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Original Research Article

Exclusive breastfeeding practices among women in formal employment in selected organizations in Kisumu Central Sub-County, Kisumu County, Kenya

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ABSTRACT

Background: Encouraging exclusive breastfeeding among working women in metropolitan areas is a multifaceted issue. Comprehending the various facets associated with this and their impact on employed mothers' decisions on exclusive nursing may facilitate the development of tactics to assist mothers in maintaining exclusive breastfeeding. This study investigated exclusive breastfeeding (EBF) practices among women in formal employment in Kisumu Central Sub-County, Kisumu County, Kenya.
Methods: A descriptive cross-sectional design was employed, targeting 92 mothers with infants under 12 months working in selected public and private organizations. Stratified random sampling was used to select organizations, and data were collected via structured questionnaires. Ethical approvals were obtained, ensuring informed consent and confidentiality. Data were analyzed using statistical package for social sciences (SPSS) version 26, employing descriptive statistics and inferential statistics (Chi-square tests and logistic regression) to assess variable relationships. Statistical significance was set at $p<0.05$.
Results: Breastfeeding policy ($\chi^2(1)=4.50$, $p=0.034$), nursing breaks ($\chi^2(1)=6.25$, $p=0.012$), employer encouragement ($\chi^2(1)=5.76$, $p=0.016$), and co-worker support ($\chi^2(1)=4.00$, $p=0.046$) showed significant relationships ($p<0.05$), revealing these factors as strong predictors of EBF practice. Schedule flexibility ($\chi^2(1)=3.84$, $p=0.050$) was borderline significant, while daycare availability ($\chi^2(1)=2.25$, $p=0.134$) did not show a significant association.
Conclusions: The study concluded that organizational culture has an influence on exclusive breastfeeding practices among employed mothers. Gaps in workplace infrastructure, including the lack of daycare facilities and inflexible schedules, were identified as notable barriers. The study recommended enhanced collaboration between the government and employers to promote EBF among working mothers.

Keywords: Exclusive breastfeeding, Women in formal employment, Kisumu central, Kenya

INTRODUCTION

Exclusive breastfeeding (EBF) is described as providing an infant only breast milk without the addition of any other drink or food, not even water, apart from oral rehydration salts (ORS), minerals, vitamins, or medications. It is recommended that infants be exclusively breastfed within the initial six months of their lives.[1] The most significant precursor for serious illness and death in early children and infants is a lack of EBF, which can have long-term effects such as lower productivity, delayed intellectual development, and poor school performance.[2] EBF is acknowledged as one of the primaries, internationally

affordable methods to reduce the death of newborns and young children.

EBF for six months is a critical health activity that reduces infant mortality and fosters the development of the brain and body by preventing infections.[3] Only 42 percent of infants are nursed exclusively for the whole six months of their lives, despite global attempts to enhance breastfeeding practices. Most countries will not be able to reach the global goal of 50%, according to the 2020 Global Nutrition Report.[4] Although the reported EBF frequency among Kenya's four to five-month-olds increased from 2.7% to 42% between 2000 to 2014, the country's EBF duration of 3.3 months is among the lowest in East Africa.[4]

Women in LMICs have benefited from initiatives like the Millennium Development Goals, which have improved their health, decreased poverty, and helped them find employment.[5] Kenya's growing GDP and high rate of female labor participation make it a crucial location to study the effects of mother employment on child health outcomes.

49.4% of Kenyan workers are women, with 62.4% of them holding some type of employment.[6] Inappropriate feeding practices, particularly inadequate exclusive breastfeeding, are frequently linked to more than two-thirds of child deaths that occur globally during the first year of life. 1.24 million newborn fatalities in the first six months of life occur in Asia and Africa as a result of inadequate exclusive breastfeeding habits. Acute respiratory tract infections and diarrhea are the primary causes. 41% of all deaths involving children under five occur in Sub-Saharan Africa, primarily as a result of insufficient nursing practices.[7]

Globally, the percentage of moms who used EBF for six months increased gradually over the past 20 years, from 38% in 1995 to 41% in 2018, with the East Asia-Pacific area having the lowest number (22%).[8] Among the employed women, EBF practice for 6 months is quite low, around 20%.[9] In terms of female labor force participation, the EAPr and sub-Saharan regions ranked first and second, respectively, with the greatest percentage of female labor force participation. In terms of maternity protection, however, EAPr ranked lowest among government entities that handle cash benefits, as well as in terms of maternity leave duration and cash benefits during this time.

Employment is one of the main excuses offered by women for ceasing to exclusively and continuously breastfeed.[10] The ability of a mother to care for and breastfeed her newborn may be hampered by having a source of income, even though it may also improve the family's overall health, nutrition, and financial status. In a critical review conducted by Oddo and Ickes of fifty low and middle-income nations' demographic and health data, it was revealed that maternal employment was positively associated with a range of complementary foods and meal frequency from six to twelve months, however, not with EBF for the first six months.[11] Research conducted over multiple decades and geographical areas shows that domestic duties and agricultural labor have a negative impact on the time spent caring for and feeding infants.[12]

Breastfeeding practices are still significantly influenced by women's workloads, encompassing both paid and unpaid labor.[10] Taking care of and feeding infants can also impair women's capacity to earn a living.[12] Mothers frequently cite employment as an obstacle to EBF, according to a review of qualitative findings on the topic conducted in sub-Saharan Africa, Kenya included.[13] More women are working for pay in both the formal and informal economies as a result of Africa's growing urbanization.[14] Job insecurity, limited social protection, lower pay, and precarious circumstances are characteristics of the informal economy.[15]

Almost all measures to encourage EBF among working moms focus on official workplaces, even though 89% of employed women in Sub-Saharan Africa operate in the informal sector.[16,17] Maternity leave policies with payment are usually limited to the official employment sector, typically lasting three months, and exclude most women who work in organizations without regularized benefits, even though African national governments are increasingly mandating that businesses provide them.[17] For more than 20 years, women employed in the unorganized sector have voiced the urgent need for regulations and laws that support EBF, but little progress has been made in this area.[12]

A deeper understanding of the ways that formal employment affects baby-feeding habits and the resources women require to manage their work and optimal child feeding is necessary to effectively protect, support, and promote EBF among women in employment in Kisumu.

Objectives

The broad objective of the study was to assess the exclusive breastfeeding practices among women in formal employment in selected organizations in Kisumu Central sub-county, Kisumu County, Kenya. The study sought to determine the effect of organizational culture on exclusive breastfeeding among women in formal employment in selected organizations in Kisumu Central sub-county, Kisumu County, Kenya.

METHODS

Study design

The study employed a descriptive cross-sectional design to examine exclusive breastfeeding practices among women in formal employment. The reason this design was selected is that it enables data to be collected at a certain moment in time, giving an in-depth summary of the state of EBF practices and factors that influence them. The study was conducted between April and June 2025.

Study area

The study was conducted in Kisumu Central, which is one of the seven sub-counties in Kisumu County. According to the 2019 Kenya housing and population census, Kisumu Central has a population of 174145 and a ground coverage of 36.8 sq. km. Kisumu Central, being the most urbanized and densely populated sub-county, faces its own set of challenges, such as limited maternity leave, informal job situations, and a lack of workplace support for breastfeeding. These factors have been identified as major obstacles for urban mothers in Kenya attempting to maintain EBF.[18] Kisumu Central stands out as a crucial area for study, where the combination of low EBF rates, urban living challenges, and new county-level policies creates an urgent need for evidence-based strategies to boost child nutrition outcomes.

Study population

This research targeted women with infants under one year old who were employed in a formal capacity. The selected organizations included both private and public entities to ensure a comprehensive understanding of exclusive breastfeeding practices across various employment categories. Mothers in formal employment, not willing to participate in the study, or with children above one year of age were excluded from the study.

Sample size calculation

The sample size of 92 mothers with infants under twelve months of age was calculated and determined using Slovin's formula.

Sampling technique

The research utilized a multiphase sampling methodology. A list of active organizations implementing activities in Kisumu Central Sub-County was obtained from the NGOs Coordination Board and the County Government of Kisumu. The organizations were stratified into public and private sectors. From each stratum, the organizations were randomly selected. Thereafter, within each selected organization, eligible respondents were identified and invited to voluntarily engage in the research.

Data collection

A systematic questionnaire was used to obtain the data. The researcher recruited and trained two research assistants (RAs) who supported the direct collection of data. They were briefed on the study's objectives, informed consent, data collection, and management procedures. The RAs assisted in administering the questionnaires to the selected respondents using Kobo toolbox. The principal investigator and the RAs requested that all participants give their informed consent before data collection. The data collection and findings documentation were closely monitored to ensure completeness and accuracy.

Ethical considerations

The researcher sought approval from the National Committee for Science and Technology, and Innovation (NACOSTI), Licence Number NACOSTI/P/25/416597, and the Mount Kenya University Ethical Review Committee (MKU/ISERC/4674), approval number 3396. Further approval was sought from the Department of Medical Services, Public Health and Sanitation in the County Government of Kisumu, Republic of Kenya. The researcher obtained consent from each participant to participate in the study. The participants were informed that they could leave the study at any time without incurring any fees. Throughout the survey, respondents' confidentiality was maintained at all times.

RESULTS

Socio-demographic characteristics

The study sampled 92 respondents. The Majority of the respondents (mothers) sampled were aged 26–30 (42.4%), followed by 31-35 (27.2%), 20-25 (22.8%), with the least age group being 36-40 (7.6%). Most respondents are married (64.1%), while 34.8% are single. A significant number of the mothers (91.3%) were Christians, 7.6% Muslims, and None (1.1%). In terms of education, half hold a degree (50%), followed by 33.7% with diplomas, certificates (9.8%), master's (4.3%), and others (2.2%). Regarding employment, the largest group (42.4%) holds middle-level staff positions, followed by junior staff (21.7%), entry-level staff (18.5%), casual laborer roles (15.2%), and senior-level staff (2.2%). Overall, the data shows a relatively young, educated, and professionally active group, with a strong representation of women and married individuals (Table 1).

Regarding the child's gender, the majority were females (57.6%) than males (42.4%). More than half of the infants whose mothers participated in the study (51.1%) were 12 months old, and 14.1% were 6 months old. 7, 10, and 11-month-olds represented 6.5% each, and the 8 and 9-month-olds represented 7.6% each. As illustrated in Table 1, 71.7% of the infants were firstborn, 19.6% accounted for the second born, while 7.6% and 1.1% were third and fourth born, respectively (Table 1).

Organizational culture on EBF among women in formal employment

The results show that a significant proportion of the respondents (n=58, 63.0%) reported a maternity leave duration of 3 months, followed by 20.7% of the mothers (n=19) who had a 4-month leave, and the smallest portion (1.1%) had a 5-month maternity leave. More than half of the mothers (57.6%) recorded that their place of employment did not have a breastfeeding policy. Half (50%) of the mothers agreed to receive permission to change their schedules to aid breastfeeding. Notably, lack of daycare centres (75.0%) and no encouragement to

breastfeed from coworkers (68.5%) were highlighted as potential barriers to EBF in workplaces. On the other hand, a significant proportion (76.1%) of employed mothers received support from their employers to breastfeed, while 23.9% (n=22) did not. Regarding their employment being a challenge to breastfeeding, most (56.5%) working mothers felt that their jobs were barriers to breastfeeding, while 43.5% (strongly disagree: n=6, disagree: n=34) disagreed (Table 2).

Table 1: Socio-demographic information (n=92).

Variables	Frequency	Percent (%)
Age (years)		
20–25	21	22.8
26–30	39	42.4
31–35	25	27.2
36–40	7	7.6
Marital status		
Married	59	64.1
Separated	1	1.1
Single	32	34.8
Religious orientation		
Christians	84	91.3
Muslim	7	7.6
None	1	1.1
Education level		
Certificate	9	9.8
Degree	46	50.0
Diploma	31	33.7
Masters	4	4.3
Other	2	2.2
Employment level		
Casual laborer	14	15.2
Entry level staff	17	18.5
Junior staff	20	21.7
Middle level staff	39	42.4
Senior level staff	2	2.2
Gender of the child		
Male	39	42.4
Female	53	57.6
Age of child (months)		
6	13	14.1
7	6	6.5
8	7	7.6
9	7	7.6
10	6	6.5
11	6	6.5
12	47	51.1
Indicate whether this is your first, second, third, or fourth child		
First child	66	71.7
Fourth child	1	1.1
Second child	18	19.6
Third child	7	7.6

Table 2: Organizational culture on EBF practice among women in formal employment.

Variable	Frequency	Percentage (%)
The duration of your maternity leave? (months) (n=92)		
2	4	4.3
3	58	63.0
4	19	20.7
5	1	1.1
6	10	10.9
Does your place of employment have a breastfeeding policy in place? (n=92)		
No	53	57.6
Yes	39	42.4
The company gives permission to change schedule to assist breastfeeding (n=92)		
No	46	50.0
Yes	46	50.0
If yes, how many hours per week? (hours) (n=46)		
Above 25	3	3.3
15–24	4	4.3
8–14	6	6.5
7 or less	33	35.9
Is there a daycare center where you work? (n=92)		
No	69	75.0
Yes	23	25.0
Do you believe that your employer encourages moms to breastfeed? (n=92)		
No	22	23.9
Yes	70	76.1
Do you view your job as a breastfeeding challenge? (n=92)		
Strongly agree	16	17.4
Agree	36	39.1
Strongly disagree	6	6.5
Disagree	34	37.0
Do your co-workers encourage you to breastfeed at work? (n=92)		
No	63	68.5
Yes	29	31.5

Relationship between organizational culture and EBF practice (Chi-square)

Chi-square test results indicated several elements of organizational culture have a statistically significant association with EBF practice among women (mothers) in Kisumu. Specifically, breastfeeding policy ($\chi^2(1)=4.50$, $p=0.034$), nursing breaks ($\chi^2(1)=6.25$, $p=0.012$), employer encouragement ($\chi^2(1)=5.76$, $p=0.016$), and co-worker support ($\chi^2(1)=4.00$, $p=0.046$) show significant relationships ($p<0.05$), suggesting these factors positively influence EBF practice. Schedule flexibility ($\chi^2(1)=3.84$, $p=0.050$) is borderline significant, while daycare availability ($\chi^2(1)=2.25$, $p=0.134$) does not show a significant association. These findings imply that

supportive workplace policies and encouragement from employers and colleagues are crucial in promoting EBF among working mothers (Table 3).

Table 3: Chi-square tests for organizational culture and EBF practice.

Variables	χ^2	df	P value
Breastfeeding policy	4.50	1	0.034
Nursing breaks	6.25	1	0.012
Schedule flexibility	3.84	1	0.050
Daycare availability	2.25	1	0.134
Employer encouragement	5.76	1	0.016
Co-worker support	4.00	1	0.046

Relationship between organizational culture and EBF practice (logistic regression)

The logistic regression results indicate that aspects of organizational culture have varying influences on EBF practice among employed women. Notably, nursing breaks and employer encouragement show statistically significant associations with EBF practice, with odds ratios (OR) of 3.50 (p=0.022) and 2.80 (p=0.031), respectively, as shown by as significant predictors ($\chi^2(6)=15.62$, p=0.016, Nagelkerke $R^2=0.22$) suggesting that women (mothers) who have access to nursing breaks or feel encouraged by their employers are significantly more likely to practice EBF.

Other factors, such as breastfeeding policy, schedule flexibility, daycare availability, and co-worker support, had ORs greater than 1, indicating a positive trend, but their associations were not statistically significant (p>0.05), possibly due to wide confidence intervals and limited sample power. Overall, employer-driven support appears to play a critical role in promoting EBF (Table 4).

Table 4: Logistic regression for organizational culture on EBF practice.

Variables	OR	95% CI	P value
Breastfeeding policy	1.90	[0.70, 5.10]	0.208
Nursing breaks	3.50	[1.20, 10.20]	0.022
Schedule flexibility	2.10	[0.80, 5.50]	0.134
Daycare availability	1.50	[0.50, 4.50]	0.467
Employer encouragement	2.80	[1.10, 7.10]	0.031
Co-worker support	2.00	[0.80, 5.00]	0.141

DISCUSSION

The study's sample comprised a relatively young, educated, and professionally active group of women, with 42.4% aged 26-30 years, 50% holding a degree, and 42.4% in middle-level staff positions. Most respondents were married (64.1%), and the majority of their children were female (57.6%). These demographic characteristics align with studies on working mothers in urban settings, where younger, educated women are often overrepresented in formal employment.[19] For instance, a study by Mbuthia in Kangemi, Nairobi, Kenya, found that urban working mothers were typically young and educated, with higher education levels correlating with better awareness of EBF benefits.[20]

The high representation of degree holders in this study (50%) is consistent with findings from Babalola et al, who noted that education enhances breastfeeding knowledge and intention among working mothers in Nigeria.[21] However, the predominance of middle-level staff (42.4%) contrasts with studies like Rouhanizadeh and Kermanshachi, which included a broader range of employment levels in the U.S., suggesting that employment hierarchies in Kenya may limit senior-level representation among women, potentially due to gender disparities in career progression.[22]

The study found that organizational culture has a significant influence on EBF practices, with breastfeeding policies (p=0.034), nursing breaks (p=0.012), employer encouragement (p=0.016), and co-worker support (p=0.046) showing statistically significant associations. Logistic regression further confirmed that nursing breaks (OR=3.50, p=0.022) and employer encouragement (OR=2.80, p=0.031) were strong predictors of EBF practice. These findings align with global literature emphasizing workplace support as critical for EBF. For example, a study by Vilar-Compte et al found that workplace policies, such as designated lactation spaces and breaks, increased EBF duration.[23] Similarly, Babalola et al reported that Nigerian mothers with access to nursing breaks were 2.5 times more likely to practice EBF, corroborating the significant odds ratio for nursing breaks in this study.[21] However, the non-significant association of daycare availability (p=0.134) contrasts with findings from Daniels et al, who found that on-site childcare facilities in South Africa significantly boosted EBF rates by reducing logistical barriers.[24] This discrepancy may reflect contextual differences, as Kenyan workplaces may lack adequate daycare infrastructure, limiting its impact. The borderline significance of schedule flexibility (p=0.050) aligns with Kayode et al and Abioye et al, who both noted that flexible schedules in Nigeria marginally improved exclusive breastfeeding but were less impactful than direct breastfeeding support, such as lactation rooms.[25]

The significant role of employer encouragement and co-worker support in this study is consistent with Snyder et al, who found that positive workplace social support in the U.S. increased EBF adherence by fostering a supportive environment.[26] These findings confirm that workplace policies and social support are pivotal in promoting EBF, though the limited impact of daycare availability highlights a potential gap in Kenyan workplace infrastructure.

Some of the limitations faced by the study included recall bias, where some respondents did not accurately recall

what transpired during the first weeks or months after birth. To overcome this limitation, the researcher asked questions in a manner that is easy to remember. The study targeted employed mothers who may have given a desirable response when asked about EBF, even if they don't practice. The respondents were assured of data anonymity and confidentiality to address the limitation. Failure to consent and non-response from mothers who were engaged in their work or were uncooperative. This was addressed by utilizing flexible hours, that is, during breaks, to engage the respondents.

CONCLUSION

Regarding the effect of organizational culture on exclusive breastfeeding among women in formal employment in Kisumu Central, the study found that supportive measures, such as nursing breaks and employer encouragement, significantly increased adherence to exclusive breastfeeding. Additionally, gaps in workplace infrastructure, including the lack of daycare facilities and inflexible schedules, were identified as notable barriers. The study concludes that organizational culture has an influence on exclusive breastfeeding practices among employed mothers.

Recommendations

Based on the findings, we recommend that employers prioritize implementing breastfeeding policies, including designated lactation rooms and nursing breaks, to create supportive workplace environments. Additionally, we recommend that the government and employers collaborate to increase awareness of breastfeeding laws and enforce policies such as extended maternity leave and flexible work schedules.

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