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Sociocultural Practices Affecting the Care of Preterm Infants in the Ghanaian Community

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Abstract

Introduction: Although culture is an integral part of health, there is scarcity of evidence on the influence of culture on caregiving experiences of parents of preterm infants. The aim of this study was to explore the influence of sociocultural practices on caring for preterm infants in the Ghanaian community. **Method:** Narrative inquiry was utilized to explore the influence of sociocultural practices on the care of preterm infants from 21 mothers, 9 fathers, and 12 household members. Data were collected through face-to-face semistructured interviews and observations at participants' homes. **Results**: Analysis of data resulted in three threads/themes—respect for the elderly, use of herbal medicines, and communal living. **Discussion:** Community and extended family members have great influence on the care of preterm infants. Traditional herbal medicines are considered effective in treating traditional illnesses among preterm infants. Understanding the influence of culture on the care of vulnerable preterm infants in the community is essential in developing interventions for infant survival.

Keywords

culture, elderly, Ghana, herbal medicine, preterm infant

Introduction

According to the World Health Organization (WHO; 1995), "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Although this definition has been challenged (Charlier et al., 2017), it remains the gold standard. It is a known phenomenon that health is largely dependent on individuals' lifestyle. In recent times, culture as an integral part of health has dominated the literature (Sarfo, 2015) resulting in emphasis on medical anthropology, which studies the explanation of causes of illnesses, treatment modalities, and health-seeking behavior among different cultural and social groups (Joralemon, 2017; Sarfo, 2015).

Over the years, there have been debates to arrive at a standard definition of culture (Ginzberg, 2017). Culture is complex and goes beyond the ways of life of a group of people. It encompasses the values, belief systems, and shared attitudes of a given social group (Bussey-Jones & Genao, 2003). It teaches people to behave in a certain manner that is deemed appropriate among a group of people. Culture can be overt or covert, and evidence suggest that the covert cultural practices are likely to cause negative health consequences when taken for granted (Napier et al., 2014). Globally, people have specific cultural practices related to food, health, and education.

Napier et al. (2014) have reported how inseparable culture is from health and have explored the effect of culture on peoples' well-being. The lack of acknowledgement of the influence of culture on health can lead to financial, intellectual, and humanitarian costs, morbidities, and mortalities (Gyimah, 2006; Napier et al., 2014). As culture forms aspect of the lifestyle of individuals, it is imperative to explore how it affects the health of individuals, especially vulnerable infants who rely solely on their parents.

The African culture is diverse; Africans have a deep sense of appreciation for their culture with most of it revolving around respect for the elderly, rites of passage, and health (Twum-Danso, 2009; Van der Geest, 2002). The African culture values human life and celebrates life in its entirety—that is, at the prenatal, intranatal, and postnatal stages (Aborigo et al., 2015). Contemporary health care practices among African people still involve the use of

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traditional cultural practices despite increased civilization (Shewamene et al., 2017).

Concept of Health and Illness Among Infants in the Ghanaian Community

In addition to the WHO's definition of health, African people also view health as being at peace with their community members and ancestors. Health is both physical and spiritual well-being of an individual (Omonzejele, 2008). A healthy infant must be plump, chubby, or overweight. Having a child who is underweight or preterm is interpreted as obvious sign of illness. Accordingly, diseases can be of both physical and spiritual origin. Traditional diseases exist in the Ghanaian community, which can only be treated by traditional healers or herbalists (Aborigo et al., 2015; Engmann et al., 2013). Although there are a number of diseases across the country, childhood illnesses such as *asram, esoro/etwa*, and *kwashiorko*r (malnutrition) have dominated the literature (Bakari et al., 2020; Douglass & McGadney-Douglass, 2008).

Asram is a spectrum of childhood illnesses considered as a spiritual disease, contracted during pregnancy or at the early postpartum period. These illnesses are diagnosed and treated by traditional healers (Okyere et al., 2010). *Esoro/etwa* is a convulsive-like illness that requires out-of-hospital treatment and requires male adult to hold the child during treatment (Engmann et al., 2013). In some Ghanaian communities, the newborn infant is denied colostrum in the early postpartum period as it is considered contagious or filthy. Keeping newborns indoors during the early postpartum period is believed to protect the infant from "bad/evil eyes."

Some spiritual illnesses are believed to be caused by evil spirits (Asamoah-Gyadu, 2015). In certain parts of Ghana, some infants, considered "spirit children," are believed to be sent to harm their families as a punishment by the gods/ancestors (Nott, 2018). Treatment is based on traditional means of pacifying the ancestors and/or infanticide (Denham et al., 2010). Additionally, the use of traditional herbal medicines is a long-standing cultural practice among African people, as it is believed that some diseases cannot be treated by the biomedical or orthodox model. Spiritualists/herbalists may be consulted for diagnosis and treatment, if diseases are believed to be of spiritual origin (Shewamene et al., 2017; White, 2015).

Although it is argued that urbanization is gradually weakening traditional cultural practices, when sick infants are discharged, these cultural practices are enacted by community members as a child is considered a responsibility of the entire community. In addition, though socioeconomic status influences child health outcomes (Gyimah, 2006), cultural practices may also have effect on child health outcomes, because culture is inseparable from health.

In Ghana, the beliefs and cultural practices in child health care have, in part, contributed to infant morbidity and mortality (Sumankuuro et al., 2019). Although Gyimah (2006) has argued that infant mortality is not directly related to sociocultural practices but rather on socioeconomic factors, there is strong evidence to suggest that cultural practices in the Ghanaian community affect the health outcomes of children (Denham et al., 2010; Nott, 2018). Furthermore, evidence on the effect of sociocultural practices on the health of preterm infants in the Ghanaian community is lacking. Thus, the aim of this study is to explore from the perspective of parents and household members, the sociocultural practices that affect the health of preterm infants in the Ghanaian community after discharge from hospital.

Method

Aim of Study

The aim of this study was to explore the influence of Ghanaian community sociocultural practices on the health of preterm infants after discharge from the hospital. Data from this study form part of a larger study that explored parents' experiences of caring for preterm infants at home/community.

Study Design

Narrative inquiry was used to explore the phenomenon of caring for the preterm infant in the community. Narrative inquiry is a qualitative research methodology that utilizes participants' stories to explore their lived experiences (Clandinin & Connelly, 2000). Narrative inquiry was deemed suitable because it allowed the researchers to journey into the lives of participants to understand how their lived experiences were influenced by their sociocultural environment (Clandinin & Connelly, 2000; Connelly & Clandinin, 2006). Additionally, narrative inquiry explores both lived experiences and cultural perspective of a phenomenon (Webster & Mertova, 2007). Participants shared their experiences in a storied manner, which were then used as research data. Narrative inquiry methodology used in this study has been extensively described by Adama et al. (2016).

Theoretical Underpinning

This study was guided by the social support theory, a middle-range nursing theory that encompasses the provision of support by social network, close family members, or community members with the sole intention of assisting the individual to achieve positive outcomes (Antonucci, 1985; Hupcey, 1998). During data collection, the social relationship among preterm infants, parents, and community or extended family members were observed, and where possible, household members were interviewed for clarification on infant care practices. The research methodology—narrative inquiry—also provided the opportunity to analyze these relationships and how they influenced the preterm infants' health.

Table 1. Demographic Characteristics of Parents and Infants.

Parent age (years)	Relationship to infant	Level of education	Parity	Infant's gestational age (weeks)	Birth weight (kg)	Admission length (weeks)
35	Mother	Tertiary	0	30	0.9	7
28	Mother	Primary	0	28	1.0	5
26	Mother	Primary	0	31	0.89	6
25	Mother	Secondary	1	29	1.1	4
32	Mother	Secondary	0	31	1.2	3
30	Mother	Secondary	1	32	1.2	4
34	Mother	Tertiary	2	33	1.5	3
25	Mother	Tertiary	0	30	1.3 and 1.0[a]	4
27	Mother	Secondary	1	29	0.9	5
28	Mother	Secondary	1	32	1.8	3
34	Mother	None	2	30	1.2	3
19	Mother	Primary	0	29	1.2	4
31	Mother	Secondary	1	28	1.3	3
31	Mother	None	1	32	0.8 and 1.1[a]	6
34	Mother	Secondary	2	30	1.9 and 1.3[a]	5
22	Mother	Tertiary	0	29	1.1	4
37	Mother	Tertiary	0	26	0.8	6
39	Mother	Primary	2	30	1.9 and 1.3[a]	5
34	Mother	Primary	0	28	1.2	3
30	Mother	Primary	0	35	1.8	1
36	Mother	None	2	30	1.3	5
37	Father	Tertiary	0	30	0.9	7
32	Father	Secondary	1	32	0.8 and 1.1[a]	6
38	Father	None	2	30	1.3	5
29	Father	Secondary	0	29	0.9	6
38	Father	Tertiary	1	26	0.8	6
24	Father	Secondary	1	29	1.1	4
30	Father	Tertiary	0	28	1	5
29	Father	Tertiary	0	30	1.3 and 1.0[a]	4
30	Father	Secondary	0	32	1.8	3

[a]Twins.

Study Setting and Participants

Study participants were recruited from four government hospitals (one tertiary and three district hospitals) in two regions of Ghana—Ashanti (Kumasi) and Western region (Tarkwa). Each district hospital neonatal unit has a capacity for 15 to 40 cots, while tertiary hospital has 100 cots. Due to the busy and crowded nature of the facilities, early discharge of stable preterm infants is practiced.

Inclusion criteria for parents included a mentally stable parent of preterm infant aged 18 years or older. For infants, a medically stable infant, born before 37 weeks gestation, and spent at least 3 days in neonatal unit. Of the 49 parents who met the inclusion criteria, 30 (9 fathers and 21 mothers) were interviewed. Ten mothers were first time mothers, six mothers had one previous birth, and the remaining had two previous births. Five fathers were first time fathers, three had one previous birth and one had two previous births (Table 1). Twelve household members who played significant roles in caring for preterm infants were informally interviewed to clarify infant care practices. Overall, data were obtained from 42 participants. Majority of participants were urban dwellers with seven being rural dwellers. Gestational age of preterm infants ranged between 26 and 35 weeks.

Ethical Consideration

Ethics approval was granted by the Edith Cowan University Human Research Ethics Committee, Australia (Project Number: 11568), and the Kwame Nkrumah University of Science and Technology, Committee on Human Research, Publication and Ethics, Ghana (Ref: CHRPE/RC/008/15). Permission was also obtained from heads of neonatal units. Participants who met the inclusion criteria were approached and information letters given or explained to them in the local language (Twi). Informed consent forms were signed or thumb-printed at participants' homes. Pseudonyms were used to protect participants' identity and maintain confidentiality.

Data Collection

Semistructured face-to-face interviews lasting 25 to 80 minutes were conducted at participants' homes. Participants were interviewed three times at their homes. They were asked the same questions at Week 1, Month 1, and Month 4 to understand their experiences over time. Both parents and/or significant others were interviewed. A total of 172 formal and informal interviews were conducted, digitally recorded, and transcribed verbatim. Field notes were recorded to consolidate data from interviews and observations (Laurier, 2016). Parents were observed for infant feeding and health practices. The preterm infants' bodies were also observed for any culturally or spiritually significant artifacts. Additionally, the influence and interaction of household members were observed.

Data Analysis

Data were analyzed using the three-dimensional narrative inquiry framework (Connelly & Clandinin, 2006). Responses from parents and household members were analyzed based on their experiences within hospital and community at any given time. Re-storying, a process of recreating a story from the original data, was undertaken to capture the stories' essence. The relationship between the participants and other people (casts) in the stories was also analyzed. The stories were read over and over to inductively generate codes, categories, and themes or threads (Clandinin & Rosiek, 2007). The stories were analyzed for the plot and the essence and how it related to the care of the preterm infant in the community. The social interactions and how that impacted on health practices was also analyzed.

Result

Analysis of the interview data resulted in three main themes/threads: respect for the elderly, use of herbal medicine, and communal living.

Respect for the Elderly

The elderly women in the community are highly respected, so questioning their decision on childcare practices is interpreted as being disrespectful. Some participants reported their inability to stop mothers-in-law or mothers when they provided care that was against medical advice:

> Madam, it is not easy to say no to your elders, my husband and I are just looking. (Maabena—Mother)

> Since my mother-in-law arrived, I have not been doing what the doctors and nurses told me. She has taken care of smallish children like this before, so I just watch her do what is best for the baby. (Aisha—Mother)

Parents, especially first-time parents, entrusted their infants' care to elderly women because they respect and trust their experience in caring for sick or preterm infants. The level of education of parents was disregarded when decisions on the health of the infant were being made by elderly women:

> I am a practising nurse, but I have been told to keep quiet for them [elders] to look after the baby for me. (Betty—Mother)

> When one day, I challenged my mother-in-law that she was not supposed to give my baby enema, she was upset with me and called me ungrateful and disrespectful. I had to allow her to do her job because she has cared for eleven children. (Ben—Father)

The concept of respect for the elderly and authority is very important in the Ghanaian culture and it is used as a measure of one's upbringing. Being disrespectful does not only bring shame to the individual, but also to their household and community. Therefore, for fear of being labelled disrespectful, parents would rather remain silent:

> You see, they have all stopped their work only to be with you and to give you the best of advice for the baby and you refuse to listen to them? That doesn't sound very respectful so it's quite a dilemma. I believe in what the doctors and the nurses say but I also believe in my people, so when they want to take the baby to the asram herbalist, I can't stop them . . . I don't like it . . . so I keep on giving a lot of excuses but how far can I go? (Simon—Father)

> My mum has been supportive since I gave birth, but you know, when they advise you and you don't take it, they feel disappointed and they may end up saying that you are being ungrateful. (Amma—Mother)

Observation. Mothers and grandmothers having misunderstanding about giving preterm infant water. Grandmothers were of the view that the preterm infant will be extremely thirsty without water.

Use of Herbal Medicines

Traditional herbal medicine is common practice among urban and rural Ghanaians. Some childhood illnesses in the community are considered not-for-hospital, requiring traditional/spiritual treatment:

> I was given the asram when I was pregnant, so he also got it. Asram cannot be treated in the hospital, so we have been to one herbalist for herbal medicine. (Doris—Mother)

Some traditional childhood illness such as *asabra* was also reported:

> If a child is suffering from asabra, his toilet is green, green, he becomes weak. . . . We use a certain leaf to treat the disease. These special leaves are sold in the market. It is grounded and

> used as enema for the baby. If you do this, the baby will defecate all the asabra. (Akos—Mother)

Participants also described how they used herbal medicines for treating their preterm infants:

> My mother is very good with the herbs. She has been treating other sick infants in our village. She diagnoses and treats asram as well. When we were discharged . . . the hospital did not give us any medication apart from telling me to breastfeed her. When she [grandmother] arrived, she mixed some herbs together and that is what I use to bathe him. . . . I do not know what the herbs are made up of. (Yaa—Mother)

Herbal concoctions were used to stimulate weight gain among preterm infants:

> We smear clay mixed with some herbs on her skin so that she can grow fat. She is too sick, so the herbalist advised us to do that. (Amma—Mother)

Although some parents did not like alternative therapies, they were unable to resist them:

> She [grandmother] took some herbs for bathing and smearing his body . . . they know I don't like it, but they do it anyway. They said they are doing it for the benefit of my child. . . . Whenever they are not around, we don't even use those herbs . . . , my auntie and mother have been a pain on my neck. They want to give my baby the herbs by all means, they said all the people who had preterm babies used the herbs. (Kojo—Father)

Charms were used to prevent "bad eyes" from inflicting the infant with spiritual illnesses:

> They also said I should use some things on his neck or wrist to prevent evil eyes from harming him. I was also told that unless I do herbal treatment, he will never grow big because he is suffering from asram. (Mary—Mother)

> Asram is dangerous, we use this bracelet as a form of protection and give her the herbal preparation as a drink twice everyday. (Aisha—Mother)

Keeping the preterm infant indoors was a common practice among participants. It is believed that "bad eyes" can cause spiritual diseases if the infant is exposed to outdoors:

> My mother said my son is suffering from asram and so he has been indoors since we were discharged; away from the bad eyes. I do not want my child to be sick. (Kwame—Father)

> If you go for the herbs and give it to the child, it protects the child from asram and if you use it while pregnant, it also protects your unborn child from asram. (Martha—Aunt)

Observation. Some infants were seen with whitish paint on their skin, special bracelets, and anklets which, were confirmed by parents as a protection against evil diseases. Mothers and grandmothers returning from herbal clinics and administering herbal concoctions to cure *asram*.

Communal Living

Among the Ghanaian people, a child is said to belong to the community. Therefore, when a sick infant is discharged into the community, neighbors, friends, and family provide spontaneous advice:

> When we came home, although I am almost always away, my wife gets all the information from the community members. . . . One of them was when the baby will not sleep in the night, one woman suggested that we give him lemon juice as she may be constipated. As she is a mother of five, we agreed . . . and gave the lemon juice. (Bright—Father)

Community members with previous experiences of caring for preterm infants shared their experiences with parents:

> Last night, when she was unwell, my neighbor who had had preterm infant assisted me with some ointment. She was too sick, very hot but it was too late to go to the hospital. My neighbor heard her crying and came to my aid. After using the medication . . . she slept well till the following day, and I took her to the hospital. (Joyce—Mother)

> My neighbors want to see her, but I tell them she is unwell. Then they want to know what's wrong with her, so that they can help. My old neighbor has been visiting her to bathe and advise me on her care. (Shu—Mother)

Some parents felt pressured to follow advice of their community members:

> They will come along with some medications and encourage us to use it. They even said I should give Lactogen [formula feed] to increase the baby's weight. The pressures from our neighbors are so strong. (Rita—Mother)

Although some community members' recommendation came in handy, others resulted in negative outcomes. Health complications and subsequent readmissions were some negative outcomes:

> The co-tenant next door, she encouraged us to go to this herbalist . . . , he gave us some herbs and concoctions for enema. After three days of administration, my baby started sleeping well, but not feeding well. When we went back to him, he gave us a different concoction, but after five days when the baby was becoming sluggish . . . we took her to the hospital . . . she was readmitted for seven days and given some antibiotics before we were discharged. (Afia—Mother)

Observation. Visits from household members and neighbors were observed. It was explained that such visits were mostly to discuss health and well-being of mothers and preterm

infants. Neighbors provided support with house chores—cleaning, cooking, fetching water, and running errands.

Discussion

Despite increased urbanization and civilization, there are ongoing traditional practices that influence the health outcomes of preterm infants in the Ghanaian community. In this study, three themes/thread emerged from the data—respect for the elderly, use of herbal medicines, and communal living.

Respect for the elderly is a valued cultural practice in Ghana (Twum-Danso, 2009). Young people are expected to be respectful and not question the decisions of the elderly. This study does not, in any way, promote disrespect for community members/elders, but to put into context how this practice affects the health outcomes of preterm infants. It is recommended that health care workers should capitalize on this practice to include elderly people in the predischarge education, so that they can serve as agents of positive change in the community. Similar results have been reported in previous studies in which maternal and child health care practices depended on the decisions of the heads of household (Adama et al., 2018; Aubel, 2012; Moyer et al., 2014).

For fear of the consequences of disrespecting elders such as incurring a curse (Twum-Danso, 2009), parents of preterm infants succumbed to the pressures of their elderly mothers or mothers-in-law and adhered to unscientific ways of care practices. For example, the use of herbal enemas and concoctions championed by elderly people could partly contribute to the increased morbidity and readmission rate among discharged preterm infants. Not only does the unknown content of herbal medicines pose a risk to the infant, the unhygienic ways of processing the concoctions could equally pose a major risk for infections. Interruption of established exclusive breastfeeding in the neonatal unit by elderly people postdischarge could also increase the risk of neonatal morbidity and mortality.

The use of herbal medicines is common practice among African people (Gyasi et al., 2016; Shewamene et al., 2017). Herbal medicines are used for treatment of many illnesses including prematurity. Parents in this study reported using different herbal preparations through topical, oral, or rectal routes. The use of herbal medicines is greatly influenced by household or community members. This finding is in accordance with the scholarly work of Tabi et al. (2006), which reported widespread use of herbal medicines in Ghana among literate people and is influenced by many factors including family and friends.

As these herbal preparations have not been scientifically studied, they are at potentially high risk of putting the preterm infant at risk of hepatotoxicity and other complications (Teschke & Eickhoff, 2015). In this study, not only was the preterm infant subjected to increased risk of morbidity, there was a high risk of unexplained infant mortality. The underdeveloped organs of preterm infants may not metabolize and eliminate by-products of herbal concoctions (Ku & Smith, 2014). In addition, there is high risk of hypothermia as infants were exposed before applying cold concoctions on their body. Some diseases such as *asram* were reported to be of spiritual origin. Therefore, herbalists and/or spiritualists were consulted for treatment. This finding is similar to that of Okyerefo and Fiaveh (2017) that reported that Ghanaians believe that disease origin can be physical—requiring physical means of treatment—or spiritual requiring spiritual means of treatment. Understanding the cultural and spiritual means of treating certain childhood diseases is essential in educating parents on their consequences.

The care of infants in the Ghanaian community is not a sole responsibility of the parents; it is considered a community responsibility. These are sociocultural practices that have existed since precolonial days. The infant's care is influenced by the community members. They provide social support, especially informational support and, in some instances, share their medications. This finding is in accordance with that of Engmann et al. (2013), which reported the influence of community members on parents' infants care decisions. Communal living and duty of care in the community is a sociocultural practice that can improve or risk the health outcome of preterm infants. Preterm infants are vulnerable group that require specialist care in the community. Lack of specialist care and the influx of information in the community place parents at risk of disregarding predischarge medical advice.

Nurse' understanding of the sociocultural practices in Ghana is essential in providing culturally congruent care, which seeks to restructure these practices through negotiation (Leininger, 1988; Schim & Doorenbos, 2010). Considering the harmful effects of some sociocultural practices, negotiation with parents and major stakeholders—grandmothers and other elderly family members—during predischarge education can potentially prevent or reduce infant morbidity and mortality in the community. It is recommended that during neonatal unit admission, nurses and other health care professionals must identify the social support network of parents and include them in predischarge and discharge health education. Further research is needed to understand the presentation of the various traditional childhood illness in the Ghanaian community and the available treatment modalities.

Conclusion

The sociocultural practices of respect for the elderly, use of herbal mediations, and communal living are long-standing practices that, when harnessed, can be used to support the care of preterm infants in the community. Given the value placed on these cultural practices, nurses and other health care professionals should negotiate within the culturally congruent framework to support parents and the community to provide culturally safe care for preterm infants in their

community. Nurses' understanding of this is essential in preparing parents for discharge into the community and subsequently reducing neonatal morbidity.

Author's Note

Sara Bayes is now affiliated with Australian Catholic University, Fitzroy, Victoria, Australia.

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