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IN-BETWEEN CULTURAL EXPECTATIONS AND MEDICAL
RECOMMENDATIONS: MOTHERING DISCOURSES
AMONG NIGERIAN WOMEN
ON FACEBOOK

by

Oluwaseyi Esther Ambrose

A Thesis submitted to the Faculty of the Graduate School,
Marquette University,
in Partial Fulfillment of the Requirements for the
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ABSTRACT
IN-BETWEEN CULTURAL EXPECTATIONS AND MEDICAL
RECOMMENDATIONS: MOTHERING DISCOURSES AMONG NIGERIAN
WOMEN ON FACEBOOK

Oluwaseyi Esther Ambrose

Marquette University, 2022

One critical health concern that hinders a child's survival and growth in Nigeria is child mortality. Yet, the factors responsible for the high child mortality rates are preventable, and many can be traced to cultural beliefs and traditional practices related to mothering and childcare. Previous research, however, especially that used social media as its focus, rarely included the perspectives of mothers. Hence, this study examines myths, cultural beliefs, and traditional practices surrounding mothering and child-rearing among Nigerian mothers via a Facebook group, *Ask the Pediatricians* (ATP). Through a textual analysis of mothers' discourses on the ATP group, the study reveals the maternal beliefs that: teething is a major cause of children's illnesses, breastfeeding is not enough for the first six months, and chubby babies are healthier babies. The corresponding actions related to these beliefs included following traditional practices of self-diagnosing and self-treating illnesses, giving babies herbal drinks, neighborhood advising roles, and experienced mothers and mothers-in-law assuming the role of a child health expert. In navigating the beliefs and practices, the mothers on the ATP Facebook group either challenged or embraced the beliefs and practices. The mothers' narratives reflect that in order to be a good mother, there are feelings of tension and a continued interplay between medical and cultural practices. In addition, the study demonstrates how new media informs community support care and recommends that policymakers build on it to achieve maternal and child wellbeing in Nigeria.

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Oluwaseyi Esther Ambrose

My Faithful Father, “How could I be silent when it’s time to praise you? Now my heart sings out, bursting with joy—a bliss inside that keeps me singing, “I can never thank you enough!” Psalms 30: 12 (TPT).

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	i
CHAPTER	
I. INTRODUCTION.....	1
Mothering and Childcare Practices in Nigeria.....	1
Cultural beliefs, Traditions, and Myths.....	3
II. LITERATURE REVIEW.....	9
Maternal and Child Health in Nigeria.....	9
Child Mortality in Nigeria.....	11
Nigeria.....	12
Factors Responsible for the Inaccessibility and Underutilization of Healthcare Facilities among Mothers and Pregnant Women in Nigeria.....	13
Structural Factors Contributing to the High Rates of Child and Maternal Mortality in Nigeria.....	16
Cultural and Traditional Practices influencing Maternal and Child Mortality.....	19
Efforts to Reduce Maternal and Child Mortality in Nigeria.....	23
III. THEORY AND METHODOLOGY.....	28
Relational Dialectics Theory (RDT): An Overview.....	28
Methodology	33
Data.....	34
Ethical Considerations and Procedure.....	34
Data Collection.....	35
Textual Analysis	36

IV.	FINDINGS.....	40
	Part One: What Mothers' Discourses on ATP Facebook Group Reveal About Cultural and Traditional Practices Surrounding Mothering and Child-rearing.....	41
	Teething Assumptions and Diagnosis.....	42
	Traditional and Cultural Myths About Breastfeeding.....	51
	Experienced Mothers and Mothers-in-law as Child Health Experts.....	59
	Part Two: Mothers' Responses to Cultural Beliefs and Practices on Child-rearing.....	71
	Resisting and Challenging Cultural and Traditional Beliefs.....	72
	Worried and Vulnerable Mothers.....	76
	Embracing and Defending Cultural Beliefs and Traditional Practices.....	80
	Summary	85
V.	DISCUSSION AND CONCLUSION	87
	Discussion	89
	RDT and Mothers' Navigation of Cultural Beliefs and Traditional Practices on ATP Facebook Group.....	95
	Implications for the study and Future Research	97
	REFERENCES	101

CHAPTER ONE INTRODUCTION

Mothering and Childcare Practices in Nigeria

I am really feeling bad right now. So, I just put to bed last week Friday to my second baby and my mil (mother-in-law) came to bath baby and she was pressing the baby's breast so I told her that we were asked to stop that during antenatal and she stopped immediately although she said he will develop big breast in future. Then a doctor friend of ours came today and was telling me that I shouldn't allow my baby to be turned and twisted after bathing and I told her that my mil (Mother-in-law) did so. So, she said she would use style and throw the talk in the presence of my mil which she did and immediately she did, so my mil just made a sigh and went out and since then she has been carrying face for me. I really feel bad and unable to concentrate since then. Do u think I approached the issue rightly and how do I pacify her now. Please while bathing baby, she rubbed soap on his face and poured water to rinse it off. I actually thought I was bold enough to tell off such practices but now that she is here my liver is just failing me (*Ask the Pediatricians* Facebook, 2021).

The above quote exemplifies the child-rearing challenges many mothers face, especially Nigerian mothers. This is because in Nigeria, as in most societies, mothers and other women are responsible for taking care of children (Hays, 1996). In Africa, child-rearing is not solely the responsibility of the mother: neighbors, older women, and others also see it as their responsibility to help raise a child. Moreover, as the above quote illustrates, while Nigeria is classified among the top-rated fertile countries in the world

(Adebowale, 2020), many medically unsound cultural practices and traditional beliefs surround mothering and child-rearing (Egharevba et al., 2017; Joseph & Earland, 2019). While some women can reject these practices or myths, others are vulnerable.

Existing literature in Nigeria reveals that cultural beliefs and myths permeate public and private discourses on mothering and child-rearing (Aworinde et al., 2019; Mishra et al., 2021; Ohaja et al., 2019). This is possible because the older generation of Nigerian women pass down or share these beliefs and myths as they “educate” younger women. As the introductory quote indicates, some of these cultural practices and myths are harmless, while others pose a danger to the health of young children (Adebayo et al., 2019; Olonade et al., 2019; Piane, 2019). For instance, Mishra et al. (2021) found that traditional practices of managing umbilical cords can lead to injuries such as neonatal burns as a result of hot water treatment. Scholars have also argued that cultural beliefs about certain food preferences influence complementary breastfeeding practices that often lead to malnutrition or unhealthy nutrition (Ariyo et al., 2021; Ayinmode & Obebe, 2018; Ekwochi et al., 2016; Yarney, 2019).

The focus of these studies, however, has not been on the ways in which Nigerian women themselves navigate these beliefs and practices. While health systems in Nigeria have largely been given the responsibility of debunking myths surrounding mothering and child-rearing, research on how mothers debunk or embrace these myths through communicative practices in women's circles, particularly discussions outside of hospital settings, is lacking. To fill this gap, this thesis investigates the ways in which some Nigerian women navigate the myths and cultural beliefs surrounding mothering and child-rearing via the Facebook group, *Ask the Pediatricians* (ATP). Aside from social

connection, Facebook group *Ask the Pediatricians* offers women alternative spaces of communication and in this case, the opportunity to discuss myths and cultural practices associated with child health and do so openly. While scholarly attention has been given to Nigerian women's social media use, little attention has been given to how Nigerian women produce knowledge, especially in cases where cultural practices permeate discourses of mothering and child-rearing in Nigeria.

As part of an ongoing effort to contribute to studies on maternal and child health in Nigeria, this study aims to contribute to scholarly research on how mothers contest or embrace cultural beliefs and traditional practices regarding mothering and child-rearing (Afiyanti & Solberg, 2015). The study also aims to understand the discourses of health and culture through Relational Dialectics Theory (RDT). It is expected that this study will be of significant use to healthcare providers seeking to understand how women make sense of and embrace or contest cultural practices of mothering and childcare. Theoretically, the study is expected to extend the use of RDT in understanding mothering and childcare discourses in a Nigerian context. It asks:

RQ1: What do the patterns of women's discussions reveal about cultural and traditional beliefs permeating discourses of mothering and child-rearing?

RQ2: What are the communicative responses of women to cultural and traditional beliefs permeating discourses of mothering and child-rearing?

Cultural beliefs, Traditions, and Myths

Because this study focuses on cultural beliefs and traditional practices about mothering and child-rearing, it is pertinent to define the terms culture, traditions, and myths. Culture, according to Campbell (2020), "includes how a social group eats, dresses,

practices its faith, interacts, speaks, and treats others, and how members of the group perceive right and wrong, among other concerns” (p.1).

Similar to other societies in the world, cultural beliefs in Nigeria include practices that have been in existence for a long time. These practices are not only health-related but concern other aspects of social life as well. Examples of common cultural beliefs include the belief that motherhood is an esteemed position. For example, among the Yorubas, there is a saying that “mother is gold” (Adebowale, 2020). Nigerians also believe in communal and extended family systems, and the extended family is involved in child-rearing, training, and caring (Amos, 2013). The provision of family and social support from grandmothers and older mothers and public celebration of newborns through naming ceremonies are common cultural beliefs and practices as well (Ojua et al., 2013; Olaore & Drolet, 2016). There is also a belief in traditional healers, medicine, and birth deliveries (Bolu-Steve et al., 2020). Nigerians also cook and share food during baby ceremonies and mothers securely strap babies to their backs for up to three years.

While there are cultural beliefs that are specific to different ethnic groups in Nigeria (Jimoh et al., 2018), some beliefs have been established in the literature as common to maternal and child health in Nigeria, irrespective of ethnic orientation. In this study, I focus on the cultural beliefs and common practices associated with mother and child health. That is, what is typically judged to be right for a Nigerian mother and child in respect to how they take care of themselves and their newborns, when and if they go to the hospital for certain health issues, where and how delivery takes place, what a mother and child should eat among others. For example, previous studies found that there are cultural beliefs associated with caring for the umbilical cords of infants (Ndikom et al.,

2020; Osuchukwu et al., 2018), while several traditional beliefs are also associated with infant teething (Bankole et al., 2003; Bankole & Lawal, 2017; Olatunya et al., 2020).

On the other hand, traditional practices focus on customs, as well as “values and beliefs held by members of a community for periods often spanning generations” (United Nations Fact Sheet No. 23, 1995, para. 4). This definition further suggests that all social groups in the world have a practicing tradition based on their cultural beliefs, which may be either beneficial or harmful. In this study, traditional practices do not refer to the practices that define all the multiethnic groups in Nigeria but rather to practices established in the literature associated with maternal and child health (Jimoh et al., 2018). For example, some traditional practices in Nigeria include: placing newborns on the mother’s chest so the heartbeat can lull the baby to sleep, singing and dancing while backing a baby to make them sleep, cooking and pampering the new mother to regain her health, breastfeeding babies until they start walking (ATP, 2019). These practices are beneficial and widely embraced.

However, not all traditional newborn care practices are regarded as beneficial, rather, many traditional practices are guided by pediatricians who determine on a case-by-case basis whether such practices are beneficial or detrimental to a child or mother (Cumbul & Uymaz, 2021). In cases where they pose a danger to the health of mothers and children, healthcare providers and health scholars call for their eradication (Cumbul & Uymaz, 2021). For instance, Bello et al. (2020) posit that some of the causes of obstetric fistula, a public health concern, among mothers in northern Nigeria include unskilled traditional birth methods and engaging in some harmful traditional practices such as early marriage and childbearing. It should be noted that this study does not focus

on the practices viewed by the United Nations as harmful traditional practices (HTP) followed in some parts of Africa, such as male-child preference, female genital mutilation (FGM), and early marriage and pregnancy (Adetola et al., 2019). In Nigeria, these HTPs are frowned upon practices by the government, and there are ongoing efforts to eradicate FGM and early child marriage among young girls in some parts of the country where such acts are practiced (Jimoh et al., 2018).

Lastly, according to Buxton et al. (2020), myths are narratives that are representations of people's traditional or religious beliefs. Though mostly of unknown origins, myths exist in all societies, and they can be found in either stories, beliefs, sayings, or warnings (Buxton et al., 2020; Wood, 2005). In this study, myths are defined as beliefs that have continued to be passed down from one generation to another with respect to mothering and child health in Nigeria (ATP, 2017). Myths are more interconnected than they are different from traditions and culture. This is because while traditions are practices upheld by a people, myths are beliefs or stories that help to express traditional practices and understand the people's culture (Buxton et al., 2020). More importantly, myths help to understand the different concerns of life, such as birth and death or what is good and bad (Wood, 2005). These reasons also explain why they have continued to be relevant from ancient times till now (Wood, 2005).

Scholars have identified several myths that permeate public and private discourses on mothering and child-rearing in Nigeria (Aworinde et al., 2019; Ohaja et al., 2019). For instance, the use of safety pin around the belly when pregnant to ward off evil spirits from the child was reported as one of the popular myths among the Yoruba tribe in Nigeria (Aworinde et al., 2019). Another myth states that a mother should not breastfeed

with tears in her eyes and that a mother should not allow her baby to fall from her back. These myths are believed to be beneficial in promoting hygiene and preventing head injuries (ATP Foundation, 2017). Myths thought to be dangerous include applying toothpaste to the umbilical cords of newborns in order for them to drop off before the naming ceremony, using breastmilk as an eyedrop when newborns' eyes are red, the need to give infants herbal concoctions to make them strong, pressing the breasts of newborns (ATP foundation, 2017). Even though pediatricians regard these practices as myths, they point attention to the types of discussions that surround mothering and the experiences of mothers in Nigeria.

Hence, a myth can become part of a tradition, even if based on false or misleading information. It can also become embedded in cultural practices and beliefs and passed down from one generation to another as fact. Because some of these myths have been associated with unhealthy practices for infants, they have gained the attention of scholars and doctors. Promoting awareness of their implications for the health of mother and child is a significant concern in Nigeria. Since these myths, coupled with traditional and cultural beliefs, have also formed women's discussions on social media spaces, it is pertinent to understand what mothers think of them and how they respond to them in taking care of themselves and their newborns.

In the next chapter, I provide insights into the state of health of mothers and children in Nigeria. I extensively discuss the factors influencing child mortality in Nigeria. I also discuss interventions made in the health sector to ensure maternal and child health: cultural beliefs and traditional beliefs associated with mothering and child-rearing are further discussed. In Chapter Three, I explain the relational dialectics theory

and its applicability to the present study. This is followed by a discussion of the method used to carry out the study. Chapter Four presents the findings with prominent themes such as *Teething Assumptions and Diagnosis*, *Traditional and Cultural Myths About Breastfeeding*, and *Mothers and Mothers-in-law as Child Health Experts*. Lastly, Chapter Five interprets the findings and provides suggestions for future research.

CHAPTER TWO LITERATURE REVIEW

Maternal and Child Health in Nigeria

The World Health Organization (WHO) defines maternal health as “the health of women during pregnancy, childbirth, and the postnatal period” (WHO, 2021, para 1). It also means receiving prenatal and postnatal care, adequate protection against neonatal infections, and choosing delivery at health care facilities (Nigeria Demographics and Health Survey (NDHS), 2018). Ensuring maternal health refers to the well-being of both mothers and their children. However, achieving maternal well-being in Nigeria has been challenging because of the high rates of maternal mortality that exist in the country.

Maternal mortality is defined as the deaths that result from complications during pregnancy or childbirth (United Nations Children’s Fund (UNICEF), 2019). For example, Nigeria recorded 917 maternal deaths per 100,000 live births in 2017 (UNICEF, 2019).

Many factors inhibit achieving maternal health in many countries, especially in developing countries. Although maternal mortality rates in Sub-Saharan Africa decreased significantly between 2000 and 2017, Nigeria remains one of the fifteen "high alert countries" (WHO, 2019, para 5). Many factors are reportedly responsible for the causes of maternal deaths, such as unsafe abortions, high blood pressure, loss of blood or malaria, and delivery complications (WHO, 2021).

These factors are reported to be preventable if attended to on time (WHO, 2021). In addition, in developing countries, women often do not get the needed care during pregnancy due to poverty, lack of information, inadequate or poor-quality services, and cultural beliefs and practices (WHO, 2019). For example, the 2018 health survey data

report by the NDHS noted that “only 39% of women in Nigeria delivered their last live birth in a health facility, while fifty-nine percent of women delivered at home” (p.176). This shows a slight increase from the 2013 data survey, where 36% of women utilized a health facility (NDHS, 2013). Delivery at home could have different rationales, such as wanting personalized services from a midwife, a doctor, or traditional birth attendants (TBAs). Previous studies, however, have established that delivery at home, for most women in Nigeria, means the absence of skilled birth attendants (SBAs) and urgent care in cases where complications occur (Chiwuzie & Okolocha, 2001; Mohammed et al., 2020). Home deliveries are usually carried out by TBAs or relatives of a pregnant woman, and in other cases, no assistance of any kind (NDHS, 2018).

In Nigeria, the focus in the health sector is to increase the number of SBAs and ensure the accessibility of basic healthcare to mothers and children in a timely fashion (Adeyinka et al., 2020; Alex-Ojei et al., 2020; Luntsi et al., 2022). This is because most health institutions, such as WHO and UNICEF, recommend that maternal and child mortality are preventable if there are enough skilled birth attendants to manage delivery and complications (UNICEF, 2019). Maternal health cannot be discussed in isolation from child health. Child health is defined as the “foundation of all growth and development.” This growth and development are necessary for the child’s overall wellbeing (Childcare.gov). This definition suggests that a child’s health begins in the mother’s womb since it is described as the foundation for growth. One factor that hinders a child’s survival and growth is child mortality. This is also recognized as one of the critical challenges facing children’s health in Nigeria.

Child Mortality in Nigeria

One of the critical health concerns for maternal and child health in Nigeria is the high rates of child and maternal mortality (WHO, 2019). Child mortality is divided into five different categories, namely, neonatal mortality (dying in the first month of life), postneonatal mortality (child's death between the first and twelfth month of life), infant mortality (child's death between birth and first birthday), child mortality (child dying between the first and fifth year of life), and under-five mortality (child dying between birth and the fifth year of life) (NDHS, 2018). Child mortality is reported to be high in Nigeria, with 271,000 newborn deaths reported in the year 2020 (WHO, 2022). This figure suggests that Nigeria ranks second among the top ten countries with the highest number of newborn deaths in the year 2020 (WHO, 2022).

Also, among the top ten countries with the highest number of deaths for children under five years, Nigeria ranks first with 844, 000 deaths in 2019 (WHO, 2022). With these being the most recent statistics released on child mortality (under five years) by WHO, mortality issues are still of the utmost concern to stakeholders in Nigeria. In addition, “there has been no noticeable change in the neonatal mortality rate” since 2013 (NDHS, 2018, p.163). This is not only a major concern for Nigeria but also for sub-Saharan Africa. Reasons for neonatal deaths generated from the WHO report include lack of quality care in the first days of life, preterm birth, infections, and birth defects (WHO, 2022). Pneumonia and malaria are listed as the death causes for children under five, while “nutrition-related factors” are highlighted as responsible for “about 45% of deaths” in this group (WHO, 2022). Hence, the Sustainable Development Goals (UN-SDG)-Goal 3

project mandates that neonatal mortality should have been reduced to twelve and under five mortality reduced to 25 per 1000 live births by the year 2030 (United Nations, 2015).

These statistics, provided by health institutions and organizations, provide data for research support purposes. It is worth looking into the literature for in-depth analysis and understanding of the underlying causes of maternal and child mortality in Nigeria.

Therefore, the following section explains the setting of this study, Nigeria, factors responsible for the inaccessibility of healthcare among mothers, and factors contributing to the high rates of maternal and child mortality in Nigeria.

Nigeria

Nigeria has over 200 million people and is the most populous and biggest country in West Africa (Kirk-Greene, 2020). Nigeria has about 250 diverse ethnic groups with hundreds of languages. While the official language is English, the main languages spoken include Yoruba, Igbo, and Hausa, representing the three major groups. Before the 20th century and before the British colonization of Nigeria, traditional religions were in operation. These traditional religions were discouraged by British policies, and now many people associate with either the Islamic or Christian religion (Kirk-Greene, 2020). However, traditional religion is still in place and practiced in some towns, cities, and villages. About half of the population of Nigerians live in rural areas, and these are the areas where researchers have noted the increase in cultural and traditional practices (Amodu et al., 2017; Mohammed et al., 2020; Odetola & Salmanu, 2021). The rural areas have also been noted as regions for high child mortality rates (Akpabio et al., 2020). Overall, Nigeria is regarded as a developing country.

Nigeria, as a populous country with different multiethnic groups, has variable data on factors responsible for maternal and child mortality. There are differences in the studies conducted in the country's different regions, especially in the Southwest, Southeast, and Northern parts of the country. For example, the under-5 mortality rate is highest in the Northern parts (187 deaths per 1,000 live births) and lowest in the Southwest (62 deaths per 1,000 live births)" (NHDS, 2018, p.164). Globally, child mortality rates are declining; achieving fewer cases of child mortality in Nigeria has, however, been at a slow pace (Fasina et al., 2020). This slow pace does not mean that stakeholders are not making efforts to ensure the well-being of mothers and children; it suggests that the efforts have not been able to meet the requirements of millennium development goals of reducing child mortality (Ezeh et al., 2015).

One crucial factor highlighted by WHO as responsible for the high mortality rates in sub-Saharan Africa is that women and children do not often get the care they need (WHO, 2022). Hence, this review starts with the factors preventing mothers and pregnant women from accessing health care in Nigeria.

Factors Responsible for the Inaccessibility and Underutilization of Healthcare Facilities among Mothers and Pregnant Women in Nigeria

Findings from several studies highlight the following factors as responsible for accessing or underutilizing health care services by mothers in Nigeria. These factors include the age and occupation of a mother, mother's level of education, income, places of residence, husband's occupation, education, and income (Adewuyi et al., 2018; Adewusi & Nwokocah, 2018; Agunwa et al., 2017; Fasina et al., 2020). These findings stress demographic and socio-economic factors as significant elements that prevent pregnant women or mothers from getting healthcare. Furthermore, in some cases, parents

do not seek childcare advice and expertise from trained healthcare workers (Dougherty et al., 2020). Citing instances from two states in Nigeria, Dougherty et al. (2020) found that cultural beliefs, gender, and socio-cultural norms play major roles among parents who do not seek childcare advice from health workers. For example, the authors note that the mothers in their study are usually responsible for physical care while the fathers are responsible for decision-making and financial care. This means that a father may disapprove of a mother seeking health care for personal reasons or traditional beliefs (Dougherty et al., 2020), which can impact not only her health but the health of the child.

While evaluating a free maternal and child health program in Nigeria, the National Health Insurance Scheme (NHIS), Onwujekwe et al. (2019) report that the program could only be utilized by 12 out of the 36 states. This undoubtedly excluded some states and villages with a high profile of maternal or child mortality (Onwujekwe et al., 2019). This suggests that pregnant women and mothers, excluded from targeted maternal and child health programs, may have problems accessing reduced-cost health care services. Another factor preventing pregnant women from accessing healthcare services is a lack of information. For instance, pregnant women in rural areas who do not listen to the radio were found to lack information on prenatal care, while women who do not read newspapers in urban areas also lacked information on prenatal care (Adewuyi et al., 2018). In addition to lack of information, Fagbamigbe and Idemudia (2015) identified three main barriers to utilizing prenatal care: the long-distance to health care facilities, lack of funds, and means of transportation. These reasons were further validated in the 2018 NDHS report, which stated there were delays in accessing care in cases where pregnancy complications occur in rural areas. This is because “major health facilities are

far away from communities and roads are bad” (NDHS, 2018, p. 180). These reasons help us to understand, beyond data figures, why there is low utilization of healthcare by mothers and pregnant women.

Further revelations from the literature reveal that the communication pattern between patients and doctors stands a chance of inhibiting access to care (Adebayo, 2020). The author disclosed that participants regularly experience a lack of interpersonal relationships and empathy between them and their doctors. Further, it was gathered that the doctors hold back full details of patients’ health information, leaving patients without fully understanding their health situation (Adebayo, 2020). Similarly, verbal dominance was evident in the way doctors interacted with their patients. Examples of such verbal dominance include doctors assuming the position of superiority and reacting negatively to patients who ask many questions about their health (Adebayo, 2020). Consequently, this culture of power extends to midwives’ communication with pregnant women. Other studies have established that some pregnant women experience verbal abuse and mistreatment from midwives (Bohren et al., 2015; Farouk et al., 2021). For example, Okedo-Alex et al. (2021) report that participants in their study experienced maltreatment, through verbal abuse and a lack of good communication, during labor.

Though these power dynamics may not prevent patients from going to hospitals for care, the conditions do not encourage favorable outcomes for medical encounters and the overall goals of accessing healthcare. In traditional health communication research, the issue of power dynamics between patients and doctors has long been established. For instance, Ellingson and Buzzanell (1999) observe in their study that patients often have to negotiate satisfaction during healthcare interaction because of the power dynamics that

underlie patients' and doctors' communication. As a result, it is suggested that doctors would benefit from patients' contextualization of meaning making instead of being perceived as communication experts who easily translate their expertise to patients in a simplified manner (Nimmon & Regehr, 2018). Also, Abubakar et al. (2018) note that socio-economic conditions in Nigeria may induce the negative attitudes of health professionals; however, it also impacts the quality of health care received in hospitals.

These findings further highlight that power dynamics between patients and doctors is a global concern in health communication research. Overall, the factors that prevent mothers and children from accessing healthcare suggest profound health implications. The following section further reviews the factors contributing to maternal and child mortality in Nigeria.

Structural Factors Contributing to the High Rates of Child and Maternal Mortality in Nigeria

Structural problems such as poverty are significant factors when considering the root causes of Nigeria's maternal and child mortality rates (Owoaje et al., 2014). This is because poverty prevents mothers from making on-time decisions about their children's health (Owoaje et al., 2014). This finding is also supported by Fasina et al. (2020) who reported that more than half of the mothers in a nationwide survey were in the poor category. According to Gordon (2008), being poor means lacking the ability to live a good life and being faced with serious economic problems, malnutrition, poor education, and housing. Furthermore, being poor also means the inability to afford primary healthcare (Gordon, 2008). These disadvantaged circumstances where there is a lack of safe water and healthcare services result in ill-health for many populations (Aluko-Arowolo, 2021; McLeod & Bywaters, 2008). Consequently, children born into poor

households are reported to have higher risks of mortality than children whose parents have stable sources of income (Ezeh et al., 2015; Fasina et al., 2020; Olawuwo et al., 2018).

For example, the latest annual report by the United Nations Development Program (UNDP) for 2016 notes that with over 170 million people, “about 62% of Nigerians live below the [old] international poverty line (PPP \$1.25 per day)” (UNDP, 2018, p. 6). Also, there is a high record of unemployment, low levels of livelihood, and low access to resources. For instance, only 40% of the population has access to electricity, and many households spend more than they earn. In addition, there are myriads of internal crises such as military insurgency, communal clashes, and threats to security that prevent the attainment of development goals meant to improve the wellbeing of the citizens in general (UNDP, 2018). Hence, poverty is reported to be a strong determinant of a child’s survival in Nigeria because of many households with low socio-economic status (Adekanmbi et al., 2016; Aluko-Arowolo & Ademiluyi, 2015).

The affordability, accessibility, and quality of services provided at Nigerian healthcare facilities also contribute to maternal and child mortality (Akokuwebe & Okafor, 2016; Ntoimo et al., 2022). In a study carried out in the northern parts of Nigeria, where maternal mortality is on the high side, the authors report that pregnant women do not utilize obstetric services because of a lack of equipment and training needed to provide such care (Abegunde et al., 2014). For instance, “only 3 of the 20 hospitals were fully functioning CEmOC (comprehensive emergency obstetric care) facilities...none of the three senatorial zones met the minimum acceptable level of one CEmOC facility per 500 000 population” (Abegunde et al., 2014, p.2). This further explains the state of health

care in the rural areas where almost half of the Nigerian population resides. Even in urban areas like Lagos state, one of the most popular cities in Nigeria and Africa, Matsuoka et al. (2020) report that there are limited facilities and health professionals compared to the number of patients. Participants in their study also perceive the services received as poor and mostly highlight the unfriendly atmosphere (Matsuoka et al., 2020). Consequently, with the poor state of many healthcare facilities in Nigeria, pregnant mothers mostly in the rural areas, perceive giving birth at healthcare facilities as unnecessary (Olonade et al., 2019; Yaya et al., 2018).

Aside from the poor conditions at healthcare facilities, there is also low awareness and utilization of prenatal care and deliveries at health centers (Fagbamigbe & Idemudia, 2015). Previous research has found that pregnant women in the northern parts of Nigeria use prenatal care at a very low rate (Adewuyi et al., 2018; Ajayi & Osakinle, 2013; Babalola, 2014). According to the NDHS (2018), pregnant women are often affected by the following factors when utilizing prenatal care: delay in seeking medical help, delay in seeking the right health care provider, and delay in receiving the needed care. In addition, under-five mortality was also reported to be high among mothers who had seven or more children and among children whose birth intervals were less than two years (NHDS, 2018). This suggests that a lack of knowledge about prenatal care prevents mothers from taking action to access health care.

Child malnutrition is another factor WHO highlights as the primary cause of death for children under five in Nigeria (WHO, 2022). Undernutrition results from a number of factors, such as living in low- and middle-income countries, socio-economic conditions of the family, inadequate spacing of children or having more than four children, and

mother's occupation (Akombi et al., 2019; Owoaje et al., 2014). How newborns are taken care of, especially in the first few weeks of life, also has a bearing on neonates' survival in Nigeria. More so, the care a child receives during the first five years of life is significant in reducing illnesses and mortality. This suggests how important it is for mothers to have the needed resources to care for their newborns. For instance, Mosuse and Gadeyne (2021) note that, aside from underlying factors, children of less empowered women are reported to have higher tendencies to be victims of child mortality. Thus, increasing the survival rates of children in Nigeria is significantly linked to women's empowerment. Women's empowerment here means providing women equal rights to education, employment, household decision-making, politics, and incorporating fathers into maternity clinics (Ahuru, 2021; Mosuse & Gadeyne, 2021). In other words, a mother with autonomy and agency will be able to make the right decisions that will enhance the health of her child rather than be constrained by societal and structural factors.

The contributing factors to maternal and child mortality found in the reviewed studies above did not, however, explain the influence of cultural and traditional beliefs. Since this study focuses on how cultural and traditional practices influence mothering and child-rearing, it is essential to explain what previous studies have found concerning cultural and traditional practices and maternal and child mortality in Nigeria.

Cultural and Traditional Practices influencing Maternal and Child Health

In developing countries where mortality rates are on the high side, several studies (Akpabio et al., 2020; Ariyo et al., 2017; Kyomuhendo, 2003; Omer et al., 2021; Shole, 2017) have established the influence of cultural factors on maternal and child health. For instance, Evans (2013), who reviewed 16 articles focusing on culture and maternal

mortality in developing countries noted that one of the most cited cultural practices is normalizing postpartum hemorrhage (PPH). This is associated with a cultural belief in low- and middle-income countries that bleeding after birth is necessary for womb cleansing. This is not a general belief in Nigeria, but PPH is common among pregnant women in northern Nigeria who prefer to deliver at home based on a cultural belief that it is a thing of pride to deliver at home rather than the hospital (Abubakar et al., 2018). More so, some women who delivered in the hospital were reported to have feelings of embarrassment (Abubakar et al., 2018).

In Nigeria, as is found in many other low-income countries, non-medical factors contribute to maternal and child mortality (Odekunle, 2016). One such cultural belief is that vaginal births are proof of women's strength rather than going through a cesarean operation (CS) (Awoyinka et al., 2006; Aziken et al., 2005). In other words, achieving vaginal delivery is a cultural tradition associated with strength and success, while CS delivery is sometimes perceived as not being "woman enough" (Matsuoka et al., 2020, p. 187). Hence, there is a stigma associated with women who go through CS, and sometimes women delay going to the hospital because of the belief that they may be asked to go through CS (Orji et al., 2001; Ikeako et al., 2006). There is nothing harmful in desiring a vaginal birth over CS. However, holding on to a cultural belief that only weak women have CS may negatively impact a woman's choice to refuse CS when that is the medical option to prevent dangerous health outcomes.

Religious beliefs are often another factor that may prevent mothers from getting care from health facilities. For instance, religious beliefs may influence the resistance to CS, and support the preference for TBAs, and female circumcision (Akapabio et al.,

2020). Culturally, Nigerians are religious people, and religious beliefs are significant factors in childbirth. For example, the necessity to protect both mothers and children from satanic attacks during delivery prompt some mothers' choices to utilize faith-based health services or maternity homes (Matsuoka et al., 2020; Mboho, et al., 2013). Furthermore, some cultures in Nigeria believe that supernatural powers are needed for a woman to carry her baby to term (Mboho et al., 2013). This is because witchcraft and other mystical forces are viewed as responsible for disease or illness rather than environmental factors (Aluko-Arowolo & Ademiluyi, 2015; Chiwuzie & Okolocha, 2001). Consequently, it is not uncommon for pregnant women to seek spiritual support from churches, mosques, or traditional healers.

Other cultural practices engaged in by women in the northern parts of Nigeria are reported to encourage obstetric fistula (a childbirth complication resulting from prolonged obstructed labor) (Amodu et al., 2017; Ijaiya et al., 2010). These cultural practices include early marriage and childbirth, which puts both mother and child at risk, especially when not utilizing skilled birth attendants. Also, traditional birth methods, including assisted deliveries by relatives, were highlighted among other factors (Amodu et al., 2017; Mohammed et al., 2020). The preference for home deliveries with TBAs or relatives was further investigated by Odetola and Salmanu (2021) who observed that places of delivery are chosen by many of the participants' husbands. Also, a little more than half of the mothers in their study believe that stronger women deliver at home as opposed to delivering in the health facilities. Though the participants acknowledge attending prenatal care, their traditional beliefs influence their choice of home delivery without skilled birth attendants (Odetola & Salmanu (2021). The implication this has on

child health is that maternal and child infections may result from poorly managed home births (Jimoh et al., 2018), and healthcare may not be sought on time.

Furthermore, there are also some cultural beliefs associated with initiating breastmilk in some communities. One common belief is that the initial milk, colostrum, is dirty and unhealthy for babies (Joseph & Earland, 2019). There are also beliefs that some religious obligations have to be fulfilled or have the breast washed before initiating breastfeeding (Shobo et al., 2020). In spite of these beliefs, WHO and UNICEF recommend initiating breastfeeding within the first hour of birth for greater chances of a child's survival (Selim, 2018). Some traditional beliefs also prevent women from eating certain foods such as eggs and snails during pregnancy (Olonande et al., 2019). In other communities, taking milk and snail is believed to make the baby salivate more than usual or make the baby dull (Chiwuzie & Okolocha, 2001). Though this is not applicable to all cultures in Nigeria, avoiding these nutritious foods indicates underlying causes of anemia or iron deficiency necessary for the well-being of a child and mother during pregnancy (Olonande et al., 2019; Elem & Nyeche, 2016).

Lastly, to round off this section, it is also pertinent to look at the myths surrounding one of the childcare practices in Nigeria that also directly impacts children's health, teething. Teething is the initial growth of a child's primary or milk teeth, which usually begins between the fourth and tenth months of life (Ige & Popoola, 2013). Teething for a child is taken seriously in Nigeria, and there are many beliefs surrounding the teething process shared by both mothers and some midwives. For example, it is believed that it is normal for a child to have diarrhea, fever, boils, and be unable to eat well when teething (Bankole et al., 2003; Bankole & Lawal, 2017; Olatunya et al., 2020).

While pediatricians do not validate the belief that these symptoms are due to teething (Olatunya et al., 2020), it was reported that traditional methods of drinking herbal concoctions, bathing with traditional soaps, or using teething powders were judged as good remedies by mothers (Bankole & Lawal, 2017). Though it is common for adults to drink herbal concoctions made from plants, how the ingredients impact a child is unknown. Consequently, teething symptoms are tagged as myths by dentists and pediatricians and described as underlying conditions of poor hygiene. However, many mothers believe that teething usually starts with fever and diarrhea symptoms (Olatunya et al., 2020; Ige & Popoola, 2013). The utilization of self-directed treatments, traditional herbs, and delay in presenting the child to a health care facility for prompt diagnosis are influential causes of serious ailments (Adimorah, et al., 2011; Sood & Sood, 2010) that may or may not cause child mortality.

These reviewed studies have not established the direct causality of cultural and traditional practices on maternal and child mortality. However, they have established that these beliefs, in one way or the other negatively impact maternal and child health. This next section explains what has been achieved in the reproductive health care sector in managing maternal and child mortality.

Efforts to Reduce Maternal and Child Mortality in Nigeria

The Nigerian health sector is operated by the government and by private enterprises. Government-owned hospitals are further sectionalized into local, state, and federal government-owned hospitals. The government-owned hospitals are subsidized while people pay out of pocket or through health insurance to access care at private hospitals. The Nigerian government is engaged in various programs to improve maternal

and child health (Fasina et al., 2020). These intervention programs include “Integrated Maternal, Newborn, and Child Health Strategy 2007, National Child Health Policy, Primary Health Care under One Roof” (Fasina et al., 2020, p.3), and many others discussed in the later parts of this section. The initiation of these programs indicates the government’s efforts to reduce maternal and child mortality rates.

However, the Nigerian health sector is characterized by limited health resources (Agunwa et al., 2017); inadequate life-saving services and financial resources (Abubakar et al., 2018; Onwujekwe et al., 2019); inadequate human resources (WHO, 2020), poorly rated health facilities, (Fashina et al. 2020), long wait times before seeing doctors at hospitals; (Adamu & Oche, 2014); lack of favorable working conditions and insufficient remuneration of health workers (Duvivier et al., 2017), and health workers’ incessant industrial strike action (Abubakar et al., 2018). Despite these shortcomings, there has been substantial attention placed on reducing maternal and child mortality rates.

For example, in 2006, a free maternal and child health program was introduced in the health facilities managed by the government (Onwujekwe et al., 2019). This was to increase the utilization and access of skilled birth attendants instead of traditional birth attendants. Unfortunately, the program only lasted for six years and was ended in 2015 because of a lack of funds for its sustainability (Onwujekwe et al., 2019). Also, between 2012 and 2014, the federal government embarked on a program known as the Subsidy Reinvestment Program/Maternal and Child Health Program (SURE-P/MCH) in different primary health facilities across the country (Findley et al., 2016). The program aimed to train birth attendants to facilitate interactions between pregnant women and health

workers (Findley et al., 2016). It was also to increase the number of health workers in rural areas and provide pregnant women with needed resources (Dias et al., 2016).

This program included a conditional cash transfer program (CCT), where pregnant women who registered for prenatal care, continued with regular check-ups, had their babies delivered at a health center, and had their babies receive the first set of immunizations were rewarded with up to five thousand naira (\$30) (Dias, et al., 2016). In assessing the effectiveness of this program, Oduenyi et al. (2019) note that some challenges were recorded with SURE-P MCH and the CCT such as issues with the participants' names from the payroll register and long waiting hours when receiving payments. Oduenyi et al.'s study did not report on the effectiveness of the maternal care program, but it did highlight that the CCT increased women's utilization of health care facilities during pregnancy.

Another recent study investigating the effectiveness of SURE-P/MCH reported that the utilization of village health workers (VHW) played a significant role in encouraging pregnant women to seek health care services (Mbachu et al., 2022). In this case, skilled health workers trained the community health workers to reach a larger number of women to register for prenatal care. Also, the VHW made regular home visits to check on mothers and advise them on healthy foods for themselves and their newborns. With cases the VHW could not handle, they referred mothers to health workers for proper management (Findley et al., 2016). The program, however, ended in 2015, but it was reported to have improved health-seeking behavior among pregnant mothers (Onwujekwe et al., 2020).

Additionally, in 2014, the Nigerian Federal Ministry of Health, partnered with two organizations, namely, the United States Agency for International Development and GE Healthcare. The partnership's goal was to reduce maternal and child deaths in Nigeria (GE Africa, 2014). The partnership, tagged the "Healthymagination Mother & Child Initiative," sought to provide funds and expertise to help improve healthcare facilities for mothers and children (GE Africa, 2014). In 2019, another initiative introduced towards improving maternal and child health was the Maternal and Perinatal Database for Quality, Equity, and Dignity (MPD-4-QED) program in Nigeria (MPD-4-QED, 2021). The program gathers data on maternal and perinatal from health facilities in Nigeria (MPD-4-QED, 2021). Before this program, it was difficult to access maternal and child data because most of these data were documented with paper records rather than stored with the aid of technology (WHO, 2016). Besides, some maternal and child mortality cases occurring outside hospitals were not documented. As a result, using the MPD-4-QED program reportedly ensures data on the maternal and perinatal death surveillance can be electronically documented. The goal of the program is to improve the quality of care received by pregnant women and their newborns (MPD-4-QED, 2021).

Despite the interventions mentioned above, desired outcomes have not been achieved (Adewuyi et al., 2016). This is because of ongoing challenges that stand as barriers. Challenges such as increasing rates of population, insurgency, and the inability to attain social progress hinder the improvement of the lives of citizens (Amoo, 2018). Overall, the literature review reveals that Nigerian health institutions have focused on providing more health facilities and trained personnel to reduce the rates of maternal and child mortality. The research shows that while the provision of health facilities and

skilled personnel is in the right direction to fight mortality, the influence of cultural beliefs indicates varying levels of awareness among mothers who are significant actors in the ongoing conversation. Focusing on health literacy regarding cultural beliefs will serve as valuable guides for policymakers and skilled birth attendants in providing helpful information and recognizing when urgent care is required (Evans, 2013).

Hence, as part of ongoing efforts to improve maternal and child health in Nigeria, this present study seeks to understand how the main participants, mothers, give voice to the discourses on maternal and child-rearing in Nigeria from the perspective of cultural and traditional beliefs.

CHAPTER THREE THEORY AND METHODOLOGY

Relational Dialectics Theory (RDT): An Overview

According to Baxter and Braithwaite (2010), relational dialectics theory (RDT) is an evolving theory that focuses on meaning-making through discourse. RDT defines discourse as a “cultural system of meaning that circulates among a group’s members and which makes our talk sensical” (Baxter & Braithwaite, 2008, p.349). In other words, meaning is contextualized in RDT such that multiple systems of meaning can be generated within a group based on a shared understanding of local meanings (Baxter & Braithwaite, 2008). RDT was first propounded in 1996 by Baxter and Montgomery, building upon a language and culture-based concept, dialogism, by Mikhail Bakhtin in 1981 (Baxter & Braithwaite, 2010). Hence, many of its features are borrowed from dialogism and applied to what it means for communication inquiry (Littlejohn et al., 2017).

RDT is located in the interpretive and critical paradigms of communication theory (Baxter & Braithwaite, 2008). As an interpretive theory, it explains the concept of meaning and culture and describes opposing discourses as struggles rather than contradictions (Baxter & Braithwaite, 2010; Littlejohn et al., 2017). Furthermore, as a critical theory, it assigns unequal weights to discourses whereby some discourses are identified to be more dominant than others (Baxter et al., 2021). The following are the core tenets of RDT.

Features of RDT

RDT posits that “meanings are connotatively located in meaning systems or discourse” (Baxter et al., 2021, p.9). This means there are embedded “claims and themes” located in a given discourse (Baxter et al., 2021). Hence, the question in a body of discourse would be what are the themes generated by this corpus of discourses? This identification and the recurrence of patterns are how researchers identify connotative meanings in discourses (Baxter et al., 2021).

The second tenet posits that “meaning-making emerges in the interplay of competing discourses” (Baxter et al., 2021, p.9). This means that meanings can also be generated from opposing discourses and, in the process, identify different kinds of discourses (Baxter & Braithwaite, 2008). The discourses present oppositions that explain the dialectical process of the theory. Additionally, these competing discourses “reproduce, challenge, and/or create meaning(s)” (Suter et al., 2017, p. 295). In other words, meanings from a body of discourse can emerge from resistance or reaffirmation (Baxter et al., 2021).

In the third feature of RDT, “textual segments—utterances—must be understood as utterance chains rather than isolated turns-at-talk or stand-alone digital entries on social media platforms” (Baxter et al., 2021, p. 10). What this feature suggests is that single utterances are not analyzed in RDT. Rather, a body of discourses (“utterance chain”) is treated as a narrative, having a chronological order to make sense of the meanings enacted (Baxter et al., 2021). More importantly, the cultural standpoint of participants engaged in a body of discourses is pertinent to the meaning-making process.

Lastly, RDT believes that “discourses are rarely on equal footing” (Baxter et al., 2021, p. 11). In other words, the past meanings of a body of discourse are needed to understand the present and future meanings. The unequal footing of discourses is understood in two ways: centripetal and centrifugal discourses (Baxter et al., 2021). Centripetal discourses are dominant and centered discourses from which other meanings can be drawn. These other meanings, labeled as alternatives, are the marginalized discourses called centrifugal. Both discourses are dependent on each other because there is a continued interplay, as one would have in a dialogue (Baxter et al., 2021). RDT has continued to be utilized in communication research, and it is found to be most applied in family communication. However, it is being extended into other areas of inquiry, such as health communication (O’Hara, 2017), and student and teacher relationships (Rudick & Golsan, 2014), among others. In the following paragraphs, I explain the application of RDT in communication research.

RDT’s Application in Communication Research

As noted above, RDT has been utilized to examine discourses mostly in family communication settings such as family relationships, child adoption, gender communication (Baxter et al., 2015; Scharp et al., 2021; Suter et al., 2018). In studies, closely related to the present study, RDT has also been utilized to understand discourses articulated by women, such as discourses about motherhood, birth versus adoption mothers, and online or social media discourses. Thus, this section briefly summarizes key findings from mothering related studies. In motherhood research, RDT researchers focus on identifying dominant discourses of motherhood, as well as tensions, and hegemonic discourses (Cronin-Fischer & Parcell, 2019; Scharp & Thomas, 2017). Informed by RDT,

Cronin-Fischer and Parcell (2019) examined the dissatisfaction of women in their transition to motherhood and found that discourses of “motherhood as deeply desired” and “motherhood as learned” were dominant in their analysis (p.154).

A more recent analysis exploring dominant and marginalized discourses present in maternal care practices revealed discourses focused on racial discrimination of African American women while assessing health care (Adebayo, 2020). Also, a RDT analysis of voluntarily childfree women’s discourses on Reddit revealed that discourses of reproduction are shaped by culture, ideology, and systems of power (Hintz & Brown, 2020). In another study, Scharp and Thomas (2017) found that, against the cultural expectations of ideal mothers, participants who had prenatal and postpartum depression validate that not all mothers immediately connect with their children. Holistically, RDT in the context of motherhood discourses has focused on women as knowledge creators and has revealed different meanings in the narratives produced by women. Hence, RDT “is understood as an excellent framework for interrogating mothering discourses” (Faulkner & Nicole, 2016, p.81). That said, contesting or embracing cultural practices of mothering and child-rearing has not been accounted for under RDT and it is anticipated that this gap will be fulfilled in this study.

RDT and the Present Study

The present study is driven by RDT, especially because it has been useful in analyzing discourses in motherhood research (Baxter et al., 2015). Based on RDT, the social world is seen as a place where meanings are constructed or challenged through communicative practices (Baxter, 2011) and discourses are understood with the context of cultural norms and ideologies (Baxter, 2011; Hintz & Brown, 2019). This position

aligns with the aim of this study in examining how women embrace, reproduce, or challenge the influence of cultural and traditional beliefs on mothering and child-rearing. The central question that RDT asks in a body of utterances is the meaning of a particular semantic object of interest and how one meaning rather than other meanings emerged in the communicative context (Baxter, 2011). Building on the tenets of RDT, this study examined the various meanings found in the discourses of mothers in the ATP Facebook group. By focusing on the patterns that reoccur as suggested by RDT, as well as the dialectical tensions that become evident, the study generated themes from the body of discourses found in the group and explained their meanings within the context of Nigerian cultural norms and ideologies.

As discussed in the following section on methodology, discourses appearing on the ATP Facebook group were analyzed not only for what the discourse says but also on the underlying meanings of maternal and child-rearing influenced by cultural and traditional practices. Further, from the perspectives of Nigerian women on the ATP Facebook group and from the standpoint of RDT, this study also examined the dialectical tensions evident in how women respond to the discourses of mothering and child-rearing amid cultural and traditional practices. Informed by RDT, this study asked the following research questions (RQ):

RQ1: What do the patterns of women's discussions reveal about cultural and traditional beliefs permeating discourses of mothering and child-rearing?

RQ2: What are the communicative responses of women to cultural and traditional beliefs permeating discourses of mothering and child-rearing?

Methodology

This study examines mothers' discourses on mothering and child-rearing on the Facebook group *Ask the Pediatricians*. I specifically focused on understanding the patterns of women's discourse that revealed cultural and traditional beliefs on mothering and child-rearing in Nigeria. I also focused on the communicative responses of women to cultural and traditional beliefs influencing the discourses. Regardless of the various methods for analyzing discourses, the use of language is at the heart of any inquiry focusing on texts or discourses (Berger, 2017). Given the goals of this study, I utilized textual analysis as my methodology. According to McKee (2003), "textual analysis is a way for researchers to gather information about how other human beings make sense of the world" (p.1). It allows us to explain how we use language to make sense of our lives and provides a means for understanding how Nigerian mothers navigate their children's health. Textual analysis is about what language represents, especially in explaining meanings derived from our social realities (Brennen, 2017).

One of the distinguishing features of textual analysis that helps explain the objectives of this study is that it examines a given text holistically (Brennen, 2017). In other words, textual analysis does not only reveal what is simply stated, it also looks at social practices, representations, or assumptions that the text reveals (Brennen, 2017). Furthermore, researchers focus on the contexts in which the texts are situated, especially by considering the historical or cultural relationships of a text in the places where it is found (Brennen, 2017). Hence, to identify what the patterns of mothers' discussions reveal about their cultural and traditional beliefs, I analyzed words, and phrases in the posts and comments posted by members of the ATP Facebook group. Discussions of

cultural and traditional beliefs about mothering practices versus mothers' lived experience(s) were given special attention. Emergent patterns and themes were then analyzed with implications for RDT and previous studies.

Data

The data used for the study are public postings by mothers and administrators on the *Ask the Pediatrician* (ATP) Facebook group (<https://www.facebook.com/groups/askthepaed/about/>). ATP is an online parenting Facebook forum with over 700,000 members (ATP, 2022). ATP is a combination of mothers, pediatricians, and other children's health care professionals as members. The group focuses on educating mothers on mothering and child health-related issues. The goal of the administrators who manage the page is to provide health education and information to mothers, fathers, and everyone involved in caring for children. The group also aims to improve child survival in Nigeria through child health literacy (ATP, 2022).

Ethical Considerations and Procedure

Permission to observe discussions and the consent to extract data from the ATP group was sought from the administrator of the group, Dr. Gbemisola Boyede, prior to the start of this study. The permission was sought by fully explaining the purpose of the research and by sending Dr. Boyede a copy of the research proposal. This step was necessary because the group is a private discussion group, and I had to gain access to the group to gather the statements. In an email dated January 11, 2022, Dr. Boyede granted permission to use discussions on the Facebook group by stating that:

I grant you permission for your research. You should send the copy of the final outcome to the group when (completed). Kindly do not extract personal

identifiable information of any member of the group in your research. This permission should be acknowledged in the final report. Kind regards, Dr.

Gbemisola Boyede

Consultant Paediatrician/Founder Ask The Paediatricians Foundation Email:

drgbemisola@askthepaediatricians.com

Hence, while extracting data from the ATP Facebook group, personal information such as names of discussants, names of children mentioned in posts, home locations, pictures, and any other personal information identifying any member of the group were not used in any way. Also, no member of the group was contacted directly for any information; the data focused solely on the discourses found in the group only. The name of the group appears throughout the paper, while the name of the founder of the group appears in the methodology, findings and discussion sections. Finally, the findings of the study will be shared with Dr. Boyede after the study is completed. In this study, I also declare that there are no conflicts of interest and there are no benefits tied to this research other than its academic relevance to contributing to scholarly research.

Data Collection

As of March 2022, the ATP Facebook group, created in July 2015, had 240 categorized group discussion-topics. Topics range from mothering-related (various child health issues, childhood immunizations, general childcare, child deaths, child nutrition, breastfeeding, pregnancy, child abuse) to general discussions (ATP family, ATP appreciation post, ATP emergencies, infections). The topic with the highest number of posts was complementary feeding, with 8,500 posts, while topics on sippy cups, health stems, blood groups, and maternity leave had only one post each. Identifying posts that

focused on mothering and child-rearing practices by categorized discussion topics was not fruitful given the large number of posts under each topic. Hence, this study utilized the purposive sampling method by using the keywords “mother” “mother-in-law” “child” “breastfeeding” “teething” “chubby,” and the hashtags #dangerouschildcarepractices and #mythsfactsinchildren to generate posts from the ATP Facebook group.

The key words, “mother and child” were chosen because they are central to this study, while “breastfeeding” “teething” “chubby” “mother-in-law” were chosen because the categorized posts that I initially studied on the group page frequently referred to them. Lastly, the hashtags #dangerouschildcarepractices and #mythsfactsinchildren were also chosen because the administrators frequently added them to the posts which I found from the keywords generated search. Therefore, a click on these two hashtags goes straight to curated posts under the topics. The posts included in the final sample featured questions by mothers and answers by pediatricians. It also featured posts made by pediatricians and comments by mothers. I analyzed both the posts and comments until saturation was reached and no new themes emerged.

Textual Analysis

The textual analysis followed the guidelines by Miles and Huberman (1994). The approach consists of four processes, namely: “data reduction, data display, conclusion drawing, and verification” (p.10 & 11). The first two stages involve organizing the data into an inductively developed coding category system and further sorting. The third stage involves drawing a conclusion using the comparative technique, which was first developed by Glaser and Strauss (1967) and later refined by Guba (1985) (Wimmer & Dominick, 2011). The steps include comparative assignment of incidents to categories;

elaboration and refinement of categories; searching for relationships and themes among categories (Wimmer & Dominick, 2011). The last stage of analysis deals with the credibility of the findings of this study. Using Creswell's (2007) method, the themes and subthemes were critiqued by my thesis committee advisor to ensure that the interpretations fits well with the analysis. The procedure for analyzing the data is discussed next.

Procedure

In the first two stages of analysis, data reduction and sorting, I familiarized myself with the ATP Facebook group posts. This is a way that a researcher immerses themselves in the data to understand what the data says (Baxter, 2011). I did this by going on the ATP Facebook page by reading and studying the topics that had been categorized for discussion. I opened each topic of interest to understand the focus of the discussions. This helped to see that I could not analyze the discourses based on the categorized topics because the number of posts were voluminous. It also informed my choice of using the specified keywords and hashtags to generate the posts to be analyzed. The discourses and the posts generated from the key word search and from the hashtags formed the data set for the study. In the final sample, there were 200 posts and 2,967 comments (cmts) as indicated below.

Keywords	Generated posts	Analyzed posts
Mother	84	29 posts, 125 cmts
Mother-in-law	95	22 posts, 7 cmts
Child	90	9 posts, 541 cmts
Breastfeeding/chubby	71/92	58 posts, 371 cmts

Teething	93	28 posts, 82 cmts
#dangerouschildcarepractices	258	21 posts, 386 cmts
#mythsfactsinchildren	914	33 posts, 710 cmts

After compiling the final the data set, I began reading the posts one after the other. While reading each of the posts, I took notes, explicitly paying close attention to the words and phrases mothers use to craft their posts and comments, the specific contexts they referred to, and whether the words suggested an influence of cultural or traditional practices. It should be noted that while some posts were a paragraph long, there were many comments that were no longer than a sentence or just three words. In the analysis, I allowed themes to emerge from the study, which was done by further immersing myself in the posts and paying close attention to recurring patterns (Pauly, 1991). The guiding questions used for categorizing were to look at the post and ask: “what is this about?” What is going on in this discourse? What concepts are used by participants to describe their situation (Lindlof & Taylor, 2017, p. 316)? This helped me to label the different segments of the discourse as the reading and studying continued and enabled me to generate categories.

Next, similar categories were matched to generate overall themes from the analysis (Braun & Clarke, 2006). I achieved this by looking at the supporting examples from the identified categories and combined similar categories and examples to establish a theme. For example, I merged the initial categories “patriarchy/no agency” with “vulnerable mothers” to later form the theme, *vulnerable and worried mothers*. I also merged the categories “the they” (initial category from many mothers’ posts saying, “they told me to do this or that.” I realized later that ‘they’ were mothers-in-law or mothering

figures in their neighborhoods) with “unsolicited mothering figures/ bullying mother figures to generate the theme *mothers and mothers-in-law serving as child health experts* because they had similar examples. The final stage, which is the conclusion drawing, I compared the results to find similarities and differences and to pave the way for refinement. In the refinement stage, the underlying meanings of the themes were documented, leading to the findings of the analysis. Thereafter, the themes across the mothers’ discourses were presented and explained to answer the research questions. The findings of this analysis are presented and explained in the following chapter.

CHAPTER FOUR FINDINGS

This thesis investigates how some Nigerian women navigate the myths and cultural beliefs surrounding mothering and child-rearing via the Facebook group, *Ask the Pediatricians* (ATP). As part of an ongoing effort to contribute to studies on maternal and child health in Nigeria, this study aims to contribute to scholarly research on how mothers contest or embrace cultural practices regarding mothering and child-rearing. The study also contributes to women's use of social media and, in this case, the opportunity to discuss myths and cultural practices associated with child health. The two research questions that this study focused on were: What do the patterns of women's discussions reveal about cultural and traditional beliefs permeating discourses of mothering and child-rearing? What are the communicative responses of women to cultural and traditional beliefs permeating discourses of mothering and child-rearing?

In this chapter, I present the major themes that reveal the cultural beliefs and traditional practices that were evident in mothers' ATP Facebook discussions on mothering and child-rearing. I also present how mothers navigated the practices found in the analysis. The findings are divided into two parts. Part one focuses on *What Mothers' Discourses on ATP Facebook Group Reveal About Cultural and Traditional Practices Surrounding Mothering and Child-rearing* and has three major themes with three subthemes. The first theme, *Teething Assumptions and Diagnosis*, focuses on cultural beliefs that perceive teething as the major cause of different childhood illnesses and how neighborhood advisers strengthen such beliefs. It has one subtheme, *Neighborhood Advisers/Advice on Teething*. The second theme, *Traditional and Cultural Myths About Breastfeeding*, focuses on cultural and traditional practices surrounding breastfeeding and

the associated concerns with having healthy babies, which connects to the subtheme, *Chubby Babies are Healthy Babies*. The third theme: *Experienced Mothers and Mothers-in-law as Child Health Experts*, focuses on older mothers' suggestions on mothering and child health issues. Part two of the findings focus on *Mothers' Responses to Cultural Beliefs and Practices on Child-rearing*. This second part describes how mothers navigate these beliefs in terms of rejecting, countering, or embracing them. It is divided into three main themes: *Resisting and Challenging Traditional Practices*, *Worried and Vulnerable Mothers*, and *Embracing and Defending Traditional Practices*.

Part One: What Mothers' Discourses on ATP Facebook Group Reveal About Cultural and Traditional Practices Surrounding Mothering and Child-rearing

This section provides examples of cultural beliefs and traditional practices revealed by the analysis. The themes discussed under this section are: *Teething Assumptions and Diagnosis*, with a subtheme, *Neighborhood Advisers/Advice on Teething*. Second, *Traditional and Cultural Myths About breastfeeding*, with a subtheme, *Chubby Babies are Healthy Babies*. The third and fourth themes are: *Mothers and Mothers-in-law as Child Health Experts* and *Miscellaneous Beliefs About Childcare Practices*. These themes are connected because they reveal beliefs and practices influencing child-rearing and child health that are common and have stood the test of time in Nigerian society. This is evidenced by the volume of comments from mothers attesting that many of the practices go on in their neighborhood. Additionally, the themes reveal that these beliefs and practices are being held true among older mothers in society. As discussed below, while many beliefs and practices are not dangerous, some are detrimental to a child's health and may cause serious ailments.

Most young mothers perceive these beliefs and practices to be unnecessary in the present age, older mothers, however, want to preserve the beliefs and practices. Because of this tension between older and younger mothers' beliefs about a child's health, pediatricians recommend that young mothers use the online health resources provided in the group to become health literate about their children's health.

Finally, the sample posts noted below frequently have numbers at the beginning of the examples to indicate different comments posted by different people. In cases where dates are included, it means the different dates the comments were posted. Also, the typos and the short-hand language used in the examples were not corrected. However, the parenthetical explanation is provided as an interpretation in cases where the indigenous language was used.

Teething Assumptions and Diagnosis

The theme, *Teething Assumptions and Diagnosis*, is the first dominant theme found in this study with twenty-eight posts and 827 comments analyzed. The attention devoted to teething in the ATP Facebook group and the high level of engagement it received indicates that it is an important developmental milestone that mothers take seriously. As a result, the childcare practices and concerns about teething that circulate informally among the mothers were regularly brought to the Facebook group, allowing the doctors to either verify or provide additional information. As the principal administrator of the group, Dr. Boyede, noted in one of her posts:

I know I am going to stay on teething issue for a while when I posted yesterday because of all the corollary that needs to follow. Teething is experienced mothers favorite no 1 diagnosis closely followed by eela/nla and jedijedi. So, let's clear it

up once and for all! I am only going to say it once and hope everyone hears it twice!! teething is not a diagnosis!! there is no teething diarrhea (igbe eyin) or teething fever or teething cough or teething rashes. bringing out teeth in babies is as normal as babies hair growing or babies walking (ATP Post, January 30, 2020).

As reflected in the post above, teething myths circulate among mothers in Nigeria. Many myths suggest that mothers should automatically assume that teething was the cause of different illness in children. These teething myths, for example, propose that a teething child will have diarrhea or fever. Similarly, a teething child is also said to have rashes or experience coughs or will refuse or vomit food. The ATP Facebook posts revealed that, these traditional beliefs about teething meant mothers self-diagnosed and many times carried out self-treatment on the children. This is because while most of the mothers broadly showed their agreement with the position of the pediatricians in the ATP group by affirming that they have learned not to self-diagnose and assume every illness is teething-related, some other mothers continued to ask questions about teething. For example, some mothers asked:

- (1) what about d stooling and vomiting it comes with...what do we do about that
- (2) Please what about teething and eye mucous (10 months) are they related?
- (March 10, 2020). (3) Good day Doctors! My questions r... Does teething affects the growth of a baby? When does babies bring out molar? Hope it won't affect his growth.? (May 22, 2021). (4) When should babies start using teething drugs [over the counter or doctor prescribed medicine]? (September 30, 221). (5) Please I need a quick answer. Bonababe and PCAAN [powders believed to be good for

teething babies], which is ideal for a baby to use during the usual teething problem? (January 28, 2021)

The examples above suggest that in the communities where these mothers interact, they regularly encountered the teething beliefs. This is further evidenced in the post below by one mother who assumed that teething was the cause of a severe child's cough. However, the child had not been presented to the hospital for a diagnosis.

Good evening doctors thanks for your good work, my baby of 10 months old is having serious cough and catarrh due to teething but since yesterday till now he can't sleep well again, it has block his nostrils although have administer steaming and pressing warm water on his nose to help the fluid to flow well but today I noticed fluid is coming out of his ear so I use cotton wool to put in his ear so to be Soaking the fluid, pls what is the cause of the fluid? is it catarrh that is coming out from the ear? which medicine should I give him now? I am totally confused (ATP Post, July 2, 2021).

In this case, the mother assumed it was a teething problem that was causing the child's symptoms and was therefore still at home seeking advice on the kind of medicine to use. Questions like this on the ATP Facebook group pages were always answered by telling the mother to immediately take the child to the hospital. The ATP Facebook group had it pinned on their wall that they do not diagnose but only offer scientifically and medically proven suggestions. Although one-on-one consultations could be done, such discussions were not carried out via the public group wall.

Teething Powders and Herbal Mixtures

Another cultural practice associated with teething is the use of teething powders and herbal mixtures that tradition says need to be used for children even before they start teething. Hence, it is not uncommon to see mothers preparing themselves with different kinds of medicines long before the child starts teething so they can help curb the pain and discomfort that comes with teething. Evidence for this can be found in the principal administrator's post that stated:

teething powders and teething mixtures are the most highly unnecessary and at times highly dangerous drugs/substances mums use for their babies. Some mums even start giving their babies from day 1 for what?? Teething is a normal physiological process or milestones like the child growing bigger, sitting, crawling, walking and saying the first words!!! How come there is no walking powder or speaking mixtures. say no to teething powder, teething mixtures aka piccan, babyrex, gbomoro, bonabebe [teething powders] and such likes. They are not only unnecessary but can be very dangerous. remember what happened with "my pikin" teething mixtures saga? if you don't know, google it! (ATP Post, July 4, 2017).

Many of the mothers' comments on the administrator's post above indicated that they had not been using the teething mixtures. For instance, one mother said, "I pray parents of this generation will just avail themselves the opportunities that abound online, as it relate to child upbringing! Kudos to you for the wonderful work!" (July 4, 2017). However, based on the various posts not initiated by administrators but made by mothers,

it appears that the belief in using teething medicine and mixtures exists and remains strong. For example, there were a few posts such as:

(1) Please ma is bonababe good for teething my baby is teething and I was advised to use bonababe” (September 4, 2020). (2) Pls doctor I av been using Piccan for my 4month old baby since she clocks 3months is it advisable to continue it I heard it helps reduce teething troubles she has been biting her fingers and anything she holds (July 29, 2015). (3) I complained two days ago about my baby refusing food both breast milk and solid. I just noticed that he could be teething because his gums are swollen and that is the reason for the refusal of food. Please can I give any medication for the teething because it’s making him not eat and I’m worried. I’m tempted to go and buy teething powder, please advice (March 1, 2022).

Some mothers also questioned the position of the pediatricians on teething powders by asking the following,

(1) Now if these mixtures are “highly unnecessary” as u described above, what exactly are they indicated for because u can still find dem on d shelves of every pharmacy. Why haven’t NAFDAC [National Agency for Food and Drug Administration and Control in Nigeria] stopped their production? case of “my pikin” was bcos of contamination not bcoz it’s a teething mixture (2) I thought we have pharmacists as moderators in the group. Don’t u think they are in d best position to address the issue of drugs? (3) So what exactly are dey indicated for? Are dey completely useless? We need to get proper information (July 4, 2017).

It is implied in these posts that these mothers, as members of the ATP group, were seeking justification to use the teething powders, but interestingly, the administrators did not respond to such questions. Instead, other mothers in the group responded to mothers by asking if they knew more than the pediatricians. Sometimes, it turned into arguments between the mothers, and more mothers came out against those who did not want to support the opinion of the pediatricians. Overall, the large number of posts dedicated to teething in the group revealed that there remain assumptions among some of the mothers in the ATP group that certain illnesses are responsible for teething and that children need to take teething powders and mixtures long before teething starts.

As revealed by the analysis, myths and cultural beliefs associated with teething are common among mothers in Nigeria because mothers who commented that they were not using teething powders or self-diagnosing noted that they became enlightened when they joined the group. Unfortunately, these myth-based teething diagnoses and self-treatments may pose dangerous health outcomes for a child. As noted by the principal administrator who called out “myths-practitioners”:

Many Nigerian children died from easily treatable illnesses because someone assumed “teething” diagnosis and fail to seek appropriate health care! let it stop! don’t give! don’t receive teething as a diagnosis from “people”, “experienced mothers” and even myths-practitioners (may work in health facilities) who are unqualified to advise you on child health issues (ATP Post, January 30, 2020).

While the ATP group proposes what is medically right on teething, the questions from the group clearly indicate that some mothers have been practicing or following more traditional methods of teething care. For instance, a mother commented thus:

“Thanks doc for the eye opener as i am written [typing] my daughter is still taking it but i wil stop it now but if a child has cough dat refuses to go after all medication and de say she is using it to grow teeth wat can one give in dis situation (August 8, 2015)? Also, many mothers who attested that they had not been using the powders reported that neighbors or friends constantly advised to use them, nonetheless. The mothers said neighbors also advised them against taking their sick children to the hospital because it was only a teething problem. I discuss this finding further in the next section as a subtheme of teething assumptions and diagnosis.

Neighborhood Advisers/Advice on Teething

Mothers reported that before coming to the ATP group with questions about their child’s health, they were advised wrongly. According to the mothers, a friend, a neighbor, an experienced mother, or messages from another mothering group that they belong to all confirmed that teething was responsible for the sickness of their children. Hence, they said they were told by the neighborhood advisers not to take their children to the hospital at the sign of a slight illness without watching to see if it was a serious concern. Indeed, the mothers noted that these advisers linked every illness with teething and assured the mothers that such symptoms would go away on their own. For example, some mothers commented that,

(1) A lot of “experienced” mums argue with me when I tell them that teething is not a sickness. (2) Advisers Association of Nigeria leading people astray. They are everywhere. For me, anyone that comes with advice I will hear u and ignore the advice. Shebi it’s my baby? Will they force me to do what I don’t want?

When I belong to groups like this and there are hospitals everywhere I cannot be

so ignorant. (3) This is actually trending in so many Facebook groups, they recommend teething drugs for ignorant mothers who post to ask of the drugs to administer for (teething) and when you as an ATP member tell them is not necessary, they attack you and tell you they are talking from 10yrs or even 20yrs of experience (January 20, 2020).

As these posts indicate, in most Nigerian communities, a mother does not need to solicit the advice of a neighbor, or a total stranger met in a cab, for mothering advice. It is typical for people to freely advise the mother on what to do with her child based on their own experience. These people are those the mothers on ATP refer to as “experienced mothers.” In Nigeria, experienced mothers typically have two to three children who are grownup or older than five years old. They are also older than other mothers in the group. They see themselves fit to offer advice or able to diagnose the sickness of a child because they believe experience is the best teacher. Because of the pervasiveness of the neighborhood advising practice, the principal administrator of the ATP group condemned the practice. She also encouraged mothers to shun any advice that posed a danger to their child’s health. She posted in the group the following:

This is why you should stop asking your neighbours about your child’s health issues. and I hope you are not this neighbour. may your hands not be stained with blood of innocent children due to your wrong advice...stop being a neighbourhood children health adviser when you are not qualified to do so... and you too parents.... take your children to the hospital and stop consulting your neighbors, I don’t get the part of not knowing what to do? a child has obvious

signs, painful swelling? take to the hospital!! let's wake up o... this is 2020
(March 10, 2020).

Unfortunately, the posts revealed that neighborhood advisers were not the only ones providing such advice. Mothers on the ATP Facebook group reported that worrisome advice was also given by some nurses whom the mothers mentioned in their posts. For instance, some mothers noted that after being told in the group that teething does not induce certain illnesses such as diarrhea and vomiting, some nurses told them otherwise. As several mothers noted:

(1) Ma at times it's not we mothers fault, my baby was discharge from general hospital dis morning for diarrhea. Almost everyone der belive its becos I didn't start giving teething powder (since) she was 3 months. Even 2 nurse, I mean qualified nurse here in d hospital advise me to go and buy bonababe as soon as we get home cos dey said my baby illness was as a result of teething (January 20, 2020). My baby is 4months and 3weeks. Everybody has been, including a nurse, has been telling me to start giving her bonababe to avoid teething issues because she is gradually getting to teething stage, please advise me, because the idea of giving a healthy child medication is not sitting well with me (February 3, 2022).

The above examples demonstrate the concerns of mothers who wanted to know the proper childcare practice for teething children but were pulled in different directions between their neighborhood advisers and some nurses who supported teething syrups and powders. Furthermore, the mothers' questions indicate their desire to get the best advice on teething, and their responses to this advice are further discussed in the later parts of

this chapter. In the next section, I discuss another prominent theme in the analysis: myths surrounding breastfeeding.

Traditional and Cultural Myths About Breastfeeding

The second dominant theme found in the analysis centered on breastfeeding with 58 posts and 371 comments. This theme describes two main beliefs associated with breastfeeding. The first and major belief is that breastfeeding is not enough for babies in the first six months. Secondly, it is also believed that breastfeeding mothers should not eat certain foods and should not breastfeed while pregnant. The subtheme, *Chubby Babies are Healthy Babies*, describes Nigerian mothers' perception that a healthy baby needs to look chubby.

Breastfeeding Is not Enough

The World Health Organization recommends that babies be exclusively breastfed for the first six months without any other form of complementary feeding or drinking water. This recommendation is what was also emphasized in the ATP group for mothers. However, the belief that underlies some mothers' discourses is that breastmilk alone is not enough for the baby. According to some of the mothers' posts, this belief is based on a number of different factors. First, based on a mother's own experience with her previous children, mothers expressed concern about whether exclusively breastfed babies were gaining as much weight as they should. Second, mothers on the ATP group reported that grandmothers helping to take care of babies believe breastmilk is not enough for the first six months of life because that was not practiced in their time. Third, mothers compared their children with their friends, relatives, or neighbors' babies who might be bigger than theirs, which, in turn, caused mothers to be concerned about whether their

babies had age-related ideal weight. The following are examples of such posts, indicating these factors:

- (1) Good morning, Doctors. My 10-week-old baby weighs 4.45kg. B.w was 3.2kg. She's on exclusive breastfeeding, latches well and drinks up to 150ml when expressed. My question is what can I do to help her add weight? From what I read here, she's underweight. My mum says the breastmilk is not enough for her that's why (ATP Post, March 31, 2022). (2) Good evening, Dr pls am really worried my 6weeks baby is not adding weight at all, and we are on exclusive breastfeeding. I don't know if the breast milk is not enough for her...Pls help make recommendations...am worried. what do I do? (ATP Post, April 6, 2022). (3) When breastfeeding exclusively, there are so many side talks from people like the breastmilk isn't enough for the baby (ATP Post, April 8, 2022).

Mothers in the ATP group who practiced exclusive breastfeeding (EBF) stated that they encountered comments that discouraged them. They indicated that there were side talks that they should complement breastfeeding before the child turns six months. For example, a mother reported that “someone insulted me on a group here on Facebook because of exclusive breastfeeding that it's only for poor people who can't afford formula” (ATP Post, October 7, 2021). It should be noted that even though the Nigerian culture has supported breastfeeding for a long time, there is a traditional belief that a baby should start complementary feeding as early as three months. This is evidenced in one of the posts in the group that “the exclusive breastfeeding rate in Nigeria is 29%, indicating that only a mere percentage of infants aged 0–6 months are exclusively breastfed” (ATP Post, October 7, 2021). The quote which was posted in the group is from a survey carried out

in 2018 by the NDHS (2018) and reported by the Nigerian Federal Ministry of Health in 2020.

Responding to this post, the principal administrator of the group noted that many mothers breastfeed, but mixed feeding and giving babies water are the reasons for the low EBF rate. The principal administrator further stated, “exclusive breastfeeding is one of the child survival strategies! if we want to see more of our children living to age 5 years and not losing 1 million of them annually, we must embrace exclusive breastfeeding” (ATP Post, October 7, 2021). The post establishes why it is important for mothers to breastfeed their babies. However, mothers in the ATP Facebook group attested that they lacked environmental support to do EBF because of the belief that breastfeeding is not enough.

Every Mother must Breastfeed

The analysis also revealed the struggles of mothers who were willing to breastfeed but could not meet the demand for exclusive breastfeeding. The reasons given by mothers in their ATP posts included babies not sucking, the demands of mothers’ jobs, and mothers not lactating well. For instance, some mothers posted that

(1) am broken, frustrated, lost and almost completely depressed. I’ve tried so hard to breastfeed, but all my effort are not useful. My 19days old no de suck na to de cry sha. Unless I pump the breast, which isn’t removing the hind milk. He’s also on formula since the breast milk isn’t filling. His tummy is always rumbling Am truly tired and I don’t know what to do. Please I need help, badly (ATP Post, April 1, 2022). (2) Good morning Doctors, what can I do to facilitate breastfeeding because my breast is not rushing and my 5 days old baby is feeding

on NAN. I really want an EBF for her. Please help me (ATP Post, February 23, 2022). (3) Some persons makes it feels as if mothers who don't breastfeed are less of a mother. Some persons has issues with lactating, have attempted many times to bring this issue here cause no loving mother will just decide not to breastfeed (ATP Post, August 7, 2021).

The comments from mothers struggling to breastfeed indicate their willingness to do EBF for their babies, but there are also feelings of frustration and disappointment because they cannot succeed. Also, because many mothers shared testimonials, including pictures of their babies, about the benefits of EBF, it may cause additional stress for the women trying to achieve EBF. The posts indicate that some mothers may go on struggling with the belief that because they are not on EBF, they may be failing in some regard.

Breastfeeding should be avoided during Pregnancy

Another traditional myth that was also found in the patterns of the mothers' discussion posts about breastfeeding was the belief that a breastfeeding mother who becomes pregnant should no longer breastfeed the baby. The mothers, who had heard such beliefs in their communities, came to the group to ask for clarification on what they should do having become pregnant while breastfeeding. Examples of such posts are:

(1) Please what is the consequence of breastfeeding baby when pregnancy is detected? Because I heard people saying the breastfeeding baby can die because the breastmilk is spoilt because of the pregnancy" (ATP Post, January 15, 2022). I am currently pregnant and have passed my first trimester. My question is am still breastfeeding my baby and still want to till I give birth, he eats very well but I

really want him to continue breastfeeding. Should I continue breastfeeding him?

Will it be harmful to my unborn if I continue? (ATP Post, January 11, 2022).

The mothers asking these questions were not mainly concerned about whether they would be able to meet the nutritional demands of combining breastfeeding and being pregnant. Instead, they were concerned about something wrong happening to either the unborn child or the child being breastfed because of their situation. These questions reflect an existing belief in Nigerian society that being pregnant and breastfeeding another child may cause the child to become sick. Connected to this is the belief that the breastmilk is no longer safe for the child's consumption. The ATP doctors' responses indicate that these myths arise from long-held beliefs. The doctors, however, let the mothers know that even though there are no adverse effects of being pregnant and breastfeeding, "keeping up with the caloric requirement/demand of the pregnancy and breastfeeding" is emphasized for any mother who wants to combine both at the same time (ATP Post, January 15, 2022). Hence, the pediatricians emphasized that it is more of the mother's decision that need not be based on a misguided belief that something terrible may happen to either of the children because of breastfeeding.

Similarly, some of the mothers' posts reflected the belief that breastfeeding mothers should avoid certain foods. The mothers on the ATP Facebook group wanted to know if some foods were not beneficial. The following exchange between an ATP mom and an administrator was fairly typical:

Mother: Good day, please I want to know as a breastfeeding mother, can anything I eat affect my baby, because I was told not to eat beans, not to drink tea, not to take sugar and milk, that all this will affect my baby (that it will make her poo

frequently and have jedi jedi). I am really confused here because I don't know what they want me to be eating now if I can't eat all that? We are on EBF and she is 8 wks old... So please can all this affect my baby?

Administrator: Dear ATP Mom, they are myths. All you need to eat as a breastfeeding mother is a well-balanced diet. Although, certain food or medication when taken can make babies to become Fuzzy or cause adverse reaction (ATP Post, April 4, 2022).

In sum, while the specific foods noted in the mother's post are examples of nutritious food for the mother to take during breastfeeding, her question reflects the ongoing impact of community "advisors" trying to convey traditional beliefs about breastfeeding. These concerns about breastfeeding and the weight of the child are connected to a subtheme that emerged, namely, that chubby babies are healthy babies. I further elaborate on this in the following section.

Chubby Babies are Healthy Babies. A subtheme within the breastfeeding myths is the myth that a chubby-looking baby is the one who has the ideal weight and is thus healthier than babies who do not look chubby. This belief emerges from Nigeria's societal cultural beliefs that a chubby person is healthy and perceived to be rich (Ovuorie, 2022). The principal administrator of the group, Dr. Boyede, described this belief as untrue. Dr. Boyede, in one of her posts on chubby babies, noted that "most mums with a perfectly normal and healthy babies with perfect weight for their age still worry the Pediatricians and doctors unnecessarily because their baby is not as chubby or fat like their friends' babies" (ATP Post, November 21, 2015).

Babies' weight comparison is aided by the setup at community health centers where immunizations are usually given to babies. Mothers do not go by appointment, there are usually stipulated times when mothers gather together with their babies, and immunizations and weight checks then take place on a first-come, first-served basis. This method allows mothers to interact openly and exchange ideas about mothering. One thing that is common in this gathering is that mothers ask one another about the weight of their babies. This gives room for comparison, especially with babies in the same age group. Similarly, in these gatherings, some mothers may share what they feed their babies so that they will gain more weight. These conversations about their babies' weight continue to inform a general belief among some of the ATP Facebook mothers that healthier babies are chubby and chubby babies get attention in society. The posts below exemplify the mothers' concerns:

- (1) Good day Drs, my baby is four months and 2 weeks. She is EBF but the issue is I think she is not adding the weight she ought to. She sucks but not as much as I want her to. Is there anything I can do to boost her appetite? Her birth weight is 3kg, at 4 months 6.5kg. I know you will tell me dt her weight is ok but really m not comfortable with her weight. what can I do pls (February7, 2021)?
- (2) Gud day doc, I HV a two months baby. he has a small stature, not chubby, he look like a month old and he eat a lot...ppl think am not feeding him well (March 7, 2022).
- (3) Hello doctors, pls does a baby's hair has anything to do with a baby being chubby? I have a 4 months two weeks baby, she is very hairy but people keep telling me to barb her hair dat when I do she will add up, but my baby is very active and her weight increases each time we go for immunization just dat she is

not chubby. am tired of explaining to people that that is her own nature (January 18, 2020).

The above posts also reflect that mothers are genuinely concerned about whether their babies are gaining the ideal weight, even though the answers to many of these posts are found in their visits to the doctors or the ATP learning section. For example, child health courses on the ATP Facebook wall have charts on how much a baby should weigh at different months. In the first post above, the mother stated that she knows the doctors will say the weight is okay. Nevertheless, and despite her daughter doubling her weight in four months, the mother asked what to do to increase her baby's appetite and weight gain. Some mothers who responded to the first post, "she must be comparing weight with that of the neighbor's baby" (February 7, 2021). Another mother also posted, "remember na u born that baby, stop comparing her with your neighbour's baby (February 7, 2021). Clearly, the above responses further serve to reflect both societal beliefs and pressure for mothers to view chubby babies as healthy babies.

While it is not wrong for mothers to desire healthy babies, in the ATP group, mothers are told that it is not right to equate chubby with healthy. The principal administrator noted that they had encountered many posts on this topic. She said,

the issue of unnecessary worry or agitation by mums because their babies are "not gaining weight" "looking lean" "not chubby" "not fat enough" "always dropping (weight)" "not looking like other children" "cannot see the food he is eating on him" and yet when the baby is weighed, he or she has a normal and perfect weight for age... pls what we need is an healthy weight not necessarily a baby looking "chubby"!!! (ATP Post, November 21, 2015).

In sum, while there were questions that the ATP pediatricians responded to in order to help underweight babies, many of the questions from the mothers about weight gain appear to reflect the larger cultural belief that chubby babies are the healthier ones. In the following section, I discuss another major theme revealed by the analysis, which is mothers and mothers-in-law serving as child health experts.

Experienced Mothers and Mothers-in-law as Child Health Experts

The third theme, *Experienced Mothers and Mothers-in-law as Child Health Experts*, is also a dominant theme with fifty-one posts and 132 comments. This theme describes the tensions and struggles between younger and older mothers in making child-rearing and child health decisions. The cause of the tension is that while older mothers want younger mothers to preserve the traditional ways of doing things, younger mothers want to embrace practices recommended by pediatricians. More importantly, it is challenging for younger mothers to discard the traditional practices because respect for someone older than one in age is emphasized in the Nigerian culture. This form of respect means someone younger must be respectful in speaking and conduct, which typically means following the recommended behavior.

Furthermore, in Nigeria, older mothers, especially a woman's mother or mother-in-law, help younger mothers transition into motherhood. The reason for this is that experience of older mothers is culturally regarded as highly necessary way for new mothers to learn motherhood roles and practices. This tradition works to further strengthen older mothers' status as being important for young mothers and babies' wellbeing after delivery. Depending on the availability of the older mothers, they may stay with the young mother for three months or more. They teach the younger mothers

how to bathe, feed, and generally take care of the babies. They also explain, based on their experience, different developmental milestones, what different baby cries mean and what to do in such cases. Aside from a woman's mother and mother-in-law, any older mother in the community can serve this role if there is an agreement to do so. Also, any experienced mother in the workplace or neighborhood can offer advice to a younger mother because of the strong sense of communal living that exists in Nigerian society. The theme also has a subtheme, *Dangerous Practices Suggested by Experienced Mothers or Mothers-in-laws*. The subtheme describes practices that older mothers used but are now discouraged by pediatricians because of the practices' likelihood of causing harm to a child's health.

While many mothers in the ATP group claimed that they dismissed unsolicited advice from their neighbors who advised them wrongly on child health, the analysis revealed that rejecting the advice from grandmothers and mothers-in-law required wisdom and caution on the part of the mothers. It was common to see posts made by mothers asking how they should go about an issue, sharing with the group what their mothers or mothers-in-law were doing that they did not like, and how some of the grandmothers forced their opinions on them. Though experience counts in mothering, the cause of disagreement for the younger mothers on the ATP Facebook group was that some of the practices suggested by these grandmothers or older mothers are no longer viewed as necessary for childcare in today's practice. More so, as noted, some of the practices have been found by pediatricians to be harmful to a child's health, and the mothers appeared to know this. For instance, Dr. Boyede, the head ATP administrator, describes the situation in a lengthy post strongly expressed thus:

I said this in answer to a post... but I need to shout it here and deliver my special FTMs once and for all. Please being a grandmother, sister-in-law or mother-in-law or even a mother of 12 children does not automatically mean they are authority on children health care issues. Many of these so-called experienced mothers are as ignorant and even more dangerous with their wrong knowledge and practices. I have seen babies who died due to the wrong childcare practices by these people who think their position mean new mothers should submit to their knowledge unquestionably. I always tell new mums you are the one who was pregnant for 9 months and it is your baby... you take the final decision supported by your pediatrician of course when it comes to the health of your baby! quote me.... I said what I said with my full chest! you don't have to subject yourself as a new mum to the tyranny of some of these experienced mothers who bully with their ignorance (ATP Post, March 5, 2022).

The above post from Dr. Boyede indicates that many grandmothers assume the position of an experienced mother without realizing that children are different from one another. More so, what worked for a particular child may not work for another. The responses to the post above indicate that many of the mothers in the group faced this dilemma.

(1) U re on point ooooo. That was wat happen wen I gave birth dat mother in law nd sister in law said baby breast mst b press with hot water, at first I allow dem cos wen I said dey knw believe until my poor son breast swell up nd got infected...after treating d boy, I explain to dem dat is not good to press baby breast with water, dat na wetin cos d infection. naso mother in law and sister in-

law start war form there say me say na dem infect baby oooo say I say dem knw neat ooo nd frm dere dey started poison ex-husband mind....tank God am out sha (2) Told my mom-in-law she was not an authority once and I entered wahala [trouble]. (3) It's not easy at all...I am still suffering from that...I only wish women will listen. I faced serious bullying and mockery all because I refused certain practices... (4) I think the greatest struggle is being able to survive 0 to 5 yrs as a child in Nigeria. That population suffer a great deal in the hands of those terribly "experienced" unsolicited advisers (ATP Post, March 5, 2022).

In the first example, the mother explained that her MIL and sister-in-law were pressing the breast of her baby with hot water. She said she initially allowed them to do this because they did not believe her that it was not good to do so. Eventually, the breast got swollen and infected, and she told them it was what they did that caused the infection. In reaction, she said both her in-laws poisoned her husband's mind against her, and she said she had to leave the marriage. In the third example, the mother did not elaborate further on what happened to her but noted that she was bullied and mocked for refusing some practices.

All of the above comments indicate the tensions that can arise between mothers and MILs regarding childcare practices. Per Nigerian tradition, MILs are seen as authorities based on their experience, age, and status as the husband's mother. Even an administrator acknowledged that this kind of tension requires a certain degree of tact because the mother's actions may be seen as disrespectful if she does not tactfully navigate the issue. For instance, one of the administrators replied to a mother thus:

Mother: ...How best can I handle this, My mother in law do give her agbo oka and Jedi Jedi every morning and she claims her farting is due to Jedi Jedi and I breast feed her only after wards. I plan to do exclusive breastfeeding.

Administrator: You need to apply wisdom in dealing with your mother-in-law.

Firmly but politely tell her that you are discontinuing the use of Agbo as all your baby needs is breastmilk. Keep breastfeeding your baby exclusively (ATP Post, November 18, 2020).

The terms "agbo oka and jedi jedi" in the post are types of herbal concoctions or mixtures made from plants and other ingredients. This concoction is not a poisonous drink, but babies are discouraged from taking such mixtures because they are too strong for their just developing digestive systems. It should be noted that while young mothers can easily persuade their own mothers and refuse any unwanted childcare practice, this is not so easily achieved with MILs because of their culturally perceived status.

Another twist to MILs' expertise in childcare practice is when husbands support their mothers, not their wives, on what practices are beneficial to the child. A few of the mothers' ATP posts indicate that when husbands do support their wives on pediatricians' recommended practices, the unnecessary and sometimes dangerous advice from the MILs are more easily discarded. However, when husbands support the MIL against the wife, the mothers surrender to the unwanted advice. For instance, the posts below describe the situation further:

Please the picture below is a concussion my mother in-law made for me on July 9, according to her, she said it's an anti-convulsion concussion, that it prevents convulsion, she also said I should administer one teaspoon full of it to my boy

every morning. She gave me this concussion when my baby was 5months old, and now he is 7months old, she said there is no English cure for convulsion, that English drugs will do extreme harm to my boy, that he might end up being paralyzed if he takes hospital treatment for convulsion. The worst part is that my baby has never ever had any convulsion, he is doing perfectly fine, so I wonder why his grandma will wish him that by giving me an anti-convulsion concussion. What baffles me the most is the ingredients used in making the concussion, there is lime in it, there is brandy gin in it, she used one unfamiliar leave (leaf)... And she warned me seriously to give it to my son when we get back to our base, I dumped it in my fridge since then. But my husband keeps saying it is not harmful, that his mother gave it to all 5 of them and to other extended relatives of them, that I should try it. My question now is, should my little boy of 7months be exposed to such high alcoholic concussion at this tender age? Please I need your help (ATP Post, September 12, 2020).

The above post is informative as it further describes the content of some of the herbal mixtures, which explains why these mixtures are rated as harmful by pediatricians. Ingredients such as alcoholic brandy gin and acidic lime are not ideal for babies. What is implied in the post is that this mother is likely fearful that her child will develop convulsions one day, and she will not have anything handy to calm the baby. At the same time, she has been exposed to lessons in the group discouraging such herbal administration. In addition, she is confused because her husband also encourages the oral intake of the herbal concoction. Furthermore, as other posts have indicated, family members will likely blame the mother in this kind of situation if the child falls sick

because of the belief that the intake of the herbal mixture would have prevented the sickness. Another example of such a case is stated below:

Good afternoon docs. Please this is the navel of my 2 weeks 2days old baby. The cord dropped on the 7th day and we've continue applying the chlorhexidine gel but it's still like this with this rashes under it, should I be worried? Do I stop applying the gel? My mother-in-law kept saying I didn't allow her use heat on it and that's what is giving my baby pains (colic). She's also insisting I get gripe water or nospamin and my husband is getting angry that do I know better than his mom. I'm really getting fed up and I feel like just going with whatever they say cos I'm tired of the argument. What do you advice please (ATP Post, November 12, 2020).

Aside from the fact that the mothers want to hear from the pediatricians; they also appear to use their ATP posts to the group as a means to express their frustrations over tensions experienced in their homes. The cultural side to this tension is that grandmothers indeed come to help, and it is their cultural right. However, the renewed awareness of medically acceptable childcare practices that young mothers are exposed to creates tensions over what and who is right or wrong. Even though not all grandmothers suggest dangerous practices, as I discuss in the following section, some of the practices suggested by mothers-in-law and posted by the younger mothers in the group are likely to cause more harm than good. The principal administrator also attested on the ATP Facebook group that these practices create a bone of contention in their medical practice as pediatricians.

Dangerous Practices Suggested by Experienced Mothers or Mothers-in-laws

This subtheme focuses on practices that mothers in the ATP Facebook group stated that experienced mothers in their community, or their mothers-in-law, suggested to them. In some situations, the older mothers completely take responsibility for the care of the baby for the first three months, except for feeding, to allow the mother to recuperate and rest well. As my analysis reveals, though young mothers appreciated the care, they complained of the imposition of unwanted practices. It is important to note that grandmothers who suggest or try to enforce their opinions on young mothers do so because they believe that it is also beneficial for the child and not because they intentionally want to hurt their grandchildren. They also do this because that was what they were taught when they were also young parents. At that time, it worked for the grandmothers, but the gap in generation between these two sets of mothers shows that things are no longer as they used to be. One of the worried mothers in the ATP group thus asked:

Why do our mothers believe that babies have stomach pain which they think is normal? Some claim that it is more serious in boys than girls, others say the opposite. They prepare all kinds of concoctions to give the newborn to ease the stomach pain. Whenever the baby cries for longer than they think is normal, they claim it's their stomach that is worrying them. My mother in-law prepared a mixture of lemon grass, ogiri and water and asked me to be giving it to my newborn. Could the pediatricians tell us if there is such a thing as this 'normal' newborn stomach pain? Thank you (February 17, 2021).

The term 'ogiri' is a local fermented ingredient used to cook soups and why mothers worry about this kind of issue is not because the contents of the concoction is

dangerous in itself, but because a newborn may react negatively to its use. Hence, pediatricians on the ATP Facebook group advise mothers to avoid them totally. Further examples of dangerous practices are also given below:

- (1) Please my paed, [pediatricians] my mother in-law is insisting that I should always apply Rub on my baby's private part if not she will have an itchy vagina when she grow up. My baby is 10 weeks old. What should I do? (June 20, 2020) (2) Good day doc, my girl of 3 years now, I didn't circumcise her, because I do hear it that is not good for girl but my mother-in-law have been reporting me, here and there because of this issue. Please state the benefit out for me. So that, I will be able to defend or explain myself properly for her (July 8, 2021). Please can a baby of 4 months take little drop of pure Honey. Please doctors what is jadi jadi, my mother in law wants to give my baby of 4weeks , cherry tea/water, she also wants to give and rub the baby cent leaf oo and I said no (August 20, 2020).

The term "Rub" is a brand of mentholated cream spelled as "Robb." It is used for colds or body aches but is not generally recommended for babies. Hence, it is dangerous to be used on a baby's private parts. In the second example, the act of female circumcision is regarded as a reportable offense in Nigeria and is widely condemned in the ATP group. However, as suggested by a few mothers, some of these practices are still encouraged by some grandmothers. Another example of a dangerous practice is massaging a baby girl's clitoris with Vaseline. The mother in the example below said she had read in a different group the purpose of such a massage, but her main concern was that her mother-in-law wanted to carry out the massage. She said,

Good morning Doctors. Please, I read in a group that the baby girl's clitoris must be massaged with warm and blue seal Vaseline applied on it, that if this is not done the baby will grow up having a long clitoris and smelling vagina and that it will even be scratching girl when she grows up. Again, that there is a sperm-like substance in the clitoris at birth which needs to be removed while bathing the baby, and this may take up to one week or two before the sperm will be completely wipe off hence the need to wash and massage with hot. Please doctors is this whole story true? My MIL wanted to do that on my baby but I refused and she was angry though she didn't explain anything to me. I hope nothing will happen to my baby in future. Kindly educate me on how to handle the baby's clitoris (ATP Post, February 20, 2022).

Initially, this practice was thought to be an outlier in my analysis, but a further search for the word "clitoris" in the ATP group brought forth a post made by the administrators asking why mothers are massaging their daughters' clitoris. The post, which gathered 471 comments from mothers, had most mothers saying they never knew such a practice existed. However, a considerable number of the mothers said they were aware but not practicing it, while a few others gave reasons for the massage. Below is the post and the reasons given for the massage:

Administrator: Why this obsession with the GIRL CHILD CLITORIS?? Glad you stopped cutting but why d need to press hot water /massage with vaseline/press in/rub powder? TALK TO ME!

Responses: (1) hmmm! my stepsister massage the clitoris of my daughter, until i started crying... because my baby was crying without control during the process. I

asked her why she was doing that, she said so that she won't love men. OMG! At that point, I knew it was a myth, if she doesn't love men, who then will she love? I quickly ask my husband to tell her to stop the process. I did that because if I had told her myself, she will object and probably think I'm naive. She already had 2 daughters at that time and said that's how she treated them. (2) I heard that by doing so, it will prevent the girl from being promiscuous in future but to me it doesn't make sense. Does it actually stop promiscuity? It is well... (3) It doesn't look nice if it sticks out Doctor Gbemisola my mom wanted to press my daughter hot water i told her not to dare it and she was so angry. I became angry and brought chair and sat down monitoring her. I insisted and told her I want my daughter's clit to be the way God created it (February 6, 2022).

Though the reasons for this massage are based on cultural myths, the mothers' posts indicate that these practices were once considered acceptable because they are traditions and there are no known reasons for them. For instance, a few of the mothers who said they had done it before noted that they did not know any better and have now stopped the practice. In other words, the women who did these things did them because they were handed down to them as a tradition that must be followed through without much explanation. For example, some of the mothers said,

(1) Way back 2004, I did press with Vaseline out of sheer ignorance with the prompting of mum. Shame def dey catch me, but I knew better by the time the second and third girls came. (2) why is this coming now, I gave birth just last month, the woman that helped with my daughter bath usually do all this to her,

inside of me i know is a wrong act, when i ask her she said so that she wouldn't be feeling so horny as time goes on.

These comments highlight some of the ways in which the girl-child is subjected to traditions that tends to control female sexuality. Edeh (2017), for example, stated that there are unknown reasons why the girl's private parts are subjected to various non-medical practices other than tradition preservation. This was rightly summed up by one of the mothers commenting on the practices relating to the girl child. According to the mother:

The need to put the African female child under one means of suppression or the other is scary. Either they want to do something to the private part so she doesn't sleep around, or they want to teach her how to end up as a good wife, or they want her to dress a certain way so men are not seduced. They want her to act and look in a way that pertains to how a man would react. What about herself... Her self-value and validation as a person (ATP Post, February 6, 2022).

Hence, as suggested by the administrators' answers on the group, a young mother has to be health literate to be aware of the dangers of these practices and be bold enough to say no to any practice that would not benefit their child. It was common for many mothers to say the ATP group had enlightened them on many of these practices. That said, the mothers on the ATP group are going up against long-held traditions and beliefs that are engrained in the culture, which is not an easy task. Lastly, there was one instance of an unusual practice found during the analysis suggested by a MIL. This practice deviated from the typical questions asked by mothers in the ATP Facebook group. It is not a shared cultural belief found among the mothers' posts. The question goes thus:

Good morning docs. My baby will be 6months by next week. He is always cheerful, plays a lot, laughs smiles at people. Generally, he is always happy. Now my mother in-law came around, saw him in his usual laughing and smiling self, she said isn't good for him to be smiling too much that air will be entering his gum (he does not have teeth yet) she said it will hinder his teeth from coming out. That whenever he smiles at me i should frown my face so he will stop smiling and also she will give me something for him to drink to help him stop smiling so he can have teeth. Please how true is this I'm worried, help a first-time mum (November 25, 2020).

Culturally, Africans are cheerful people; thus, it is odd that a baby would be judged negatively because he is cheerful, and the MIL thinks that this will keep him from teething. What is, however, dangerous here is the MIL telling the mother to keep frowning her face and advising that something will be given to make him start teething. Teething is a natural process, and whatever will obstruct this process may likely be dangerous. Hence, this suggestion seems to deviate from the kinds of practices typically found in the group because it does not connote a shared meaning among the discourses found in the group, otherwise, other mothers would have also asked similar questions. This leads to the second part of the finding revealed in this study that indicates how mothers respond to these cultural beliefs and traditional practices permeating the discourses of child-rearing on ATP.

Part 2: Mothers' Responses to Cultural Beliefs and Practices on Child-rearing

The second part of this analysis focuses on mothers' navigation of the cultural and traditional beliefs influencing child-rearing discourses in the ATP Facebook group. Three

themes were found within mothers' responses in the ATP Facebook group across all the topic areas. The first theme, *Resisting and Challenging Cultural and Traditional Beliefs*, focuses on the set of mothers who were aware of the beliefs circulating in society but nonetheless strictly followed the pediatricians' advice. The second category are the *Worried and Vulnerable Mothers* who were aware of the cultural traditions and beliefs, worried about them, and sometimes practiced them because of the fear of offending others. The last theme, *Embracing and Defending Cultural Beliefs and Traditional Practices*, focuses on mothers who were aware of and defend the traditional cultural beliefs and practices and did not state that they followed the doctors' advice. Overall, the analysis revealed that despite these three different ways in which mothers respond to the practices and beliefs, many of the mothers on the platform declared that the ATP group has helped them challenge the beliefs and traditions and taught them to follow the pediatricians' recommendations closely. In the following sections, I explain these three sets of responses found in the group in detail.

Resisting and Challenging Cultural and Traditional Beliefs

This theme was the largest in this category because many of the mothers noted that they were following the recommendations of the ATP. The mothers challenging cultural and traditional beliefs opined on the ATP Facebook group that they were aware of the cultural beliefs and traditional practices associated with becoming a mother in the Nigerian setting. They also shared how they overcame and navigated the beliefs and practices. Many mothers acknowledged that what they were told during their antenatal care period was also emphasized in the ATP group. Hence, there was a synchronization

between what they heard in the hospital and what the pediatricians told them to do in the ATP group. For instance, a mother noted that:

Despite the fact that I live with mil when I had my 1st child, I didn't listen to everything she advised that is against what I learnt in ante natal, because of that, she neglected me and my baby, now we are in our house and I have 3kids, did exclusive for them, the last is a year and 5months and have been weaned, they are doing fine, throughout their nursing period, she does not intervene and am happy abt that (May 7, 2019). (2) THANKS ma, we were taught in the hospital not to give any medication unless prescribed, many talked me into giving my baby, but I refused.

Other posts to the group show that the knowledge, benefits, and support the mothers received from the ATP group equipped them to be able to challenge and reject the traditional beliefs. For example, one of the mothers noted that:

Truth be told I have really benefited from this group. I joined randomly after I gave birth to my first baby and since then it's been a smooth ride in motherhood for me. And I try to enlighten those around me even though some experienced mothers see me as ITK [someone who think they know everything] but I don't care so long as it concerns my babies health. Although right from time I wasn't a huge fan of unnecessary drugs and herbal drugs but when I joined ATP I had proofs to back up my claims, and anytime there is something we don't understand my hubby will say ask the Facebook doctors (July, 7, 2021).

Challenging these beliefs also means that some mothers had to suffer strained relationships either with their MILs or close neighbors who suggested traditional

practices and beliefs to them. These struggles are reflected in the following posts by the ATP group mothers:

(1) I stood my ground when I had my child then, my MIL came with all sort of traditional shit. But I refuse to allow it with my kid. Till date she wasn't happy but am cool my kid is a big boy now. I mean physical birth rights and traditional method of throwing them up and down when they eat or bath them. The ones that was meant for me as a new mum to drink. I collected but never use (August 2, 2021). (2) I've really learnt a lot too from this group, almost everyone I know calls me ITK cos I refused few unnecessary things (July 5, 2021). (3) They will usually say, you are now claiming to know it all 'just because you have giving birth to 1'. And so what?' Especially at health centers when women come together. (4) I can recall how so many women in my hood stopped talking to me because I refused to heed to their advice concerning my own child (5) My neighbor is angry with me reason is dt I too Sabi. I DNT take advise of experienced mothers. Any small thing, hospital. She even went as far as telling hubby" dis ur wife just Dy waste money, na teeth Dy worry dis pikin na mk am Dy hot". Hubby just told her if na dt one she take Dy waste d money I like am. I knw the pains in bringing them forth. Can't trade my children for anything ooo (March 10, 2020).

As noted above, the term ITK is an abbreviation for "I too know," which has the same meaning as "know it all." It is also a form of insult to show that the person knows too much. Hence, many mothers attest that they were described with this term because they refused to embrace traditional practices. Furthermore, some said they lost their

relationship with their neighbors or MIL because they chose to reject the traditional practices. In the last example, the mother noted that her neighbor complained that she was wasting money because she went to the hospital when her child was sick. In this case, going to the hospital or purchasing prescribed medicine is perceived by the neighborhood advisers as a waste of money (not as a cultural belief) because home remedies are cheaper. These examples imply that rejecting these practices also defined how the mothers were perceived among close friends, family, or neighbors who did not understand their refusal to embrace the traditional beliefs and practices.

The mothers' ATP posts also indicated that they sometimes pretended to embrace the traditional beliefs in order to avoid strained relationships between their MILs, family, and neighbors. They saw this as a way to navigate the struggle between embracing or rejecting the beliefs without offending the people close to them. For instance, some of the mothers' posts indicated they lied because they were being asked to do what they did not want to do.

(1) my baby is 6months today. EBF for sure. EBF to the world. I will always advice all mothers. It might not be easy o. But it's the best. I never had any reason to take her to the hospital for any sickness whatsoever... I got discouraged severally. Even my mother-in-law was against me with no water of a thing. When I saw that it was becoming another issue. I told yes, I am giving her Water. Na me know wetin I Dey give my baby (September 30, 2021). (2) When I had my twins different people with different talk I was just confuse I can't go under knife(CS) to have my babies and loose them so I never tried any of those myth they told, I will just respond, 'tank you, I will do it later' trust me I never tried it even those

concoction dey give wen pregnant I will collect and empty just my pregcare and my twins weighed 3.7 each at birth so I don't believe...those nonsense (January 26, 2020).

The mothers rejecting these beliefs were demonstrating agency because they determined the practice to take on behalf of their children irrespective of what they were told to do. The mothers further expressed this willpower and agency by stating that they had the final say over their children and not what others suggested. For example, one mother noted, "exactly, it is my child. I went through d journey & I have the final say." Another mother also said, "I don't give my kids drugs when on exclusive, even when my in laws tell me its necessary for them. I don't listen to them" (March 5, 2020). As stated earlier, the word "drugs" in the last example and used previously by mothers in this study refers to over the counter or doctor-prescribed medicine and not the known addictive drugs like cocaine or marijuana. In contrast to the mothers who were stood up to the pressures to adopt traditional cultural beliefs and practices, are the mothers of the ATP Facebook group who were unable to resist. The next theme, *Worried and Vulnerable Mothers*, focuses on the reactions from mothers concerned about the practices but find it difficult to say no to them.

Worried and Vulnerable Mothers

The second theme focuses on the set of responses by vulnerable mothers who either 1) allowed others to take the lead on their behalf in caring for their children, or 2) found out actions they didn't want were taken without their knowledge, or 3) feared offending their mothers-in-law, relatives or neighbors. Some of the mothers who allowed some traditional or cultural practices, attested on the ATP Facebook group page that they

allowed these practices because they were confused about what to do. For example, some mothers said:

(1) What can I do to ease my 7 weeks old bowel movement? He always strain and fart with no success at pooing by himself. My mom always have to stimulate his anus with cotton bud before the poo comes out. I am very worried about this (January 13, 2022). (2) Good afternoon Doctors, please my baby's eye was white at birth but while still at the hospital we noticed yellowing of the white part, bilirubin level was checked before the yellowing and after baby was discharged and certified okay by the pediatrician. I was told to continue breastfeeding well on demand...but my people insist on giving the baby fermented pawpaw water and putting her to early morning sun...I am still okay with the early morning sun since doctor certified that the bilirubin level is okay. Please advice a first time mum...mother in law and my own family said pawpaw water is what many has used and some of them also used...to avoid misunderstanding I allowed small drops to be given but I am not comfortable with this because baby is on exclusive breastfeeding (December 18, 2020).

The above posts show that these mothers were aware that the practices could be dangerous for the children, which was why they came to the group with questions about it. Despite their discomfort, they did not appear to have the willpower to make their own decisions. Nonetheless, the mothers were also clearly worried about the consequences on their children's health.

Another set of vulnerable mothers are those mothers who found out that the decisions and practices they did not want were taken without their knowledge. According

to their posts on the ATP Facebook group, these decisions were primarily taken by their mothers-in-law. In other words, the mothers were not there when a decision was taken to embrace a particular practice or belief, or the mothers were forced to comply with a specific practice. For instance, some mothers posted the following:

- (1) Please I have been going through the group since this evening and I have seen so many advice you gave based on drugs. The truth is that I never wanted to give my baby any drug at all when I gave birth to him because the doctor told me not to do so, but the problem here is that my mother-in-law went and bought those drugs without letting me know and she started giving it to him the week I gave birth to him. And when I refused them she got angry that I don't listen. Doc I have so many things to say but I can't really type them all because I have someone here. My baby is 3 months, and I don't know if it will affect him if I stop giving him those drugs especially abidec. (2) Good evening Doctor, please can I on fan for my two weeks baby, cos he sweat and its causing rashes on his fore-head, but my mother in law will not lemme on d fan, she did not allow me to on the fan since I gave birth, she said it will cause cold and convulsion for the baby. how true is that? (November 10, 2021).

These posts suggest that the mothers wanted something else for their children, but their mothers-in-law took the lead in making the decisions. In the second example, turning on the fan, for a boy who had already developed heat rashes due to the heat, was not allowed to do so because of the belief that newborns need heat. The ATP administrator who responded to the question about the fan indicated that children could sleep in rooms with fans and air conditioners as long as they are adjusted to the room

temperature and without directly facing the child. However, beyond what the mothers stated in their posts, there are implications that the mothers-in-law, in this case, were controlling the home and likely using their positions of power to force their opinions on the first-time mothers. Hence, this set of posts indicates worried mothers who were not able to make their own decisions.

Lastly, the example below (which also opened Chapter 1) suggests that some mothers were afraid to offend their mothers-in-law or didn't know how to relate with the MIL when they resented the mother's objections. These mothers posted that this was why they decided to keep quiet, when in reality, they did not like what was being done to their child. Following the mother's post is the administrator's response.

Mother: Doctors I am really feeling bad right now. So I just put to bed last week Friday to my second baby and my mil came to bath baby and she was pressing the baby's breast so I told her that we were asked to stop that during antenatal and she stopped immediately although she said he will develop big breast in future. Then a doctor friend of ours came today and was telling me that I shouldn't allow my baby to be turned and twisted after bathing and I told her that my MIL did so. So, she said she would use style and throw the talk in the presence of my mil which she did and immediately she did so my mil just made a sigh and went out and since then she has been carrying face for me. I really feel bad and unable to concentrate since then. Do u think I approached the issue rightly and how do I pacify her now. Please while bathing baby she rubbed soap on his face and poured water to rinse it off. Is this right? I actually thought I was bold enough to tell off such practices but now that she is here my liver is just failing me (May 9, 2021).

Administrator: You did nothing wrong. You need to firmly and respectfully stand up to your mother in-law, politely educate her on the risks associated with such dangerous traditional practices. Also get your husband to talk to her. If she is on Facebook kindly add her here. The child is yours, you and your husband are in the best position to take decisions about the baby (May 9, 2021).

The administrator's response encouraged worried mothers that the decisions to be taken on their children rested with them. However, this is a tricky path for some young mothers because even politely standing up to one's mother-in-law could be interpreted as a disrespectful act by the young mother. This is because, as noted above, the mother-in-law in Nigerian society is culturally accorded a "revered position" either as the husband or wife's mother (Saibu, 2018, p 6). Mothers-in-law are expected to teach younger couples to navigate married life and make them aware of existing family traditions or practices that the couple is supposed to know about. They are also involved in taking care of their grandchildren, and wives are expected to make their MILs their friends for the well-being of the marriage (Saibu, 2018). As suggested by the pediatricians, the way out of being vulnerable to traditional practices is to get the husband's support. However, securing the husbands' support could be challenging if the husbands embrace the practice. In the next section, the mothers' posts indicating that they embraced Nigerian cultural beliefs and traditional practices on child-rearing are further explained.

Embracing and Defending Cultural Beliefs and Traditional Practices

The last theme focuses on mothers who appear to embrace the cultural beliefs and traditional practices of child-rearing. According to the ATP Facebook group posts, these mothers believed that since they were raised with many of the practices, it is equally

acceptable for them to continue with the tradition. These mothers also believed that experienced mothers have convincing stories because they have also cared for a child in the past. Dr. Boyede, the ATP principal administrator, addressed this set of traditional practices and myths embracing mothers on different occasions in their posts. She said, “let me drop this here for those whose argument was... our mothers did it and we are okay...so we will keep the practice ongoing...: (May 19, 2020). She included in the post a story of a Nigerian woman who forcefully fed a child in the US in May of 2019 (<https://guardian.ng/news/court-sentences-nanny-to-15-years-in-prison-for-death-of-baby-she-force-fed/>). The child died as a result of the forced feeding. Dr. Boyede used the example to warn mothers who still practiced many of the old practices because they were handed over to them.

Dr. Boyede’s post also suggests that there were mothers in the group who asked questions yet stuck with the beliefs and practices that went around in their communities. This can be seen in the posts below, which indicate the mothers practice the beliefs yet still have a sense of uncertainty and come to the group with questions.

(1) Good morning doctors. Please my 3 months and 3 weeks baby has been kinda restless since morning today. I’ve been trying to find out the cause, and realise she’s feeling pain in her ears, my mother-in-law said I should apply breast milk, which I did and it seemed to have calmed her down. Please, I want to inquire what might be the cause of the pain and should I continue applying breast milk to her ears? (ATP Post, August 2, 2021). My baby will be a month old by Monday. He’s on exclusive but sometimes I give him water from herbs boiled for his bath. and d day before yesterday i gave him gripe water twice bcos of his stomach. He didn’t

poo throughout yesterday and even up till now. And I learnt dat babies are supposed to poo everyday for the first month (ATP Post, February 4, 2022). (3)

My baby of eight months often feels like vomiting whenever he sucks mine right breast. But feel comfortable with the left breast. Somebody told me that i should express my breast and put an ant into it, if the ant dies my breast is soured. I did it and observed that the ants died. Pls my question is does breast gets sour and what can be the cause? (January 28, 2021).

Interestingly, the questions asked by these mothers are covered in the ATP learning section, which focuses on different topics that cover a wide range of child health and care practices. Mothers are told in one learning module, for example, to desist from using breastmilk as ear or eye drops and are discouraged from the use of herbs as well. Explanations are offered in these learning modules, which are also accompanied by videos, but based on the ATP Facebook group posts some mothers seem to prefer listening to their neighbors than the doctors. In reaction to such questions, Dr Boyede opined that, “STOP AND THINK when neighbors give you advice! Some will be arguing with professionals here but won’t think twice before taking advice from ignorant people about their child’s health issues” (February 17, 2020).

The mothers who embraced and defended cultural beliefs and traditional practices, also appeared reluctant to independently post questions to the ATP group. Instead, they commented on existing posts by either countering what was suggested by pediatricians, or answering questions meant for pediatricians using their own experiences and what worked for them. Below is an example of a post made by an administrator which

influenced different comments, but only those embracing the traditional cultural beliefs and practices are included here:

Administrator: Coconut water for colic; pawpaw water for jaundice; bitter leaf water for whatever! Where is space for breastmilk?

Responses: (1) You might not believe it but is working. (2) It's working, in fact na pumpkin leaf and bitter leaf, I dey boil to cure fever and jaundice, I don't joke with it. (3) The question is why does it work???? (May 7, 2019). The question is why does it work???? All to your tent O Israel. Do Wat works for u (4) All those things works (5) If u use herbs and it works for ur baby, isn't it better than chemical in bottle given a tush name to make u buy them... Dats y I like Korean, they stick to their herbs but we African condemn, all in name of civilization.

These responses to the administrator's post/question indicate that the mothers believed that these herbs work and, at the same time, questioned the doctors about why the herbs work. Hence, it appears that they see no reason to stop the practices if they have results. Probing further into why some mothers embraced the beliefs, the analysis revealed reasons offered by the other mothers who rejected the traditional beliefs and practices. For example, Dr. Boyede asked the following question, and some of the mothers' responses are indicated below.

Administrator: All myths-defending Mums, why are you here? Since You know it all and don't need to Ask The Pediatricians anything!" (May 7, 2019).

Responses: Anyway doctor it will take some time because some of these beliefs were practiced for a number of kids as they will put it "nothing bad happened" or something happened and they never knew the cause or it's just God's grace and

then some of these beliefs were introduced by “trusted” folks like mom, aunt, mother-in-law, neighbors etc. (2) I just pity our newborns....most of our new generation mothers are still living under the rocks (3) If you try to advise all you get to hear is, our grandmothers that did it, what has happened to them (May 7, 2019).

In the above comments, mothers offered various explanations and reasons as to why some mothers continue to embrace the traditional cultural beliefs and practices. One explanation was that the mothers trust their folks more than the doctors. Other comments indicate that some of the mothers also want immediate results as opposed to going through the process of seeing a doctor, navigating the long waiting times at clinics, and going to the pharmacy.

Overall, while there were three types of mothers who wholly or partially embraced traditional cultural beliefs and practices, the majority of posts indicate that more women on the ATP Facebook group rejected them and tried to practice the pediatricians’ recommendations. This larger group of mothers signified this by referring to themselves and others as ATP moms or ATPians. Also, according to their posts, the ATP group had helped them learn, unlearn, and relearn childcare practices. They also worked to separate themselves from the “Embrace and Defend” mothers by alerting the administrators and by tagging a mother who was trying to share a traditional practice that worked for them. Many times, they also expressed their dissatisfaction that some mothers still embraced and practiced traditional or cultural beliefs. For instance, some of the ATP mothers challenging the traditional myths and beliefs posted that:

(1) God will help newly mothers. Every practice is all done out of ignorance.

Thank you ATP for sharing free knowledge to us all. Sometimes when (you) tell some ignorant family and friends this they will say you argue too much. (2)

Thanks for the information, I pray parents of this generation will just avail themselves the opportunities that abound online, as it relate to child upbringing!

Kudos to you for the wonderful work! (July 4, 2017).

The ATP moms also expressed gratitude to the doctors for attending to all manners of questions in the group. Being grateful to the doctors further demonstrates a contrast between those rejecting and embracing traditional practices in the group.

Summary

This study's findings indicate that discourses on teething and breastfeeding elicited a lot of interaction from mothers, which may explain why doctors received many questions about the myths surrounding the two topics. Other discourses revealed mothers-in-law and neighborhood advisers as propagators of traditional practices. The analysis also revealed other dangerous practices surrounding child-rearing in Nigeria such as massaging a girl's clitoris with powder or mentholated cream, pressing babies' breast with warm water, stimulating babies' anus to make them poop and giving herbal drinks to babies. Lastly, how mothers navigate the beliefs and practices were also presented. Overall, mothers are concerned about the health of their children, which is why they join the group. However, while many mothers said that they utilize the resources in the group to inform their choices, a few of the mothers' questions indicate that they do not. Most importantly, the mothers in the group are young mothers who

noted that many of these practices are carried out in society. This was found when they cited the cases of their friends, siblings, or colleagues who embrace the beliefs.

According to the mothers in the group, grandmothers, especially mothers-in-law, are the ones who insisted on these practices and sometimes forced young mothers to embrace them. The ATP then serves as a forum for mothers to ask for opinions on a child's health and as a space for mothers to express their concerns regarding what their mothers-in-law or neighbors asked them to do for their child's health. Further discussion on these findings and their implications for the theory of RDT are presented in the following chapter.

CHAPTER FIVE DISCUSSION AND CONCLUSION

In this chapter, I interpret the findings of this study in connection with previous research on cultural beliefs and traditional practices and the theoretical framework applied in the study. Lastly, I present the implications of the study and suggestions for future research. To briefly review, this study examined the discourses on mothering and child-rearing in the Facebook group, *Ask the Pediatricians* (ATP). Specifically, the study sought to understand how mothers in the group navigate myths, cultural beliefs, and traditional practices surrounding mothering and child-rearing via the ATP Facebook group. The ways in which mothers' discourses countered or embraced these traditional beliefs and practices can help address the gaps in the literature. Furthermore, while attention has been given to the use of social media among women, this study highlights the ways mothers' produced knowledge on cultural practices influences mothering and child-rearing in Nigeria.

The research questions that guided the inquiry were: What do the patterns of women's discussions reveal about cultural and traditional beliefs permeating discourses of mothering and child-rearing? What are the communicative responses of women to cultural and traditional beliefs permeating discourses of mothering and child-rearing? I conducted a textual analysis of mothers' discourses on ATP Facebook group, and the following are the major cultural beliefs and traditional practices that the analysis reveals.

Five major beliefs found in the study are associated with breastfeeding and teething. Two beliefs are focused on babies' teething process, while the other three are focused on breastfeeding. The first belief is that teething is a major cause of childhood illness with symptoms such as fever, diarrhea, vomiting, loss of appetite, rashes, and

coughing among others. Second is that teething herbal mixtures or medicine need to be administered to a child as early as possible to prevent the sicknesses believed to be associated with teething. Three of the five major beliefs were on breastfeeding; the first is that exclusive breastfeeding is not sufficient for babies under six months as recommended by WHO. Second is the belief that chubby babies are healthier than babies that are not chubby. Lastly, there is a belief that a breastfeeding mother needs to stop breastfeeding when pregnant to prevent something wrong from happening to either the unborn child or the child being breastfed.

Four major traditional practices were also found from the mothers' discourses:

- The practice of self-diagnosing and self-treating illnesses.
- The practice of giving baby herbal drinks.
- Neighborhood advising on child health issues.
- Mothers and mothers-in-law assuming child health experts' roles based on experience.

These beliefs and practices revealed by the study influenced discourses of mothers in the ATP Facebook group and also answers the first RQ set for the study. Other practices that did not dominate the discussions include the pressing of a baby's breast with warm water, using breastmilk as ear drops, massaging a baby's private parts with powder, warm water, Vaseline or mentholated cream, stimulating baby's anus or inserting mentholated cream or small pieces of soap to make them poop. The analysis did not reveal findings on mother's health because most of the mothers only discussed their children's health. Hence, there were no analyzed discourses indicating mother's health.

The second RQ focused on mothers' navigation of the beliefs and practices in terms of rejecting or embracing them. The findings revealed that mothers navigate them in three ways; the first is by resisting and challenging the beliefs and practices. In this case, mothers who are aware of the beliefs circulating in society nonetheless strictly followed the pediatricians' advice. The second way mothers navigate the practices and beliefs is by being vulnerable to them. In this case, mothers are aware of the cultural traditions and beliefs, are worried about them, and sometimes practice them out of fear of offending others. The last way is embracing and defending the cultural beliefs and traditional practices. This means, mothers are aware of and defend the beliefs and practices and do not follow the doctors' advice. In sum, the analysis revealed that despite these three different ways mothers respond to the practices and beliefs, many mothers on the platform declared that the ATP group helped them challenge the beliefs and traditions and taught them to follow the pediatricians' recommendations.

Discussion

Cultural Beliefs

The two major beliefs associated with teething found in the study agree with previous findings that in Nigeria a common cultural belief or myth is that teething children usually experience fever, diarrhea, or vomiting (Bankole et al., 2003; Bankole & Lawal, 2017; Olatunya et al., 2020). Mothers' ATP posts indicated that these beliefs circulated in their environment. In addition, this study also revealed that teething is automatically assumed to be responsible for other unrelated symptoms such as boils, ear infections, cough, rashes, or running nose (ATP post, November 4, 2015). Also, the beliefs that teething medicines and oral intake of herbal concoctions are remedies for teething align with Bankole and Lawal's findings (2017), who noted similar teething

beliefs in their research. For example, some mothers asked the ATP doctors for brands of medicine to use or at what period they should administer the medicine. In some other cases, mothers noted that their mothers-in-law had prepared herbal mixtures for the babies or bought the medicines themselves. However, the discourses indicated that many mothers in the ATP Facebook group did not believe in these teething myths because of their exposure to teething lessons. More importantly, the beliefs shared on the ATP Facebook group imply that they have stood the test of time as older mothers in Nigerian society push the argument as the way to go on child rearing. They also point attention to the relevance of myths, beliefs and practices influencing child health choices.

Furthermore, my findings on breastfeeding beliefs are similar to Joseph and Earland's (2019) work, which found that various beliefs were associated with breastfeeding mothers in Nigeria. However, mothers in this study did not state that religious obligations needed to be performed before they initiated breastfeeding, as noted by Shobo et al. (2020). This is because many of the mothers in the ATP Facebook group noted that they were practicing exclusive breastfeeding. These mothers also attested that they attended prenatal care and engaged with the learning materials in the ATP group. Therefore, it is expected that their beliefs may be somewhat different from previous studies that were carried out among rural women who do not have access to many of these online resources. What some of the ATP mothers appeared to mostly believe is that exclusive breastfeeding is not enough for the baby in the first six months. The popularity of this belief is further evidenced by the NDHS (2018) report that only 29% of mothers in Nigeria exclusively breastfeed their babies. The report by Nigeria's Federal Ministry of

Health (FMOH) also noted that many mothers are not aware of breastfeeding benefits, and they do not receive enough support from the environment (FMOH, 2020).

One example of inadequate environmental support is exemplified by findings from this study. Many mothers indicated that they were discouraged by people close to them not to breastfeed their babies exclusively. These were their neighbors, relatives, mothers, or mothers-in-law who did not believe in EBF because that was not obtainable in Nigeria long before now. Even though breastfeeding is culturally embraced, it is also believed that a child will need complementary foods beginning at three months instead of the six months recommended by WHO. The difference in these findings and previous studies further demonstrates that a mother's education is pivotal to child's health (Adewusi & Nwokocha, 2018; Fasina et al., 2020). This is because mothers in this study can be said to be mostly educated women who navigate Facebook well, read the courses, engage in the learning modules, and ask questions when they need to do so.

This study also finds support in the findings of Olonade et al. (2019), who noted that the belief that pregnant women should not eat some foods was common among some cultures in Nigeria. There were instances of this belief in this study when breastfeeding mothers were concerned because they were asked not to eat certain foods such as beans or milk that Olonade and colleagues also highlighted. In addition to existing beliefs established in the literature, this study adds that having a chubby baby is thought by mothers to be a way of attaining a healthy status and ideal weight for the baby. This belief comes from the myth that breastfeeding is not enough for the baby and a general African belief that being chubby is associated with health and wealth (Ovuorie, 2022). In sum, the study revealed that these beliefs often caused mothers to delay in taking their

children to the hospital because children's illnesses could easily be explained away. The beliefs also exemplify the findings of Dougherty et al. (2020) who opined that cultural norms are one of the factors that contribute to delay in seeking healthcare services among mothers in some states in Nigeria.

Traditional Practices

The traditional practices found in this study are corresponding actions to the beliefs stated and explained above. Firstly, the corresponding practices related to teething beliefs are self-diagnosis and self-treatment and the administration of herbal concoctions and teething powders on babies. Because there is a widespread belief in Nigeria that teething is often the cause of child's illnesses, the perceived symptoms are self-treated. The danger in this practice is that medical treatment is not sought on time. This is further evidenced by one of the posts by Dr. Boyede, the principal of the ATP Facebook group when she noted that

the concern I have... is the issue of DELAY IN SEEKING APPROPRIATE MEDICAL CARE for our children when sick. It has always be baffled me when I get inbox messages or posts on ATP about very ill children with the question what should I do? I always think it is obvious that sick children should be taken to the hospital? Is there something I am missing" (ATP Post, January 2, 2019)?

This post further shows that self-diagnosis and self-treatment are a common enough problem warranting the post by Dr. Boyede, as was also reflected in some of the mother's posts. However, there were other reasons responsible for self-treatment and diagnosis, as evidenced by mothers' comments made on the post above. For example, lack of funds, long waiting times or distance to many government-owned hospitals, the attitude of

health care workers and older mothers' influence were highlighted as reasons many mothers practiced self-diagnosis and treatment in Nigeria. This is summed up by one of the mothers' comments:

On the 31st of December my baby and I spent 5 solid hours at the hospital to see doctor. If it was serious, a child would deteriorate. Those parents whose children were with serious symptoms were told to remove clothes, buy pure water and pour on head, ... A woman carried a 6 yr old girl for hours till she had to spread her wrapper on the floor and lay her naked and wet daughter there. If she had sought neighbours' advice, the child & mother MAY not go through that stress and time wastage. It was a health centre! General is worse. Another reason is not enough money (Nigeria has no free healthcare!) FBC alone is 2000... Another is health workers attitude. Me I don't mind coz I always try to wear a smile. (those people sef dey try. The crowd and workload is much) ... Another one is distance! Where I stay is a bit far from the closest health centre. (I used to fear delivering in a bus in traffic. lolz. I almost registered with one woman like that in our area! That's where most people here use.) The last reason I'll give and maybe the most common is "peer influence", "environmental influence ". We young mothers tend to look up to elder mothers. We think their experience can be our guideline even though syllabus has changed. They in turn lord these experiences over us. If you're a shy and timid mother, you fall. Coz they keep shouting and even drag the child from you. They believe if it worked for one it should work for all (January 2, 2019).

This post summarizes the reasons for self-diagnosis, self-treatment, and the popularity of herbal concoctions and teething powders. Many mothers highlighted the same reasons and mostly pointed out that poverty was the main trigger for the practice. These reasons also point to underlying structural problems which gives credence to the findings of Owoaje et al. (2014), who noted that poverty prevents mothers from making on-time decisions about their children's health. Though pediatricians in the ATP group empathized with the mothers, they still recommended that sick children should be taken to the hospital. Most importantly, they also encouraged mothers to follow the guidelines recommended on the ATP site to reduce frequent occurrences of illnesses in children.

Secondly, regarding the practice of neighborhood advising and older mothers and mothers-in-law serving as child health experts, mothers commonly affected are the first-time mothers. Findings of this study indicate that what makes mothers embrace or reject these practices depends on the following factors. One is the mother's level of education and health literacy which was previously indicated by Fasina et al. (2020). As evidenced in the ATP posts, when mothers are health literate, it can be easier to reject the traditional beliefs. This action was also previously highlighted by Mosuse and Gadeyne (2021) when they suggested that a mother with autonomy and agency will be able to make the right decisions that will enhance her child's health. Two, husbands who do not support their wives make them susceptible to embracing traditional beliefs. More importantly, it was found that to avoid strained relationships, young mothers would need to be polite in navigating the beliefs and practices. This is because all the parties involved have the best interests of the child, irrespective of their different opinions. In the following section, I

discuss the implications of the study's findings for the theory, Relational dialectics theory.

RDT and Mothers' Navigation of Cultural Beliefs and Traditional Practices on ATP Facebook Group

In this section of the paper, I briefly attend to mothers' navigation of cultural beliefs and practices and the dialectical tensions on mothers' narratives in the ATP posts, guided by RDT. Firstly, RDT suggests that the process of meaning-making in interactions are guided by shared systems of meaning that are intelligible to members of that culture (Baxter et al., 2021). Consequently, through the identification and the recurrence of patterns in the mothers' discourses on the ATP Facebook group, the analysis established that cultural beliefs and traditional practices are an integral part of mothering and child-rearing in Nigeria. The two discourses at play in the analysis are the medical and cultural discourses. This is evidenced by the themes generated from the corpus of discourses explained and discussed in the previous sections. Having identified the themes in Nigerian mothers' discussions on mothering, it becomes important to see how the different discourses interplay and compete with one another even as these mothers navigate the often-conflicting views and perspectives between cultural expectations and medical recommendations about mothering.

Secondly, RDT recognizes tensions or oppositions that can be uncovered from a body of discourse (Baxter et al., 2021). Throughout the data, naturally occurring conversations about mothering reveal existent dialectical tension between traditional beliefs on mothering and the voice of medicine. Interestingly, the administrators on the ATP Facebook served as the voice of medicine while the mothers served as the voice of culture. Though not all the mothers embraced cultural beliefs and practices, they served

as resources by bringing to the group examples from their neighborhood of how culture and traditions permeate mothering in the Nigerian society. There were also various instances where the principal administrator, Dr Boyede, would ask the mothers to talk about a certain practice or belief, which usually generated many comments from mothers who cited practices in their different communities.

The young mothers were mostly in the middle of the opposition between the pediatricians and the custodians of traditional practices. These dialectical tensions demanded navigation from the young mothers, and this was done in three ways: mothers who prioritized medical recommendations over cultural beliefs, mothers who value both medical recommendations and traditional practices, and mothers who prioritized cultural beliefs over medical recommendations. The first two categories reflects the negotiation of the practices and close relationships with the custodians of traditional practices because these are not relationships that can be easily ignored.

Thirdly, RDT recognizes that discourses are oftentimes in dialectical tensions with one another as they compete for dominance or centrality in people's talk (Baxter et al., 2021). That is, only one discourse is centered per time and in this study, the medical discourse takes centrality in the mothers' discussions. This is because of the medical setting of the ATP Facebook group with clear goals of advancing medical practice and educating mothers based on those goals. More importantly, the discourses revealed that outside of the ATP Facebook group, cultural beliefs and traditional practices, discussed in this study, are prevalent and widely embraced as dominant mothering practices. Though previous studies mostly report that traditional practices and cultural beliefs are prevalent in Nigeria's rural and northern parts (Mohammed et al., 2020; Odetola & Salmanu,

2021), this study adds that cultural beliefs and practices are operational in other parts as well. The difference, however, is that the kinds of beliefs found in previous studies, such as women preferring TBAs or home births over skilled birth attendants and low attendance at prenatal clinics, were not found in this study. Nonetheless, the meanings generated from this study further establishes the theory as valuable in understanding the cultural meanings and dynamics of a group of people (Baxter & Braithwaite, 2008).

Lastly, though this study did not analyze dialogues in interpersonal communication as RDT exemplified with the utterance chain (Baxter et al., 2021), with the lens of RDT, this study describes how mothers make sense of mothering. It considers culturally existing practices upheld by older mothers to understand younger mothers' tension with recommended medical practices. It also establishes mothers' narratives that in order to be a good mother, there are feelings of tensions and a continued interplay between medical and cultural practices.

Implications for the study and Future Research

One of the gaps noticed in the literature was that the perspectives of mothers were often missing from studies focusing on maternal and child health, especially studies utilizing discourses and social media. However, this study was able to include the voice of mothers as participants in the conversation on mothering and child health-related research in Nigeria. The influence of cultural beliefs and traditional practices indicates varying levels of awareness among mothers. This suggests that campaigns and projects focusing on health literacy among mothers on mothering and child health needs to be intensified.

What prompts mothers to embrace cultural beliefs and traditional practices is simply their love for the child. Whether they are aware of some of its dangers or not is why many of the mothers on the ATP Facebook joined the group, evidenced by their questions to ascertain the right child health practice. However, regarding the main practices found, the study agrees with previous studies that the utilization of self-directed treatments, traditional herbs, and delay in presenting a child to a health care facility for prompt diagnosis are influential causes of serious ailments (Adimorah et al., 2011; Sood & Sood, 2010). Therefore, in order for policymakers to provide helpful information (Evans, 2013) for mothers, it is essential to focus on health literacy that targets cultural beliefs and practices.

Furthermore, the setup and resources available on the ATP Facebook group by the principal administrator, Dr Boyede, demonstrate how new media informs community support care. This then suggest the need for government or private-owned health care facilities to develop continued interactions between pregnant women, mothers, and their doctors or midwives using social media platforms. Though prenatal care is emphasized as significant, much emphasis is not laid on postnatal care. As evidenced by the mothers' narratives, it is during the post-natal period that many practices such as teething and breastfeeding myths or herbal concoctions are suggested to mothers. Hence, policy makers should also focus on healthcare systems' utilization of social media platforms in communicating health to mothers and further following up the health literacy created during antenatal care. Though this would only work for women who have access to social media, mostly in the urban areas, mothers in the rural areas without access would need to be engaged using other channels such as religious and community support groups.

The cultural beliefs and traditional practices found in this study cannot be said to cause child mortality directly. More importantly, they indicate beliefs and practices that make mothers delay taking their children to the hospital on time. Consequently, this delay can lead to undesirable outcomes depending on the situation. Also, some of the dangerous practices found in this study indicate that propagators of these practices and traditions are not aware of their health implications for newborns. Hence, it is suggested that health institutions incorporate health campaigns targeting older mothers or grandmothers at the grassroots levels on the health implications of the dangerous practices.

In conclusion, this study's findings further foreground the essence of meaning-making and discourse analysis in health communication research. Analysis such as demonstrated in the study establishes the significance of the influence of cultural beliefs in understanding mothering health behaviors. As suggested by Wood (2005), myths often act as guides to understanding the cultural narratives of a people. As exemplified in this study, myths are embedded in cultural practices as older mothers pass down the values that worked for them to their grandchildren. Even though they are based on myths and doctors do not recommend some of them, they do this because they believe it is best for the child. Therefore, this study's findings align with the previous studies that defines culture as an integral component of health communication rather than a separate entity (Head et al., 2021; Raman et al., 2016). This explains why scholarship in health communication calls for the role of cultural backgrounds in understanding how diverse groups of people communicate about health (Head et al., 2021). In response to this call,

this study described the influence of some of Nigeria's cultural beliefs and traditional practices on mothering and child-rearing discourses.

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