International Journal of Community Medicine and Public Health
Machila CM et al. Int J Community Med Public Health. 2021 May;8(5):2150-2154
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20211731

Original Research Article

Level of awareness of the benefits, socio-demographic and cultural factors influencing exclusive breastfeeding among mothers attending MCH clinic in Tudor sub county hospital

Consolata Mandi Machila[1]*, Jane Karonjo[1], Dominic Mogere[2], Peterson Kariuki[1]

[1]School of Public Health, [2]School of Nursing, Mount Kenya University, Kenya, East Africa

Received: 20 February 2021
Accepted: 31 March 2021

***Correspondence:**
Consolata Mandi Machila,
E-mail: consolatamandimachila@gmail.com

ABSTRACT

Background: Knowledge of exclusive breastfeeding (EBF) among women is essential when promoting optimal breastfeeding practices. Breastfeeding is recommended for the first six months of life and continuation of breastfeeding and adequate complementary foods for up to two years of age or beyond.
Methods: A descriptive cross-sectional study design was used. This study utilized a mixed method approach (qualitative and quantitative).
Results: The prevalence of exclusive breastfeeding was low at 33.6%. Data revealed that 60.9% of respondents were knowledgeable on the benefits of EBF, while 38.6% were not knowledgeable, the rest of the respondents did not respond or their answers were not valid.
Conclusions: Women's knowledge on benefits EBF and intention to practice it is still low. There was significant difference in the participants place of residence (rural versus urban).

Keywords: Exclusive breastfeeding, Descriptive cross-sectional, Prevalence, Level of awareness

INTRODUCTION

Researchers have identified breastfeeding during the first year as one of the most important strategies for improving child survival.[1] Knowledge of exclusive breastfeeding (EBF) among women is essential when promoting optimal breastfeeding practices. Based on this, WHO recommends EBF for the first six months of life and continuation of breastfeeding and adequate complementary foods for up to two years of age or beyond.[2] Despite the awareness being created by various government and non-governmental organizations on benefits of EBF, its practice remains lower than the globally recommended standard especially in developing countries.[3]

In Nigeria, the federal ministry of health (FMOH) in their document 'saving newborn lives maternal and child health' reported that Nigeria has one of the lowest EBF rates in the african continent.[4] The recent data indicated that the percentage of infants exclusively breastfed to the age of six months is fluctuating, from 17% in 2003 to 13.1% in 2008 and returned to 17% in 2013, while the proportion of children less than six months who received complementary foods increased from 18% to 35% in 2008 and dropped to 23% in 2013.[5]

Exclusive breastfeeding is known for its many benefits to both the mother and child. For an infant, the presence of vital nutrients likes proteins, vitamins and carbohydrates helps to protect the child from numerous diseases like ear infections, lower respiratory illnesses and meningitis, also protects the child from obesity. Moreover it protects the

child from developing allergies and also lowers the baby's risk of sudden infant death syndrome (SIDS). For the mother, EBF reduces stress level and postpartum depression, reduces the risk of getting breast and ovarian cancers and helps to reduce unplanned pregnancies enabling her to take good care of other children. It provides a strong bonding between the mother and her new born.[6] In 2012, WHA 65.6 resolution emphasized on countries to ensure that maternal and child nutrition especially the six global targets are met by 2025 and mostly more efforts were to be put on increasing the rate of exclusive breastfeeding by 50%.[7]

In Kenya, EBF was prioritized as one of the most important strategy in the reduction of maternal and infant mortality. EBF rates nationally was 32% and by 2017 it was expected to increase to 80%, but currently it's at 68%.[8,9] In 1991 baby friendly hospital initiative hospital was launched by WHO and UNICEF to strengthen EBF and to ensure the response is tremendous globally.[10] Hence the current study aimed at identifying any existing gaps which would ensure proper intervention measures can be put in place so that maternal and child health is safeguarded and specifically reducing infant morbidity and mortality within the study area.

Increase in morbidity and mortality in infants is mainly contributed to lack of exclusive breastfeeding practices which contributed to 11.6% mortality equivalent to 804,000 deaths in 2011 worldwide.[11] Globally 38% of infants are exclusively breastfed. In east Africa countries prevalence of are as follows Uganda 63.2%, Kenya 61% and Tanzania 50%, while in Mombasa county, the uptake is 67-68% and in Mvita constituency its 49%.[12]

METHODS

Research design

A descriptive cross-sectional study was adopted. It was preferred because it helps to describe the factors affecting exclusive breastfeeding among mothers at that point in time.

Inclusion and exclusion criteria

Mothers with infants below two years, from Tudor location and also those who signed consent forms were interviewed. The researcher interviewed mothers with infants below two years because some mothers brought infants for growth monitoring. The basis is that if the researcher dwelt only on mothers with babies who are 6 months old, she may have not been able to achieve the desired sample size.

Mothers with children above two years, not from Tudor location and refused to sign consent form were not interviewed.

Target population

The study targeted a population of 12,150 breastfeeding mothers attending MCH clinic at Tudor sub-county hospital.

Sampling procedures and technique

The study area was chosen among the 6 constituencies conveniently and purposively because it hosts four large slums within the county with people from different background and class.

As for the respondents, the MCH attendance register at the hospital was used to identify the first mother to arrive at the facility and systematic sampling method was used to get the rest of the required sample size. The facility per day receives 40 mothers and monthly 1760 and the sample size was 422, then the sampling interval was 4. Sampling interval was achieved by the following method; 40 mothers per day, 44 days duration of data collection, 422 sample size. Therefore,

$K=\frac{N}{n}$

$K=\frac{40\times44}{422}=\frac{1760}{422}$ = 4.1 (which is approximate to 4).

Therefore the sampling interval was 4 which is the K. The first respondent was assigned an even number and all mothers with even numbers were interviewed. The sampling frame per day was 2,6,10,14,18,22,26,30,34,38,.....,422.

Sample size determination

Since the population of the under-five is greater than ten thousand it was calculated using the formula below,[13]

$n=\frac{Z^2pq}{d^2}$

where,

n=desired sample (population >10,000); population greater than 10,000,

Z^2=1.96 (confidence interval). The standard normal deviate usually set at 1.96 or simply 2.00 which correspond to 95% confidence level,

p=the proportion of target population (0.5=50%) if prevalence is not known,

q=1-p (1-0.5),

d=0.05 or 0.02,

D=design effect (1 if its 95%, 2 if its 99%).

Therefore,

$n = \frac{1.962 \times 0.5 \times 0.5 \times 1}{0.05^2}$

n =384.

10% for none respondents,

$\frac{384 \times 10}{100} = 38.4$

Therefore the sample size was,

384+38=422.

Construction of research instrument

Both quantitative and qualitative data was collected in this study. Quantitative data was collected using questions which had multiple choices for the respondents to choose. Qualitative data was collected using open ended questions in the interviewer schedule, which was constructed using simple english language which was easy to interpret to breastfeeding mothers. Leading questions were also avoided to minimize biasness. All the variables were covered in the research instrument.

Testing for validity and reliability

Validity means the quality or correctness of a measure. The tool measures what is supposed to measure. This was ensured by pre-testing the research instrument after the training research assistants before administering it on breastfeeding mothers. A pre-test of the questionnaire through a pilot study was carried out to ascertain the clarity of the research instrument. The pre-test included 15 respondents who were deemed knowledgeable on issues regarding EBF. A pilot study was conducted at Shimo annex dispensary to assess the validity and reliability of the data collected. Thereafter the interviewer schedule was adjusted based on the pre-test recommendations.

Pre-testing ascertained the respondents understood the questions in the study tool. Reliability refers to stability of measurement over time even after several repetitions. It was measured using split half technique.

RESULTS

Prevalence of exclusive breastfeeding in tudor sub county

The prevalence of EBF was low at 33.6%. The following Table 1 and Figure 1 represent a summary of the findings.

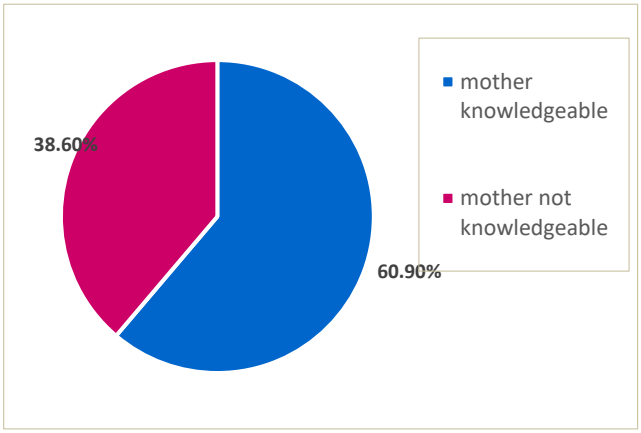

Figure 1: Prevalence of exclusive breast feeding in Tudor sub county.

Level of awareness of the benefits of exclusive breastfeeding in Tudor sub county

Data revealed that 60.9% of respondents were knowledgeable on the benefits of EBF, while 38.6% were not knowledgeable, the rest of the respondents did not respond or their answers were not valid. The following Table 2 and Figure 2 is a summary of these findings.

Table 1: Prevalence of exclusive breastfeeding.

	Frequency	Percent	Valid percent	Cumulative percent
Giving breast milk and other foods within first 6 months	269	66.4	66.4	66.4
Giving breast milk only for 6 months	136	33.6	33.6	100.0
Total	405	100.0	100.0	

Table 2: Mothers knowledge on the benefits of exclusive breastfeeding.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Mother knowledgeable	248	60.9	61.2	61.2
	Mother not knowledgeable	157	38.6	38.8	100.0
	Total	405	99.5	100.0	
Missing	(No response)	2	0.5		
Total		407	100.0		

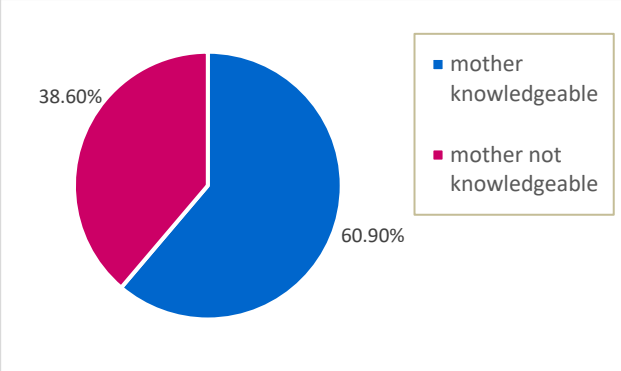

Figure 2: Level of knowledge on the benefits of EBF in Tudor sub county.

DISCUSSION

Prevalence, socio-demographic and cultural factors associated with EBF in Tudor sub county

The prevalence of EBF was observed to be low at 33.6%. This is far much lower than the national prevalence of EBF prevalence reported in the 2014 as 61%.[14] This can be explained by the fact that the national prevalence is not uniform throughout Kenya and some regions in Kenya like Mombasa county have low prevalence of EBF.

In a national study in rural Ghana, education, occupation, economic factors and marital status were the factors affecting EB.[15] In contrast, to this finding, an inverse relationship was observed in developing countries. This was possibly due to a perception that breastfeeding was old fashioned or an indication of lesser social status. There is an association between higher education and socioeconomic status. This increases the mother's ability to purchase infant formula. In addition to educational attainment, maternal age has been identified as among the factors most strongly influencing the initiation, duration and level of infant feeding.[16]

Level of awareness of the benefits of exclusive breastfeeding

As indicated in this study, the level of awareness of the benefits of EBF was 60.9%. Close to 40% women had inadequate knowledge on the benefits of EBF. Studies conducted in other parts of the world have shown that one of the reasons why women do not practice EBF is inadequate knowledge on the benefits of EBF.[12] These findings are in accordance with other studies.[11] More so, the poor knowledge exhibited by the participants might be associated with their parity since this is the first time they are exposed to experiences of motherhood and quite a good number of them claimed they had not witnessed other mothers breastfeeding exclusively.

A similar observation was also noted in Kware town of Sokoto state of Nigeria where only 31% of the mothers had adequate knowledge of exclusive breastfeeding.[17]

CONCLUSION

The prevalence of EBF among women of reproductive age in Tudor sub county is 33.6%. The level of awareness of EBF among women of reproductive age is 60.9%. Findings of this study revealed that women's knowledge on EBF and intention to practice it is still low. There was significant difference in the participants place of residence (rural versus urban), EBF knowledge sources and EBF knowledge, while the maternal age, educational attainment, EBF knowledge and sources of information about EBF were found to be significant predictors of good intention to practise EBF.

Recommendations

Health workers should carry intensify health education to increase the level of awareness of benefits of EBF among women of reproductive age in Tudor sub county. Health workers should empower men on importance of EBF so that they can emphasize to their wives on adherance and also offer social support. Professional employed husbands should be encouraged to apply for paternity leave so that they can offer social and moral support to their wives to help in the implementation of the practice.

ACKNOWLEDGEMENTS

We would like to thank my colleagues Ahamed Juma and Amumah Zealot for their encouragement. I cannot also forget to thank the research assistants who ensured that good quality data was collected through their commitment. Lastly, my gratitude goes to my husband Thomas Chula, sisters Getrude and Zaina, aunty Samba, uncles Rassul and Crispin for their inspiration and encouragement.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Machila CM, Karonjo J, Mogere D, Kariuki P. Level of awareness of the benefits, socio-demographic and cultural factors influencing exclusive breastfeeding among mothers attending MCH clinic in Tudor sub county hospital. Int J Community Med Public Health 2021;8:2150-4.