

Forced Feeding Practice in Yoruba Community of Southwestern Nigeria: Evidence from Ethnographic Research

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ABSTRACT Despite health policies on child care, forced feeding is still a widespread practice in Yoruba culture. It is not clear the factors sustaining the practice. This study describes the practice and highlights the factors responsible for its continuity despite advances in medicine and health transition. Ethnographic data were collected in Aiyedire community, examining the biographies of mothers, through focus group discussion with women and men categories, key informant interviews, and case studies. Data revealed that the practice is sustained through gender stereotypes, traditions, and peer influence of mother-in-law. Reasons advanced for the practices include the perception that child will have intimacy with mother, and child's poor attitude to better food and medication. Gender dynamics exists between male and female as the practice is female role. Respondents do not have the knowledge of the health implication of the practice. It was concluded that public enlightenment programme targeting mother and the significant others identified in the study should be put in place.

INTRODUCTION

Forced feeding is a widespread childcare practice in Yoruba culture. The practice is learnt by females through socialization process, and practiced as an expected role of a responsible mother. The elderly women in the family, "Iya agba," assist the young mothers to force-feed their babies in order to provide enough guidance about child care practice. Another cultural practice that reinforces the practice in modern day Yoruba society is the mother-in-law/daughter-in-law relationship, which allows mother-in-law to change residence temporarily to take care of a newly born grand child.

However, forced feeding practice remains a major childcare practice for some other reasons. In many rural areas, where women faced strenuous work with little or no time spared for child feeding; serious low income earning; ignorance on child nutritional health; as well as gender stereotype; and babies' attitude against bitter drugs, there is a resurgence of forced feeding practice. Also enhancing the practice of forced feeding are the notions that forced feeding brings intimacy between mother and child; and that babies fed with bottle-feed are "cow babies", and such babies do not like to eat voluntarily.

Studies have shown that infant feeding practices influence their health status. For instance, diarrhoea, cholera, respiratory tract infections (RTIs), kwashiorkor have been associated with child feeding practice (Oni et al., 1991; Oke and Yoder, 1989; Oke, 1989 and 1982; Escobar et al., 1983; Ekanem et al., 1991, Jegede et. al. 2002a). A UNICEF report observed that of the 14.8% infant mortality rate in Nigeria, 35% was due to diarrhea disease (UNICEF, 1998). This accounts for 3 to 4 million under five children dying from the disease per year in Nigeria.

The relationship between culture and health has also been stressed by Oke (1989); Odebiyi (1998); Jegede (2002b); Odebiyi (1977); Jegede (1998) and Ajala (2002). Jegede (1998) noted that certain cultural variables including subsistence and the social institutions affect people in taking decision about health issues. Ajala (2002) observed the implication of cultural beliefs on people's perceptions of maternal and childcare among rural dwellers in Osun state. Also, Oke and Yoder (1989) observed how specific cultural practices might lead to certain ill health in child caring. Odebiyi (1977, 1998) in separate studies found out negative effect of some traditional practices on health.

In patriarchal societies like Yoruba, male

children are more valued than female children and this influences differential care given to them (Jegade, 1995, 1999). Therefore, because of knowledge of the relationship between the prevailing high morbidity and mortality rate and child care practices, it is not unlikely that gender factor will play major role in how male and female children are fed. This paper, therefore, is a descriptive analysis of forced feeding practice in a Yoruba community to demonstrate the prevalence of the practice despite the influence of modern health care system.

Background to the Study

Nigeria where the study was conducted is currently made up of 36 states and Abuja, the Federal Capital Territory. It is divided into four health zones and most recently into six geopolitical zones – North-East, North-West, North-Central, South-West, South-East and South-South. Nigeria has mixed economy in which petroleum plays a key role. It accounts for about 90% of Exports and 80% of government revenue. Nigeria, being a multi-ethnic country, became independent from the United Kingdom in 1960. It is one of the largest countries in Africa situated on the Gulf of Guinea in West Africa. It is bounded by Niger in the North, the Atlantic Ocean in the South, Cameroon to the East, and Benin Republic on the West. It covers an area of about 923,768 square kilometers with estimated population of 130 million, making Nigeria by far the most populous country in Africa.

The main thrust of the Nigeria's health care delivery system is the Primary Health Care (PHC) programme and recently the National Health Insurance Scheme (NHIS). The 1981-1985 4th National Development Plan established government's commitment to provide adequate and effective primary health care that is promotive, protective, preventive, restorative and rehabilitative to 80% of the population by 1985 and to extend the same to the entire population, within the available resources by the year 2000. As a result, the country was divided into four health zones – A, B, C and D. South-east, South-west, North-east and North-west, which constitute the study sites for this study. Maternal and child health care service is a major component of this Nigeria health policy including nutrition.

This study was conducted in a Yoruba

community in the South Western geopolitical zone of the Federal Republic of Nigeria. The study area falls within the B health zone (South-west) of Nigeria where Ayedire Local Government Area (LGA) of Osun State was purposively selected for the study location. The Yoruba people occupy the deciduous rainforest region of Southwestern Nigeria. The region falls within the core of tropical rainforest ecological zone of the sub-Saharan Africa. Presently the large expanse of this group covers the Coast of Lagos, up to the southern bank of River Niger, extending eastward to the confluence region of Lokoja. From Lokoja, Yoruba territory extends downward linking the Edo people of the old Benin Kingdom in the mid-western Nigeria who are also noted to be a brand of Yoruba. From there, Yoruba community extends Southward back to the Coast of Lagos and shares the Western boarders with the Republic of Benin (Ajala, 2002). Specifically, Yoruba people occupy Lagos, Ondo, Ogun, Oyo, Osun, Ekiti, parts of Kwara, and Kogi States in Nigeria. The population was estimated at 46 million in 1990 (NPC, 1990). Geographical location of Yoruba people provides opportunities for rich fauna and flora, which form the basis of rich cultural heritage in terms of belief and economy associated with their nutritional culture.

Osun State was purposively selected as a follow-up of an initial study on socio-cultural factors affecting maternal and child healthcare in Osun State. The most striking finding of that study is that children's health is largely affected by harmful practices associated with maternal and child healthcare in the rural communities of the State (Ajala, 2002). Among those harmful practices, harmful nutritional practice singles out. Thus, this particular study purposively selected one of the Local Governments in the State having features that are more rural. Ayedire Local Government apart from being a rural Local Government was one of the six Local Government Areas selected for the previous study mentioned above. Its choice then was motivated by the fact that the Local Government area was one of the Local Government areas selected for pilot execution of Primary Health Care Programme (PHCP) in 1985, yet, the Local Government area still suffer the resilience of certain harmful practices associated with child healthcare.

The study was carried out in three major communities of Ayedire Local Government Area. Ayedire Local Government has three main

dispersed communities viz: Kuta, Ile-Ogbo and Oluponna. The Local Government area has a population of 127,000 people with its headquarters at Ile-Ogbo. The respondents were scientifically selected through multi-staged random sampling system.

DATA COLLECTION PROCEDURES

Ethnographic research design was adopted for the study. Data collection lasted for 6 months and commenced with a reconnaissance study to familiarize researchers with the geosocio-cultural topography of the area. All the study sites were visited to assess the actuality of the research problems. Visits were paid to traditional rulers of the communities, health official, Local Government Authorities, religious leaders and community leaders. At the reconnaissance stage the researchers did a social mapping of the communities by collecting information on history, location of healthcare institutions, infrastructure, political system, economic system and so on.

A pretest of the study guide was conducted in another community with similar social characteristics with the study sites. During the pretest such issues as definition of concepts, selection of key informants, time of the day respondents are like to be at home and others were resolved. The pretest revealed certain inaccuracies in the study guide, which were corrected and put into consideration for data collection.

In each of the sites, the research consisted principally of detailed narrative interviews taking the form of forced feeding and research engagement 'biographies'. These traced parents' unfolding experiences with each child, and took an open-ended format that enabled the narrative to follow the issues most important to them. The nine biographies conducted in both sites built on 12 focus group discussions held with men and women group by age category which complemented another 27 key informants, involving nursing mothers, married men, health workers, and community leaders. The biographies are complemented by non-participant observations to explore issues surrounding infant health, and the social dynamics shaping health practices.

Existing studies of parents' engagement with childcare practice and medical research in the study area have been based either on questionnaire survey and qualitative data. This

study aims to reveal people's beliefs and attitudes around forced feeding practice. Generally the approach helps to consider how people's engagement with forced feeding unfolds, and how this is linked to broader contexts of infant care and of people's social worlds.

During this research, it was difficult to have direct observation of the consent process or the institutional monitoring of this. This clearly places limitations on the ability of the study to describe implementation practices in detail. Rather the focus is on representations of these practices as given in the narratives of fieldworkers and the community members.

Fieldwork: One of the researchers who reported on daily basis to other researchers supervised the fieldwork for the study. They discussed issues arising from the field with the fieldworkers and technical support in difficult areas. Also experienced research assistants (RAs) were also trained to moderate the discussion sessions. In most cases, the moderator and note taker were familiar with the cluster of the study areas assigned to them. The discussions were conducted in the Local Yoruba Language of the interviewees. This gave everybody opportunity to communicate freely. Data collection lasted one month. Although, Interviewers visited some respondents several times before they could conclude their interview, majority of the respondents (90.0%) were interviewed during the first visit, while 5.0% and 5.0% were conducted with 2nd and 3rd return visits.

Data Management: All data collected were stored in notebooks and scrutinized before storage into a computer. The Research Assistants were monitored on the field while data collected were checked on daily basis by the researchers. All data received were kept strictly confidential. To protect the confidentiality of the respondents, codes were used for questionnaire and interview sheets. Only the Investigators had access to the complete data set that contained the names of respondents. Confidential information relating to their health status and medical records were not released to anyone except members of the research group or those professionals who must provide them essential medical care. No information from the study was communicated or discussed with any spouse or partner of the respondents. For proper handling of qualitative data received, all tapes were reviewed at the end of each session to ensure that the recording was

good. Notes taken were also reviewed by going through some of the questions randomly with the respondents or participants after every interview and FGDs to ensure that correct responses were recorded. Each review exercise lasted for about 5 minutes. All tapes were transcribed verbatim. To check for validity of transcription, 5% of the tapes were re-transcribed by another person to ascertain that the information recorded is accurate.

Data Analysis: Data collected were transcribed from tapes and entered into computer using the word pad software before transferring them into text. Responses were tagged and coded subject to similarities. After coding, data were analyzed using the open code software. Those who collected the data from the field and other members of the research group participated in the discussion of the data before the analysis and report writing.

RESULTS

Forced Feeding Practice: Yoruba like any other human society believes in three basic needs of man, feeding, shelter and clothing. Out of these three, feeding is considered to be more important to man's survival as emphasized in a Yoruba adage that "*tounje ba kuro ninu ise, ise buse*", meaning that "poverty lessens with ability to feed". By extension feeding a child is a must and it must be done in a way to reduce the burden of childcare as it was revealed that "*omo ti ko ba jeun ko see toju*" (meaning "a child who is not well fed is difficult to nurse"). The desire to feed children forces women to engage in forced feeding practice. Among the Yoruba, there are two types of forced feeding practice. The first entails putting the baby on mother's lap in a lying position across the mother's knees with the baby's head slightly downward. In this position, liquid food is poured into the folded palm of the mother already put in feeding position at the baby's mouth, with one of the mother's fingers (the thumb) blocking the baby's nostril for two reasons. Primarily for the baby to forcefully eat the food as revealed by a woman saying: "*ti won o ba di imu e ko ni fe jee sugbon ti won ba dii yoo jee pelu agidi to ko ni lee mi daadaa*" meaning blocking the nostrils will force him/her to eat the food. Also to serve as protective measure so that the liquid would not enter the brain through the nostrils as indicated by a woman saying: "*ta ba see be ko ni lee gba*

omi tabi onje s'ori" meaning water or liquid will not enter the brain. Therefore, as the baby opens its mouth to breathe, the food passes into the mouth, and the baby is half-breathed. Most of the mothers indicated that they use this method. This is because it is quicker as indicated by many of the mothers. For instance a woman said: "*o maa nje ki o ya daadaa. Sugbon ti ko ba je bee awon omo yen ko ni fe je ko ya*" meaning: doing it that way makes it faster. Some mothers also used it because it is the method inherited from their mothers as indicated by a woman saying: "*ba se ba l'owo awon iya wa ni yen. Awa naa sit un lo iru ogbon bee*" meaning: that is how we inherited it from our mothers and we are using the same method. The second type of forced feeding practice involves sitting the baby on her mother's lap while the head is made to rest on the mother's chest. Then the mother folds her palm and puts it in the baby's mouth using the thumb to block the nostrils as earlier described. Also as the baby opens the mouth for breathing, the food in the mother's folded palm forcefully gulps to the baby's mouth. Few mothers use this method because it is not convenient for mothers unlike the first method. Health care workers in the study communities are on the contrary as they argued that forced feeding is a bad practice and they always told pregnant women and nursing mothers on clinic days to desist from doing it. According to them it can lead to complications apart from the fact that it not a hygienic way of feeding babies. For instance, a nurse argued say: "*forced feeding is not good. One of the things we educate nursing mothers on is how to feed their babies. We make sure we put it as our health education talk for every clinic day but the people are so deep in tradition*".

Social Engagement in Forced Feeding Practice: Mother-in-law play significant role in childcare practice in Yoruba society. It not uncommon for a mother-in-law to serve as baby sitter for a period up to one year or more. This is considered as a way of enjoying the fruit of their labour and is widely discussed among peers. Therefore, a woman without an opportunity to baby sit her grand child does not always like it and so the occasion is usually an expected moment in every mother's-in-law lifetime as indicated by a woman saying: "*being a mother-in-law is honorable and rewarding. Every woman wants to experience such a moment in her life time*". This may probably explain

differential in gender preference and childcare in the study area. This is because to be a mother-in-law one must have a son. Studies have explained relationship between mother-in-law and daughter-in-law. Mother-in-law assumes significant role in decision-making especially in matters relating to childcare as reasons are found in experience and tradition. Sometimes this brings conflict between mother-in-law and daughter-in-law. Data revealed that the role of mother-in-law is still significant, most especially that there is no difference in residence pattern as both live in the same compound. In this circumstance the husband plays little role when the mother is around than to provide for the family. This alters significantly household authority in relation to childcare as women at their old age assume male status and reinforce traditions.

Gender Dynamics in Force Feeding

Practice: Although data did not show difference in how male and female children are forced fed but gender dynamics exist in terms of who should feed a baby. Female children are socialized to the practice as soon as they are of age. This demonstrates that forced feeding is gender biased in the sense that men would not engage in forced feeding their babies. In fact, some men indicated that *“that is women role. How can I sit down and force feed a baby?”* Data revealed that most of the men in the study area except few supported the practice as a respondent said: *“what is wrong in it. That is how they brought us up and I want my children to be brought up same way. It helps a child to be close to the mother and learn how to behave properly”*. But a few who did not agree are of the opinion that it is no more fashionable to feed babies that way. According to some of them they have tried to tell their wives to stop feeding their babies that way because the babies do not look comfortable. For instance, a man said: *“any time my wife wants to feed the baby I make sure I find somewhere to go because I always pity the baby the way she will be crying and the mother will not bother. I don’t think it is easy for the children”*.

Reasons for Practicing Forced Feeding:

Mother-Child Intimacy: Forced feeding is practiced for various reasons. For instance, some respondents believe that it creates intimacy between children and their mothers. According to them, while the child lies on mother’s lap and feeding from her the child in turn establishes emotional attachment to the mother. A woman

FGD participant who force-fed all her children revealed that: *“All my children truly know that I am their mother; they do not want me to suffer at all. They take proper care of me all the time, except one of them whom I fed with feeding bottle. That one does not care and does not have mercy on me at all”*. This view was common to all nursing mothers. Also some male respondents support the fact that it creates intimacy between mother and child. For instance, a male participant in the FGD commented that: *“on most occasions the relationship between mother and child is stronger than the one between child and father. This is one of the reasons”*. Another male key informant was of the opinion that childcare practice is far more than mothering or fathering a child; it involves adequate care that will strengthen the bond of relationship. For him *“omo ti ‘won ba fi omu maalu toju maalu ni o jo”*. Meaning: *“a child that is fed with cow milk will resemble cow”*. However, some participants were of contrary opinion as they attributed forced feeding to inadequate knowledge of its associated problems. For instance, a health officer explained that it is due to ignorance and an attempt to find good reasons for action saying: *they will always have reasons for doing it. Many of them do not know that it dangerous*.

Eating Pattern: Another reason associated with forced feeding practice is that mothers believe that children do not always want to eat. It was explained that children would continue to play when they suppose to eat and waste a lot of time. Some of mothers explained that some times one might want to quickly feed the baby and go back to what one was doing but they will not want to eat. As a result, the mothers have to force the baby to eat. For instance, a woman indicated that: *“children will not want to eat on time. Some times the mother may be doing something so important and may want to feed the baby. In this circumstance the mother will have to force the baby”*. Another woman revealed that some children do not want to eat at all may be because they do not have appetite. Such a baby will be forced to eat. She explained: *“if a baby does not eat one will not leave him/her like that the best thing is to force such a baby to eat. This is because if the baby does not eat it is a problem the parents and the society”*.

Medication: Data revealed that children generally do not like to take bitter medicines. For many of the respondents (82%) it is difficult to

care for a child who does not use medicines. In order to make them take bitter medicine some times it has to be by force. A respondent argued: *"if a child is sick and refuse to take medicine there is no other thing to do than to force the medicine down his/her throat"*. Some male respondents also share their opinions as many of them said that using medicine for children is a major problem especially when the medicine is bitter. According to a male respondent: *"I have witnessed many occasions when my wife would want to use medicine for our daughter. It was very difficult. Sometimes I have to assist her to force the baby use the medicine because if we do not do it that way the sickness will not go"*. Also, some respondents revealed that bitter drugs are sometimes mixed with baby's food administered as food content.

Knowledge of the Health Effects of Forced Feeding: Data revealed that mothers are not aware of the harmful implications of forced feeding. Mothers believe that they are providing good care for their babies. Case-study analysis showed that 60.0% of the mothers lamented saying: *"Sebi tire naa la n se"*, meaning, "I am trying to attend to you". When they were informed of the harmful implications of forced feeding, they could not comprehend how forced feeding could cause health problems as some of the mothers commented saying: *"You educated people; you have come again with your ideas. This is a custom we have being involved for a long time. How then can such a practice lead to ill health, which can kill children"*? Most mothers engaged in the practice do not know that it lead to such problems as diarrhea, GIT and so on. Case studies also revealed that some mothers would not wash their hands properly before they feed the babies. On most occasions they only dip their hands in water and remove it. The utensils are not also properly cleaned. Child's feeding satisfaction is measured by mother's perception while she observes the child's stomach. If the stomach is heavy, the child is assumed to have been satisfactorily fed. However, this situation often results in over-feeding which lead to pain and constipation. Children express discomfort by crying for a long time after feeding exercise is over. When the child expresses discomfort persistently by crying the mother may stop feeding exercise. This implication is that if the situation continues it may lead to poor feeding and malnutrition. .

Forcing children to feed involves treating the baby harshly to comply while still lying on mother's lap half-breathing. This may cause the baby to experience choke and eventually convulsion. Respondents affirmed the incidence of convulsion while forced feeding. Although they do not see any relationship between forced feeding and convulsion they sometimes attribute such circumstance to spiritual attack saying: *"aye ti ye si"*, that is, "witches and sorcerers have cursed the child". Sometimes food particles or liquid may escape to the brain and lung of the babies while force-feeding them, which may result in serious cough and other respiratory tract infections or sudden death.

DISCUSSION OF FINDINGS

Despite all the harmful implications in forced feeding among the Yoruba of southwestern Nigeria, the practice persists. With the introduction of PHC, which encompasses child survival initiatives including healthy nutritional culture for children, one expects that the forced feeding practice should have been eradicated. The resilience of the practice reveals that there is need for persistence and continuity in healthcare programmes meant to discourage the practice. It also implies that changing the cultural practice of the people requires an understanding what the practice is, its meaning, reason for doing it, and the knowledge of the people about its implications.

This study demonstrates that forced feeding is a widely form of infant feeding practice in the study area. In fact, two types of the practice exists as described by respondents but none of them seem comfortable for children. Although some of the women respondents indicated that they practiced the second method as a better alternative to the first method little or no difference exists between the two. They both have common effects on children. Since the practice is susceptible to unhygienic condition of childcare it may be a source of infection to children. Studies have shown that forced feeding is a source of some opportunistic infections among infants that contribute to high infant mortality rate bedeviling Nigeria (Odebiyi, 1977; Oke, 1993; Ajala, 2002). In particular, Odebiyi (1977) found out that the unhygienic preparation of forced feeding might lead to cholera epidemic among the children. Also, Oke (1993) noted the relationship between infant

feeding practice and diarrhoea in Yoruba culture. The 2004 Demographic and Health Survey for Nigeria showed increased trends of diarrhea from 26.6% in 1990 to 29.4% in year 2003 and also infant mortality rate increased from 87.4 in 1990 to 100 per 1,000 live births in 2003 (Measure, 2004). Although it is difficult to show the proportion of forced feeding contribution to these problems but it constitutes one of the daily harmful traditional practice that expose children to danger and subsequently have direct and indirect impact on their health status. In fact, forced feeding practice has been condemned among animals. For instance, a laborer force-feeding a goose to enlarge its liver for the production of foie gras in Israel was declared cruel by the state High Court of Justice and the court decreed that it must be stopped (Reinfeld, 2005 C:\Documents and Settings\user\Desktop\force feeding.htm). However, a major problem responsible for the blurred perspective about the contribution of the practice to the problems stated above is that very few, if any, studies exist on measuring the role of forced feeding in childcare. Therefore, this is a gap in child survival studies that need to be addressed by nutritionist and anthropologists.

Mother-in-law plays important role in childcare practice in the study area. Generally, the role of mother-in-law is reinforced by social engagements involved in the role as peer influence challenges role expectations and responsibilities of the people involved. Lucy Mair in her work demonstrated the role of mother-in-law in marriage system and came up with the concept of 'mother-in-law/daughter-in-law joking relationship' (Mair 1985). Nicolaisen (1963) found among the Arabs that kinship behaviour is characterized by a respect-relationship towards older generations. There is also a kind of avoidance between certain in-laws known as *nsib* (male) or *nsiba* (female). The avoided relatives in-law are the following:- father-in-law, mother-in-law, son-in-law, daughter-in-law, younger brother's wife, younger sister's husband, older brother of spouse, older sister of spouse (<http://www.economics.uci.edu/~dbell/Nicolaisen.pdf>). This relationship may explain structural problems of decision making at the household level as such avoidances may influence daughter-in-law to be bound hand and foot by tradition and cultural beliefs. In fact, Durkheim (1951) considers the beliefs, practices, and consciousness of the collective to be coercive on individuals as actors.

In this sense, Durkheim has a structuralist approach, considering the social structures to exert a strong influence on social action. Of course, it is individuals who act, but they do not act on a purely individual basis. Rather, they have obligations and duties, and generally act in ways that are strongly influenced by the structures of which they are part. Therefore, a wife may not support certain decisions but may not be able to act contrarily due to the normative value as some respondents expressed in this study. This, therefore, has serious implications for child survival.

Certain reasons, which were mentioned for engaging in the practice, include intimacy with mother, and attitude of children to food and medication. These factors even though frequently mentioned do not justify the practice because it is still difficult to show that they fulfill the objective. It raises certain questions. Can we say that in cultures where forced feeding is not practiced there is no intimacy between mother and child as some of the respondents argued? This may not be true in the sense that psychological studies on child development have not shown vividly the relationship between forced feeding practice and intimacy between mother and child. May be this is a new area to be explored but generally it does not compare favourably with other societies. Also how can one justify that forced feeding enhances positive attitude to food and medication? These are difficult to measure in the sense that the amount of intake and waste in the process of forced feeding has not been calculated. What is shown is the quantity prepared and utilized in the process not minding the amount that is wasted whereas studies have shown high rate of nutritional deficiency in Nigeria (Measure, 2004).

On gender dynamics, data revealed that forced feeding is mainly female role but it is interesting to note the support of men for the practice. Only very few men did not support the practice in the study area. The implication of this is that even household decision-making is fully in support of the practice since men who assume the headship of household in the study area approves the practice. This means that males have great responsibilities in eradicating the practice as decision not to practice it but a wife may be highly influenced by the husband as demonstrated by earlier studies in the study area (Olawoye et al., 2001). It is noted that there is no gender differential between how a male and female

children are fed. This is contrary to earlier studies that showed preferential treatment for male child in the patriarchal society (Jegade, 1999). This is a complete departure from existing knowledge showing that it is not in all cases that parents care for children differently based on gender.

Contradictory policies may be attributed to continuity of many harmful traditional practices. For instance, with the introduction of the Primary Health Care (PHC) in 1985 exclusive breast-feeding and bottle feeding of babies were introduced as the case is in many other developing countries for child spacing and welfare (van de Walle & van de Walle, 1991). But in the 1990s campaigned against the use of bottle feeding and emphasis on the use of cup and spoon to feed babies and children may have sent wrong signal to people. Therefore, it is difficult to understand the exact policy framework on a particular issue. As a result it may be difficult to comprehend government seriousness and clarity especially in society dominated by high population of illiterates like the study area. Although policy issues were not investigated in this study but health workers in the study communities revealed efforts they have made to discourage the practice, yet the people continue with it. As we are not exonerating the people it is always better to mobilize a population along a clear cut policy and inculcate the ideal in them through appropriate health education and social engagement model.

CONCLUSION

The study shows that forced feeding practice is prevalent in the study area and that certain factors are responsible for the continuity. Therefore, there is need to engage the people in massive public enlightenment programme on the inherent danger in the practice and the need to change. It is important to note the role of significant others in the practice especially the mother-in-law and the husband. These two categories of people must be targeted in any program designed for maternal and child health education.

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