

Original Research Article

Factors influencing exclusive breast feeding among women attending maternal and child health clinic at Kyanamira health centre 111, Kabale district

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ABSTRACT

Background: There is an increasing trend of mothers failing to exclusively breastfeed their babies and this has led to an increasing number of malnourished babies worldwide. This study was aimed at determining the factors that influence exclusive breastfeeding in Kyanamira HC III.

Methods: A systematic random sampling technique was used to get all the 175 study participants.

Results: 64% of the study participants were aged between 20 and 30 years, and 86.6% of them were peasants. The study found out a strong negative statistical association between community perception and exclusive breast feeding ($p=-0.141$, $r=0.182$), and majority of the mothers (62.6% do not support Exclusive breast feeding. There was no positive significant value related to exclusive breastfeeding in our study.

Conclusions: Factors that are negatively influencing exclusive breast feeding in Kyanamira HC III are social, cultural and maternal physiological factors

Keywords: Exclusive breast feeding, Mothers, Kyanamira HC111

INTRODUCTION

Exclusive breastfeeding (EBF) is one of the optimal infant and young child feeding practices however, it remains a major global challenge.¹ Globally out of the 56 million infants, approximately 22 million (39%), were exclusively breastfed.² West and Central Africa was reported to have the highest rates of infant malnutrition in the world and this was attributed to low rates of EBF. For example, only 23% of infants less than 6 months were breastfed exclusively. The rate of exclusive breastfeeding was reported to be 26% in the Middle East and North Africa, while breastfeeding rates of 39% were observed in Eastern and Southern Africa.³ In Sub-Saharan Africa, 20% of women reported exclusive breastfeeding of their last-born infant. This led to increased death of children who were born before the last born infant due to

malnutrition related causes. This showed that children that are not exclusively breastfed are more likely to die in the first months of life than those who are exclusively breastfed.⁴ In East Africa, the EBF rates are quite impressive with Rwanda (84.9%), Burundi (69.3%), Uganda (63.2%), Kenya (61.4%) and Tanzania (50%) all having more than half of the infants 0–6 months old exclusively breastfed.⁵ Despite the recent increase in EBF to 63.2% from 32%, Uganda has the third lowest rate among the East African countries. Exclusive breastfeeding rates in Kampala as the study site is 42.8% which is way below the national rate of above 60% and the WHO target of 90%.⁶ Therefore, it is upon this background that researcher is determined to find out the factors influencing exclusive breastfeeding among women attending maternal and child health clinic at Kyanamira Health Centre III, Kabale District. In 2015, the Ugandan Government set the EBF targets of 80%. To

achieve these targets, initiatives and policies like the labour law on maternity leave, mobilization of male partners to support breastfeeding mothers, and peer counsellors to provide support for breastfeeding mothers was promoted. In 2017, Uganda surpassed the global targets of at least 50% of infants exclusively breastfeeding. Despite this achievement, the EBF targets still seem too far from being achieved especially in rural areas. Consequently, infant malnutrition and mortality rates remain very high; a situation that can be backtracked to early infant feeding practices. In the light of EBF practice rates in developing countries including Uganda, concerted effort through well designed study is required to identify factors, especially socio-cultural, socio-economic and maternal physiological factors associated with the declining rates. A research that was conducted in 2020 cited that (24.3%) of the children within Kabale district had or were being exclusively breastfed and half of them (50.5%) drank boiled water.⁷ A few of the children (10.7%) were infested with soil transmitted helminthes. However, despite the benefits of EBF, little is being done to give greater priority to increase the rates of EBF to reach the world's 100% coverage target recommended by UNICEF. This study therefore aimed at assessing the factors affecting exclusive breast feeding among mothers attending young child clinic at Kyanamira health centre III-Kabale district.

METHODS

Study design, location, duration and population

This was a cross-sectional descriptive study, which employed both quantitative and qualitative data collection techniques. The study was conducted at Kyanamira HC III, Kabale District located in Western Uganda. Kyanamira HC III is 4 km from Kabale town and 200 meters from Kabale-Mbarara high way. It is bordered by Kanjobe HC II from the north, Kigata HC II from North East, Rubira HC II from the East, from the South, we have Muyumbu HC III and Nyabushabi HC II from South East. Kyanamira serves a community of over 2000 clients and monthly they receive around 700-1000 total attendances. The study was conducted from August to November 2021. The study included all breastfeeding mothers who attended maternal and young child clinic at Kyanamira HC III.

Inclusion and exclusion criteria

Inclusion criteria for current study were; breast feeding mothers who came for antenatal visits at Kyanamira HC III, breastfeeding mothers who had brought babies for immunization services at Kyanamira HC III. Exclusion criteria for current study were; breastfeeding mothers who had sick babies and those that were too weak to answer the questions, breastfeeding mothers who could not consent to the study, breastfeeding mothers who were outside the catchment area.

Sample size determination

The sample size was determined using Krejcie and Morgan table. Kyanamira HC III received around 320 mothers for maternal and child health clinic a month before the interviews, therefore in reference to the Krejcie and Morgan table, the sample size was 175.⁸

Sampling procedure

Consecutive sampling technique was used, the researcher sampled every mother attending maternal and young child clinic in Kyanamira HC III. On average, 10 mothers visited maternal and young child clinic. Data was collected in 30 days in order to interview a total of 175 breastfeeding mothers. Approximately 6 mothers were selected and interviewed on each day. On each day, the researcher went to maternal and young child clinic and sampled every new mother registered in the patients register until at least 6 were interviewed. The same procedure was followed until a total number of 175 mothers were recruited.

Data analysis

Data was entered into a computer-based system, analyzed using the Statistical Package for Social Sciences (SPSS) IBM version 26 (2019). Social demographic characteristics were summarized using descriptive statistics. Inferential statistics were used to determine association between dependent and independent variables. After bivariate analysis, factors with $p < 0.2$ were analyzed in multivariate logistic regression model. Factors with $p \leq 0.005$ were found to be the factors that influenced exclusive breastfeeding.

RESULTS

Social demographic characteristics

Majority of respondents were aged 20-30 years (64%), christians comprised of 78.3% and majority tribe were Bakiga (63.4%). Most participants had studied upto primary level (60%), peasants (88.6%) and married (37.7%) (Table1). Majority of the respondents were not staying with their husbands (62.1%) and only (37.9%) stay with their husbands. Most study participants had produced less than 4 children (61.14%) and only (38.86%) had more than four children. Economic factors: majority (66.9%) of respondents earn $< 100,000/=$ Ugx per month and only (33.1%) earn $> 100,000/=$ Ugx. On duration of breast feeding, most mothers (68.7%) breast fed their babies for less than 6 months and only (31.3%) of the respondents were able to breastfeed their babies for more than 6 months (Table 2). There was a strong significant association between family income and the duration of b/feeding or EBF ($p=0.036$, $r=0.158$). This means that level of income greatly influences the length of breastfeeding among participants in this study (Table 3). Social-cultural factors: majority of the respondents

stated that their culture does not support EBF and just a handful (36.6%) affirmed that their culture has no problem with EBF.

Table 1: Showing social demographic x-tics of the respondents (n=175).

Variables		N	%
Age (years)	<19	14	8.0
	20-30	112	64.0
	31-40	32	18.3
	>40	17	9.7
Religion	Christianity	137	78.3
	Islam	31	17.7
	Others	7	4.0
Tribe	Mukiga	111	63.4
	Munyankole	57	32.6
	Others	7	4.0
Level of education	Tertiary level	11	6.3
	Never attended school	105	60.0
	Primary level	38	21.7
	Secondary level	21	12.0
Occupation	Peasant	155	88.6
	Professional/Employed	19	10.9
	Business	1	0.6
Marital status	Married	66	37.7
	Not married	47	26.9
	Divorced	62	35.4

Table 2: Duration mothers breastfed their babies.

Variable	N	%
Length of b/feeding (months)	<6	112 68.7
	>6	51 31.3

On reasons why cultural support or does not support exclusive breast feeding, out of the 64 mothers whose culture supports EBF, (71.9%) attributed to its cheapness and (28.1%) to its being healthy. (66.7%) of those whose culture doesn't support EBF state that breast milk weakens the baby and (33.3%) stated that milk will be too much for the baby (Table 4).

There was a strong negative relationship between community perception and EBF (p=-0.141, r=-0.182) (Table 5). This means that myth the community has about exclusive breastfeeding is strongly negatively impacting its practices. Research findings indicate that majority (62.6%) of the mothers do not support exclusive breastfeeding, and only (37.4%) do. Inferential statistics indicate that mother's refusal to support exclusive breastfeeding negatively impacts EBF practices (X²=4.262, p=0.039, OR=0.493, CI=0.250 - 0.970) (Table 6). Research findings also revealed reasons why some mother support EBF and others do not support it. Among the mothers who supported EBF, (72.6%) of them stated the reason for their liking of EBF to be a method for natural family planning, and breast milk being healthy to the baby (27.4%).

Table 3: Showing correlation of duration of breastfeeding and family income.

Correlations		Length of breast feeding	Family income
Length of breast feeding	Pearson Correlation	1	0.158*
	Sig. (2-tailed)	-	0.036
	N	175	175
Family income	Pearson Correlation	0.158*	1
	Sig. (2-tailed)	0.036	-
	N	175	175

*Correlation is significant at the 0.05 level (2-tailed).

Table 4: Shows reasons why culture supports/does not support EBF.

Variables		N	%
Why culture supports EBF	Cheaper	46	71.9
	Healthy	18	28.1
Why culture doesn't support EBF	Weakening the baby	74	66.7
	Too much milk	37	33.3

For those who do not support EBF, most mothers had a fear of their breasts sagging due to excessive breastfeeding (67.03%) by the baby and others cited EBF to be time consuming (32.97%) (Figure 1). The findings from the qualitative data analysis showed that most

mothers were not practicing EBF despite all the attempts by the health facility staff to educate the mothers on advantages of EBF. Majority of the mothers were reported not to be attending health education talks by the health workers in the health facility yet the facility conducts health education talks >twice a week. The findings also indicated that cultural factors play a very big role in influencing EBF among mothers who are breastfeeding. This was supported by mothers mentioning that their mother in-laws could not allow them to exclusively breast feed their babies citing a number of reasons that are related to cultural and traditional taboos. The study discovered that the level of income greatly influences the length of breastfeed because most of mother who earn more money are able to stop at any

preferred time as opposed to those mothers who do not have a stable source of income.

Table 5: Association between community perception and EBF.

Correlations		Length of breast feeding	Community perception about EBF
Length of breast feeding	Pearson Correlation	1	0.182*
	Sig. (2-tailed)	-	0.020
	N	163	163
Community perception about EBF	Pearson Correlation	0.182*	1
	Sig. (2-tailed)	0.020	-
	N	163	175

*Correlation is significant at the 0.05 level (2-tailed).

Table 6: Cross tabulation of mother’s support for EBF and duration of breastfeeding.

If mother supports EBF and Length of breast feeding crosstabulation			Length of breast feeding (months)		Total
			<6	>6	
If mother supports EBF	Yes	Count	36	25	61
		% of total	22.1	15.3	37.4
	No	Count	76	26	102
		% of total	46.6	16.0	62.6
Total	Count	112	51	163	
	% of total	68.7	31.3	100.0	

Table 7: Statistical tests.

Tests	Value	Df	Asymptotic significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.262 ^a	1	0.039	-	-
Continuity correction	3.572	1	0.059	-	-
Likelihood ratio	4.201	1	0.040	-	-
Fisher's Exact test	-	-	-	0.054	0.030
Linear-by-linear association	4.236	1	0.040	-	-
N of valid cases	163	-	-	-	-

0 cells (0.0%) have expected count less than 5. the minimum expected count is 19.09, computed only for a 2x2 table.

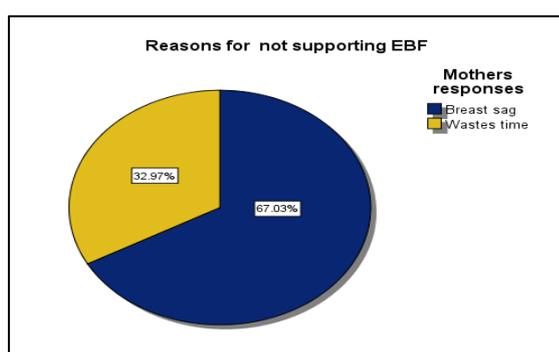


Figure 1: Reasons why some mothers do not support EBF.

DISCUSSION

Social economic factors

The study discovered that about 90% of the respondents could not breastfeed their babies’ due various reasons

known unto them. In my own view, some factors that could have led to this situation could be medical related or work demands. This finding is concurrent with the finding of the study conducted by Chrisitin Chung that sited a smaller number of babies being breastfed in Africa than in Poland.⁹ These findings make us deduce factors such as work demands and medical ailments to be among the factors hindering EBF practices. This study also discovered that out of the mothers who breast their babies, only (31.3%) breastfed their babies for more than six (6) months exclusively. This figure way lower than the figure noted by Mundagowa in a study that was conducted in Gwanda-Zimbabwe were EBF rate was at 40%.¹⁰ Another report released by CDC in 2018 cited number of babies who are exclusively breast fed to be at 57% at the 6th month.¹¹ It is also possible that EBF is very low because mothers lack enough knowledge about the advantages of EBF. This very study noted that there was no significant correlation between level of income and EBF. This means that both the rich and the poor have same practices in relation to EBF. Another study that was conducted in Ethiopia had contradicting results because it

noted financial status to be impacting EBF as mothers with low income were more times practicing EBF than those who had money.¹² Another Ugandan study cited wealthy women not to be practicing EBF as compared to their counter parts.¹³ Conclusively, our study showed no impact of money on EBF ($p=0.072$, $r=-0.141$).

Social-cultural factors

Our study reported that culture most cultural values and norms did not support the implementation of EBF (63.4%). Only a few cultures supported the implementation of EBF (36.6%). Another study that was conducted in Lebanon cited cultural beliefs such transmission of menstrual cramps to the baby, having bad luck and inherited inability to produce milk; thus, the study having similar findings like our study.¹⁴ Other cultural myths such as bad milk, milk weakening the baby, and baby taking too much milk could be the reasons for the failure of the cultures to adopt EBF. Among those whose culture supported EBF, factors associated with the support included the cheapness, ready availability and the healthiness of the breast milk. Consequently, the very study cited negative community perception about EBF, correlation results showed a negative association between community perception and EBF ($p=-0.141$, $r=-0.182$). This means that myth the community has about exclusive breastfeeding was strongly negatively impacting EBF practices. A Kenyan study also cited cultural factors such as babies failure to thrive without water, unsupportive mothers in-law, and clan elders threatening to disown mothers who practice EBF.¹⁵ Negative community perception could also be due to the less community sensitization on EBF.

Maternal physiological factors

This study showed that majority of the mothers under the study don't support EBF (62.2%) but only (37.4%) do. On running inferential analysis further, we found out that failure of the mothers to support EBF has a negative impact on EBF practices ($X^2=4.262$, $p=0.039$, $OR=0.493$, $CI=0.250-0.970$). These findings relate with the findings of the study that was conducted in China that cited perceived low milk quality, primiparity and fatigue due to breast feeding as factors causing premature cessation of EBF among the study participants.¹⁶ Other reasons discovered that led to failure of the mothers to support EBF included breast sagging and time consuming. These findings are in line with the findings of Matare et al where he cited use of gripe water to relive baby's distressing symptoms, water given in perceived thirst, mothers workload, and inadequate support from the father.¹⁷ Another study with similar findings cited parity and mothers education to be significantly influencing EBF.¹⁸ Failure of the mothers to support EBF will lead to malnutrition among their babies and unplanned pregnancies.

CONCLUSION

The study found out that majority of the respondents were aged between 20 and 30, Christians and peasants. Factors that were found to be negatively significantly influencing EBF were social-cultural and maternal physiological factors. No social-economical and no positive influencing factors found during the study.

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Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

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