Journal of Global Initiatives: Policy, Pedagogy, Perspective

Volume 8
Number 1 *Democratic Governance, Economic Growth and Sustainable Development in Ghana*
Article 6

January 2013

Exclusive Breastfeeding Practices of Mothers in Duakor, a Traditional Migrant Community in Cape Coast, Ghana

Solomon Sika-Bright
University of Cape Coast, Ghana, sikabright@yahoo.com

Georgina Yaa Oduro
University of Cape Coast, Ghana, yaaoduro@hotmail.com

Journal of Global Initiatives
Volume 8, Nos. 1 & 2, 2013, pp.87-102

Exclusive Breastfeeding Practices of Mothers in Duakor, a Traditional Migrant Community in Cape Coast, Ghana

Solomon Sika-Bright and Georgina Yaa Oduro

Ensuring child health and well-being is critical in Ghana's development. Central to initiatives for ensuring child health is the World Health Organization's (WHO) recommended exclusive breastfeeding, which is increasingly being promoted in Ghana. As the name connotes, the practice requires that babies from age zero to six months are breastfed. This practice is however interpreted and practiced differently in line with the traditional mode of feeding babies in most communities in Ghana. This paper presents the findings of a study that examined how mothers breastfeed their babies in the first six months at Duakor, a traditional migrant community in Cape Coast, Ghana. The study involved 48 mothers and data was collected through semi-structured interviews. Among others, the study found that friends' ways of feeding were influential in the way mothers fed their babies. Significantly, traditional feeding habits, such as giving babies water and porridge were found in the migrant community. The study further discovered that an exclusive breastfeeding practice among mothers in Duakor was far from ideal as recommended by the WHO. The study therefore recommends the need for intensive sensitization education and culturally sensitive infant feeding initiatives, taking into consideration traditional homeland feeding practices.

Introduction

The beauty and value of breastfeeding is such that right after birth, the baby is placed on the mother's bare breast and it knows instinctively to latch on and start sucking. Latching on its mother's breast makes the baby feel good and comfortable, and creates bonding and security. Additionally, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have recommended exclusive breastfeeding[1] for the first six months of a baby's life in view of its health benefits such as prevention of some childhood diseases and allergies, freedom from contamination, and prevention of future obesity, among others (WHO, 2003; UNICEF, 1990). Exclusive breastfeeding effectively reduces the likelihood of child mortality, which is Millennium Development Goal 4, with the potential of saving 1.3 million lives yearly (Jones, Steketee, Black, Bhutta & Morris, 2003). The above benefits have caused Knaak (2005) to describe exclusive breastfeeding as the medical golden standard for infants.

[1] Exclusive breastfeeding is used in this article to mean feeding the baby in the first six months with only breast milk without water, formula or porridge.

In fact, nearly 40% of babies in the developing world are exclusively breastfed until after six months when they are introduced to complementary feeding (Black et al., 2008). Poor feeding practices—particularly untimely introduction of formula and other foods substances for infants—is a major cause of child malnutrition along with common illnesses often exacerbated by intestinal parasites (UNICEF, 2007). An increase in exclusive breastfeeding prevalence can substantially reduce mortality and morbidity among infants (Kramer & Kakuma, 2002). Healthy infant feeding practices such as exclusive breastfeeding and delayed introduction to complementary foods, are promoted by health clinicians as well as numerous national and international organizations such as WHO, UNICEF, and Ghana Health Services. Mothers, however, base their infant feeding decisions and behaviors on a number of factors, including their experiences, family demands, socioeconomic circumstances, and cultural beliefs (Pak-Gorstein, Haq & Graham, 2009). This paper sought to find out how mothers in Duakor, Ghana, feed their babies in the first six months of the babies' lives.

Statement of the Problem

As noted earlier, exclusive breastfeeding has the potential of reducing infant mortality. As such, in order for Ghana to achieve the Millennium Development Goal 4 of reducing child mortality, appropriate infant feeding practices have been identified as one of the major intervention areas (Jones et al., 2003). The literature on infant feeding practices is primarily based on nutritional and economic factors and benefits, to the neglect of how infant feeding practices are culturally perceived especially among marginalized groups such as migrant mothers in Ghana with strong traditional beliefs. Health promotional programs focus on educating mothers on the immunological and nutritional superiority of human milk over artificial substitutes, especially in the developing world contexts where challenges relating to poverty and healthy infant feeding practices are more pronounced. However, studies have shown that maternal choices of alternative infant feeding practices are based on a number of complex issues including environmental constraints, geographical location, socio-economic and political conditions, women's workloads, and cultural beliefs about the nature of children and the nature of food (Dettwyler, 1988).

No research evidence, however, exists that tells us about the factors that influence traditional migrant mothers' exclusive breastfeeding practices in Ghana. Moreover, there is little evidence that helps us to know whether the relocation of mothers from their homeland to other geographical areas influences their breastfeeding practices in the first six months of their babies' lives. Additionally, one is not sure about the relationships between the socio-demographic and familial factors and maternal perceived barriers to exclusive breastfeeding practices among traditional migrant mothers in disadvantaged communities in Ghana. It is these gaps that have necessitated and informed this study. The paper therefore examines the phenomenon of exclusive breastfeeding practices among traditional migrant mothers in Duakor, Ghana, using the symbolic interactionist perspective as a guide, thus situating the study in a sociological context compared to the popular medical context (Esterik, 2002).

Within the context of the foregoing background information, the paper reviews relevant literature on the subject of breastfeeding, discusses the theoretical framework and methodology followed, and ends with a discussion of the study findings.

Literature Review: Factors Influencing Infant feeding Behavior

Studies on factors that influence exclusive breastfeeding practices in different settings show that the level of maternal education, social class, mother's comfort in breastfeeding, father's occupation, religion, and hospital-related (obstetric and pediatric) factors inform mother's decision to initiate and continue exclusive breastfeeding (Aidam, Perez-Escamilla, Lartey, & Aidam, 2005; Kelly & Watt, 2005; Lawoyin, Olawuyi, & Onakedo, 2001; Venancio & Monteiro, 2006). Other factors, such as the attitudes of mothers regarding breastfeeding, mother-infant bonding, mode of delivery, and family support are important in initiation and sustaining breastfeeding (Beck & Watson, 2008; Chandrashekhar, Joshi, Binu, Shankar, Rana, & Ramachandran, 2007; Scott & Binns, 1999).

Specifically, older and more educated women are a subgroup most likely to choose breastfeeding as their preferred infant feeding method, and generally they breastfeed their children longer than other groups (Scott & Binns, 1999; Arora, McJunkin, Wehrer, & Kuhn, 2000). Multiple studies addressing the factors associated with infant feeding practices have "identified adolescent mothers as one group that is unlikely to breastfeed" (Volpe & Bear, 2000, p. 196). Most investigators agree that full-time employment and school enrollment are associated with decreased breastfeeding duration as a result of environmental barriers at both work and school (Flacking, Nyqvist, & Ewald, 2007; Spisak & Gross, 1991). Married women breastfeed their infants more often than single women (Arora et al., 2000; Scott & Binns, 1999). Similarly, unmarried women with less than a high school education choose breastfeeding at much lower rates than married women or women with a higher level of education. De La Mora, Russell, Dungy, Losch, and Dusdieker (1999) in a study on infant feeding practices in the United States found the attitudes of married women concerning breastfeeding more positive than the attitudes of single mothers.

Several socioeconomic factors differentiate urban and rural mothers (cf. Flacking, Nyqvist, & Ewald, 2007; Heck, Braveman, Cubbin, Chavez & Kiely, 2006; Iddrisu, 2013; Mbada et al, 2013). These differences may play a role in the infant feeding decisions of women. Generally speaking, families living in rural areas are less educated and are more likely to be living in poverty than their urban counterparts. However, breastfeeding rates are especially low in economically deprived, inner-city areas (Hawthorne, 1994, p. 27). Additionally, urban women are more likely to have access to health education and breastfeeding information. Similarly, urban mothers are more likely to have access to lactation consultants for education and support (Alexy & Martin, 1994, Aryeetey & Goh, 2013; Mbada et al, 2013).

Mothers are more likely to feed their infants in the same manner in which they themselves were fed (Hawthorne, 1994; Meyerink & Marquis, 2002). Mothers are also influenced by other women in their social groupings and communities. Women are more likely to choose to feed their infants in the same manner as their friends. Having breastfeeding role models such as friends and mothers, together with positive attitudes to breastfeeding, are important in the final decision to breastfeed (Aryeetey & Goh, 2013; Hawthorne, 1994).

Hospital practices also affect infant feeding practices, with regards to the initiation and duration of breastfeeding, and the introduction of infant formulas (Ford & Labbok,

1990; Aryeetey & Goh, 2013; Tampah-Naah & Kumi-Kyereme, 2013). Hospitals with baby- friendly initiatives are associated with successful exclusive breastfeeding practices (cf. Tampah-Naah & Kumi-Kyere, 2013; Mbada, et al., 2013). The role of the healthcare professional can be very critical in providing women with the information they need to make the decision on how to feed their baby. Negative attitudes and lack of knowledge on the part of healthcare providers can be barriers to successful infant feeding practices (Black, Blair, Jones, & DuRant, 1990).

Within this context, this paper examines how mothers of Duakor feed their babies in the first six months in line with WHO and UNICEF's recommendations. The effect of socio-demographic characteristics such as age, level of education, type of employment, marital and residential patterns, and community contexts in Duakor mothers' decision to exclusively breastfed their babies are also explored. The paper is guided by the following research questions:

- How do mothers at Duakor feed their babies in the first six months?
- How do factors such as their socio-demographic background, friends, and family influence their breastfeeding practices?
- How has their geographical location affected their breastfeeding practices?

Theoretical framework

The symbolic interactionist perspective of George Herbert Mead (1934) frames this paper. In *Mind, Self, and Society*, Mead explained how behaviors are constructed from a symbolic interactionist's perspective. Rather than viewing behavior solely as a product of conditioning and social reinforcement, Mead believed that the mind plays a most important part in attempting to understand human behavior. Karp and Yoels (1993) define symbolic interactionism as "a theoretical perspective in sociology that focuses attention on the processes through which persons interpret and give meanings to the objects, events, symbols and situations that make up their social worlds" (p. 31).

The mind equips humans with three special abilities. First, it helps people to create and appreciate symbols. Through language and reflection, people name and make judgments regarding objects, feelings, and behaviors in their environment and within themselves. Second, the mind enables people to imaginatively rehearse their behavior. People have internal conversations in their minds about what is going on, what they feel, and what they want to do. Third, mind gives people the ability to make choices about these feelings and behaviours that give meaning to the social world (Longres, 2000). A pregnant woman may imaginatively rehearse how she will feed her baby, and what people will think of her as a result. Her choice, as it is lived out, may become inscribed with personal meanings for her performance of the role of mother.

The mind produces human society and it is in turn influenced and re-shaped by society. People symbolize, use language, and communicate through ongoing interactions in a complex mode of perceptions. Through this relationship between the mind and society, the social system of norms, values, and institutions are formed and re-formed. The Self, which is the set of concepts we use in defining who we are (Hughes & Kroehler, 2005), is created from the relation of mind to society. A self-concept is derived from this ability to see one's behavior from the point of view of others, and ultimately from the point of view of the standards of society. A self is chosen from imaginative rehearsals and meaningful

lines of action that a person decides upon. Through this perspective we see the mind, self, and society as interrelated processes.

The development of the self is central to symbolic interactionism which occurs as an individual imaginatively constructs the attitudes of others about a particular role, and thus anticipates the reaction of the other (Bailey, 2001). It must be noted however that not all "others" are equally influential in constructing the self. Three categories of "others" exert various forms of influence on the construction of the self. First, the "generalized other," thus the widespread cultural norms and values we use as reference in evaluating ourselves (Macionis, 2000). For example, marketing, advertisement, and media portrayals of infant care products are the generalized others for nursing mothers since such portrayals have the tendency to influence them in their infant feeding practices (Newman & Pittman, 2002).

Second, "reference groups" are social groups to which people may or may not belong but use as a standard for evaluating their values, attitudes, and behaviors (Merton & Rossi, 1950 in Andersen & Taylor, 2006). Thus groups with which the individual interacts that are capable of influencing them. Family, friends, neighborhood, and workplace groups may become such reference points for mothers who are feeding their infants (Scott & Mostyn, 2003).

Third, "significant others" are considered the actual influential people with whom an individual interacts. Most often they are members of a primary social group where face to face contact occurs (Longres, 2000). Intimate partners have been found to exert substantial influence on mothers' infant feeding choices (Rempel & Rempel, 2004).

Exclusive breastfeeding choices can be framed in symbolic interaction terms. A woman who occupies a social status as a mother must decide on an infant feeding behavior with special reference to societal expectations. Decisions are made about the symbolic meanings of these behaviors for the performance and roles of the mother. These behaviors are carried out with both the perception of the relative benefits of the behavior and the influences of key reference groups and/or significant others. That is, if a mother's family tradition is mixed feeding, she then has a reference group that may encourage continued mixed feeding. However, a key significant other who supports and encourages exclusive breastfeeding may trigger a behavioral change. Fjeld et al. (2008) in a study on the potentials and barriers of exclusive breastfeeding in Zambia, and Aryeetey and Goh (2013) in a study on exclusive breastfeeding duration in Ghana have both established the strong influence of family and friends on breastfeeding practices.

Through this process of role taking and role performance, a sense of identity and meaning making are formed as the symbolic interaction continues. How mothers feed their babies in the first six months is therefore behavior with important symbolic value for most people.

Methodology

We now turn to the study context, research design, sampling decisions, population, and how the data generated for the paper was analyzed.

The Study Context

Duakor, a migrant community in the Cape Coast Metropolis, was selected as the site for the study. It is located on Ghana's southern coast, between the historic towns of Cape Coast and Elmina. The residents of Duakor are mostly descendants of migrants from the Volta region in eastern Ghana. Fishing forms the core of Duakor's economy, with most of the men involved in fishing-related jobs. The women on the other hand are into cassava processing products such as "gari," "cassava dough," "cassava cake" with others working as fish-mongers.

Duakor has a population of 1,039 (GSS, 2002) and qualifies as a village based on the population and level of infrastructural development. Community members also exhibit what the renowned sociologist, Emile Durkheim (Ritzer, 2008) calls mechanical solidarity in that they engage in similar economic activities and general lifestyle. Duakor was selected as the study area purposely because it is a traditional migrant community which is very close to the University of Cape Coast with a more cosmopolitan lifestyle. We were therefore interested in finding out how the closeness of traditional Duakor to the cosmopolitan lifestyle of the university had impacted the breastfeeding practices of Duakor mothers since most of them patronize the University of Cape Coast hospital which is a baby-friendly hospital for antenatal and postnatal services.

Research Design

The prioritization of the subjective experiences of Duakor mothers' exclusive breastfeeding practices led to the adoption of an explorative research design. Explorative study according to (Creswell, 2003) is useful in studying under-researched topics, such as the subject matter of this paper. It is especially useful for discovery and gaining insight or understanding of emerging social issues (Babbie, 2005). We further used semi-structured interviews that covered questions on the socio-demographic background of the breastfeeding mothers as well as their breastfeeding practices during the first six months of their baby's life. Some of the external factors as well as attitudes of significant others that informed mothers that breastfeeding decisions and practices were also explored.

Utilizing snowball and purposive sampling methods, data was collected from 48 mothers between September and December 2012. Purposive sampling tends to focus on people with peculiar characteristics which in this case referred to all mothers with children from age six months to two years. Thus, mothers whose children were less than six months were not included because they had not yet passed the recommended age of six months for exclusive breastfeeding to know whether they had practiced it or not and which may have biased the study. After identifying some mothers, they in turn directed us to other mothers. The snowball technique was easily utilized in this community due to the small size of the community and the fact that members knew each other.

The closeness of the Duakor community to the University of Cape Coast (about a quarter of a kilometer from the university) had exposed Duakor members to research saturation from the University. Community members were therefore apprehensive of the presence of researchers, this situation posed a challenge for us in gaining access to the community. We therefore sought the assistance of some students from the university who shared the same ethnicity and language with the community members. Through this me-

dium, we were able to gain access to the mothers. After explaining the purpose of the study to them, they opened up and volunteered to participate. Thus, in consonance with ethical considerations such as informed consent, voluntary participation, confidentiality, and anonymity (Miles & Huberman, 1994), 48 mothers out of the total community population of 1,039 (GSS, 2002) were recruited for the study. Interviews with mothers lasted between 30 and 45 minutes.

The data analysis started with the translation and transcription of recorded interviews. Pseudonyms were also employed for all study participants. The transcribed data was then coded and analyzed with the support of Nvivo 8 computer software.

Findings

Socio-Demographic Characteristics of Respondents

Socio-demographic variables such as the age, marital status, education, and employment categories of the lactating mothers who were interviewed in this study are summarized in Table 1. These variables were known to influence infant feeding practices, particularly, exclusive breastfeeding practices (Alexy & Martin, 1994; Aryeetey & Goh, 2013; Arora et al., 2000; De La Mora et al., 1999; Tampah-Naah & Kumi-Kyereme, 2013). Mothers' ages were categorized into three groups. Seven of the 48 mothers interviewed were aged between 15 and 19, with almost all of the other mothers (72.9%) aged between 20 and 39 years. However, there were six mothers interviewed who were 40 years and above.

As shown in Table 1, the participants' marital status indicated that the majority (25, (52.1%)) of mothers were married. Sixteen mothers were cohabiting with their partners while five mothers mentioned that they were not married. None of the respondents reported being widowed; however, two mothers were divorced. Eighteen mothers had never been to school, with some 22 mothers having had basic education. Six mothers mentioned that they had secondary education with only two participants having had vocational/technical education. None of the participants reported having tertiary education and this is an indication of the fact that Duakor is a community with low levels of socio-economic status and development. Half of the mothers (50%) interviewed were fishmongers while 11 mothers were traders. There were six farmers and seven unemployed mothers. Follow up questions on employment status of mothers revealed that most mothers predominantly engaged in trading in fish and cassava products. Thus they buy and sell the fish products which the men in the community bring ashore.

Infant Feeding Patterns of Migrant Mothers

The first research question sought to find out how Duakor mothers fed their babies in the first six months. Contrary to the principles of exclusive breastfeeding, where babies are fed only breast milk without water or any additional food, babies at Duakor were introduced to other foods such as infant formula, juice, porridge locally known as *akatsa*, and water, among others at varied times in the first six months of the child's life. Figure 1 shows the infant feeding patterns of mothers who participated in the study. As shown, only four mothers practiced exclusive breastfeeding contrary to WHO (2003) recommendations. Ten out of the 48 mothers reported that they gave their babies formula foods

only. The remaining 34 mothers admitted that they introduced their babies to mixed feeding in the form of breast milk, formula foods and other traditional baby foods such as porridge or *akatsa*. In technical terms, they practiced mixed feeding within the first six months of their infants' lives.

Table 1: Socio-Demographic Characteristics of Mothers

Characteristic	Frequency (N =48)	Percent
Age		
15-19	7	14.6
20-39	35	72.9
40+	6	12.5
Marital Status		
Married	25	52.1
Cohabiting	16	33.3
Single mothers	5	10.4
Divorced	2	4.2
Education		
No education	18	37.5
Basic education	22	45.8
Senior high	6	12.5
Vocational/Technical	2	4.2
Employment		
Unemployed	7	14.6
Fishmongers	24	50.0
Traders	11	22.9
Farmers	6	12.5

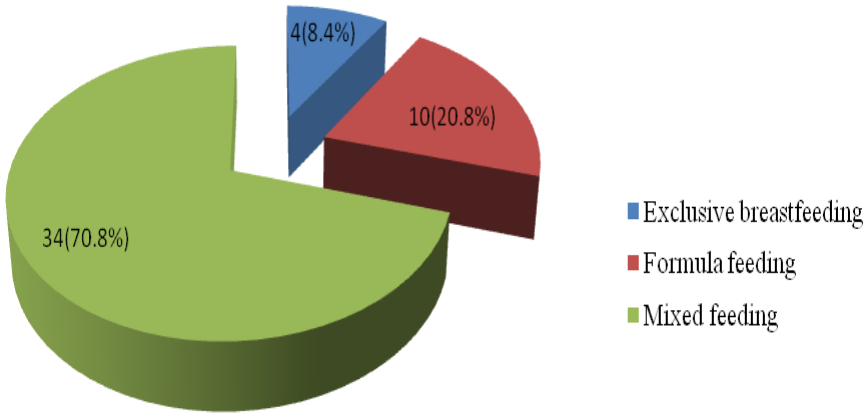
The majority of mothers who mixed fed their babies as shown in Figure 1 above were asked what food they introduced to their infants in the first six months of life. The responses gathered indicated that they gave their babies water, porridge, and other beverages in addition to formula foods. Some of their expressions are presented in the following dialogue:

> Interviewer: What food did you give to your baby in the first six months?
> Response: I give my child water and cerelac (formula) as well as any food that I eat so far as the baby expresses interest in it. (Dzifa, a 30-year-old mother with a 10month-old baby)

Another added:

> I have been giving my child "akatsa" (porridge) and at times water. The nurses at the hospital asked us not to give the babies water in the first six months, but Ghana is too hot and I feel pity for the baby so I give it water. (Dela, a 28-year-old mother with a 2-year-old baby girl)

Figure 1: Infant feeding patterns of mothers



Factors Influencing Infant Feeding Practices in the First Six Months of Life

Cardinal among the focus of the study was to explore how exclusive breastfeeding was carried out in the traditional migrant community. This section therefore looked at the influence of significant others, reference group members as well as generalized others such as mothers' friends, family, and health attendants on feeding practices in relation to mothers socio-demographic characteristics. Three out of the four participants who exclusively breastfed were within the ages of 20 and 39 years. Only one 42-year-old mother practiced exclusive breastfeeding, most of the remaining mothers in her year category engaged in mixed and formula feedings. According to the remaining five mothers in the 40 years and above category, they experienced low supply of breast milk and felt compelled to add other supplementary foods to get the babies satisfied. One 43-year-old mother expressed it as:

> Interviewer: So why did you not exclusively breastfed your baby?
> Response: I tried, but I realized I was not producing enough breast milk for my baby, I am sure it's because of my age, so I added "koko" and lactogen. (Mama Afi, 43-year-old mother with a 15-month-old baby boy)

> Mama Afi's choices might be attributed to her age for different studies have established the relationship between age, mixed feeding practices, and lower milk production (cf. Aryeetey & Goh, 2013; Mbada et al, 2013; Tampah-Naah & Kumi-Kyere, 2013).

None of the mothers below 20 years of age did exclusive breastfeeding, as all of them practiced mixed feeding. They complained of lack of adequate support from family and friends since they themselves are young mothers. One teenage mother remarked:

> I can't give her only breast milk because the baby's father refused the pregnancy and I feel very hurt without his support. I worry a lot, am not happy. Also I don't get enough

> milk for the baby, it can suck for a long time without getting satisfied. (Adjovi, an 18-year-old teenage mother with a 7-month-old baby boy)

Though the psychological state of Adjovi and her inability to produce enough milk might be reasons for not practicing exclusive breastfeeding, it still corroborates the assertion that teenage mothers do not often practice exclusive breastfeeding. This study concurs with such claims since none of the teenage mothers in this study practiced exclusive breastfeeding. Again Scott and Binns (1999) and Arora et al. (2000) have reported that older women were more likely to exclusively breastfeed, and it could be seen from this study that all the exclusive breastfeeding mothers in this study were older mothers between that ages of 20 and 39 years. This, too, is consistent with other research findings. Data on marital status and exclusive breastfeeding practices revealed that all the four mothers who engaged in exclusive breastfeeding were married.

Mothers' level of schooling was considered in relation to feeding patterns. Interestingly, though research has established a positive correlation between higher education and exclusive breastfeeding (Arora et al., 2000; De La Mora, et al., 1999) this study discovered that most of the exclusively breastfed mothers were those with no schooling except one untrained teacher. Those with senior high, technical, and vocational education were not exclusively breastfeeding. Mothers' occupation and infant feeding patterns also showed that two of the mothers who exclusively breastfed were those without employment, even though there was one farmer and one untrained teacher. However, the fish-mongers and traders were largely practicing mixed and formula feeding. Bick, Mac Arthur, and Lancashire (1998) and Aryeetey and Goh (2013) have made it clear that mothers who are engaged in multiple and formal occupations are less likely to maintain exclusive breastfeeding. And this was echoed in this study as almost all working mothers could not maintain exclusive breastfeeding. Occupation therefore plays a major role in conditioning mothers' infant feeding practices.

Influence from Reference Group Members and Significant Others

The influence of significant others and reference group members such as mothers, mothers-in-law, husband, friends as well as neighbors and community practices emerged strongly among the factors that influenced the breastfeeding practices of Duakor mothers. Thirty-four out of the 48 mothers involved in this study reported practicing mixed feeding which was the influence of mothers, mothers-in-law, and husbands. Thus argued Davi Abla, a 37-year-old mother with an 8-month-old baby girl:

> This child followed the feeding pattern of all the other children and family members. My mother and mother-in-law are part of this household and when I had my first child, they taught me how and what to feed it. They asked me to give it porridge 'akatsa,' cerelac. . . in short they asked me to make sure that whenever, I am eating I give the baby some. (Davi Abla, 37-year-old fish-monger with an 8-month-old baby girl)

Another mother added:

> As for me, my husband is the final authority in this house and woe betides me if I disobey him. He asked me to give the baby additional food when the baby was not gaining

> weight. He knows I don't have enough breast milk and I did. (Daaga, 48-year-old trader with a 1-year-old baby boy)

Obviously, the influence of mothers, mothers-in-law, husbands, and previous experiences were all at play in the above quotations. Thus, the composition of the household with mother and mother-in-law had a great influence of infant feeding practices. Additionally the gender dynamics and power positions of the husband in Daaga's case come to the fore. This finding concurs with a similar study by Fjeld et al. (2008) in Zambia where they discovered the strong influence of family and friends as well as the strong role of cultural and traditional beliefs in the fight against the promotion of exclusive breastfeeding practices (cf. Otoo, Lartey & Perez-Escamilla, 2009; Iddrisu, 2013).

Ten of the mothers who practiced formula feeding also reported that they picked the practice from friends and the media, specifically the television. Thus, argued Mama Adjo,

> The fact is I wanted to do the exclusive breastfeeding because so much noise is being made about it. But I was confused at a point because all my friends (started mentioning names) were feeding their babies from feeding bottles, and I fancy it. I think it makes you modern when you do that so I also copied it. (Mama Adjo, 17-year-old unemployed woman with a 6-month-old baby girl)

It is not surprising that a teenage and unemployed mother like Mama Adjo was influenced by her friends to go for formula feeding. Worrying, however, was how Mama Adjo was going to sustain her infant feeding practices since formula feeding tends to be more expensive compared to breastfeeding.

The impact of reference group members such as neighborhood and community influence also emerged strongly in this study. The 71% of mothers found to be engaged in mixed feeding at Duakor mentioned neighborhood and community practices reflected in advice and practices by mothers, mothers-in-law, neighbors, siblings, and other members of the community. As a small community, different generations of family members lived in the same household and saw each others' practices. This community practice was reflected in the voice of a 19-year-old mother who observed:

> The fact is, our elders and community members know what is best for us. They raised and fed us with the right food to this age and so I listen to them instead of what these young nurses tell me when I go for ante-natal and post-natal care. (Yawa, 19-year-old gari seller with an 11-month-old baby girl)

This position was corroborated by an older mother who argued that:

> The *akatsa* (maize porridge) that we give to our babies are practices from our homeland in the Volta region. My great grandmother who passed away recently used to tell me a lot of stories from our homeland including feeding practices. (Aku, 42-year-old mum with a 2-year-old baby boy)

The narratives of Aku and Yawa address the third research question of how the geographical location of Duakor mothers had influenced their breastfeeding practices. However, the demonstration of the stronghold of traditional homeland practices on the infant feeding practices of the current generation of Duakor mothers shows that their geograph-

ical location and proximity to the University of Cape Coast had not had much influence them. It also confirms the assertion of Otoo, Lartey, and Perez-Escamilla (2009), Iddrisu (2013), and Tampah-Naah and Kumi-Kyereme (2013) on the Ghanaian cultural belief and practice of receiving guests with water, thus receiving the babies with water from the ancestral world to the world of the living as well as the giving of water and other concoctions to infants in a tropical and hot country like Ghana to quench their thirst. Duakor generally remains "traditional" in outlook, reflected in their architectural designs and occupation types in spite of its location. This is a real challenge to WHO and UNICEF's child health promotion initiatives. It is also a challenge to the University of Cape Coast hospital's baby-friendly initiative practices since most of the inhabitants of Duakor patronize the university hospital.

Until 1991 when Ghana adopted the WHO's Baby Friendly Hospital Initiatives and the Ghana Breastfeeding Promotion Regulation in 2000 (otherwise known as Legislative Instrument [LI] 1667)(GSS, 2008; Tampah-Naah & Kumi-Kyereme, 2013) to help promote and scale up exclusive breastfeeding practices, the rate of exclusive breastfeeding was very low. Exclusive breastfeeding rose from 2% in 1993 to 63% in 2008 (GSS, 2008) after the introduction of the afore-mentioned initiatives. Unfortunately, recent data from the Reproductive and Child Health Unit (RCH) of the Ghana Health Service reveals a drop in exclusive breastfeeding practices from 63% in 2008 to 46% in 2011 (Asiedu, 2013). This observation is quite worrying and needs further investigation, although it is perhaps therefore not surprising that most of the mothers interviewed in the Duakor study, practiced mixed feeding.

Influence from the Generalized Other

Symbolic interactionism further focuses on the role of the generalized other in people's perception of the self, identity, belief systems, and practices (Newman & Pittman, 2002). Thus, the influence of professional healthcare personnel on breastfeeding practices for a few mothers at Duakor also emerged. The four people who reported practicing exclusive breastfeeding mentioned the role of nurses and education from ante-natal and post natal clinics as informing their decision. They reported that they patronize the University of Cape Coast hospital for their health needs and that informed their decision to stick to the exclusive breastfeeding practices no matter the strong influence from the community. This is captured in the words of a 23-year-old untrained teacher as follows:

> Whenever I go for antenatal clinic at the University hospital I learn that exclusive breastfeeding is good for my baby, that is why I am giving only breast milk to my baby even though my friends and neighbours keep on telling me to give my baby water and other foods just like other people in this village. (Yayra, 23-year-old pupil teacher with a 6-month-old baby boy)

The narrative of the 23-year-old untrained teacher underlines the importance of clinical nurses and other health workers in advocacy and health promotion initiatives. This finding supports that of Black et al. (1990) who emphasized the enormous role health workers play in shaping infant feeding practices of mothers. However, the role of clinical

nurses in shaping infant feeding habits in the Duakor community is not much felt as only four mothers practiced exclusive breastfeeding.

Conclusion

Current infant feeding practices were found to be associated with the following demographic variables: age, marital status of mother, level of education, and employment status of mother. Also, family and friends were found to play a major role. Findings from this study show some of the possible challenges that might undermine the achievement of the Millennuim Development Goal 4 of preventing child mortality in Ghana and to the WHO and UNICEF's policy of exclusive feeding for the first six months. This finding is worrying and problematic in view of the health and immunological benefits of exclusive breastfeeding. The vast majority of mothers in Duakor practice mixed feeding despite their proximity to the University and access to healthcare providers. Different studies have established the positive benefits of investing in children's' health with economic development. Paolo, Bustreo and Preker (2005), for example, argue that investing in children's health is not just a moral obligation and public health issue but a very sound economic decision for governments to take. According to them, such investment results in better educated and more productive future workforce, sets in motion favorable demographic changes, and prevents or reduces permanent impairment over people's life course as well as prevents the intergenerational transfer of poverty. It therefore behooves child health policy implementers in Ghana, particularly clinical nurses who were identified as the major source of infant feeding information, to intensify their education by incorporating positive cultural practices such as breastfeeding into mothers support groups, especially since the study also identified mothers as more likely to feed their babies the way their friends and mothers feed their babies. Support group training might also be extended to those who assist the mother in taking care of their baby since they were also found to influence mother's choice of infant feeding practices.

It is therefore recommended that health workers and authorities do not only target the mother as the sole recipient of infant feeding education, but also other caregivers including relatives, friends, the general community, and public at large, since anyone could be a reference point or a significant other for a lactating mother. Also infant feeding educators should take into consideration the culture and meanings of practices of the mothers they educate since cultural beliefs are very difficult to change.

References

Aidam, B. A., Pe´rez-Escamilla, R., Lartey, A., & Aidam, J. (2005). Factors associated with exclusive breastfeeding in Accra, Ghana. *European Journal of Clinical Nutrition, 59*, 789–796.

Alexy, B., & Martin, A. C. (1994). Breastfeeding: Perceived barriers and benefits enhancers in a rural and urban setting. *Public Health Nursing, 11*(4), 214-218.

Andersen, M. L., & Taylor, H. F. (2006). *Sociology: Understanding a diverse society* (4th Ed.). Belmont CA: Thompson Higher Education.

Arora, S., McJunkin, C., Wehrer, J., & Kuhn, P. (2000). Major factors influencing breastfeeding rates: Mother's perception of father's attitudes and milk supply. *Pediatrics, 106*(5). Retrieved from http://www.pediatrics.org/cgi/content/full/106/5/e67

Aryeetey, R. N. O., & Goh, Y. E. (2013). Duration of Exclusive Breastfeeding and Subsequent Child Feeding Adequacy. *Ghana Medical Journal, 47*(1), 24- 29.

Asiedu, W. A. (2013). Breast milk in short supply. *The Mirror, Ghana, 23 November*. Retrieved from http://www.graphic.com.gh/news/general-news/5261-breast-milk-in-short-supply.html

Babbie, E. (2005). *The basics of social research.* City, state: Thompson Wadsworth.

Bailey, K. D. (2001). Systems theory. In J. Turner (Ed.), *Handbook of sociological theory* (pp. 131-154). Albany, NY: SUNY Press.

Beck, C. T., & Watson, S. (2008). Impact of birth trauma on breastfeeding: a tale of two pathways. *Nursing Research, 57*, 228-236.

Bick, D. E., MacArthur, C., & Lancashire, R. J. (1998). What influences the uptake and early cessation of breastfeeding? *Midwifery, 14*(4), 242-247.

Black, R. F., Blair, J. P., Jones, V. N., & DuRant, R. H. (1990). Infant feeding decisions among pregnant women from a WIC population in Georgia. *Journal of the American Dietetic Association, 90*(2), 255-259.

Black, R.E., Allen, L. H., Bhutta, Z. A., Caulfield, L. E., de Onis, M., Ezzati, M., Mathers, C., Rivera, J. & Maternal and Child Undernutrition Study Group (2008). Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet, 371*(9608), 243-60.

Chandrashekhar, T. S., Joshi, H. S., Binu, V.S, Shankar, P. P., Rana, M. S. & Ramachandran, U. (2007). Breast-feeding initiation and determinants of exclusive breast-feeding—a questionnaire survey in an urban population of western Nepal. *Public Health Nutrition*, 10, 192–197.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd Ed.). London: Sage Publications.

De La Mora, A., Russell, D. W., Dungy, C. I., Losch, M., & Dusdieker, L. (1999). The Iowa infant feeding attitude scale: Analysis of reliability and validity. *Journal of Applied Social Psychology, 29*(11), 2362-2380.

Dettwyler, K. A. (1988). More than nutrition: Breastfeeding in urban Mali. *Medical Anthropology Quarterly, 2*(2), 172-183.

Esterik, P. V. (2002). Contemporary trends in infant feeding research. *Annual Rev. Anthropology 3*(1), 257-278.

Flacking, R., Nyqvist, K. H., & Ewald, U. (2007). Effects of socioeconomic status on breastfeeding duration in mothers of preterm and term infant. *European Journal of Public Health, 17*, 6, 579-584.

Fjeld, E., Siziya, S., Katepa-Bwalya, M., Kankasa, C., Moland, K. M., & Tylleskar, T. (2008). 'No sister, the breast alone is not enough for my baby': a qualitative assessment of potentials and barriers in the promotion of exclusive breastfeeding in Southern Zambia. *International Breastfeeding Journal*, 3,26.

Ford, K., & Labbok, M. (1990). Who is breast-feeding? Implications of associated social and biomedical variables for research on the consequences of method of infant feeding. *American Journal of Clinical Nutrition, 52*, 451-456.

Ghana Statistical Service (GSS) (2002). *2000 Population and Housing Census: Summary report of final results*. Accra: GSS.

Ghana Statistical Service (GSS), Ministry of Health, & Macro International Inc. (MI). (2008). *Ghana: Demographic and Health Survey 2008.* Accra, Ghana: GSS, MOH and ICF Macro.

Hawthorne, K. (1994). Intention and reality in infant feeding. *Modern Midwife, 4*(3), 25-28.

Heck, K. E., Braveman, P., Cubbin, C., Chavez, G. F. & Kiely, J. L. (2006). Socioeconomic status and breastfeeding initiation among California mothers. *Public Health Rep. 121*(1), 51-59.

Hughes, M., & Kroehler, C. J. (2005). *Sociology: The core* (7th Ed.). New York: The McGraw-Hill Companies.

Iddrisu, S. (2013). *Exclusive Breastfeeding and Family Influences in Rural Ghana: A Qualitative Study* (Master's thesis). Malmo University, City, Sweden.

Jones, G., Steketee, R. W., Black, R. E., Bhutta, A. Z. & Morris, S. S. (2003). The Bellegio child survival study group. How many child deaths can we prevent this year? *Lancet*, 362, 65-71.

Karp, D. A., & Yoels, W. C. (1993). *Sociology in everyday life* (2nd ed.). Itasca, IL: F.E. Peacock Publishers.

Kelly, Y. J. & Watt, R. G. (2005). Breast-feeding initiation and exclusive duration at 6 months by social class—results from the Millennium Cohort Study. *Public Health Nutrition 8*, 417–421.

Knaak, S. (2005). Breast-feeding, bottle-feeding, and Dr. Spock: The shifting context of choice. *Canadian Review of Sociology and Anthropology*, 42, 197-216.

Kramer, M. S., & Kakuma, R. (2002). *The optimal duration of exclusive breastfeeding. A systematic review*. Geneva, Switzerland: World Health Organization.

Lawoyin, T. O., Olawuyi, J. F., & Onakedo, M. O. (2001). Factors associated with exclusive breastfeeding in Ibadan, Nigeria. *Journal of Human Lactation*, *17*, 321–325.

Longres, J. F. (2000). *Human behaviour in social environment* (3rd ed.). Belmont, CA: Wadsworth/Thomson Learning.

Macionis, J. J. (2000). *Society: The basics* (5th Ed.). New Jersey: Prentice Hall.

Mbada, C. E., Olowookere, A. E., Faronbi, J. O., Oyinlola-Aromolaran, F. C., Faremi, F. A., Ogundele, A. O., Augustine, O. A. (2013). Knowledge, attitude and techniques of breastfeeding among Nigerian mothers from a semi-urban community. *BioMed Central Research Notes.* 6, 552. Retrieved from http://www.biomedcentral.com/1756- 0500/6/552

Mead, G. H. (1934). *Mind, self, and society* (C. Morris, ed.). Chicago, IL: University of Chicago Press.

Meyerink, R. O., & Marquis, G. S. (2002). Breastfeeding initiation and duration among low- income women in Alabama: The importance of personal and familial experiences in making infant-feeding choices. *Journal of Human Lactation, 18*(1), 38-45.

Miles, M. B. & Huberman, A. M. (1994). *Qualitative data analysis: A sourcebook of new methods* (2nd Ed.). Newbury Park CA: Sage.

Newman, J., & Pittman, T. (2000). *The ultimate breastfeeding book of answers.* New York, NY: Three Rivers Press.

Otoo, G. E., Lartey, A. A., & Perez-Escamilla, R. (2009). Perceived Incentives and Barriers to Exclusive Breastfeeding among Peri-Urban Ghanaian Women. *Journal of Human Lactation, 25*(1), 34-41.

Pak-Gorstein, S., Haq, A., & Graham, E. A. (2009). Cultural influences on infant feeding practices. *Pediatric Review*, 30, 11-21.

Paolo, C. B., Bustreo, F. & Preker, A. (2005). Investing in children's health: what are the economic benefits? *Bulletin of the World Health Organization, 83*(10), 777-784.

Rempel, L. A., & Rempel, J. K. (2004). Partner influence on health behaviour decision making: Increasing breastfeeding duration. *Journal of Social and* Personal *Relationships, 21*(1), 92-111.

Ritzer, G. (2008). *Modern sociological theory* (7th ed.). Boston, MA: McGraw-Hill.

Scott, J. A., & Binns, C. W. (1999). Factors associated with the initiation and duration of breastfeeding: A review of the literature. *Breastfeeding Review, 7*(1), 5-16.

Scott, J. A., & Mostyn, T. (2003). Women's experiences of breastfeeding in a bottle-feeding culture. *Journal of Human Lactation, 19*(3), 270-277.

Spisak, S., & Gross, S. S. (1991). *Second follow up report: The surgeon general's workshop on breastfeeding and human lactation.* Washington, DC: National Center for Education in Maternal and Child Health.

Tampah-Naah, A. M. & Kumi-Kyereme, A. (2013). Determinants of Exclusive Breastfeeding among Mothers in Ghana: a Cross-Sectional Study. *International Breastfeeding Journal, 8*, 13. Retrieved from http://www.internationalbreastfeedingjournal.com/content/8/1/13

UNICEF. (2007). Monitoring the situation of children and women: Birth registration. New York, NY: UNICEF. Retrieved from http://childinfo.org/areas/birthregistration/

UNICEF. (1990). *Strategy for Improved Nutrition of Children and Women in Developing Countries*. New York, USA: UNICEF.

Venancio, S., & Monteiro, C. A. (2006). Individual and contextual determinants of exclusive breast-feeding in Sao Paulo, Brazil: a multilevel analysis. *Public Health Nutrition, 9*, 40–46.

Volpe, E. M., & Bear, M. (2000). Enhancing breastfeeding initiation in adolescent mothers through the Breastfeeding Educated and Supported Teen (BEST) Club. *Journal of Human Lactation, 16*(3), 196-200.

World Health Organization. (2003). *Infant and young child nutrition*. Geneva, Switzerland: WHO.