the mother well so she can breastfeed successfully,"* both men and women agree. He should also provide a good sleeping place that is comfortable and free from fleas and bedbugs. In Apac some fathers said that a good father *"should help the mother grow enough food for the family."*³ A good father, both men and women agree, provides money for the children's formal education (school fees and uniform) and for their health care. He sees to it that his children are immunized. One father of seven children pointed out that a father may not be able to carry out his duties because of lack of money.

Many mothers and some fathers say that a good father should communicate with his wife and be a well-behaved and responsible person.

Women have the primary responsibility for farming and some were observed digging their small farms, sometimes with their babies strapped to their backs. Older children are sometimes taken to the farm to watch the baby while the mother works, or they may be left home to watch the baby and to call the mother when the baby cries.

Many women complain that men leave all the work to the women. In Rwoho in Mbarara District, where there is currently an experimental wheat farm project the female informant said the men work on the experimental farms too -- supervising. In another community in Mbarara District, an informant said the only responsibility the men generally accept is to pay school fees and buy school uniforms; the men do not even help them fence their gardens against wild animals that destroy their crops because they consider that a woman's job. In Apac District, a grandmother said, *"in the past, mothers always stayed at home--to care for the children, cook food, and brew beer for their husbands--and the husbands used to go out and dig and cultivate gardens for food. These days it is the other way round--men stay around the home drinking all day while the women do all the work."*

In the cattle-raising areas, all agreed that caring for cattle was a man's job. But it was common sight to see children or very young men (some said to be hired) herding the cattle. When this was pointed out, the male informants in Mbarara District said it was the men's job to "supervise" the cattle-keeping. A few men, such as teachers, have salaried jobs; some are traders and artisans.

Alcoholism, particularly in men, is often mentioned as a problem. A father, it was repeatedly mentioned, should not drink too much for, as a mother said, *"a drunken father never bothers about what goes wrong in his house."*

■ ■ Program Implications

- All program decisions must consider the multiple roles of women and their heavy daily burdens, both physically and in terms of time.
- Traditional roles -- mother as nurturer and father as supporter and provider -- can be linked explicitly to breastfeeding. Mothers may also respond to an association of *optimal breastfeeding* with being a *responsible* mother.

³ However, both grandmothers and mothers in Apac complain that men do not help on the farms.



- The idea that a mother needs to eat well to breastfeed well needs to be handled with care. Although research shows that it is only under conditions of extreme deprivation that the quantity or quality of milk is compromised. Yet, because diets may be marginal, lactating mothers should eat as well as they can, aiming for three meals per day which include a variety of foods.
- Specific ways that fathers can provide support that are compatible with traditional values need to be defined, possibly including providing special attention to nourishment when their wives are pregnant or nursing, taking on physical responsibilities during their wives' late pregnancy and early postpartum period, and limiting drinking.
- Poorly nourished children are linked to too closely-spaced births, and promoting exclusive breastfeeding for birth spacing is likely to be an effective motivator.

PREGNANCY AND DELIVERY

Many respondents indicate that a pregnant mother should eat good food, although most women say they eat only whatever they have. Greens, fruits, nuts, beans, milk, cabbage, "posho" (millet porridge) are the foods most often cited as being good for pregnant women. Some say they could not afford the good foods that they know they should eat. In predominantly agricultural areas of Mbarara District, women say a mother has to prepare enough millet flour for making porridge (*bushera*) to drink during the postpartum period in order to produce enough breastmilk. Mothers rarely said too much food may make the baby too big for safe delivery.

Almost all agree that no foods are prohibited during pregnancy. Food restrictions were mentioned only by the Apac women and the Itesot immigrants living in Mbale. In Apac District, the foods said to be bad for the pregnant woman are dry meat and smoked fish (cause baby to choke at birth); wild animals such as the Uganda kob; honey (baby will salivate too much); sugar cane (causes cuts on the baby's skin; and a type of mushroom called *obebege* (causes retained placenta). According to the Iteso women, offal or bony meat might also cause abnormalities or death in the fetus; rituals have to be performed after delivery to permit the eating of those foods.

Many, including fathers, agree that a pregnant woman should get plenty of rest and avoid heavy work. The woman, some fathers explained, needs the energy to push during delivery and to have a healthy baby, and the father should help the woman during her pregnancy, by, for example, bringing in firewood and water. A father of seven said, "*if she does all the work and not get adequate food, she may deliver a weak baby, but most fathers have no money to hire help.*" Another father: "*pregnant women are overworked, but through health education with the father, he will not overwork the woman so she can have a healthy baby.*"

In Mbarara District, especially, women see husbands' behavior as playing an important role in the pregnancy outcomes. One of the requirements for a healthy pregnancy is "*freedom from a husband's abuses.*" The course of the pregnancy, according to a grandmother, "*depends on the husband's care; if the mother is mistreated, such as beaten, the pregnancy will not be normal.*" In addition to "peace of mind" a pregnant woman needs a clean environment and adequate sleep to have a healthy pregnancy and baby.



In the cattle-raising families in Luwero and Mbarara Districts, it is common for a woman to go to live with her mother some time before her due date, and to stay until a few months after the delivery.

In all areas, pregnant women seek health care from both the formal and informal health systems. A pregnant woman goes to the clinic, usually very few times, to find out how the pregnancy is doing, to detect abnormalities, and receive immunizations and treatment for illnesses. She also goes to a traditional birth attendant (TBA) or an "old woman" for herbs which are prepared for drinking, wearing, smearing on the skin, for use as an enema, or insertion in the vagina. These herbs, women say, treat nausea, abdominal pain, vaginal discharges, including leaking lochia, and even "syphilis." Such herbs help a woman to deliver a clean baby (because they cause her to urinate a lot), "correct malpresentation," relax the pelvic muscles and ligaments, and promote easy delivery. A mixture of herbs and clay (for eating) called "mumbwa" is prized by pregnant women but is available only in the city.

In the rural areas with no formal health facilities, most women are delivered in their own homes by older women, TBAs or by themselves. Women with a history of delivery problems are more likely to elect to give birth in a health facility. Because of poor transportation, a woman who wants to deliver in a health center or hospital sometimes chooses to be admitted to the health facility some time before due date.

In Kamira (Luwero District) mothers say that for two months after delivery fathers buy special food for the mother to help her regain her strength and to breastfeed successfully. The extra foods are sugar, milk, maize meal, offal, beans, and *matooke* bought according to the father's financial ability. After the two months the mother eats what the rest of the family eats ("*the same poor food*") which they say is mostly cassava. If they had the money, mothers say they would continue to buy better food for themselves.

■ ■ Program Implications

- The idea that a pregnant woman needs to eat well is already accepted but should be reinforced.
- Because most women seek prenatal care, breastfeeding education given during prenatal visits should reach a high percentage of women. Since women do not attend the clinic very often, breastfeeding education should be given every time they are seen.
- Traditional health providers are still very important in maternal health care delivery. The training and cooperation of traditional birth attendants is a promising means of reaching many mothers with breastfeeding information and support.
- Older female relatives also appear to have an influence on maternal practices, and could be targeted for breastfeeding education.
- Husbands' support is seen as influential in pregnancy outcomes and, in some areas, in recovery from childbirth. This support concept should be built upon -- reinforced and expanded -- and specific culturally-compatible behaviors identified and promoted. Men seem to be aware of some supportive actions they can take; these ideas should be reinforced and encouraged.



POST-NATAL PRACTICES

Prelacteal Feeding

Giving liquids or foods to the infant before the mother's milk comes in (prelacteal feeding) is not only unnecessary, but also increases the risk of gastro-intestinal infection and may interfere with the establishment of suckling. However, in the three southern districts (Luwero, Mbarara, and Mbale) prelacteal feeding is virtually universal and believed to be necessary for the baby. Water is the most common first feed, even in the milk-drinking areas. In Mbarara a grandmother said that boiling water to be given to the baby is one of the grandmother's duties while the mother is in labor.

Other substances given instead of, or more usually, after the first drink of water, are sugared water, glucose water (especially among those influenced by health workers), cow's milk (usually diluted), ghee, mushroom infusion (mentioned only in Luwero District), and other herbal concoctions. Undiluted cow's milk is given only by the cattle-keepers in Ngoma in Luwero District. *"Even a baby will refuse diluted cow's milk,"* a grandmother said. A mother said, *"we give cow's milk; when you deliver, cow's milk is to be bought immediately."*

Prelacteal feeds are given any time from within half-hour after birth to the following day, but most commonly after the baby and mother have bathed. The non-breastmilk feeds (along with breastmilk) are continued for one to three days until lactation is judged to be well-established and then stopped.

There are many reasons for giving prelacteal feeds:

- It is tradition. In some of the communities in Mbarara, there is even a special name for the first drink of water (*malogaboga* in Nyakitunda; *kwandura* in Rwoho; *okugundira* in Nyakashashara). In some cases, after the water is given to the newborn, some of it is also offered to the next older child.
- The baby is hungry (which is *"why he cries soon after birth"*).
- If the baby cries too much from hunger the umbilical cord will bleed.
- Prelacteal feeds *"help the baby open its mouth,"* clear the throat of mucus, lubricate the throat, clear the meconium from the gut.
- The baby's jaws are too weak for suckling.
- Prelacteal feeds prevent rejection of the breast. One mother stated, *"if the baby is not given something to swallow immediately, it may refuse the breast and may not be able to swallow breastmilk. Giving small sips of water also ensures that the jaw is strong and functioning."*

The main reason for continuing use of the non-breastmilk feeds in the first days is to assuage baby's hunger and thirst when there is not yet enough milk in the breast. (In fact, an infant needs no foods or liquids during this time; the colostrum is all the neonate needs.) The feeds are usually given by spoon, but one grandmother in Rwoho said it is given on a banana leaf. It is believed that if the baby is not given interlacteal feeds, he/she will cry too much from hunger and may even die.

In contrast to the south, in the north in Apac District, both mothers and grandmothers say the baby is not given prelacteal feeds. The baby is thought not to be hungry soon after birth, and water is believed to upset the baby's stomach. Soon after the baby is born and during the first day the mother is given plenty of prepared bitter vegetable drinks to stimulate her breastmilk production. On the following day,



colostrum "is vigorously expressed into a piece of cloth until the breastmilk is white," and then the baby is put to the breast. Before then if the baby cries the mother comforts it as best as she can.

The other group who reports not giving prelacteal feeds routinely are the Itesots (displaced from their homes in Kumi and Soroti districts and living in Mbale).

Timing of initiation of breastfeeding

Barring unusual circumstances, all Ugandan mothers initiate breastfeeding. Ideally, breastfeeding should begin within an hour of delivery. Where prelacteal feeds are given, most Ugandan mothers initiate breastfeeding after the first non-breastmilk feed has been given (within "about half-an hour"), but some delay it for as long as two days post-delivery. One grandmother in Mbarara District said that a health worker had taught her to give water for the first three days before initiation of breastfeeding. In the majority of cases mothers continue offering the breast to the baby along with interlacteal feeds until lactation is firmly established in one to three days. One reason to initiate breastfeeding early (soon after the prelacteal feeding), some say, is to prevent rejection of the breast by the baby. Many also point out that suckling stimulates milk production. A few mothers in Luwero District mentioned that midwives sometimes encourage breastfeeding on the delivery table soon after the baby is born.

Among the Itesots, mothers initiate breastfeeding after mother and baby have bathed after delivery. While breastfeeding the baby, the mother eats porridge with milk, or drinks milk. Simultaneous feeding, they believe, helps both mother and baby to gain weight.

Apac mothers, as described above, delay initiating of breastfeeding until the day after delivery.

Use of colostrum

Colostrum is the first milk secreted after birth and is especially rich in anti-viral and anti-bacterial agents. Its color and texture differ somewhat from later milk. Many Ugandan women see colostrum as being different from the later breastmilk; some think it is the same. It is called *nsiika* in Mbale and *adoc* in Apac, *edos* by the Itesots.

Views on the nature and desirability of colostrum differ widely in Uganda. Many women believe colostrum to be harmful, others do not know whether it is good or bad and do not give it any special consideration (except the Itesots who believe it to be good for the baby). It is described variously as "dirty," "thick," "watery," "yellow," "less mature," and "hot" ("*scalds the mouth and the baby may refuse it*"). Some believe colostrum to cause diarrhea. Whatever they think about it, most mothers in the south say they feed it to the baby, some after first expressing a small amount to "unblock the ducts" or to get rid of "old" milk. Mothers in Kabunyata in Luwero District and in Apac in the north say they discard it. Apac women consider it "unclean," and full of disease organisms. Only the Itesot mothers report that colostrum is traditionally considered good for the baby's stomach: "*It washes out bad things.*"

■ ■ Program Implications

- Breastfeeding is positively regarded in the culture and initiated by almost all mothers. Therefore, breastfeeding promotion efforts need to move beyond general statements that "breastfeeding is best" and develop messages to address specific feeding behaviors which need improving.



- Breastfeeding immediately after delivery is not widely practiced, and needs to be promoted. This behavior may be fairly easily accepted, since there is already considerable variation in time mothers wait before initiating breastfeeding. Some mothers report that midwives are putting the infant to the breast soon after delivery; possibly this is the result of training given to midwives⁴ and also suggests that this practice is acceptable. Further, some mothers say (correctly) that immediate suckling stimulates milk let-down and production; clearly, information has reached some women and they find it acceptable.
- Giving prelacteal and interlacteal feeds to infants should be discouraged. Perhaps messages could encourage mothers to offer breast for the same reasons they give other feeds, such as to stop baby crying, lubricate the throat, or clear the gut of meconium.
- Giving colostrum needs to be universally practiced. Discarding of colostrum is a problem primarily in Apac and in some communities in Luwero. Colostrum could be associated with the reasons why mothers give prelacteals: for satisfying hunger, clearing the throat, starting jaw functioning. Mothers need assurance that colostrum is specially made for the newborn and provides everything the infant needs. Another possibility is to promote it as a kind of immunization (an intervention which appears to be well accepted as necessary for children) or protection for the child.
- Since mothers are often assisted with childbirth, the knowledge and attitude of older female relatives and TBAs are very important in helping the mother begin breastfeeding correctly after delivery.

EXCLUSIVE BREASTFEEDING AND INITIATION OF SUPPLEMENTARY FEEDS

Maximal health and nutrition benefits accrue when an infant is fed breastmilk alone -- without any other foods or liquids -- for around six months. Ugandan mothers do believe that babies can be well nourished on breastmilk alone for some period during infancy.

One to three days after delivery when lactation is perceived to be established (or "when the milk comes in"), most mothers stop giving water and other non-breastmilk feeds to the neonate, and a period of exclusive breastfeeding is initiated.

The duration of exclusive breastfeeding varies widely, even among mothers in the same community. Both early and late supplementation is found, beginning as early as one month or as late as eighteen months. The most common age to introduce supplements seems to be around three months. Most mothers think six months is too long for exclusive breastfeeding and would not readily follow advice to breastfeed exclusively for six months unless they are given good reasons to do so by a health professional. On the other hand, a grandmother in Mbarara District said that breastmilk is usually enough for the first six months and another said, "*supplementary foods should be given at seven months even if the baby refuses them.*"

⁴ The MotherCare project and the American College of Nurse-Midwives developed a Life-Saving Skills curriculum which included instructions to initiate breastfeeding as soon after birth as possible.



The mother's perception of the adequacy of her own milk supply appears to be a prime determining factor in the decision to begin supplementation. Even in a cattle-raising community in Luwero District known for its liberal use of cow's milk, some mothers said they did not begin supplementary feeding until 18 months. ("*I had enough breastmilk; I drink milk so why would I not have enough breastmilk?*" one mother insisted when others doubted her assertion).⁵ A few mothers perceive that they have never had enough breastmilk and they begin routine supplementation at birth. (See section on insufficient milk, which explores the perception of inadequate milk in detail.)

Other reasons mentioned for introducing supplements are based on cues from the baby -- for example, crying a lot, showing "signs of readiness for food" by sucking fingers or stretching an arm for food when others are eating, or apparent rejection of the breast. Poor weight gain is also seen as indicative that supplements are needed. One group of mothers in Luwero mentioned that cow's milk should be given at three months because it has "special vitamins." In some cases a mother may begin supplementation very late because she cannot afford cow's milk or other supplements.

Mothers employed in the formal sector (mostly in the urban areas) begin supplementation by the second month to get their babies accustomed to non-breastmilk feeds before the end of their 45-day maternity leave. Unmarried teachers start supplementing even earlier because they are not entitled to maternity leave.

The first supplementary food most commonly given in all areas is cow's milk. While breastmilk is considered important for the health of the baby, cow's milk is also regarded as very good food for a baby. Except for the pastoralist peoples in Ngoma in Luwero District, all mothers, including pastoralists in Mbarara, dilute the cow's milk before feeding it to the baby. Ngoma pastoralists regard diluted milk as unworthy of consumption by anyone ("*even a baby will refuse it,*" a grandmother said.). Mothers who do not have or cannot afford cow's milk may start with maize or millet porridge (watery, more like a drink) without milk.

Cow's milk is usually given by cup or by a covered cup with a pierced spout. Solids are fed with a spoon or fingers. Feeding bottles are used mostly by upper income mothers in urban areas and are rarely used by rural mothers.

The age at which solid foods are initiated varies considerably. The solids given include Irish potatoes (many mention this rather than the more common sweet potato), beans, banana (*matooke*), rice, cabbage, greens, soya, or "whatever is available." Cow's milk, Irish potatoes, and soya beans are considered especially suitable and nutritious by both mothers and fathers.

Mothers are the main decision-makers on infant feeding, but a few fathers said they discuss the baby's feeding with the mothers. Grandmothers offer advice to their daughters and daughters-in-law, but those in Mbale complained that mothers think they are old-fashioned and do not take their advice. Most fathers say the father controls the family funds "because he earns it." The mothers ask their husbands for money when they need it. (One mother mentioned that fathers sell the crops the mothers grow and keep the money.) A few fathers said that they plan the family budget with their wives and a few said that since mothers know best what is needed in the home they control the family funds.

⁵ Non-pastoralists interviewed in that community had the perception that the cattle-keepers use cow's milk liberally for all ages.



■ ■ Program Implications

- The notion that infants can be well nourished on breastmilk alone is accepted; the challenge is to extend the period of exclusive breastfeeding to around six months. Since there is already variation in the timing of the introduction of supplements, mothers who tend to supplement early may be open to trying to extend the length of exclusive breastfeeding as some of their neighbors do.
- Emphasize the idea that mother, not baby, should decide when supplementary feeds are needed.
- Messages regarding determinants of maternal milk supply need to be disseminated: that concerns about milk supply need to be dealt with by *more* suckling rather than less; that breasts tend to feel different (less full) when the infant is around three months of age; that virtually all women, even poor ones with very basic diets, can breastfeed exclusively for around six months.
- Mothers may feel more willing to continue exclusive breastfeeding for longer periods than they are doing now if they can be reassured that their babies were receiving enough breastmilk. Messages regarding indicators of adequate milk should be developed.
- Late onset of weaning is also a problem. Certainly by eight months all children should be receiving as nutritious weaning foods as possible in addition to breastmilk.
- Although mothers and sometimes grandmothers are the main decision makers on infant feeding, in most families fathers control the family income. Messages on supplementary foods will need to target fathers and grandmothers as well as mothers.

PERCEPTIONS OF INSUFFICIENT BREASTMILK

The quantity of breastmilk a woman produces is a function of demand; it is rare for a woman to be physiologically unable to produce enough milk to exclusively breastfeed for six months. In Uganda it is believed that most women can exclusively breastfeed for some amount of time, but that the quantity of milk becomes inadequate at some point, most commonly when the infant reaches three to four months of age. It is also believed that some mothers by nature never produce enough milk to breastfeed exclusively. Otherwise, the problem of insufficient milk is usually attributed to insufficient intake of food and drink.

Manifestations of insufficient breastmilk are said to include:

- a baby crying a lot even while on the breast or after breastfeeding
- flabby or empty-feeling breasts
- a baby's stomach remaining small even after feeding
- baby losing weight
- a mother experiencing breast pain because baby "sucks on an empty breast."

Grandmothers have varying ideas about insufficient milk. For example:

- Mothers these days do not produce enough breastmilk, a condition uncommon in their own day. "*These days there are women who are absolutely incapable of producing enough milk.*" Women now face many social hardships, are over-worked and underfed. (Mbale and Luwero)



- Insufficient breastmilk can be caused by witchcraft, frequent illness, or frequent pregnancies. (Mbale)
- Women who cannot produce enough breastmilk are uncommon. (Mbarara)
- A mother's milk is generally not enough for the baby by three months. (Apac)

The most common remedy suggested for increasing breastmilk production is drinking and eating more. The recommended drinks include millet or sorghum porridge⁶, tea, sour milk, herbal preparations, soup made from a bitter vegetable known as *malakwang* (in Apac), and local beer. Greens, beans, sorghum, sugarcane, sesame seed (*simsim*) are also mentioned as stimulating breastmilk production. In Mbarara District, mothers believe hot porridge stimulates milk production while cold porridge maintains it. Drinking of porridge is preferable, but a mother may drink water if porridge is not available. However, one mother cautioned that drinking of water by the mother causes the baby to catch a cold. One key informant, a teacher and Resistance Committee member in Mbarara, said that there is also a belief that drinking too much water, rather than porridge, dilutes the breastmilk, but mothers did not mention this. They did all agree that if a woman could afford it, her drink would be millet or sorghum porridge rather than water.

According to Apac grandmothers breastmilk production can be stimulated by a TBA making cuts on the breast and rubbing in herbal medicine. (*"If a mother has not produced milk by the end of the first week, immediately this is done, milk starts flowing from the nipples."*)

While some mothers think that treatments are effective, others feel that whether these measures work or not depends on the mother's physiology or "blood."

Ideas about the relationship between frequency of suckling and milk volume were explored. Within almost every group, there was a difference in opinion about the effect of frequent suckling on breastmilk supply.

- A large majority of both mothers and grandmothers believe that when a baby breastfeeds frequently, the milk supply is reduced because it is not given a chance to remain in the breast. The fewer times a baby breastfeeds, the more milk a mother will have.
- Some women believe the breastmilk supply is not affected as long as the mother eats and drinks enough (an Apac District grandmother: *"if the mother feeds well and has enough milk, the baby is assured of getting enough milk every time the baby feeds"*).
- Others in Apac said that frequent suckling does not deplete the breastmilk, it just makes it "watery." This watery milk (*awelo*) does not satisfy the baby.
- A minority of women, including the Itesot women, said that the amount of breastmilk will increase with frequent suckling.
- Some mothers believe the effect of frequent suckling depends on the mother's physiological make-up (*"if the mother has blood enough breastmilk will be produced; if she is weak, the frequent suckling will reduce available breastmilk"*).

⁶ Ugandans use the term porridge, but what is referred to is more like a drink.



Mothers with older children (around one year) sometimes "save" their breastmilk for night feeding. Some grandmothers in Mbale District believe a child over six months should be discouraged from suckling "too much" because he may not accept other food.

■ ■ Program Implications

- The fact that increased demand or suckling will lead to increased supply is a key concept to convey. The first solution that mothers (and health workers) need to think of for "insufficient milk" is to feed more frequently.
- Mothers and health workers need to understand that even a basic diet is sufficient for producing enough milk, although they should be encouraged to eat as well as they can.
- Education should include the idea that babies cry for many reasons, and that crying after breastfeeding is not necessarily a sign of dissatisfaction with breastmilk.
- Mothers and health providers could be taught indicators for sufficient milk. If baby is brought in to be weighed, feedback on weight gain could be reassuring. Otherwise, frequent urination may be used as another indicator.
- Mothers need reassurance that it is normal for breasts to feel less full after several months than in the months after childbirth.

FREQUENCY AND DURATION OF FEEDS

Almost without exception, mothers say they breastfeed their babies on demand indicated by the baby crying. (Only one mother in Luwero District says she breastfeeds on schedule because she believes it best to feed the baby at regular times. Many cannot say how many times they breastfeed, but many in Apac and some in Mbale Districts say they breastfeed three to four times a day only. Since crying is an important cue to feed, a baby who sleeps a lot apparently gets fed fewer times. Indeed in Apac, mothers said a baby may breastfeed only three times a day because "*a mother who eats well gives birth to a baby who is already satisfied and does not need to eat much.*" Thus it appears that some proportion of infants are not getting the recommended 10-14 feeds per 24 hours for optimal growth.

Most mothers in all areas breastfeed day and night, taking the babies with them to the farm during the day and sleeping in bed with them at night. If there is an older child, a mother may leave the baby at home to be brought when the baby needs to be fed.

Many rural women believe that educated, well-to-do mothers, and those working in the formal sector breastfeed only at night, because they are not home during the day. However, many of these babies appear to grow well because those mothers can afford nutritious supplements and are knowledgeable about appropriate child feeding.

Most mothers cannot say how long a breastfeed lasts, though some say about 10 minutes. They breastfeed, they said, until the babies themselves stop breastfeeding, or fall asleep at the breast.



Most women say they feed their babies on both breasts although some may favor one breast or the other because it is easier to hold the baby in a particular position. In Apac mothers added that if one breast is unused, it would swell up and the milk in it would spoil.

■ ■ Program Implications

- Number and duration of feeds may be a problem. More information is needed to determine the adequacy of the frequency and duration of breastfeeding. Since mothers cannot accurately recall this information, a small observational study should be conducted.
- Demand breastfeeding is the norm, but perception of and cues for demand appear to be unreliable.
- The critical role of frequency of breastfeeding in maintaining lactation should be emphasized.

TERMINATION OF BREASTFEEDING

Breastfeeding, most women said, should continue for one and a half to two years, because it prevents sickness. The conditions that make breastfeeding termination necessary before these ages are:

- pregnancy
- a very sick child who cannot suckle (because it interrupts breastfeeding which should not be resumed after the interruption)
- separation from the baby for more than one day (especially if the baby is not too young)
- a child who is frequently sick (because bad breastmilk is probably the cause)
- a desire to get pregnant
- tuberculosis, breast abscess or epilepsy in the mother; otherwise the mother can continue if she has other illnesses.

Although almost all men and women, urban and rural, agree that breastfeeding should stop when a mother becomes pregnant, some say the termination could be delayed until the pregnancy has been underway for two to three or even five months. It is thought that the milk of a pregnant mother causes the breastfeeding child to have diarrhea or to develop kwashiorkor. A few mothers say they have breastfed while pregnant or have observed others do it with no ill effects. One father said that a mother may be forced to continue breastfeeding while pregnant (to the detriment of the health of the breastfeeding child) because she cannot afford suitable alternatives.

■ ■ Program Implications

- The current long-term breastfeeding practiced by most mothers should be reinforced and supported.
- The idea that breastmilk can be "bad" and cause the child to become ill needs to be dispelled.
- Messages encouraging mothers not to terminate breastfeeding abruptly when they become pregnant should be disseminated. At the same time, it is important that a mother try to eat as well as she can if she is nursing while pregnant.



ATTITUDES TOWARDS INTERRUPTION OF BREASTFEEDING

In all areas studied interruption of breastfeeding for more than a day is frowned on and strongly discouraged. Some women say, "*it is unheard of.*" A young infant should always be with the mother and not left behind if the mother is to spend a night away. If separated for more than one day, many mothers say they would stop breastfeeding, because the milk would cause the baby to have diarrhea or even die.

Most mothers have no experience of spending extended periods of time away from their babies and do not know what to do if they had to separate for more than 24 hours, but some believe there are some options other than termination of breastfeeding:

- If separation from baby is no more than 24 hours, a mother should express the fore-milk (which is considered spoiled) into a cloth to prevent it from dripping on the ground and continue breastfeeding the baby.
- Some mothers in Mbarara District have heard that termination of breastfeeding may not be necessary after separation, because there are herbal medicines that can be smeared on the breasts or ingested to treat the spoiled breastmilk.

A teacher in Mbale pointed out that she had once resumed breastfeeding after a three-week interruption and nothing had happened to her baby.

According to a grandmother in Mbarara District, "*long ago a mother could not interrupt breastfeeding; she was chased away from home if she did. Nowadays women can continue breastfeeding even after an interruption of more than 24 hours.*"

■ ■ Program Implications

- The idea that mothers should not separate from their infants is positive and should be reinforced.
- If separation is inevitable, mothers need to be reassured that they can and should resume breastfeeding.
- Beliefs may be amenable to modification since they seem to be changing somewhat from the last generation and there is some difference of opinion on the matter.

ATTITUDES TOWARDS EXPRESSION OF BREASTMILK

Women expressed amazement, disbelief, amusement, or almost horror at the idea of expressing breastmilk to feed to a baby: "*It is never done.*" One mother said: "*only cows are expressed*" and another, "*if you are found doing it people will think you are a witch.*" Indeed one teacher in Mbale said she had witnessed a mother-in-law rushing out of a hospital room screaming that her daughter-in-law was a witch who wanted to kill her because the daughter-in-law had been expressing her milk into a cup. Apparently the cup should be destroyed because any adult, especially an in-law, who used it would die.

If for reasons such as engorged or painful breasts a mother has to express her milk, there are several ways to handle the situation:



- Most in the south say that the milk should be expressed into cloth so none of it drops on the ground. In Mbarara District it is also said that 'he milk should not be fed to the baby.
- In Apac, grandmothers said that if a sick baby cannot suckle, the milk should not be expressed into a cup but directly into the baby's mouth.
- If breastmilk has to be expressed (when the breast is engorged or a sick baby refuses to suckle), the expression should be done with the upper arm, not the fingers, with the nipple directed towards the back of the body (Mbale grandmothers).

In spite of the strong feelings against feeding expressed breastmilk, a few pointed out that it might be necessary in certain cases, and two women said that they had expressed their milk for their hospitalized babies when asked to do so, and another two said they had seen milk expressed for premature babies in the hospital.

Associated with the taboo against expressing breastmilk is a traditional belief against breastmilk dropping on the ground (hence the reason for expressing milk into a piece of cloth if it has to be done). Many believe that the baby will die if the milk drops on the ground. However one skeptical young mother in Mbarara District said that nothing will happen if milk is expressed and it drops on the ground and that *"old people had created the "taboo" to prevent babies from being left at home by their mothers."*

■ ■ Program Implications

- The prohibition against expressing breastmilk appears to be strong and is not likely to be overcome except at a health provider's request, in a clinical setting.
- Since few mothers separate from their infants and few other situations call for expressing breastmilk (and since the taboo is strong), overcoming this prohibition should not be a major focus of the communication program.
- In urban areas among employed women (who appear to supplement very early), it may be worth targeting a small, more educated group to adopt this practice.

SPOILAGE OF BREASTMILK

Almost all respondents, including the urban employed women believe that milk spoils under certain conditions. A few women in Mbarara District said they do not believe breastmilk can spoil. (In fact, maternal milk cannot spoil; even if mastitis or breast abscesses occur, it is the breast which is affected, not the milk.) To most, spoiled milk is "watery," but others say it is thick and yellowish: "like colostrum" or pus. It is believed that spoiled breastmilk most often causes diarrhea but can also cause kwashiorkor.

The conditions commonly cited as causing milk to spoil are pregnancy, breastmilk that has not been suckled for several days, and breast abscess. Pregnancy causes milk to spoil because of the "heat" it produces. A mother may even become aware of her pregnancy from the deleterious effect of her breastmilk negatively on her suckling child: *"you may know that you are pregnant when the baby's condition changes; then you stop breastfeeding."*



Other causes that were less frequently cited include:

- Menstruation (mentioned only in Nyakitunda, Mbarara, by both mothers and grandmothers): Menstruation spoils the milk and causes diarrhea in the baby, but mothers do not interrupt breastfeeding during menstruation. The diarrhea, it is said, stops after the period.
- Milk left un-suckled by a previous (dead) baby.
- Milk in a breast that has been suckled by a man (Mbale District): Among the Bagishu in Mbale District, both men and women believe that milk in a breast that was ever suckled by a man is contaminated. If the mother admits to the incident before initiating breastfeeding and rituals are performed, the child's death may be averted. (The incident may be suspected if the mother loses more than one baby soon after birth. She is then urged to confess so she can be treated.) The men declared being aware of the taboo not to suckle a young woman's breast but admitted to sometimes being carried away during love-play.

No one, except the Itesots, believes that sexual activity affects the breastmilk, except maybe when a breastfeeding woman has sexual contact with a man who is not the baby's father. The Itesots (now living in Mbale) believe a breastfeeding woman should not have sexual contact with her husband, and consequently abstain for about two years. The man is allowed to have another woman. With the advent of the AIDS epidemic, the women said, more couples are breaking the taboo so that the man will not seek an outside partner, causing some women to get pregnant again when their babies are still young. When two women admitted they were unwilling to stop breastfeeding when they resumed sexual relations, the other mothers expressed disapproval of their actions.

■ ■ Program Implications

- The idea that breastmilk remains pure under all circumstances -- that it cannot spoil -- needs to be promoted.

BREASTFEEDING AND AIDS

Many people had not seen any cases of mothers with AIDS, but they had all heard that babies can get AIDS from their mothers through blood, and some thought transmission through breastmilk possible.

People have different opinions about whether a mother with AIDS should breastfeed. Many feel that if the mother had it the baby probably had it too; if they were going to die anyway, the mother might as well breastfeed until they both die ("*What else can she do?*"). Some feel that the mother should not breastfeed if the baby does not have the disease. Others do not know whether or not the mother should breastfeed.

■ ■ Program Implications

- The AIDS scare has not caused changes in breastfeeding patterns in any significant way, and therefore AIDS and breastfeeding need not be a central component of a public information campaign. (Health providers, however, need to be well informed so that they give proper advice to mothers.)



- The World Health Organization (WHO) recommendation should be followed: All mothers should be encouraged to practice optimal breastfeeding, unless it is known that the mother is HIV+, the child is HIV-, and an adequate supply of nutritious and hygienic foods can be provided to the child.

KNOWLEDGE OF LACTATION AND FERTILITY

Breastfeeding has a fertility suppression effect. If a woman is practicing exclusive breastfeeding, is amenorrheic, and her child is less than six months old, she is over 98% protected against becoming pregnant. The fertility suppression effect is maximized by frequent feeding. For many women, the contraceptive benefit extends much beyond six months.

Everyone agrees that the interval between delivery and resumption of menses varies from woman to woman, ranging from resumption of menses soon after delivery to two years. Many also agree that some get pregnant before menstruating again (*"I never see blood except in childbirth,"* one mother said). Most believe the differences between women depend on "nature," "God's arrangement," or "the mother's blood or health." Some believe that healthy mothers or more fertile ones resume menstruation earlier. Some simply do not know what influences resumption of menstruation after birth.

Because of the observed variation between breastfeeding women (and sometimes even for the same woman after different pregnancies), most feel that breastfeeding has no effect on the return of menses after childbirth. However, others feel breastfeeding probably affects menstruation because *"I don't menstruate when I am breastfeeding,"* and that women breastfeeding infrequently resume menstruation earlier than those who are frequently breastfeeding.

It was mentioned that one reason to stop breastfeeding is a desire to become pregnant. Yet most respondents still think that breastfeeding has no relationship to birth intervals because they know of examples of getting pregnant during lactation. (*"My wife delivers every two years and she breastfeeds"* and *"breastfeeding does not help even those who breastfeed 10 times a day"*). In addition, there are women who do not become pregnant months or even years after terminating breastfeeding. One mother said, *"I stopped breastfeeding four months ago and I am still not pregnant."*

For most, sexual activity resumes according to the couple's, often the man's, desires (*"he might beat you if you refuse"*) and post-partum abstinence is said to last anywhere from only a few days to about three months. Pastoralist women (in Luwero and Mbarara) may move to their parents' home before delivery and stay for varying periods of time after the birth. Moslems practice sexual abstinence for 40 days after delivery. Only the Itesots have a culturally-mandated long period of postpartum abstinence linked with breastfeeding. Some mothers indicate they stop breastfeeding so they can resume sexual relationships.

■ ■ Program Implications

- A better understanding of the relationship between breastfeeding and child spacing is needed.
- Encouraging exclusive breastfeeding for its protective effect against pregnancy is important since in many cases sexual relations are resumed early.



- Among specific groups, it may be necessary to dispel the idea that a lactating woman should not have sexual relations.

COMMUNICATION

Radio and television: The reach of radio is limited. It appears that fewer than half of the households have radios.⁷ Most people say they do not listen very much to the radio because they do not have time for it. When women listen, mostly at night, they like women's programs, news and announcements. Men say they like to listen to the news, announcements, programs on family planning, local government, and current affairs. A few women said men move about with the radio so the women do not get to listen to it.

There are indications that for those who do have access to a radio, the information transmitted can have an impact. One mother had happened to hear a brief program on nutrition that, unbeknown to her, the research assistant had broadcast; when asked what the program said, the mother accurately recited the main points, some parts verbatim.

Television is rarely found in the rural areas. Television stations are government owned.

Folk media: The AIDS prevention program uses drama to convey health information, and drama appears to be popular. According to Unicef⁸, there are hundreds of drama groups in the country. Music may also be a means of reaching people.

Literacy: According to Unicef, about 19% of rural women were able to read a simple sentence in English, although 43% could read the same sentence when written in the local vernacular.⁹

Credible sources of information: Most mothers believe nurses and doctors are knowledgeable and would consider following their advice if given reasons for doing so. Family members, especially fathers, are not seen as particularly reliable sources of health information. Fathers are thought to know little about child feeding.

Materials: There are few materials of any kind, on any topic, in the villages. There are no breastfeeding materials.

Organizations: There are a number of ways that people might be reached by community organizations. The Resistance Committee organizational structure reaches into virtually all rural villages as a vehicle for political participation. The great majority of the population belongs to a Catholic or Protestant church, and many of the churches operate hospitals or clinics and provide other social services. The Community-Based Health Care Association, a joint NGO-government umbrella organization financially assisted by UNICEF, encompasses a wide network of community development agents who work with local villages to identify development needs and decide what actions need to be taken.

⁷ According to *Children and Women in Uganda* (Unicef, 1989), only 26% of the population owned a radio in 1987.

⁸ Ibid.

⁹ Ibid.



People are very interested in discussing health issues. Even though the intent of the focus groups was not to teach, the process of asking questions and soliciting ideas on topics was one that engaged the villagers. It was difficult to limit the size of the groups, because others would gather around saying, "I want to learn." Often, after concluding a group, someone would ask, "When are you coming again?"

■ ■ Program Implications

- The very limited reach of mass media and the low levels of literacy create a special challenge for the creation of a communication strategy to reach rural populations.
- Radios reach only a percentage of the population, but the audience size is probably continuing to grow as the country recovers economically. Since radio programs seem to leave an impression, and since it is possible that those who hear the radio discuss what they hear with others, radio should still be considered as a means of transmitting infant feeding information. Consideration should be given to radio listening groups, in which community groups listen to and discuss special programs broadcast by radio, as in the Tanzanian Mtu ni Afya ("Man is Health") program from the 1970s.
- Use of folk media should be explored as a possible means of conveying infant feeding messages.
- Simple pictorially-based print materials need to be developed. Simple reference materials for service providers are also needed.
- Although Ugandan villages tend to be scattered and isolated, there appears to be great potential for encouraging positive health behaviors via a community-based approach. There is a tremendous interest in health issues, and there are several organizational structures already in place which could be tapped for this purpose.
- Part of the reason for the extraordinary interest in the focus groups may be the approach used. In this situation the researchers were genuinely interested in learning villagers' own perceptions, and were careful not to communicate any judgments about anything that was said. In this setting people are free to talk. Typically, however, health providers and others in positions of authority tend to lecture to their clients. Community outreach workers will need to develop skills in communication and counseling in addition to acquiring breastfeeding knowledge.
- Establishing training programs for all levels of service providers is essential. They need to have and know how to communicate correct infant feeding information, and know how to handle breastfeeding problems. The advice given by medical personnel is influential, and the misinformation given to mothers is a contributing factor in the decline in the traditionally long period of exclusive breastfeeding.



MESSAGE DEVELOPMENT MATRIX: RESISTANCES AND POTENTIAL MOTIVATORS

The following table shows practices that need to be changed, as well as resistances and constraints, and possible motivators for improving the practice.

Desirable behaviors, resistances, constraints and potential motivators

DESIRABLE BEHAVIORS	RESISTANCES STEMMING FROM BELIEFS AND ATTITUDES	CONSTRAINTS	MOTIVATION
Increase prenatal visits		<ul style="list-style-type: none"> ● Inadequate health services ● Lack of transportation 	<ul style="list-style-type: none"> ● Detection of health problems ● Treatment for lack of blood ● Immunization provided at prenatal care
Initiate breastfeeding within half-hour of delivery	<ul style="list-style-type: none"> ● Baby must be given water first according to tradition (except Apac people and Itesots) ● Jaws not ready ● Baby crying because of hunger ● No breastmilk ● Mother and baby must first wash before feeding 	<ul style="list-style-type: none"> ● Inadequate prenatal education in preparation for breastfeeding 	<ul style="list-style-type: none"> ● Babies are born ready to suckle ● Available breastmilk is enough for baby ● Suckling stimulates breastmilk production
Stop prelacteal feeds (in Luwero, Mbarara, Mabale, excluding Itesots)	<ul style="list-style-type: none"> ● Baby needs water first to lubricate throat, prepare mouth and gut ● Breastmilk not yet in breast ● Baby hungry at birth ● Water cleans gut of meconium 	<ul style="list-style-type: none"> ● Inadequate prenatal education 	<ul style="list-style-type: none"> ● Enough breastmilk is available for newborn ● Breastmilk will "lubricate" mouth and throat ● Baby HAS to cry at birth to live ● Breastmilk helps clean gut of meconium ● Water may upset baby's stomach
Feed colostrum (in Apac and some pockets of the south)	<ul style="list-style-type: none"> ● Colostrum is dirty and harmful ● Colostrum is different from real breastmilk 	<ul style="list-style-type: none"> ● Strong cultural belief 	<ul style="list-style-type: none"> ● Colostrum looks different because of its special protective properties ● Provides first "immunization" for baby



DESIRABLE BEHAVIORS	RESISTANCES STEMMING FROM BELIEFS AND ATTITUDES	CONSTRAINTS	MOTIVATION
Stop interlacteal feeds in first days	<ul style="list-style-type: none"> ● Not enough breastmilk: <ul style="list-style-type: none"> -baby hungry -cries too much -umbilicus may bleed from too much crying -baby may die 	<ul style="list-style-type: none"> ● Strong entrenched practice 	<ul style="list-style-type: none"> ● Suckling increases breastmilk production ● Available breastmilk sufficient for baby ● Crying baby will quiet with suckling ● Non-breastmilk feeds may upset baby's stomach
Feed breastmilk exclusively for first six months	<ul style="list-style-type: none"> ● Not enough breastmilk ● Mothers diet too poor for successful exclusive breastfeeding ● Babies ready for solids before then 	<ul style="list-style-type: none"> ● Skilled breastfeeding support persons not available ● Overworked mothers; adequate food not always available ● Growth of babies not monitored ● Mothers in formal sector must return to work 	<ul style="list-style-type: none"> ● Adequate weight gain indicates sufficient breastmilk ● Adequate urination by baby indicates sufficient breastmilk
Breastfeed young infant at least ten times per 24 hours even if baby does not cry	<ul style="list-style-type: none"> ● Baby does not need to be fed if not crying 		<ul style="list-style-type: none"> ● Some babies are "quiet babies" and have to be encouraged to suckle ● Frequent suckling keeps up milk production
Feed appropriate solids from six months	<ul style="list-style-type: none"> ● Baby does not need solids if mother has enough breastmilk 	<ul style="list-style-type: none"> ● Appropriate food not always available ● Starchy bulky foods predominate ● Mothers generally cook two times a day only ● Mothers not always confident about best weaning diets 	<ul style="list-style-type: none"> ● After six months breastmilk alone not adequate for most babies



APPENDIX I: LIST OF CONTACTS



APPENDIX I: LIST OF CONTACTS

LUWERO DISTRICT

Luwero

Dr. Stephen Sessanga, District Medical Officer

Mr. Deo Nsereko, Chairman, RC V

Mrs. Teddy Muhumuza, District Executive Secretary

Mr. Francis Waryina, District Administrator

Mr. John Kiwanuka, Dresser, District Health Office

Kikube

Joseph Kirumira, member, RC I

Kisalizi Parish

Mr. Fredrick Semwanga, Chairman, RC V

Miss Christine Nabakooza, Secretary for Women, RC II

Mr. Samuel Sajjali, Medical Assistant

Mr. Paul Mutumba, Enrolled Nurse

Mr. Gawera Sebhidda, Health Assistant

Kikalaganya

Joseph Byaruhanga

Ngoma

Mr. Yakobo Mukasa, Medical Assistant, Wakyoto Dispensary

Mr. Kabwama, RC Member

MBARARA DISTRICT

Mbarara

Dr. Patrick Byaruhanga, District Medical Officer

Mr. Tinako Mukasa, Secretary for RCV

Ndajia

Mr. Alubakal Sselwanga, Acting Sub-County Chief

Mr. Bosco Mwesigye, health worker

Rwoho

Mrs. Mwiru, RCIII

Mrs. Kwatampora, Secretary for Women, RCII

Mr. John Katongola, Sub-Parish Chief

Nyakashashara

Mr. Butunturi, RC coordinator

Kiruhura

Mr. Bazungi, Medical Assistant

Mr. Bugingo Rwamutwaza, Council Member, RCIII

Mrs Florence Eugingo, Secretary for Women, RCIII

Nyakitunda

Mr. John Birakwate, Senior Dresser, Sub-Dispensary, also RCII member

 **MBALE DISTRICTS** **Mbale**

Mr. Kabunga, District Executive Secretary
Dr. Richard Othieno, District Medical Officer
Ms. Christine Wasagali, District Health Educator
Ms. Grace Akurut, District Health Visitor
Mr. William Mwangula, Acting District Health Inspector

 Bumbulo County

Mr. James Masete, Sub-County Chief
Mr. L. Malakakwa, Ag. Sub-County Chief
Mr. J. Kundu, Medical Assistant - Bumbo Health Centre
Mr. Khuloka, PHC/CBHC Trainer - Bumbo Parish

 Budadiri County

Mr. Danieri Nadangah, Chairman RCI, Bumasola village - Bunaseke Parish.
Mr. Wilson Wosaha, Secretary for Defence RCIII, Bumasifwa Sub-County
Mr. John Nakedi, RC1 Bumansi, Bumansi Parish

 Bulambuli County

Mr. G. Wamala, Medical Office - Bunambutye Dispensary
Ms. D. Namusoke, Registered Midwife
Mr. N. Nyongesa, PHC worker

 Bungokho County

Mr. C. Wafula, RCII Chairman
Ms. I. Etyana, RCI, Women Representative
Mr. Ahmad Hamid, RCI, Youth Representative

 APAC DISTRICT **Apac**

Mr. Geoffrey Isodu, District Executive Secretary
Dr. T.J. Odongo, Acting District Medical Officer
Ms. C. Akene, District Nursing Officer

 Cawente Sub-County

Mrs. C. Odongo Adiga, Midwife-In-Charge, Iwal Mission Maternity Home

 Nabyeso Sub-County

David Bongo, Sub-County Chief

 Bala Sub-County

Geoffrey Ekel, Sub-County Chief
Simon, RCIII Secretary for Information

 Aber Sub-County

Vincent Abita, Sub-County Chief



APPENDIX II: GUIDE FOR FOCUS GROUP DISCUSSION



APPENDIX II: GUIDES FOR FOCUS GROUP DISCUSSION

FOCUS GROUP INTRODUCTION

We are grateful that you were kind enough to come and help us in this project. We are interested in health issues in Uganda and ways that the health of mothers and children can be improved. It will be helpful to us to know your views on some health areas. The best way to help is to let us know what you do and what you think. There are no right or wrong answers; we welcome all opinions. All your views are important. If you disagree with something that is said, please feel free to state your views.

We will be taking notes so that we can remember your comments. We would also like to have your permission to record the discussions on a tape recorder. The tape would only be used to make sure that our written notes are complete. Do you have any questions?

My name is _____. Just to make the discussion easier, why don't we go around and give our first names, and also say how many children we have and the age of the youngest. Can we start here?
Your name is....?

DISCUSSION GUIDE FOR MOTHERS OF INFANTS 0-12 MONTHS

DATE: _____ DISTRICT: _____ VILLAGE: _____

GROUP TYPE: __mothers __grandmothers __men __other

Remarks:

Attendees: age # children age youngest education ethnicity

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

1. Social perceptions

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

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

If a father has a young infant, how would he show he's a good father?

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

What makes a baby healthy?

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

Please look at this photo:

What do you think of the child?

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

Could exclusive breastfeeding make him look like that? [for both well and malnourished infant]

What kind of mother do you think he has?

What kind of father do you think he has?

Does the family have to be rich (or poor) to have a baby like this?

Please look at this photo:

What do you think of the lady?

How does she feed her child? Why do you say so?

Does she breastfeed? For how long? Why?

2. Prenatal care

Are there any preparations a pregnant mother needs to make with respect to feeding the baby?

Probe:

Do mothers go to see any health provider during their pregnancy? Why? Who do mothers see for prenatal care?

(Probe also traditional providers if not mentioned.)

How many times do mothers go to see ___ during their pregnancy?

Does anyone give you advice about feeding? Who? Anyone else?

What do they say?

Are there special foods that a mother should eat while she is pregnant? Why? Do you eat those special foods when pregnant?

Are there any special foods that a mother should not eat while she is pregnant? Why?

3. Delivery / immediate postpartum

We will now talk about the care and feeding of the baby soon after it is born.

Probe:

Where did you deliver your baby? Who assisted you?

Do they give any advice about what to give the baby? What?

What is given to the baby soon after birth? How soon after birth?

Anything else? Why is ---given? How is it 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 a baby is born is it put to the mother's breast? Why?

Do mothers here give babies colostrum? Why or why not? Is there a difference between colostrum and breastmilk? What?

4. Early infancy

After your milk has come in, do you continue to give ____? Why/Why not?

Probe:

Do you continue to give water? Why/Why not?

Do you ever give breastmilk alone? Why?

How many times in a day do women here give the breast to a young infant? How many times at night? How long is each feed?

Do any mothers prefer to breastfeed at night? Why do they do that?

At what age of the baby do they prefer to feed only at night?

Do you feed from one or both breasts at a feed?

Do you always start with the same breast, or do you alternate?

How do you know when the baby has had enough milk?

5. Supplementation

At what age do you start (routinely) giving liquids to the child?

Probe:

Why do you start at that age?
 Did anyone advise you to begin then?
 How do you know the child is ready?
 What do you give? How do you give it?

At what age do you start (routinely) giving solids?
 Why do you start at that age?
 Did anyone advise you to begin then? Who?
 How do you know that the child is ready for solids?
 What do you give? How do you give it?

If insufficient milk mentioned,

probe:

How do you know if you have enough milk?
 Why does a mother lose her milk?
 Is there anything a mother can do if she thinks she doesn't have enough milk? Has any of you ever tried to increase the amount of breastmilk?
 If a baby suckles a lot, does it affect the amount of the mother's milk? How? Why?

6. Interruption and termination of breastfeeding

What do you do about feeding if you must be separated from your baby?
 For more than a day?

Probe:

Do women here ever express their breastmilk? Why/why not?
 Do they ever express breastmilk and feed it to the baby?
 [If yes] how is the milk fed to the baby?
 When does a mother stop breastfeeding a child altogether?
 [If not mentioned, ask about:
 child illness, mother illness, pregnancy, separation, sexual relations]
 Does a mother's milk ever spoil? Why? How?
 How do you know that the milk is spoiled?

What about mother with AIDS? Does she continue breastfeed?
 How can a baby get AIDS?

7. Lactational amenorrhea

How long after childbirth do woman's menses return?
 It seems that for some women it returns quickly, for some it returns after a long time. Why?
 How do you know?
 Does it matter how long she has been breastfeeding?
 Does it matter how often she is breastfeeding?
 Should a woman who is breastfeeding play sex? What happens if she does? Why?
 Is there anything a woman should do if she falls pregnant while breastfeeding? Why?

Does breastfeeding have anything to do with the length of time between births?

8. Communication

Do any of you have a radio in your house?

Does the radio work?

How often do you listen?

What do you like to listen to?

Have you ever heard any information about infant feeding on the radio?

 Now in closing I would like you to think about this situation. What if you had just delivered your baby, and your husband advised you not to give the baby anything like (mentioned items) for the first few days -- to give only your breastmilk. Would you follow that advice?

[If no:] What if your mother told you...

Now what if a nurse who told you...

A doctor told you...

What if your husband told you not to give anything at all except breastmilk FOR SIX MONTHS -- would you follow that advice?

What if your mother told you...?

What if a nurse told you...?

What if a doctor told you...?

THESE ARE ALL THE QUESTIONS WE HAVE. WE LEARNED A LOT FROM YOU TODAY.
 THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK WITH US.

GUIDE FOR FATHERS OF INFANTS 0-12 MONTHS

1. Social perceptions

What are the characteristics/qualities of a good father? Why?
If a father has a young infant, how would he show he's a good father?

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

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

2. 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 does he/she have?

Please look at this photo:

What kind of mother do you think this woman is?
How do you think she feeds her baby?

3. Breastfeeding and weaning

Are there any special things a woman should do when she is pregnant in order to have a healthy baby?

What does a young baby need to grow 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? Solids? Why? What?
Who decides 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 feeding of the baby?
Are there any reasons why a woman should not breastfeed?

4. Lactational amenorrhea

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

Probe:

Why?
Does it matter how long she has been breastfeeding?
Does it matter how often she is breastfeeding?
Should a mother who is breastfeeding play sex? Why/why not?

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

5. **Household control of income**

Who should decide how much money should be spent on food for the family?

Probe:

Why?

How about for the baby? Why? For what food?

Does the amount of money allocated for the family food change if a new baby is born? Or if the mother is pregnant? Why/why not? Who makes the decision?

6. **Communications**

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?

How would you like to receive this information?

Do any of you have a radio in your house?

Does it work?

What do you like to listen to?

THESE ARE ALL THE QUESTIONS WE HAVE. WE LEARNED A LOT FROM YOU TODAY.
THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK WITH US.

DISCUSSION GUIDE FOR GRANDMOTHERS

1. Social perceptions

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

2. Prenatal care

Are there any actions a pregnant mother should take to ensure a healthy baby?

Probe:

Whom should a mother seek advice from during the pregnancy?
What should she eat?
Do you give your daughters/daughters-in-law advice during their pregnancy?
What kind of advice?

3. Delivery / immediate postpartum feeding

What should be done for a baby right after birth? Why?

Probe:

Where was your youngest grandchild delivered?
If at home did you assist at the birth?
What is given to a baby soon after birth?
Anything else? Why? How is it given? For how long do you give it? [For things mentioned other than breastmilk (eg. water, tea, glucose, sugar water, ghee, mushroom water, etc?) ask why given?]
What would happen if it wasn't given?
Is (water, tea, etc) given before or after breastmilk is first given? Why?
How soon after a baby is born is it put to the mother's breast? Why?
Is colostrum given to babies? Why/why not?
Is there a difference between colostrum and breastmilk? What?

4. Early infancy

After the breastmilk has come in, does the mother continue to give _____?

Probe:

Is breastmilk given alone with nothing else? For how long?
Does the mother give water also? Why/Why not?
How many times in a day do women here give the breast to a young infant? How many times at night?
How long is each feed?
Do any mothers prefer to breastfeed at night only? Why do they do that?
Do you feed from one or both breasts at a feed? Why?
How does a mother know when the baby has had enough milk?

5. Supplementation

At what should a mother start (routinely) to give liquids to the child?

Probe:

Why?

Do you ever give your grandchild's mother advice about this?

How do you know the child is ready?

What should be given? How should it be given?

At what age should a mother start (routinely) to give solids? Why?

Do you ever give your grandchild's mother advice about this?

How do you know the child is ready? What should be given? How fed?

[If insufficient milk mentioned]

Probe:

How do you know if there is not enough breastmilk?

Why does a mother not have enough milk? Is this common?

Is there anything a mother can do if she thinks she doesn't have enough milk? Have you ever given advice on this?

If a baby suckles a lot, does it affect the amount of the mother's milk? How? Why?

What should a mother do about feeding if she must be separated temporarily from her baby for more than a day?

Do women here ever express their breastmilk? Why/why not?

Do they ever express breastmilk and feed it to the baby?

[If yes] how is the milk fed to the baby?

When does a mother stop breastfeeding a child altogether?

[If not mentioned, ask about: child illness, mother illness, pregnancy, separation, sexual relations]

What about a mothers with AIDS? Does she continue breastfeed?

How can a baby get AIDS?

Does a mother's milk ever spoil? Why? How do you know it is spoiled?

Do you see any differences in the way infants are fed these days from the way you fed your children? What do you think of the differences?

THESE ARE ALL THE QUESTIONS WE HAVE. WE LEARNED A LOT FROM YOU TODAY. THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK WITH US.

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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