**FACTORS INFLUENCING EXCLUSIVE BREASTFEEDING AMONG MOTHERS ATTENDING CHILD WELFARE CLINIC AT MAKINDU SUB COUNTY HOSPITAL**

**BY**

**A RESEARCH PROJECT SUBMITED TO KENYA MEDICAL TRAINING COLLEGE IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF DIPLOMA IN COMMUNITY HEALTH NURSING.**

**July, 2021**

# **DECLARATION**

I declare this study is my original work and has not been presented anywhere else.

SIGN…………………………………...DATE…………..…………………….

**Admission no**:

This research proposal has been submitted with my approval

**SUPERVISOR**:

SIGN……………………………............DATE…………………………………

**Department of nursing**

# **DEDICATION**

I dedicate to my Almighty God who has enabled me to go through my study with minimum snags. I also extend my dedication to my dear parents for giving moral, spiritual, financial support throughout my education and making it possible for me to climb this far.

# **ACKNOWLEDGEMENT**

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My immense thanks go to my supervisor Mr Jonah Nyachae for what he has impacted in me academically.

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**OPERATION DEFINATION OF TERMS**

**Exclusive breastfeeding** - is the feeding of infants with only breast milk, be directly from breast or expressed, except drop or syrups consisting of vitamin, minerals supplements or medicine.

**Birth characteristics** - This means birth related factors such as birth weight, method of delivery and birth order

**Complementary feeding -** Refers to feeding a child with foods in addition to breast milk

**Dietary intake -** Food or drink eaten or consumed in a day

**Maternal characteristics -** Refer to the mother’s education level, parity, marital status, morbidity and mode and place of delivery.

**Socioeconomic status** – This economic and sociological combined total measure of an individual’s social position relative to others in that cohort based on income.

# **THE LIST OF ABBRIVIATIONS AND ACRONOMYS**

**CDC** - Centre of disease control

**CWC** - Child welfare clinic

**EBF**- Exclusive Breastfeeding

**HIV**- Human immunodeficiency virus

**KDHS** - Kenya demographic and health survey

**LLLI** - La leche league international

**MOH**- Ministry of health

**PMTCT** - Prevention of mother to child transmission

**UN** - United nation

**UNICEF** - United nation children’s fund

**WHO** - World health organization

# **ABSTRACT**

**Background**: exclusive breastfeeding is essential for optimal survival, development and growth of infants. World health organization and United Nations children’s fund recommend that infants are exclusively breastfed from birth up to six months of age to achieve its benefits. However, exclusive breastfeeding rates across the world and in Makindu sub county hospital are below the recommended targets. This study’s aim was to investigate the factors influencing exclusive breastfeeding among mothers attending child welfare clinic at Makindu sub county hospital.

**Methods:** A cross-sectional study design was carried out among 234 women of reproductive age (15-49 years) with infants zero to six months attending child welfare clinic in Makindu Sub County Hospital. Data were collected using a structured questionnaire.

**Results:** Among the factors that hindered EBF, the social demographic factors were age, marital status, level of education and employment status. The mothers‟ ages ranged from 15 to 44 years. The highest percentage of the mothers (51%) were in the age group of 25- 29 while the least percentage (5%) were in the age group 40-44 years. The mean age of the mothers was 25 years. Most of the mothers 31% had secondary education while 15% had tertiary education three times more likely to exclusively breastfeed compared to participants with no formal education. Participants who were semi-skilled and skilled were less likely to exclusively breastfeed. Being a professional and having other types of jobs were associated with the likelihood of breastfeeding exclusively. Participants with cultures that had beliefs of giving baby other fluids were more likely to breastfeed exclusively compared to those with no belief of giving fluids. An association was found between participants whose believed that milk was a satisfactory to growth was stated by most (51%) mothers as a belief of their culture that made practicing exclusive breastfeeding less difficult.

**Conclusion:** Exclusive breastfeeding practice is sub-optimal in Makindu sub county hospital. Exclusive breastfeeding practice is influenced by participants’ level of education, most usual occupation source and most relied source of information on breastfeeding. Health staff should intensify awareness of exclusive breastfeeding and its benefits to mothers, their spouses, families, traditional leaders and influential persons in community. Furthermore, health staff should build mother’s confidence by teaching appropriate techniques in expressing, storing and cup/spoon feeding.

# **CHAPTER ONE: INTRODUCTION**

## **1.1 Background Information**

Breastfeeding is a process whereby the infant receives breast milk from the maternal breast (Kong et al., 2014). Exclusive breastfeeding has been defined as feeding of an infant with breast milk only without giving any other foods, not even water (Drane, 2017).Milk is the primary source of nutrition for newborns before being able to digest other foods other than milk. Breast milk is the milk produced by the breast (or mammary glands) or the human female for her infant. Breastfeeding offer health benefits to mother and child when exclusively breast fed. Among the benefits of exclusive breastfeeding to infant are lower risk of infant death syndrome, increased intelligence, cold and flu resistance, lower risk of childhood onset diabetes, risk of asthma and eczema, decrease likelihood of contracting middle ear infection, dental problem, obesity life, risk of autism, risk of childhood leukemia developing psychological disorders particularly in adopted children and exclusive breastfeeding, reduces the risk of HIV transmission from mother to child (UNICEF, 2016).

About 60% of under-five mortality is caused by malnutrition either directly or indirectly, whereby more than 2/3 of those associated with inappropriate breastfeeding practices during infancy. Breastfeeding practice can save many as 1.5 million infants’ lives every year as it provides significant protection against diseases. Orphan child is more likely to die before reaching age of two years than child whose mother survival (WHO, 2011).

35% of infants worldwide are exclusively breastfeeding during their first four months of life although the rates differ from one country to another. Brazil 58%, Bangalore 40%, Iran 69%, Lebanon 10.1%, Nigeria 20%, Bangladesh 34.5%, and Jordan 77% (WHO, 2014).

Study findings from a UK based research indicated that reasons for low breastfeeding rates included cultural attitudes, limited knowledge of the benefits of breastfeeding and heavy media promotion of bottle-feeding. The same study revealed that undesirable breastfeeding practices were found to be associated with urban residence, younger mother’s age and higher educational attainment (Mitch et al., 2014).

In Sub-Sahara and Africa countries exclusive breast-feeding rate for six months is about 30% (UNICEF. 2006), 47% in Ethiopia, and 13% in Kenya. Although the CDC reported that, the breastfeeding is rising by 2% (CDC, 2012). One of the studies indicated that, the race, maternal age, maternal occupation, parent's educational level, social-economic status, insufficient milk supply, infant health problems, maternal obesity, smoking, parity, method of delivery, maternal interest, social culture and lack of knowledge were among factors that cause inadequate exclusive breastfeeding (Roudbari, et al. 2009).

In Kenya, poor infant feeding practices have been identified. While close to 40% of the infant are not breastfed within 1 hour of birth. Only 2% are exclusively breastfed for the first 6 months and 15% stop breastfeeding by the end of 1 year

## **1.2 Problem statement**

According to the health records in Makindu District Hospital, the number of mothers who practice exclusive breastfeeding is extremely low. Observations during clinical support supervision indicated that more than 50% of lactating mothers admitted with their children less than six months of age have already started complementary foods. In Kenya, only 13% of children below six months are exclusively breastfed (UNICEF, 2016). Despite all these efforts and more from MOH the number of mothers practicing EBF is on the low.

The Makindu district hospital has held several sensitization programs where information, communication and education is used as a strategy to tackle the problem of non-compliance to exclusive breastfeeding. Prevention of mother to child transmission of HIV/AIDS trainings are held to ensure that mothers are well informed of the importance of exclusive breastfeeding even when they are HIV positive. This could be attributed to other factors such as age, social status, religion, cultural beliefs, employment or the lack of it and other factors that this research seeks to find out so that further interventions can be put in place to control the problem.

## **1.3 Study objectives**

### **1.3.1 Broad objectives**

To determine factors influencing exclusive breastfeeding among mothers attending child welfare clinic at Makindu sub county hospital.

### **1.3.2 Specific objectives**

1. To determine socio cultural factors influencing breastfeeding among mothers attending child welfare clinic at Makindu sub county hospital.
2. To determine demographic factors that influence exclusive breastfeeding among mothers who attend child welfare clinic at Makindu Sub County Hospital.
3. To determine economic factors that inhibit mothers attending the child welfare clinic from practicing Exclusive breastfeeding.

## **1.4 Research questions**

1. What are the socio cultural factors influencing exclusive breastfeeding among breastfeeding mothers attending child welfare clinic at Makindu sub county hospital?
2. What are the economic factors affecting exclusive breastfeeding among breastfeeding mothers attending child welfare clinic at Makindu sub county hospital?
3. What are the demographic factors influencing exclusive breastfeeding among breastfeeding mothers attending child welfare clinic at Makindu sub county hospital?

## **1.5 Justification of the study**

The study was expected to assist the Ministry of Health, Stakeholders, Policy makers as well as individual person in planning feasible intervention and strengthening the existing factors on exclusive breast feeding and all other effect that are related to exclusive breastfeeding so as to support the Sustainable Development Goals 2030, by supporting exclusive breastfeeding and reducing the morbidity and mortality rate to children. By determining the factors affecting exclusive breastfeeding, the study will help increase the number of mothers practicing exclusive breastfeeding and hence contribute to achieving the sustainable development goal number 4 which is to reduce child mortality (UN, 2016).

Determining these factors will increase adherence to exclusive breastfeeding which reduces the risk of both under nutrition and overweight later in childhood. Breastfed children are healthier and have fewer hospitalizations than non-breastfed children (WHO, 2014). It has been estimated that exclusive breastfeeding for the first six months of life could reduce infant mortality by a remarkable 13% and by an additional 2% were it not for the fact that breastfeeding may transmit HIV.

## **1.6 Scope and limitations**

This research was limited to the mothers attending children welfare clinic in Makindu Sub- County hospital because of limited time and resources. This study only focused on Makindu Sub- County hospital to generalize the situation. The study was aimed to see factors influencing exclusive breastfeeding among mothers attending child welfare clinic.

# **CHAPTER TWO - LITERATURE REVIEW**

## **2.1 The historical background of breastfeeding**

Breastfeeding has been practiced since mammals existed on earth. Breastfeeding was rarely described even by those few ancient writers interested in infant health. The ancient Greek and Roman medical writings from Hippocrates, Soranus and Galen included infant health and feeding to some extent in their broader treatises on health (Scott, 2012). As far as the duration of breastfeeding accepted in ancient civilizations was concerned, it was said that “Plotinus at the age of eight used to run from his tutor to his nurse and clamor for the breast” (Littmas, 2013).

Lutter et al. (2000) estimated average breastfeeding duration of 3 – 4 years among “primitive” peoples. Hawaiians were said to breastfeed for five years and Eskimos for about 7 years reaching a maximum in King William Land of up to 15 years. Ford, (1945), noted that breastfeeding continued for 3 years or longer in 15 of 45 “primitive” cultures, for 2 years in 16 of them, for 18 months in 13 of them and for 6 months in one culture. Rayne, (2002) located one source from the late 1400s suggesting that it was by then normal to breastfeed for only about one year in Germany.

In Italy, it was noted that women gave up breastfeeding by the third month and stopped breastfeeding by the 13th month. Before the 1900s, if a mother did not breastfeed, a substitute “wet nurse” was hired to do it (Gordon et al., 2014). Traditional patterns of both breastfeeding and other care for nutrition have been subjected to erosion. Wet nursing by grandmothers, a very valuable custom, rarely received reinforcement from breastfeeding programs and hence has been lost (Ebrahim, 1991). During the early 1900s, the technology of formulas and feeding improved.

Throughout the 1950s and early 1960s, interest in breastfeeding further waned. In the 1970s, breastfeeding enjoyed a resurgence, which has since leveled off (Gordon et al., 2014). In 1981 and 1987, the La Leche League International (LLLI) board of directors voted to support the WHO / UNICEF International Code of Marketing of Breast milk Substitutes. In February 1988, the board directed LLLI to cooperate and network with other key breastfeeding organizations around the world and to lend strong US support to struggling countries. In October 1988, the board voted to support the efforts of the American Academy of Pediatrics for their policy opposing direct advertising of infant formula to the public. This was recognized as a positive step towards increasing the incidence and duration of breastfeeding in the US. The move was to lend support to breastfeeding worldwide.

On July 21, 1991 a historic meeting was held in the USA to discuss the marketing of artificial infant feeding in the US. At this meeting a consortium drafted the “Declaration for the Protection, Promotion and Support of Breastfeeding” (Hogan et al, 2008). Breastfeeding was the normal way of feeding infants in all traditional societies. In a world - wide study of 45 different cultural and ethnic groups in the 1940s, it was found that on average the infant breastfed for 1.5 – 2 years. In some communities it continued for as long as 6 years (Ebrahim, 2011).

A multi – nation study sponsored by WHO, in 1981 found three main patterns of breastfeeding; in the first pattern, breastfeeding was rarely continued beyond 6 months and there was a tendency to terminate breastfeeding even sooner than that. On the other extreme, breastfeeding was prolonged and almost universal with about 50% of the mothers continuing to breastfeed at the age of 18 months. A third group of mothers exhibited a pattern which fell midway between the two extremes (Ebrahim, 2011).

## **2.2 Socio demographic factors**

A study done by Della in Turkey investigated the social factors in relation to duration of exclusively breast feeding, the study indicated, as the age of the mother increases also the duration of exclusive breast-feeding increases, which means that the young mother lacking the breastfeeding experiences and might not be able to make their own decision on how to feed the babies. The same study identified the factors related to early stopping exclusive breast feeding, the investigator reported that the mother with higher level of education were more likely to practice exclusive breastfeeding than those with middle level of education, also mother who employed breast feed exclusively longer than those mothers who did not to about 68.8% and 47% respectively (Zekiye, 2006).

The literature on the determinants of breastfeeding has consistently identified lower maternal age as predictors of lower breastfeeding rates. A young mother with her first child may find it difficult to believe that she can breastfeed successfully. Breastfeeding fails easily in a young school girl who has a baby that she really did not want. The young mother feels shy to breastfeed and this impairs milk secretion. The young women to a large extend perceive their breasts in terms of their attractiveness rather than their function. Several mothers with a child at the end of a large family give up breastfeeding rather easily, although they had no difficulties with earlier children (UNICEF, 2016).

## **2.3 Economic factors and Level of knowledge**

Generally educated women tend to breastfeed less and are likely to introduce supplementary feeding earlier than those with little or no education. This is attributed to the fact that a better educated woman is more likely to work away from home which makes breastfeeding difficult. The KDHS (2003), found an inverse relationship between education and mean duration of breastfeeding (Luan, 2013).

High qualities of counseling improve an adherence and long duration of exclusive breastfeeding up to six months (WHO, 2011). The research carried out in Zambia at Nola area, under the program of PMTCT, reported that nursing mother who had received adequate counseling on exclusive breastfeeding had high rate of practicing exclusive breast feeding than those who do not, 56% to 70 % respectively (Lewisky, et al., 2008). Mother who had the knowledge regarding the importance of exclusive breast feeding was likely to adhere to exclusive breastfeeding compared to those with limited knowledge on importance of exclusive breastfeeding, for example a study conducted in South Africa, Zambia and Zimbabwe among HIV infected and HIV uninfected mothers indicated that consistent messages and high quality of counseling improved adherence and longer duration of exclusive breast feeding up to six months. About 75% of Nigerian mothers believed breastfeeding could not go beyond the first one year (Salami, 2016).

Having adequate information about breastfeeding and failing to experience problems during breastfeeding period are found to influence mothers to breastfeed their infants. One of the elements to empower a woman to breastfeed is that she has sufficient knowledge to make decisions. Breastfeeding choice and success are usually associated with higher knowledge on breastfeeding (UNICEF, 2016).

Women in low-income settings often consume inadequate amounts of micronutrients because of resource limitations. They have a limited intake of animal source foods, fruits and vegetables. Intake of micronutrients less than the recommended values increase women's risk of micro nutrients deficiencies (Baker, 2010).

Adequate nutritional status of women is important for good health and increased work capacity of women themselves as well as for the health of their babies (Brutta, 2010). Lactating mothers from low-income settings are considered as nutritionally vulnerable group. Due to the nursing process mothers are subjected to nutritional stresses. Frequent pregnancies followed by lactation increase the health risk of mother resulting in high maternal mortality (Salil, 2010).

## **2.4 Socio cultural factors**

Cultural practices and beliefs influence mothers practicing exclusive breastfeeding especially in Sub Saharan countries. Due to cultural beliefs and practices, Infants are given fluids or water a few days after delivery. West Africa studies reported the culture practice of giving infant mixture herbal for protection, and believe the milk is not satisfactory to growth because milk does not contain enough nutrients to infant (Adejuyigbe, et al., 2008).

Breastfeeding in a public place or in the presence of friends is an activity that is extremely sensitive to cultural norms. Findings of the study done among women in Hong Kong showed that majority of the women agreed that it was unacceptable to breastfeed in front of others except the husband and the health care workers. Society has stressed modesty and frowned on baring breasts in public even in so good a cause as nourishing babies. In most African countries, breastfeeding is still considered an important part of the traditional culture and is actively supported and promoted by community members (Kong et al., 2014).

Cross sectional study design done in Uganda, aiming to identify the factors affecting the infant feeding. The study indicated most of lactating mothers started early pre-lacteal feeding, mainly to wait the breast milk flow; also believed that, water used to clean the baby throat, to reduce baby’s hungry, about 51.1% infant were given water-based liquids as pre-lacteal feeds within the first three days of their life (Adejuyigbe, et al., 2008).

Early initiation of breastfeeding stimulates mothers to produce the first milk quickly known as colostrum. Pre-lacteal feeds inhibit a baby from receiving adequate protection from colostrum. The colostrum contains a high concentration of immunoglobulin which has protective role against viral and bacterial pathogen in the gut. Some of community believes that the colostrum is not good to their babies as result it is discarded (King, et al., 2007).

## **2.5 Theoretical framework**

There are factors that play a role in factors influencing exclusive breastfeeding among mothers attending child welfare clinic at Makindu sub county hospital, Demographic, socio-economic factors and maternal knowledge. These determine which feeding option a lactating mother will settle for as the best for her situation. If she settle to practice exclusive breastfeeding and adheres to this method, the infant will enjoy good nutrition status, reduce infant infections and also reduce mortality and morbidity (WHO, 2015). This is the summary in figure 1.1 below:

**Independent variables**

1. **Demographic factors**

**2 .Social economic factors**

**3. Social cultural factors**

**Dependent variable**

Exclusive Breastfeeding

Figure 2.1 Theoretical frame work

## **2.6 Summary of the literature review**

Studies have shown that there are efforts made globally to improve exclusive breastfeeding because it has become more than just a lifestyle decision but has become a public health concern (AAD, 2015). Although increases in exclusive breastfeeding rate have been recorded over the years, these increases still fall short of recommendations set by WHO to afford infants the basic nutrients they need to grow and develop. Factors shown to influence exclusive breastfeeding among mothers with infants in different locations across the world in the above literature are socio-demographic factors, maternal knowledge on exclusive breastfeeding and its importance. Information on these factors as well as how they influence breastfeeding exclusively is however inadequate in Makueni and in Makindu sub county Hospital most especially.

# **CHAPTER III -: MATERIALS AND METHODS**

## **3.1 Introduction**

This chapter describes the methodology that the researcher used to find answers to the research questions. It sets out various stages and phases that were followed in order to complete the study. It also involves a blueprint for the collection, measurement and analysis of data. It includes the procedures and techniques that were used in the collection, processing and analysis of data.

## **3.2 Study design**

The study design was cross-sectional design. A descriptive research determines and reports the way things are and helps to gather data at a particular time in order to describe the existing conditions and determine the relationship that exists between specific events. Descriptive Study design according to Mertens and McLaughlin (2004) has the advantage of collecting information from a large number of people. The information can be collected from the participants themselves, from other people or by examining records.

## **3.3 Study area**

This study was carried out in, Makindu sub county hospital in Makueni County among mothers attending child welfare clinic.

## **3.4 Study population**

The study targeted 561 lactating mothers who have children of less than 6 months old visiting Makindu Sub County Hospital in Makueni County. This is located in Kibwezi west, along Mombasa road. Kibwezi west is surrounded by Kibwezi East to the south and Kilome to the north.

### **3.4.1 Inclusion criteria**

This included all lactating mothers who have children of less than 6 months old visiting Makindu Sub County Hospital in Makueni County.

### **3.4.2 Exclusion criteria**

This included those who didn’t consent to participate after explanation about the purpose of the study and or mothers who had children with over 6 months and above.

## **3.5 Study variables**

### **3.5.1 Dependent variable**

Factors influencing exclusive breastfeeding among mothers attending child welfare clinic.

### **3.5.2 Independent variables**

The independent variables of the study were; age, marital status, religion, education, employment, maternal knowledge on exclusive breastfeeding and its importance as well as malnutrition and feeding options affecting exclusive breastfeeding.

## **3.6 Sampling techniques**

The sampling technique that was used for this study was a convenient sampling which is a non-probability sampling method. This is whereby respondents were chosen based on their proximity and ease accessibility to the researcher. This was done at the MCH where these mothers get postnatal services.

## **3.7 Sample size determination**

The sample size of this proposal was calculated by using Taro Yamane [Yamane, 1973]. Formula with 95% confidence level.

The calculation formula of Taro Yamane 1973 is presented as follows

n=N/1+N[e]2

Where; n=the desired sample size

N=Number of people in population [561]

e=allowance era [%]

n= 561/1+561[0.05]2

n=561/1+561[0.0025]

n=561/1+1.4025

n=561/2.4025

n=234

Sample size population is 234.

## **3.8 Development of data collection instruments**

The data was collected using open ended and closed ended questionnaires and one to one interview. The questionnaire was designed to collect qualitative and quantitative data whereas one to one interview was conducted using prepared schedules. The structured questionnaires were used to save time and money as well as to facilitate an easier analysis as there was an immediate usable form; while the unstructured questionnaire was used to encourage the respondent to give an in-depth and fill response without feeling held back in revealing of any information. The end results were then grouped together as per the objectives and be presented using graphs, charts and percentages.

## **3.9 Data Collection process**

Data was then acquired through self-administering questionnaires to the respondents. This was either in closed sessions or free whereby a respondent was allowed to stay with the questionnaire for certain duration, fill, and then returns.

## **3.10 Pretesting of the study**

A pre-test was conducted by the investigator to determine the feasibility, validity and reliability of the research instruments at Kibwezi sub county hospital a neighboring branch hospital. The sample size for the pre-test will be 5 respondents (10%) of the study sample size (Mugenda, 1999).

## **3.11 Validity**

Data validity was performed by the investigator since it is a continuous process during data collection. The questionnaires was coded with a unique identity number and hence compare the source and target data

## **3.12 Data analysis**

Data analysis was then be analyzed using quantitative analysis whereby data was measured in terms of numbers. This included the calculation of frequencies of variables and differences between variables.

## **3.13 Ethical Considerations**

While conducting the study, the researcher ensured that research ethics are highly observed. Clearance was sought prior the study from KMTC Makindu college of study to allow me to freely conduct research on their grounds then get the same from the facility then the clinic and both written and verbal consent. Participation in the study was voluntary. Privacy and confidentiality was observed. The objectives of the study were explained to the respondents with an assurance that the data provided was used for academic purpose only.

# **CHAPTER FOUR** **- RESULTS**

## **4.1 Introduction**

This chapter provides detailed findings obtained from the determinacy of factors influencing exclusive breastfeeding among mothers attending child welfare clinic at Makindu sub county hospital. This is followed by factors that hinder exclusive breastfeeding practice, maternal understanding of exclusive breastfeeding, and the relationship between socio – demographic characteristics and exclusive breastfeeding practice. The data was collected using questionnaire on 234 participants who attended the health facility. The findings have been presented using the frequency distribution table and figures.

## **4.2 Socio – demographic characteristics of the mothers**

1. **Mothers age distribution**

The sample size of the study population was 234 mothers. The variables of interest researched on were age, marital status, level of education and employment status. The mothers‟ ages ranged from 15 to 44 years. The highest percentage of the mothers (51%) were in the age group of 25- 29 while the least percentage (5%) were in the age group 40-44 years as shown in the figure 4.1.

**Figure 4.1: Mothers' age distribution**

1. **Level of education of the mothers**

Most of the mothers 31% had secondary education while 15% had tertiary education as shown in the figure 4.2

**Figure 4.2: Level of education of the mothers**

1. **Marital status**

More than three quarters of the mothers (78%) were married while 22% were single.

**Figure 4.3: Marital status**

## **4.3 Social Economic and Knowledge factors**

53% of the participants stated that they had no source of income while majority (40%) of those who were working indicated that they depend on their business. It was found that majority (71%) 166 of the participant were well informed that the age in which the baby should be breastfed exclusively is 6 months. 64% of the participants affirmed that they discuss with their spouse always (79%) about breastfeeding compared to 5% who rarely did as illustrated in the table 4.1 below:

|  |  |  |  |
| --- | --- | --- | --- |
| Variables | | Frequency = n | % |
| The age in which the baby should be breastfed exclusively | 2 weeks | 0 | 0% |
| 3 months | 40 | 17% |
| 4 months | 13 | 6% |
| 6 months | 166 | 71% |
| 1 year | 5 | 2% |
| Others | 10 | 4% |
| Do you discuss with your spouse about breastfeeding? | Yes | 150 | 64% |
| No | 84 | 46% |
| If yes how often | Always | 115 | 49% |
| Most of the times | 87 | 37% |
| Sometimes | 21 | 9% |
| Rarely | 11 | 5% |
| Employment | Self employed | 61 | 26% |
| Part time employment | 40 | 17% |
| Full time employment | 9 | 4% |
| No employment | 124 | 53% |
| Form of employment | Office work | 11 | 5% |
| Business | 94 | 40% |
| Farm Work | 63 | 27% |
| Others | 66 | 28% |

**Table 4.1 Social Economic and Knowledge factors**

**Approximate income**

It was found that most (125 out of 234) of the participants earned less than 5000 according to the study as indicated in the table below.

**Figure 4.4 Approximate income (n=234)**

**Benefits of breast milk to your baby**

Many of the participants stated that breastfeeding prevents illness, diarrhea and creates bond between the mother and baby represented by 47% (110), 27% (65) & 21% (50) respectively as illustrated in the figure 4.5 below:

**Figure 4.5**: **Benefits of breast milk to your baby**

**Mother’s knowledge on exclusive breastfeeding**

In determining the proportion of mother’s with infants who exclusively breastfeed, results showed that majority (90%) of participants agreed that breastfed babies are healthier. Most (60%) of the participants declined that babies who are fed exclusively are not from rich family and 50% of the participants lacked the knowledge of whether frequent and prolonged breastfeeding prevents pregnancy after birth. Majority (64%) of participants reported that no one feeds the baby exclusively after feeding poorly. (60%) of participants indicated that Breast milk protects infants from illness as well as encouragement and support in breastfeeding from husband is important. Majority (70%) of the participant didn’t knew that Child does not need colostrum in the first hour after birth as shown in the Table 4.2 for detailed results.

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | | **Frequency**  **N=234** | **%** |
| Breastfed babies are healthier | Agree | 211 | 90% |
| Disagree | 5 | 2% |
| Don’t Know | 18 | 8% |
| Babies who are feed exclusively are from rich family | Agree | 70 | 30% |
| Disagree | 140 | 60% |
| Don’t Know | 24 | 10% |
| Frequent and prolonged breastfeeding prevents pregnancy after birth. | Agree | 61 | 26% |
| Disagree | 56 | 24% |
| Don’t Know | 117 | 50% |
| Breastfeeding women are less likely to develop cancer of breasts and cervix | Agree | 73 | 31% |
| Disagree | 51 | 22% |
| Don’t Know | 110 | 47% |
| Mother eating poorly cannot breastfeed her child exclusively | Agree | 150 | 64% |
| Disagree | 47 | 20% |
| Don’t Know | 37 | 16% |
| Encouragement and support in breastfeeding from husband is important | Agree | 140 | 60% |
| Disagree | 59 | 25% |
| Don’t Know | 35 | 15% |
| Breastfeeding makes my breasts loose shape | Agree | 2 | 1% |
| Disagree | 131 | 56% |
| Don’t Know | 101 | 43% |
| The quantity of breast milk depends on mother’s food | Agree | 115 | 49% |
| Disagree | 84 | 36% |
| Don’t Know | 35 | 15% |
| Child does not need colostrum in the first hour after birth. | Agree | 23 | 10% |
| Disagree | 47 | 20% |
| Don’t Know | 164 | 70% |
| Breast milk protects infants from illness | Agree | 140 | 60% |
| Disagree | 82 | 35% |
| Don’t Know | 12 | 5% |

**Table 4.2: Mothers knowledge on exclusive breastfeeding**

## **4.3 Socio-cultural practices influencing exclusive breastfeeding**

Concerning socio-cultural factors that influence exclusive breastfeeding, results showed that almost three-quarters (73%) of mothers with infants zero to six months could breastfeed their infants in the presence of other people whom they are not related to as shown in the figure 4.6 below.

**Figure: 4.6 Breast feeding in presence of non relatives**

Majority (67%) of participants declared to have fed their infants with other fluids like water and or herbal products while 33% declined to have given their infants any fluids after delivery. Believing that milk was a satisfactory to growth was stated by most (51%) mothers as a belief of their culture that made practicing exclusive breastfeeding less difficult as illustrated in the table 4.3 below;

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | | **Frequency n=234** | **Percentage**  **%** |
| After delivery have you ever given your child any other fluids like water or herbal products | Yes | 77 | 33% |
| No | 157 | 67% |
| Do you believe the milk is satisfactory to growth of the infant? | Yes | 119 | 51% |
| No | 115 | 49% |

**Table 4.3 Social economic factors**

# **CHAPTER V - DISCUSSION, CONCLUSION & RECOMMENDATION**

## **5.1 Discussion**

The main objective of this study was to investigate factors influencing exclusive breastfeeding among mothers attending child welfare clinic at Makindu sub county hospital. Descriptive research design was used in the study. The study population was mothers of infants aged below 6 months and the sample size was 234. From the findings of the study, there were many factors that hindered the practice of exclusive breastfeeding practice, including maternal understanding of exclusive breastfeeding, and the relationship between socio – demographic characteristics and exclusive breastfeeding practice. Among the factors that hindered EBF, the social demographic factors were age, marital status, level of education and employment status. The mothers‟ ages ranged from 15 to 44 years. The highest percentage of the mothers (51%) were in the age group of 25- 29 while the least percentage (5%) were in the age group 40-44 years. The mean age of the mothers was 25 years. Most of the mothers (31%) had secondary education while 15% had tertiary education And this reveals that as the age of the mother increases also the duration of exclusive breast-feeding increases, which means that the young mother lacking the breastfeeding experiences and might not be able to make their own decision on how to feed the babies. It makes evident of a strong relationship between participants being well educated and exclusively breastfeeding as participants who were well educated were found to be three times likely to breastfeed exclusively compared to those who had no education at all. Mothers ability to understand literature and messages on how important and beneficial it is to exclusively breastfeed for both infant and mother including being motivated may contributory factors to what we observe in findings. (Elisabeth et al., 2017). This finding resonates with similar studies by (Lutter et al., 2000) who found that mother’s with high educational status were more likely to breastfeed exclusively and mothers with low education, less likely to do so.

Another important factor that influenced exclusive breastfeeding was most usual occupation source since 53% of the participants stated that they had no source of income while majority (40%) of those who were working indicated that they depend on their business. Most prominent in the results was that Office workers, farmers and other workers were most inclined to breastfeed their babies exclusively compared to participants who were unemployed. Suggestive of the factors contributing to this might be that these quality of workers have flexible and less stressful work schedules. They may not be overly pressured and therefore have time to be with infants, breastfeeding them and for longer periods. Similarly, Adejuyigbe(2008) showed that those with low economic status were more likely to breastfeed.

Maternal understanding of EBF and its recommended period in Makindu region was low though it was found that majority (71%) 166 of the participant were quite informed that the age in which the baby should be breastfed exclusively is 6 months. 64% of the participants affirmed that they discuss with their spouse always (79%) about breastfeeding compared to 5% who rarely did. Having adequate information about breastfeeding and failing to experience problems during breastfeeding period are found to influence mothers to breastfeed their infants. One of the elements to empower a woman to breastfeed is that she has sufficient knowledge to make decisions and including her husband to breastfeeding discussion is very paramount. Breastfeeding choice and success are usually associated with higher knowledge on breastfeeding (UNICEF, 2016).

Many of the participants stated that breastfeeding prevents illness, diarrhea and creates bond between the mother and baby represented by 47% (110), 27% (65) & 21% (50) respectively. Further non-exclusive breastfed infants have been shown to have significantly higher rates of stunting compared to EBF children. Stunting is a well-established risk factor for poor child motor and cognitive development among children. Cohort studies have shown stunting before age 2–3 years predicts poorer cognitive and educational outcomes in later childhood and adolescence (Isidro, 2012). It seems policies to promote EBF like Baby Friendly Hospital initiative (BFHI) and infant and young child feeding (IYCF) of which the Kenya government has endorsed are not optimally functioning and there is a need to ensure consistent implementation of these initiatives.

It was found that most (125 out of 234) of the participants earned less than 5000 according to the study. Working mothers were able to continue breastfeeding although the EBF rates were low. Return to work was the main reason cited for the cessation of EBF (Scott, 2012). Women who are unable to take an extended leave from work following the birth of their child are less likely to continue breastfeeding when they return to work. According to Ford (2012), maternal employment outside the home was often cited as a major factor to short – term breastfeeding patterns throughout the world. Mothers who were employed cited work away from home as a hindrance to exclusive breastfeeding. This research concurs with findings of other researchers who found out that maternal employment was a factor as in Hong Kong women’s decisions to wean early (Fisher *et al*. 2008). The global recession has forced women back into the labour market immediately after giving birth. The result is that mothers are forced to return to full time jobs with a shorter breastfeeding time span, which in most cases may not be exclusive. In developed countries, many working mothers do not breastfeed their children due to work pressure (Scott *et al*., 2012).

Employment of any form negatively affects EBF. A verbal interview with the nurses revealed that they did not practice EBF especially because they had to leave the baby and be on duty at night. Work outside the home can complicate plans to breastfeed. Some women can juggle both a job and breastfeeding, but others find it too cumbersome and decide to formula- feed instead (Freed, 2013). Perez *et al*. (2015), suggested that the working status did not show any significant relationship with the prevalence of EBF. Working women might have started introducing foods / liquids long before resuming their jobs, so the relationship between a negative effect of having a job and EBF was not identified.

It was found that good knowledge on EBF (i.e. benefits of breastfeeding) was associated with twice the odds of EBF the infants. In a study done by (Henderson, 2010) also found that women with EBF knowledge were five times more likely to EBF compared to others, while other researchers did not find the association (Luan, 2013). Innovative strategies to increase women’s awareness and knowledge on breastfeeding in general and in EBF are needed outside the usual facility channel. One strategy that Kenya may consider would be using EBF promotion peer counselors in the community or women’s groups which have recently been shown in community trials and health facilities to increase the awareness of EBF in our country. It was noted that many of the participants stated that breastfeeding prevents illness 47%, diarrhea 27% and creates bond between the mother and baby 21% while no any understood the delay of menstruation. Since health facilities and providers are trusted source of knowledge and information and apart from increasing counseling efforts at facilities they should be leading in organizing linkage with community groups regarding breastfeeding as 70 % of the women reported that child does not need colostrum in the first hour after birth meaning there is a gap in disseminating the key messages.

Community beliefs influenced EBF in this setting. Results showed that almost three-quarters (27%) of mothers with infants zero to six months could not breastfeed their infants in the presence of other people whom they are not related; these reasons given by women were observed in different settings as noted by other researchers in other counties. There is a need to target this when designing public messages and communications in EBF. Consistent with findings from studies in (Adejuyigbe, 2008).results from this study indicated that how and what a mother’s culture sees and says about exclusively breastfeeding infants 0-6 months influences whether a mother will practice it or not. Participants whose culture indicated exclusive breastfeeding was good were more likely to breastfeed exclusively compared to participants whose culture said it was not good for the infant. Cultures will put in mechanisms to get its people to practice what it sees and says to be good.

Majority (67%) of participants declared to have fed their infants with other fluids like water and or herbal products while 33% declined to have given their infants any fluids after delivery. Mother’s culture that allowed giving other fluids after delivery however did not prevent some mothers from breastfeeding exclusively in this study. This did not resonate with similar findings in Ghana by Tampah-Naah & Kumi-Kyereme (2013), Aborigo et al., (2012) and Mozambique by Arts et al., (2011) where mothers, due to cultural beliefs and practices resorted to giving fluids which hampered exclusive breastfeeding. Believing that milk was a satisfactory to growth was stated by most (51%) mothers as a belief of their culture that made practicing exclusive breastfeeding less difficult. Further if key gate keepers in the community like TBAs believe this, then the advice they would give will deter EBF interventions. The need for tailored interventions to target this misconception Makindu sub county hospital is urgently needed.

## **5.2 Conclusion**

The proportion of mothers with infants who exclusively breastfeed is sub-optimal. Educational level, occupation source, cultural beliefs and what culture indicates about breastfeeding exclusively also influence the practice of exclusive breastfeeding. Furthermore, how difficult it was for mothers to exclusively breastfeed their babies for six months and how difficult it was for them to breastfeed on demand influence the practice of exclusive breastfeeding and this indicates how and what a mother’s culture sees and says about exclusively breastfeeding infants 0-6 months influences whether a mother will practice it or no

## **5.3 Recommendation**

Health staff should intensify awareness of exclusive breastfeeding and its benefits to all stakeholders including mothers, their spouses, families, traditional leaders and influential persons in community and thus the following is recommended.

1. All mothers, irrespective of their age, marital status, education level and employment status should be encouraged to exclusively breastfeed their infants. Public forums should be used as a channel to promote EBF.
2. There is a great need for health education to explain to mothers the importance of breastfeeding the child on demand to sustain the quantity of breast milk production. This should be done in both antenatal and postnatal clinics in health facilities. Mothers need counseling if they doubt their milk is inadequate or if going back to work.
3. Staff in the ministry of Public Health concerned with child health should be more aggressive in implementing the existing policy on EBF. It should be made clear to the mothers the meaning of exclusive breastfeeding, its recommended period and its health benefits both for the mother and infant.
4. To reduce cases of malnutrition, early introduction of complementary foods to infants by mothers should be discouraged.
5. Research beyond this descriptive study (qualitative research) is needed; for instance a research on the adequacy of breast milk in meeting the nutritional needs of infants to 6 months.

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# **APPENDICES**

## **APPENDIX – QUESTIONNAIRE**

**Introduction**

I am a nursing student at Kenya medical training college doing diploma in Kenya registered community health nursing. I am carrying out a study on a factors influencing exclusive breastfeeding among mothers attending child welfare clinic at Makindu sub county hospital**.** You are therefore kindly requested to participate on answering the questions below. The information you will give will be highly confidential.

**Questionnaire number**………………………………………………….

**INSTRUCTIONS**

**Fill the questions below by using a tick (√).**

1. **SOCIAL DEMOGRAPHIC CHARACTERISTICS OF THE MOTHER**

**Please tick in the bracket of one of the answers**

1. Age ……………………….years
2. Marital status: a) Married ( ) b) Single ( )
3. Level of Education: a) None ( ) b) Primary complete ( ) c) Primary incomplete ( ) d) Secondary complete ( ) e) Secondary incomplete ( ) f) Secondary and above
4. Number of children …………………………………………..
5. **SOCIAL ECONOMIC AND KNOWLEDGE**

**Please answer yes or no in the following statements.**

1. Up to what age should the baby be breastfed exclusively?
2. 2 weeks ( ) b) 3 months ( ) c) 4 months ( ) d) 6months ( ) e) 1 year Others (specify)……………………………………………………….
3. Do you discuss with your spouse about breastfeeding
4. Yes ( )
5. No ( )

Is yes, how often

1. Always ( )
2. Most of the times ( )
3. Sometimes ( )
4. Rarely ( )
5. Employment:

a) Self-employed ( )

b) Part time employment ( )

c) Full time employment ( )

d) No employment ( )

1. Form of employment a) Office work ( ) b) Business ( ) c) Farm work ( )

d) Others (specify)…………………………………………….

1. Approximate income
2. >5000
3. 5001- 10000
4. 10000-20000
5. 20000 above
6. What are benefits of breast milk to your baby (tick were applicable)
7. Prevent illness ( )
8. Create bond between mother and baby ( )
9. Prevent diarrhea ( )
10. Delays menstruation ( )
11. Intelligence ( )
12. In each of the following statements, indicate whether you agree, disagree or don’t know

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Statements** | **Agree** | **Disagree** | **Don’t know** |
|  | Breastfed babies are healthier |  |  |  |
|  | Babies who are feed exclusively are from rich family |  |  |  |
|  | Frequent and prolonged breastfeeding prevents pregnancy after birth. |  |  |  |
|  | Breastfeeding women are less likely to develop cancer of breasts and cervix |  |  |  |
|  | Mother eating poorly cannot breastfeed her child exclusively |  |  |  |
|  | Encouragement and support in breastfeeding from husband is important |  |  |  |
|  | Breastfeeding makes my breasts loose shape |  |  |  |
|  | The quantity of breast milk depends on mother’s food |  |  |  |
|  | Child does not need colostrum in the first hour after birth. |  |  |  |
|  | Breast milk protects infants from illness |  |  |  |

**D) SOCIO-CULTURAL**

1. Do you breastfeed in the presence of other people whom you don’t relate with?
2. Yes ( )
3. No ( )
4. After delivery have you ever given your child any other fluids like water or herbal products?
5. Yes ( )
6. No ( )

If yes, explain why?

………………………………………………………………………………………………………

1. Do you believe the milk is satisfactory to growth of the infant?
2. Yes ( )
3. No ( )

If no, why?

............................................................................................................................................................................................................................................................................................................

**Thank you for your participation**

## **PPENDIX IV – APPROVAL LETTER**



## **APPENDIX V – LOCATION OF MAKINDU SUB-COUNTY HOSPITAL**

