

**AKENTEN APPIAH MENKA UNIVERSITY OF SKILLS TRAINING AND
ENTREPRENEURIAL DEVELOPMENT**

**EXAMING COMPLEMENTARY INFANT FEEDING PRACTICES AMONG
NURSING MOTHERS IN THE SUNYANI MUNICIPALITY**

GLADYS BATINGE ADORLO

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**A Dissertation in the Department of Catering and Hospitality Education, Faculty
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University Of Skills Training and Entrepreneurial Development in partial
fulfillment of the requirements for the award of the degree of Catering and
Hospitality Degree**

MARCH, 2023

DECLARATION

STUDENT'S DECLARATION

I, **GLADYS BATINGE ADORLO**, declare that this Dissertation, except for quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my original work, and it has not been submitted, either in part or whole, for another degree in the Akenten Appiah-Menkah University of Skills Training and Entrepreneurial Development, Kumasi or elsewhere.

SIGNATURE:

DATE

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of this work were supervised under the guidelines for supervision of Dissertation as laid down by the Akenten Appiah-Menkah University of Skills Training and Entrepreneurial Development, Kumasi

NAME: **DR. GILBERT OWIAH SAMPSON**

SIGNATURE:

DATE

DEDICATION

I dedicate this work to my lovely family for their prayers and support.

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First, all thanks and praise to almighty God for the guidance and protection. A document of this nature could not have been completed without the support, encouragement, technical and professional guidance of some individuals whose efforts and contribution have to be acknowledged.

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ABSTRACT

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants and globally, the public health recommendation is that infants should be exclusively breastfed for the first six months of life to achieve this. The benefits of exclusive breastfeeding for both mother and child are universally acknowledged by health providers, global health agencies, and lay people. In Ghana, an estimated 84% of children younger than 2 months are being exclusively breastfed. The purpose was to assess the factors affecting the feeding practices of mothers of nursing mothers among Sunynani Health Centre. A descriptive cross-sectional study design was used to collect data through a quantitative approach. The design was chosen as it focuses on collecting data concerning factors affecting mothers or caregiver knowledge, attitudes and practices on optimal infant feeding practices at one point in time. The target population comprised all breastfeeding mothers or caregivers with infants between ages zero to six months in Zongo communities. The sample size selection will be calculated using the kish and leslie formula. Systematic sampling technique was used to randomly select every third mother in the line awaiting services as it is cheaper and easier to implement. Only 330 mothers were available at the time of the study. Out of these, 15 declined to be included in the study, 4 were unavailable and 11 dropped out of the study. Quantitative data was collected from 300 respondents from Sunynani at the Government Health Centre in October 2022 using questionnaires. A greater proportion of mothers had primary education (28.7%) whereas (16.7%) mothers had secondary education. This could impact on infant feeding practices since most uneducated mothers are less likely to practice the ideal feeding. The Majority of the feeding practices were, 184 (61.3%) infants weighed 3 kilograms or more at birth and 61.4% (113) of them were breastfed or bottle fed with breast milk compared to only 40.0% (20) of 50 (16.7%) low birth weight babies. Birth weight had a significant relationship with infant feeding practices (0.000). More than half of the infants, 226 (75.3%) were born by spontaneous vaginal delivery and comprised the greater percentage 55.3% (125) of all breastfed babies than those born by induced vaginal delivery and caesarean section combined. Majority of respondents, 108 (36%) attributed bottle feeding to lack of enough breast milk and 66.7% (72) practiced bottle feeding with cow's or formula milk. The study concluded that not all infants aged zero to six months are exclusively breastfed, social-demographic factors have a significant effect on infant feeding practices and culture is significantly related to infant feeding practices.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Breastfeeding of human infants has been a common feature of all cultures and all times because our very survival depends on it. In contrast, other modes of infant feeding: what is fed, when, how and by who have differed according to both time and place (WHO, 1990). The world health organisation recommends exclusive breastfeeding of infants for the first six months using on demand feeding and with initiation within the first hour of birth. Nutritionally adequate, safe and appropriate complementary foods should be introduced after six months. Breastfeeding should be encouraged for up to two years (Ulak et al., 2012). Exclusive breastfeeding for six months of age is recommended for HIV positive mothers with abrupt cessation of breastfeeding and introduction of safe and appropriate weaning and other foods. When implemented in both developed and resource poor developing countries, these recommendations have been shown to reduce both morbidity and mortality and also provide more pronounced benefits to the mother (Kruger and Gericke, 2001; Ulak et al, 2012).

Breastfeeding is accepted as the natural and optimal means of nourishing an infant and of preventing morbidity and mortality. The superiority of breast milk has been confirmed: it is the best (Kruger and Gericke, 2001). Colostrum, the yellowish, sticky breast milk produced at the end of pregnancy, is recommended by WHO as the perfect food for the newborn, and feeding should be initiated within the first hour after birth.

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants and globally, the public health recommendation is that infants should be exclusively breastfed for the first six months of life to achieve this.

Thereafter, in order to meet their evolving nutritional requirements, nutritionally adequate and safe complementary feeding, with continued breastfeeding for up to two years of age or beyond is recommended.^{1, 8} Infants are particularly vulnerable during the transition period when complementary feeding begins.

Globally, an average of about 35% of infants between ages 0-6 months are breastfed exclusively. The nutritional, immunologic, and economic advantages of breastfeeding are well recognized. In the 2009 Paediatric Nutrition Surveillance System (PedNSS), 61.7% of infants were ever breastfed, 27.0% were breastfed for at least 6 months, and 18.5% were breastfed for at least 12 months (CDC, 2011). Poor breastfeeding and complementary feeding practices have been widely documented in developing countries with only about 39% of infants exclusively breastfed for the first six months.

A similar report in 2011 indicated exclusive breastfeeding rates at 35% at 3 months and 14.8% at 6 months. In India, according to 2005-2006 report, 58% of infants under four months were exclusively breastfed while 46% of those under 6 months were breastfed exclusively. The 2014 Ghana Demographic and Health Survey (GDHS) is designed to provide data for monitoring the health situation of the population in Ghana. The 2014 GDHS is the sixth Demographic and Health Survey conducted in Ghana since 1988. In Ghana, only 8% of children under four months of age are breastfed and 45% are given some form of supplementary feeding by age three months (Awumbila, 2003).

Despite efforts by Health Service Providers (HSPs) to increase the percentage of breastfed babies, not much success has been achieved because feeding practices are directly related to varied economic, socio-cultural and religious factors in the community and to various dynamics prevailing at the household level (Awumbila,

2003). Sub-optimal breastfeeding and complementary feeding practices are associated with various factors including maternal age, marital status, education level and occupation; antenatal and maternity health care; health education and media exposure; culture, socio-economic status and area of residence; and the infant's birth weight, birth order and use of pacifiers (Kimani-Murage et al, 2011).

1.2 Statement of the Problem

The benefits of exclusive breastfeeding for both mother and child are universally acknowledged by health providers, global health agencies, and lay people. In Ghana, an estimated 84% of children younger than 2 months are being exclusively breastfed. By age 4 to 5 months, nevertheless, only 49% continue to receive exclusive breastfeeding (Ghana Statistical Service & ICF Macro, 2009 p. 187). Many attempts and hard work to promote exclusive breastfeeding have achieved less than desired outcomes and in order to comprehend and appreciate the dynamics of the practice, a number of studies have been conducted in Ghana and in many parts of the world. Much of these studies have focused on factors and barriers to exclusive breastfeeding. Several studies have looked at the health outcomes of exclusive and non exclusive breastfeeding whereas others have also considered the prospective position of husbands in breastfeeding. Much less attempts however, have been made at examining the practice of exclusive breastfeeding among professional working mothers particularly in sub Saharan Africa. This research is therefore an undertaking to realise the present knowledge gaps.

Complementary feeding is a pitfall for most mothers and they have poor knowledge on complementary feeding. A study in India in 2008, among 500 mothers with children under two years found that 62% and 90% of the mothers did not have adequate

knowledge about the appropriate amount and frequency of complementary feeds respectively; and their source of information were family members (78%) and doctors (23%). In Sunyani Ghana in 2013, the major source of information about complementary feeding were friends and relatives (61%), health workers (30%) and the media (9%). Having family and relatives as the major source of information will keep the cycle of poor feeding practices going.

1.3 General Objectives

To assess the factors affecting the feeding practices of mothers of Nursing mothers among Sunynani Health Centre.

1.3.1 Specific Objectives

1. To determine the feeding practices of mothers of infants zero to six months in Sunyani attending Government health center.
2. To establish the relationship between social-demographic factors and feeding practices of mothers of infants zero to six months in Sunyani attending Government health center.
3. To establish the infant factors affecting feeding practices of mothers of infants zero to six months in Sunyani attending Government health center.

1.4 Research Questions

1. What are the feeding practices of mothers of infants zero to six months in Sunyani attending Government health center?
2. How do social-demographic factors affect feeding practices of mothers of infants zero to six months in Sunyani attending Government health center?

3. How do infant factors affect feeding practices of mothers of infants zero to six months in Sunyani attending Government health center?

1.5 Significance of the Study

Infant feeding practices are important determinants of nutrition and health status of children. Poor breastfeeding practices, especially the lack of exclusive breastfeeding during the first 6 months of life and inadequate complementation are important risk factors for infant and childhood morbidity and mortality. The study aimed to assess the knowledge, attitude and practices of mothers related to infant feeding practices, its benefits and introduction of supplements. As a result it will create awareness among mothers and improve standards of nutrition in infants and young children. Poor feeding practices such as sub-optimal breastfeeding is still pervasive and frequently leads to undernourishment which is a foremost cause of more than half of all child deaths (Sokol et al. 2007).

Through research and identifying the practice of exclusive breastfeeding among professional working mothers in Ghana will add to an enhanced appreciative of how indispensable health interventions with established and confirmed empirical effectiveness including as exclusive breastfeeding can be enhanced and promoted. Again, it is believed that this research's findings will add to the rising body of scientific understanding and knowledge on newborn feeding practices and how to plan and position health interventions among professional working mothers. Additionally, this research will certainly provide a basis for future research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Infant Feeding Practices

Infant feeding practices generally refer to the various feeding methods employed by the mother or caregiver to provide the necessary nourishment to their infants. These range from either exclusively breastfed, predominantly breastfed, mixed fed or not breastfed at all.

2.1.1 Breastfeeding

Breastfeeding is an integral part of infant feeding and is the natural form of supplying nourishment to an infant. In a study, "Preliminary Data from Demographic and Health Surveys on Infant Feeding in 20 Developing Countries" authors Marriott, Campbell, Hirsh and Wilson determined that of the 20 countries studied, 99.6% of 0-6 and 87.9% of 6-12 month old infants were breastfed. Breast milk provides total food security for the baby as it is a hygienic source of food with the right amount of energy, protein, fat, vitamins, and nutrients for infants in the first six months. It is the only safe and reliable source of food for infants in an emergency.

2.1.2 Exclusive Breastfeeding

Exclusive breastfeeding necessitates feeding an infant on breast milk only continuously for six months without giving any other fluids even water with the exception of vitamins, minerals and medicines. UNICEF (2012) indicates that it is the perfect way to provide the best food for a baby's first six months of life. Breastfeeding is so much more than food alone since breastfed infants are less likely to die from diarrhea, acute respiratory infections and other diseases.

2.1.2.1 Benefits of exclusive breastfeeding

The United States Agency for International Development (USAID) recognizes exclusive breastfeeding for the first six months of life as the best feeding practice for enhancing child survival, growth and development. It also protects against diarrhea by eliminating the infant's exposure to water-borne pathogens.

Breast milk provides protective antibodies from the mother to help protect infants against acute respiratory infections, bacterial meningitis, atopic disease, childhood asthma and childhood leukaemia. Breast milk prevents long term complications such as diabetes mellitus, obesity, Crohn's disease and lymphoma.

Breastfeeding stimulates an infant's immune system and response to vaccination as well as boosting cognitive development (Burby, 2012). Breastfeeding saves money by reducing costs that would otherwise be used to treat illness or buy breast milk substitutes, feeding equipment or fuel for preparation. It is environmental friendly since it is a natural, renewable, sustainable resource that requires no fuel for preparation, packaging, shipping, or disposal (Alive & Thrive). Breastfeeding can reduce stress level and risk of postpartum haemorrhage as well as reducing the risk of ovarian and breast cancers. It promotes mother to child bond and meets the baby's emotional needs (USAID, 2009). Breastfeeding contributes to optimal child spacing (Burby, 2005).

2.1.3 Predominant Breastfeeding

Predominant breastfeeding means that the infant's predominant source of nourishment has been breast milk including that expressed from a wet nurse as the predominant source of nourishment. However, the infant may have also received other liquids such

as water, water based drinks, ritual foods, fruits, juices, drops or syrups and oral rehydration solution.

Monterrosa et al, in their study in 2008 indicated that a lower incidence of gastrointestinal infections was associated with predominant breastfeeding from zero to six months compared to non predominant breastfeeding. Shiva, Ghotbi & Padyab (2007) agree that partially breastfed infants are likely to be hospitalised more frequently than predominantly breastfed babies. In their study, there was no significant difference in the risk of hospitalisation associated with being predominantly or exclusively breastfed.

2.1.4 Mixed feeding

Mixed feeding entails breastfeeding a child while giving non-human milk or food-based fluids and solid foods. The introduction of foods other than breast milk before six months of life is not only undesirable, but could also be harmful since they displace the nutritious mother's milk and serve as a precursor for infectious pathogens leading to severe illness (Ulak et al., 2012).

In a breastfeeding and mixed feeding practices study in Malawi to find out the timing, reasons, decision makers, and child health consequences determined that 65% of children were given food in their first month, only 4% were exclusively breastfed for 6 months. The common early foods were *mzuwala* and *dawale* (herbal infusions), water and porridge. *Mzuwala* was introduced by grandmothers to protect children from illness while other foods were introduced by mothers or grandmothers in response to perceived hunger. The early introduction of porridge and *dawale* was associated with worse

anthropometric status compared to *Mzuvwula*, which is not associated with poor growth and is usually made with boiled water and given in small amounts. On the other hand, porridge which is associated with poor child growth, is potentially contaminated and served in larger amounts, which would displace breast milk.

Similarly, Kapil U., et al (1993) in a study to assess breastfeeding practices in a sample of 818 children established that 100% were ever breastfed. However, only 15% were exclusively breastfed for the first four months of life, 85% received water thus increasing risk of gastrointestinal infections. Water is believed to improve hydration and tea, which is advised by parents and even medical personnel, believed to relieve pain and quench thirst.

2.2 HIV and Infant feeding

Infant feeding in the context of HIV poses significant challenges due to risk of transmission of the virus via breastfeeding and the complexity of the major influence that feeding practices exert on child survival. The dilemma is to balance the risk of infants acquiring HIV through breast milk with the higher risk of death from other causes in particular malnutrition and diarrhea (UNICEF, 2012).

HIV transmission may occur for as long as a child is breastfed but the risk is nearly twice as much among women recently infected than for those infected before or during pregnancy due to the high viral load shortly after initial infection (WHO, 2003). The method of infant feeding is clearly associated with the risk of transmission through breastmilk. Compared to mixed feeding, the risk of HIV transmission is 3-4 fold lower with exclusive breastfeeding for the first six months. In a study by the WHO 2007 only

4% of exclusively breastfed infants became infected with HIV between 6 weeks and 6 months even in the absence of ARVs (UNICEF, 2012).

UNICEF indicates that HIV transmission through breastfeeding can be reduced if HIV positive women breastfeed exclusively for six months rather than practising mixed feeding. It is assumed that HIV transmission is higher in HIV infected women who take ARVs and mix feed compared to those who breastfeed exclusively, are infected and on ARVs. Thus mixed feeding should be discouraged in the first six months (2012).

The 2010 recommendations are that national authorities should decide which infant feeding practice and interventions are appropriate for the country. These include either breastfeeding with an ARV intervention or avoidance of breastfeeding altogether. If a country selects breastfeeding with an ARV intervention, mothers infected with HIV are recommended to breastfeed their infants until 12 months of age with exclusive breastfeeding for the first six months. ARVs should be provided to the mother or infant depending on the country's PMTCT protocol until one week after all breastfeeding has ceased. If replacement feeding is chosen, it should not be used unless it is acceptable, feasible, affordable, sustainable and safe (AFASS) (UNICEF, 2012).

2.3 Feeding Practices in Relation to Social-Demographic Factors

2.3.1 Age

Maternal age has been shown to have an influence on breastfeeding. Park, Meier & Song (2003) studied characteristics of teenage mothers and predictors of breastfeeding initiation. The breastfeeding initiation rate of United States mothers younger than 20 years old was 36% in 1995 compared to that of 63% among mothers older than 25. CDC researchers reported that several factors can contribute to lower breastfeeding rates including the mother being young. Similarly, Tucker and Wilson (2011) agree that

adolescent mothers in the U.S. are less likely to initiate breastfeeding and those who do breastfeed for shorter durations.

In 2004, the Department of Health, Social Services and Public Safety (DHSSPS) reviewed literature that showed many young mothers lack access to key sources of information and advice on breastfeeding such as antenatal services, peer support programmes, friends, family and other social support networks. Young first time mothers may further lack assertiveness and are therefore reluctant to ask for information or advice on issues such as breastfeeding.

In Uganda, although universally practiced (99%), breastfeeding is less likely to be undertaken by adolescent mothers who often leave their babies in the hands of grandmothers due to socioeconomic reasons. Furthermore, poor weaning practices result to malnutrition in babies born to adolescents (MoH, 2000).

2.3.2 Literacy

Studies indicate varied opinions on the effect of maternal education on breastfeeding practices. Shwetal et al., (2012) showed that the rate of mothers initiating breastfeeding was higher in literate mothers compared to illiterate mothers. Anandaiah & Choe (2000) suggested in their report that in India the proportion of children age two months who are not breastfed at all is highest in the medium- mortality states and lowest in the high-mortality states. However, in both states two month old infants whose mothers are literate are less likely to be breastfeed than are children of illiterate mothers. Studied breastfeeding patterns in Nigeria and the findings showed no significant difference in the breastfeeding pattern of literate and illiterate mothers. Whether a mother is literate

or illiterate, she sees breastfeeding as an important factor in fulfilling her child's right to live.

2.3.3 Marital status

Papp (2012) indicated that mothers report that their partners provide a significant and unique source of emotional and instrumental support especially during the early weeks of breastfeeding. Mothers with higher levels of marital satisfaction following their child's birth were more likely to breastfeed as planned throughout the first year.

In Eastern Uganda, only women well provided for could afford to practice exclusive breastfeeding. Men consider exclusive breastfeeding as a sign of poverty and as a sign of them failing to provide for the infant (Engebresten et al., 2010).

2.3.4 Occupation

Employment, maternity leave and the length of maternity leave are very influential on the incidence of exclusive breastfeeding and thus affect mother's choice of feeding practice (Jahangeer et al., 2009). The length of maternity leave is positively associated with the duration of breastfeeding (Chen et al, 2006; Singh, 2010).

Breastfeeding has declined significantly in the United States over the last few years. Breastfeeding dropped from 60% in 1984 to 52% in 1989. Prolonged breastfeeding declined from 24% to 18% in the same period. Mothers who work full time tend to breastfeed for shorter intervals than those who work part time or are unemployed. It is also evident that mothers that work full time stop breastfeeding their infants earlier than other women due to lack of areas for breastfeeding at work. Employed women in Jordan were more likely not to practice full breastfeeding compared to unemployed women (Khassawneh et al, 20006).

Heck et al., (2006) indicates that employment may decrease breastfeeding because women in lower-status occupations may have more obstacles to expressing breast milk at work, or women with hazardous occupations might be concerned their exposures might affect breast milk. However, in Asian countries, and in many joint family systems, grandparents and other nonworking family members fulfill the need for childcare when the mother is at work thus provides her the necessary support to perform her dual role efficiently.

2.3.5 Area of residence

Levels of malnutrition among slum dwelling infants are much higher compared to those in rural areas. In Urban slums, families either receive incorrect or little information about proper feeding practices and this lack of information contributes to high infant and child mortality rates (ICDDR, 2012). Most Indian studies show a low exclusive breastfeeding rate among slum dwelling residents.

Infant feeding and weaning practices in slum dwellers of a district in Bangladesh and concluded that only 20% infants feed on breast milk while 45.5% feed on sugar water as their first food. Mixed feeding and early weaning was observed with majority of respondents citing lack of money as the reason for not giving nutritious foods to their children. Still in India, exclusive breastfeeding rates at 4% as opposed to the high predominant breastfeeding rates in an urban slum. Discarding colostrums was still a common practice as well as giving pre-lacteal feeds. Although exposed to urbanisation some women still delayed to initiate breastfeeding. Similarly, in urban slums there is a serious erosion of breastfeeding practices. Exclusive breastfeeding rates range between 30-40% of infants while 90% discard colostrum with a universal pre-lacteal feeding practice.

Kimani-Murage et al., (2011) in a study of two urban slums in Nairobi, Ghana indicated neighbourhood (slum of residence) as one of the factors associated with sub-optimal infant breastfeeding and feeding practices. Slum children are reported to be sicker and to have higher mortality rates than any other sub-group in Ghana including the rural areas.

2.4 Feeding practices in relation to cultural factors

2.4.1 Culture

In humans, breastfeeding behaviour is highly variable from one culture to the next. Cultural tradition dictates the initiation, frequency and termination of breastfeeding. Learning plays a key role in the lactation process, but is focused on beliefs, attitudes and values of culture (Lawrence, 2011). The practice of exclusive breastfeeding is hindered by many cultural and practical obstacles. Some traditional beliefs, practices and rites encourage use of pre-lacteal feeds as well as giving extra water, tea and herbs to breastfeeding babies (Nankunda et al, 2006).

In the West, early weaning is encouraged because it is seen as a sign of infant development. An infant who does not easily wean at a socially expected (early) age is seen as overly dependent, demanding and spoiled (Mojab, 2000). In North and Western Europe, breastfeeding in public is not accepted since it is embarrassing. Independence is valued in the American society and children should be taught from early infancy to be independent. As such, bottles are introduced so that others can feed the baby thus facilitating mother-child separation. Thumb sucking is perceived as a step towards independence. Babies and children sleep in a separate bed and room from parents. The American reverence for science is partly rooted in the belief that humans are masters of

nature which cannot be trusted to properly manage itself. It is believed that scientists can create an infant food that is superior or equivalent to the milk produced by nature. Thus many mothers have fed their infants with formula believing it is as, or more hygienic than their own milk. Such cultural beliefs are often the basis of the distrust that many American women have in the quality and quantity of their own milk. This leads to supplementation with formula, early introduction of solids and early weaning (Mojab, 2000).

In India however, Sinhababu et al., (2010) revealed that although the practice was common among cultures, there was an international consensus that providing other liquids in addition to breast milk in the first six months of life was unnecessary and harmful. Similarly Agampondi et al., (2007) agrees that feeding a baby with mother's milk is a well-accepted and well praised behaviour in the Sri Lankan culture.

However, Inayati et al (2012) in a retrospective study on infant feeding practices in Nias Indonesia established a widespread perception that prolonged breastfeeding would interfere with the child's growth. The belief that pregnant women should not breastfeed since it would harm the foetus by reducing its food intake resulting in the birth of a thin, sickly and feeble minded baby was another factor hindering breastfeeding. Birth spacing was short and as such a new pregnancy led to the decision to wean too early. Mothers if ill were not to breastfeed due to supposed transmission of illness to the breastfed child through breast milk in which case breastfeeding was halted and family foods were given to young children. Grandmothers had a negative influence as far as exclusive breastfeeding duration and time of introduction of complementary feeding was concerned. Singh (2010) reports of rural Rajasthan district in India where 77% of study population discard colostrum.

In Nigeria, Ogunbiade & Ogunleye (2012) established that the breastfeeding culture is well enshrined in various ethnic groups but the low practice of exclusive breastfeeding persists. Women do not breastfeed due to fear that breasts become flabby and they become unappealing to their husbands. The Nigerian Demographic Health Survey 2008 showed that only 13% of children below six months were breastfed exclusively while 87% of infants below six months receive complementary liquids or foods. Colostrum is not given to the baby sometimes due to fear that the yellow milk will give the baby jaundice (Qinn et al.). Early introduction of complementary feeding affects breastfeeding initiation and sustainability. A common belief among the Yoruba people is that exclusive breastfeeding is beneficial to the mother and infant, but complementary feeding is essential for babies to adapt to other meals with ease (Ogunbiade & Ogunleye, 2012).

In Third World countries, exclusive breastfeeding is the safest way to nourish an infant for 3-6 months. However, many women in Eastern Africa practice mixed feeding which includes substitutes such as water, sugar water and other traditional beverages used for traditional or cultural reasons (Weber, 2012).

In Uganda, breastfeeding remains culturally acceptable with up to 99% initiating breastfeeding. Exclusive breastfeeding rates are however low and poor weaning practices predispose infants to malnutrition (MoH, 2000). Pre-lacteal feeds, water-based liquids commonly, are given to infants since "mothers have to wait for milk to start flowing, the baby is hungry, cleaning the baby's throat, relief from pain and exhaustion of delivery, traditions and advice from health staff" (Engebresten et al., 2007).

Many women in Ghana, especially in rural areas and among urban poor populations, do not exclusively breastfeed their children due to cultural beliefs and practices. Culture is a major obstacle to exclusive breastfeeding for six months. In some cultures a mother is not to breastfeed if she has had a quarrel with her husband since it would pass 'bad blood' between her and the person she quarrelled with to the child. Some are prevented from eating foods rich in protein to prevent them from increasing their weight and that of their babies (Coastweek, 2012). Poor childcare practices such as diluting breast milk with water expose children to diarrhea and worm infestation thus preventing proper nutrient absorption and retention.

2.5 Feeding Practices in Relation to Infant Factors

2.5.1 Birth Weight

Several studies have shown an influence of birth weight on breastfeeding. Low birth weight babies are less likely to breastfeed (Barros et al, 1986). Feeding at the breast is quite challenging for mothers and very low birth weight infants. Many infants who initially receive their mother's milk are not successful in transition to feeding at the breast and most problems are attributed to feeding limitations of the infant as opposed to maternal milk production. Infants who are small for gestational age or hypoglycemic may require supplemental feedings as opposed to their healthy counterparts. This may have to be given in the form of bottle feeding since they are too small to latch on or suckle effectively at the breast. Sometimes the baby's mouth appears too small for the mother's nipple and areola.

2.5.2 Bottle feeding

Infants must learn to attach and suckle properly at the breast during the first few days of life to breastfeed successfully. Exposures to artificial nipples are believed to contribute to breastfeeding problems and early weaning. Bottle feeding is routinely used to provide supplements to breastfed infants and supplemental formula is strongly associated with early breastfeeding termination. In the study the authors conclude that supplemental feedings regardless of method (cup or bottle) have a detrimental effect on breastfeeding duration.

Fathers of both breastfeeding and bottle feeding babies were unaware of the health benefits of breastfeeding to both mother and child. Bottle feeding mothers were supportive of the practice although less negative towards breastfeeding. Breastfeeding mothers, however, were more supportive towards breastfeeding than their partners. Fathers of both bottle and breastfed babies were more embarrassed than their partners about mothers breastfeeding in front of non family members.

2.5.3 Method of delivery

Internationally, studies have shown decreased breastfeeding initiation and continuation with cesarean birth.

Breastfeeding practices in relation to method of delivery. There was no significant association between delivery method and breastfeeding initiation. Breastfeeding duration to four weeks was less in induced vaginal delivery compared to the spontaneous vaginal delivery group while no significant association was observed in those who had planned or emergency cesarean deliveries. At 6 months, the induced vaginal and emergency cesarean delivery groups were less likely to breastfeed

compared to the spontaneous vaginal delivery group. Breastfeeding duration varied substantially with the method of delivery at 45.2 weeks among spontaneous vaginal delivery, 38.7 weeks among planned cesarean delivery, 25.8 weeks among induced vaginal delivery and 21.5 weeks among emergency cesarean delivery groups respectively. Similarly in Jordan, women who had caesarian delivery were more likely not to practice full breastfeeding compared to those who had vaginal delivery (Khassawneh et al, 2006).

2.5.4 Birth order (Parity)

Breastfeeding initiation decreases as birth order increases hence multiparous women are less likely to initiate breastfeeding (Sutherland et al., 2011). An Indian study shows that breastfeeding within one hour decreases and infant mortality increases with increase in birth order (Pandey, 2006). However, Taylor et al., (2008) assert that U.S. mothers are likely to choose the same feeding method for each of their children regardless of the number of children they have. In their study mothers with two, three, four and five or more children breastfed all their children 52.6%, 48.4%, 44.7% and 57.1% of the time. Mothers made the same feeding choice whether breast or bottle feeding for each of their children.

2.5.5 Morbidity

Exclusive or predominant breastfeeding can significantly reduce morbidity rates (Mihreshashi et al., 2008). Various studies have shown a protective effect of breastfeeding against diarrhea, acute respiratory and gastrointestinal infections respectively. It is however important that mothers continue breastfeeding their infants during illness as well as when well.

Bentley et al., (1991) studied maternal feeding behavior and children acceptance of food during diarrhea, convalescence and health in Sierra Peru and revealed that child acceptance of food increased during health compared to diarrhea. This decrease during diarrhea was attributed to anorexia rather than withdrawal of food by mothers who in response to a reduction in child appetite during illness were likely to encourage them to eat. However, mothers tended to be passive feeders after the diarrhea had stopped.

2.6 Other Factors Affecting Infant Feeding Practices

2.6.1 Knowledge on breastfeeding

The influence of maternal knowledge on breastfeeding initiation and duration has been described. Knowledge of the benefits of breastfeeding has been shown to predict breastfeeding. Paternal knowledge and social support may also be involved with the decision not to breastfeed (Heck et al, 2006).

Giugliani et al., (1995) studied maternal knowledge on breastfeeding and related factors and concluded that mothers who received prenatal orientation about breastfeeding and had at least 5 prenatal visits had better knowledge compared to those who received postnatal orientation. Although maternal knowledge on many breastfeeding aspects was low, postnatal orientation did not increase this knowledge whereas prenatal orientation had a positive impact on breastfeeding knowledge. However, even with the increase in knowledge there was still prevalence of early interruption of breastfeeding.

2.6.2 Antenatal and Maternity Care

It is imperative for a woman going through a pregnancy to have access to absolute care for herself and her unborn child (Epitales, 2012). Lack of proper information regarding breastfeeding sometimes acts as a barrier to its practice. The place of antenatal treatment and delivery can have an impact on the mother's feeding practices since public

health sectors offer more information on proper feeding practices and have adopted the Baby Friendly Hospital Initiative (BFHI), thereby encouraging proper breastfeeding initiation and successful exclusive breastfeeding for six months. This is however not the case in the private sector (Jahangeer et al., 2009).

2.6.3 Health education

Encouragement by health care providers positively impacts a mother's decision to initiate breastfeeding especially in populations that are less likely to breastfeed. Efforts must be intensified to educate prospective mothers on the need and benefits of breastfeeding.

In India, very few women have access to counselling services on infant and young child feeding. As such the mother's main source of information is through family and friends which is often inadequate (Ekambaram et al., 2010).

2.6.4 Media exposure

Mass media content is likely to influence the decision of women to breastfeed their newborn children (Foss and Southwell, 2006). In the U.S.A low levels of breastfeeding have been reported even with exposure to mass media. Foss & Southwell (2006) agree that through advertising media not only alerts the public to new merchandise, but also teaches people why they need a product. Thus by informing new parents of commercial milk substitutes and emphasizing the need for a new product, media outlets are likely to encourage widespread adoption of breast milk substitutes.

In Jordan studies show that women with a high media exposure were significantly more likely to initiate breastfeeding within six hours if the birth was after the media campaign (McDivitt et al., 1993).

The effectiveness of mass media promotion can be seen in results of formula advertising. Literature that showed a four country survey found that majority of women recalled mass media advertisements of commercial infant foods, even though the advertisements had been discontinued prior to the survey.

2.6.5 Workload

Women do the majority of unpaid work that sustains their families and the workload that results from this gender unequal division of work affects the time and energy available for breastfeeding (ILCA, 2007).

Most child-rearing work can be shared with others, but it is only mothers who carry a child through pregnancy, give birth, and provide their milk to feed and protect the child. When compared to men and to women without young children, this additional work of reproduction puts childbearing women at a competitive and financial disadvantage for supporting themselves and their families (ILCA, 2007). Women had to perform income generating activities for an average of six hours per day in informal sectors mostly away from their homes and as such it would be difficult to breastfeed during their absence from home. As a result there was a decline in breastfeeding frequency and ultimately cessation of breastfeeding (Adeyinka et al., 2008). Engebresten et al., (2010) asserts that among women in Eastern Uganda exclusive breastfeeding was regarded as extremely difficult to combine with domestic chores and is seen as an obstacle to pursuing income generating activities. "Women felt they were constrained in their daily life: obligations, exhaustion, studies, domestic work, employment and family pressure were factors which made exclusive breastfeeding difficult.

2.6.6 Socio-economic status

Differing aspects of socio-economic status may be associated with knowledge, attitudes, experiences and beliefs leading a woman to a particular infant feeding choice. Paternal and maternal income have been shown to affect breastfeeding in different directions since maternal income is associated with employment hence breastfeeding loses its worth. Higher socioeconomic status women are more likely to have supportive workplace and/ or home environments for breastfeeding. Socio-economic status is associated with attitudes towards breastfeeding which may reflect experience with a peer group or a health care provider whose opinions the mother values (Heck et al., 2006).

Similarly, Bently, Dee and Jensen (2003) assert that women who make decisions about how to feed their infants live in communities where they are exposed to local organisations or workplace environments that can either support or discourage breastfeeding. For example, hospitals that encourage 'rooming in' and providing in hospital lactation to women who need it to build their skills and help them gain confidence in breastfeeding. Contrary to both studies, although middle class mothers report health visitors as a valuable source of advice on infant feeding, the working class groups reported personal and family experience as well as practical support to be more helpful.

2.7 Conceptual Framework

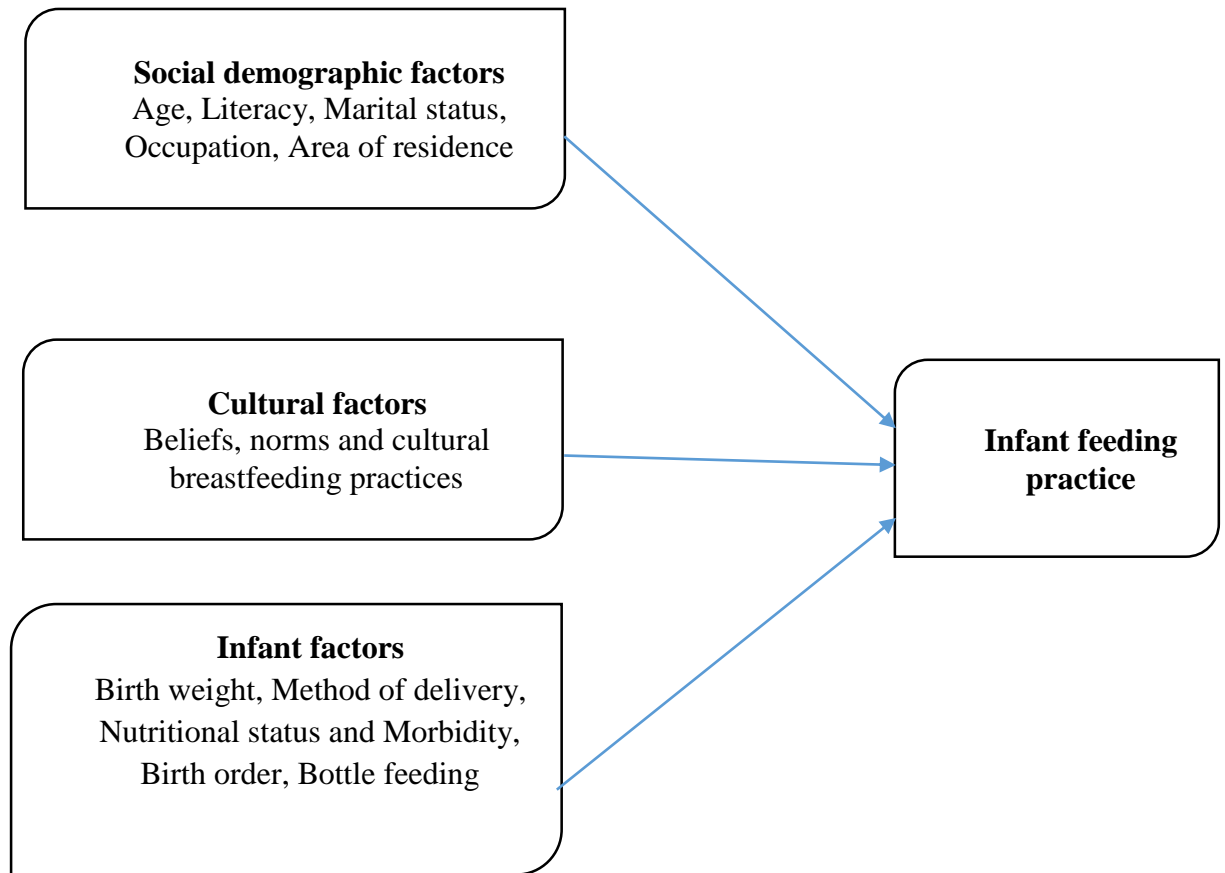


Figure 1: Conceptual Framework

The conceptual framework above shows the independent variables, social-demographic, cultural and infant factors respectively that affect the dependent variable, infant feeding practices.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

A descriptive cross-sectional study design was used to collect data through a quantitative approach. The design was chosen as it focuses on collecting data concerning factors affecting mothers or caregiver knowledge, attitudes and practices on optimal infant feeding practices at one point in time.

3.2 Study Area

Sunyani Government health center is a city council health facility that offers both out-patient and in-patient services including antenatal care, basic emergency obstetric care, postnatal care, immunisation, growth monitoring and promotion, curative in-patient and out-patient services, family planning, HIV counselling and testing, prevention of mother to child transmission of HIV, home based care and rural health training centre at the rural health centers. It was chosen as the study area since most mothers reporting to the health center are residents of Zongo areas that is characterised by a gross unavailability and inaccessibility to basic vital goods and services which could have a direct impact on the practice of optimal infant feeding.

3.3 Study Population

The target population comprised all breastfeeding mothers or caregivers with infants between ages zero to six months in Zongo communities. The accessible population consisted of breastfeeding mothers or caregivers of infants zero to six months in Zongo areas attending Government Health Centre.

3.4 Sample Size Calculation

The sample size selection will be calculated using the kish and leslie formula.

$$N = \frac{Z^2 * P(1-P)}{d^2}$$

- Z²- Standard value of 1.96
- P- Estimated prevalence of variable being measured according to (KDHS, 2008-09) 32% hence 0.32
- d²- margin error at 5% (standard value of 0.05)

$$\text{Therefore } n = \frac{1.96^2 * 0.32 (1 - 0.32)}{0.05^2}$$

$$n = \frac{0.83593216}{0.0025}$$

$$n = 334$$

3.4.1 Inclusion criteria

The study population included breastfeeding mothers and caregivers with children zero to six months and reside in Sunyani Municipal.

3.4.2 Exclusion criteria

Mothers with children between zero to six months that do not consent were excluded from the study as well as those with children more than six months of age.

3.4.3 Sampling technique

The sampling frame consisted mothers reporting to Government Health Centre from Monday to Friday for immunization clinic as well as those in the postnatal unit. Systematic sampling technique was used to randomly select every third mother in the

line awaiting services as it is cheaper and easier to implement. Only 330 mothers were available at the time of the study. Out of these, 15 declined to be included in the study, 4 were unavailable and 11 dropped out of the study.

3.5 Data Collection Techniques

3.5.1 Instrument

Interviewer administered questionnaires were used to collect data from mothers and caregivers. The questionnaire contained sections to assess feeding practices and factors that affect child feeding practices. The questions included were both open and closed ended. The researcher was concerned with identifying variables that could not be directly observed such as views, opinions, perceptions and feelings of the mothers towards infant feeding practices.

3.5.2 Data Collection Procedure

Quantitative data was collected from 300 respondents from Sunyani at the Government Health Centre in October 2022 using questionnaires. The questionnaires were personally administered by the researcher with the help of two trained research assistants to facilitate fast data collection. The purpose of the study was clearly and concisely explained to the participants who signed the consent form before answering the questions. Data was collected from mothers or caregivers of children in the age group zero to six months after obtaining the authorization for research.

3.6 Data Management

The data collected was analysed using the Statistical Package for Social Sciences (SPSS) version 16. Socio-demographic data was analysed using univariate analysis to

obtain descriptive statistics. In this study, the independent variables are categorical while the dependent variable is continuous. Chi-square test was used to compare differences between the categorical frequencies. $P < 0.05$ level of significance was used for analysis. The analysed data is presented in tables and figures.

3.7 Ethical Issues

Following the Permission granted by the heads of department in the health centre, the District Health Officer and from participants of the study. Once the permission was granted, the researcher proceeded to collect data.

The major ethical issues in this study were informed consent, privacy and confidentiality, anonymity and researcher's responsibility. An informed consent was provided for the respondents and was attached to each questionnaire. It informed them about the procedure and purpose of the study including their rights especially the right to refuse to participate in the study. Confidentiality and Privacy of the respondents was upheld by use of codes. The study was descriptive in nature and no experimentation or interventions took place.

CHAPTER FOUR
RESULTS AND DISCUSSIONS

4.1 Demographic Characteristics of Respondent

Table 1: Distribution of respondents by their Social-demographic characteristics

Variable	Frequency (N=300)	Percentage (%)
Age	74	24,7
18 years or less	105	35.0
19-24 years	105	35.0
25 years and above	121	40.3
Level of education		
No education	73	24.3
Nursery	91	30.3
Primary	86	28.7
Secondary	50	16.7
Tertiary	0	00
Marital status		
Single	56	18.7
Married	113	37.7
Divorced/ separated	45	15.0
Widowed	35	11.7
Cohabiting	51	17.0
Occupation		
Employed	65	21.7
Unemployed	235	78.3
Parity		
One	94	31.3
Two	80	26.7
Three or more	126	42.0
Residence		
Urban formal settlement	32	10.7
Urban informal settlement	268	89.3

4.2 Social Demographic Characteristics

The frequency distributions for social demographic characteristics are presented in Table 1 above. Majority of respondents were 25 years and above. Most (28.7%) were educated to Primary level while (16.7%) to Secondary level respectively. Less than half (37.7%) were married while widows comprised the least (11.7%). More than half (78.3%) of respondents were unemployed while (21.7%) were employed or self-employed. Most respondents had three or more children (42.0%) while (26.7%) had two children. The largest number of respondents (89.3%) resided in urban informal settlements.

4.3 Infant Factors Affecting Infant Feeding Practices

Feeding practices were defined either as breastfed and/or bottle fed with breast milk only or bottle fed with cow's or formula milk respectively. Out of the respondent 50.7% said that, the best method for feeding your infant is to breastfeed while 49.3% responded prefer cow's or formula milk instead. The results are presented in Figure2.

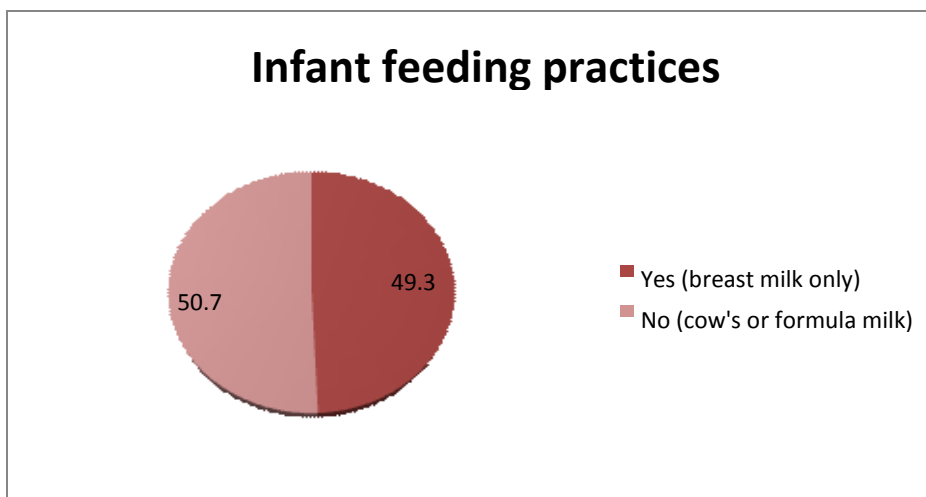


Figure 2: Pie chart showing infant feeding practices

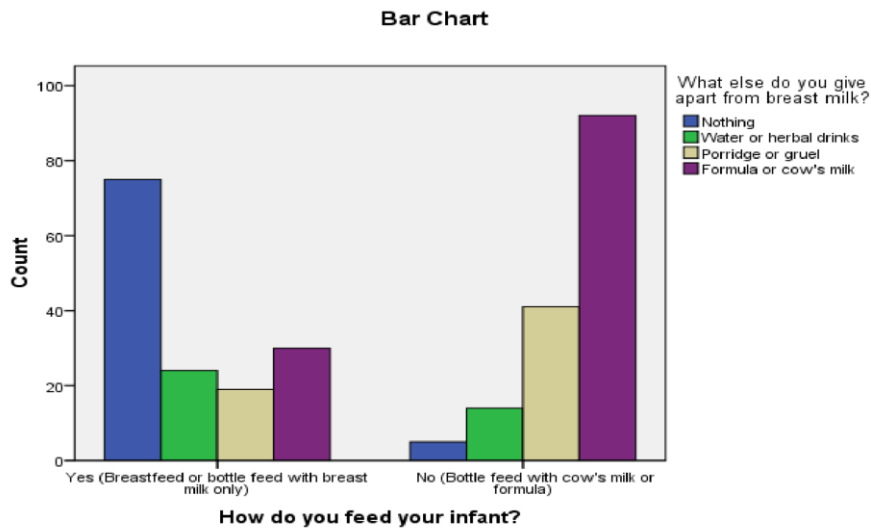


Figure 3: Bar graph showing other feeding practices

A large proportion of respondents in the breastfeeding group gave nothing else apart from breast milk to their infants. However, majority gave water and herbs compared to the infants given other types of milk. More than half of the infants fed on cow's or formula milk and most received porridge or gruel compared to the breastfeeding group.

Table 2: Infant factors affecting infant feeding practices

Variable	N (%)	Infant feeding		χ^2	P-value
		Yes	No		
What was your infants birth weight?					
3kgs or more	180(61.3%)	113(61.4%)	71 (38.6%)	31.176	0.000
2.5-29 kgs	66(22.0%)	15(22.7)	51(77.3%)		
2.4kgs or less	50(16.7%)	20 (40)	30 (60.0%)		
Method of delivery					
Spontaneous vaginal delivery	226 (75.3%)	125 (55.3)	101 (44.7)	13.162	0.001
Induced vaginal delivery	34 (11.3%)	10 (29.4%)	24 (70.6)		
Planned caesarea section	0 (0.0%)	13 (32.5%)	27 (67.5%)		
Emergency caesarean section	40 (13.3%)				
Feeding problems (Nutritional Status					
Yes	123(41%)	37 (30.1%)	86(69.9%)		
No	177 (59%)	111(62.7%)	66(37.3%)		
Morbidity/ recent illness					
Yes	111 (37.0%)	46 (41.4%)	65 (58.6%)	4.390	0.036
No	189 (63.0%)	102(54.0%)	87 (46.0%)		
Birth order					
First born	94 (31.3%)	68 (72.3%)	26 (27.7%)	32.304	0.000
Second born	80 (26.7%)	32 (40.0%)	48 (60.0%)		
Third born	78 (26.0%)	25 (32.1%)	53 (67.9%)		
Fourth born	35 (11.7%)	16 (45.7%)	19 (54.3%)		
Fifth born or above	13 (4.3%)	7 (53.8%)	6 (46.2%)		
Bottle feeding					
Breast milk not enough	108 (36%)	36 (90.0%)			
Breast pain	54 (18%)	4 (10.0%)			
No time to breastfeed	30 (10%)	0 (0.0%)			
N/A	108 (36%)				

Majority, 180 (61.3%) infants weighed 3 kilograms or more at birth and 61.4% (113) of them were breastfed or bottle fed with breast milk compared to only 40.0% (20) of 50 (16.7%) low birth weight babies. Birth weight had a significant relationship with infant feeding practices (0.000). The poor feeding practices in these infants were possibly due to either poor attachment or failure to latch on the breast. As such most mothers preferred using bottles to feed their babies. These findings were similar to Facts for Feeding (2006).

More than half of the infants, 226 (75.3%) were born by spontaneous vaginal delivery and comprised the greater percentage 55.3% (125) of all breastfed babies than those born by induced vaginal delivery and caesarean section combined. The method of delivery had a significant relationship with infant feeding practices (0.001). Mothers who gave birth by spontaneous vaginal delivery demonstrated further increased likelihood to breastfeed frequently and for a longer duration than their counterparts. These findings were consistent with both Ahluwalia, Li & Morrow (2012) and Khassawneh et al (2006).

Both nutritional status and morbidity were shown to significantly influence infant feeding practices ($p= 0.000$ & $p= 0.036$) respectively. 177 (59%) of respondents reported no feeding problems for their infants and most, 62.7% (111) were practicing breast or bottle feeding with breast milk. 111 (37.0%) respondents reported infant recent illness and less than half, 41.4% (46), of them gave breast milk to their infants compared to 102 (54.0%) of those who reported no recent infant illness. There was a significant relationship between recent illness and infant feeding practices ($p=0.036$). This could probably be due to the fact that most infants are likely to have a reduced appetite in the course of illness a period in which most mothers experience feeding

problems. Similarly, Bentley et al (1991) revealed that child acceptance of food decreased during ill health.

The proportion of infants breastfed or bottle fed with breast milk reduced significantly with the birth order of the child. First borns were 72.3% (68) likely to be breastfed than children born fifth or above 53.8% (7). Birth order was significantly related to infant feeding practices ($p=0.000$). This could possibly result from diminishing motivation or enthusiasm as mother gets more children or the monotony of practicing the same routine repeatedly. Similarly Sutherland et al (2011) revealed in their study that breastfeeding decreases with increasing birth order. Majority of respondents, 108 (36%) attributed bottle feeding to lack of enough breast milk and 66.7% (72) practiced bottle feeding with cow's or formula milk. There was a significant relationship between bottle feeding and infant feeding practices (0.000). This could cause a barrier to successful and efficient infant feeding practices by either resulting to breast refusal or increased infections as a result of poor hygiene. The duration of breastfeeding among mothers of bottle fed infants reduced drastically with increasing infant age dropping to zero at two years. This finding was consistent with Howard et al (2003) that bottle feeding is associated with early termination of breast feeding and has detrimental effects on duration of breast feeding.

Social-demographics were defined as mother's age, educational level, marital status, occupation, husband's occupation and level of education respectively. Results are presented in table 3.

Table 3: Social- demographic factors affecting infant feeding practices

Variable	N (%)	Infant feeding practice		χ^2	P-value
		Yes	No		
Age					
18 or less	74 (24.7)	20 (27.0)	54 (73.0)	20.975	0.000
19-24	105 (35)	55 (52.4)	50 (47.6)		
25 and above	121 (40.3)	73 (60.3)	48 (39.7)		
Educational background					
None	73 (24.3)	15 (20.5)	58 (79.5)	42.068	0.000
Nursery	91 (30.3)	56 (61.5)	35 (38.5)		
Primary	86 (28.7)	40 (46.5)	46 (53.5)		
Secondary	50 (16.7)	37 (74.0)	13 (26.0)		
Tertiary	0 (0.0)		86(69.9%)		
Marital status					
Single	56 (18.7)	14 (25.0)	42 (75.0)	37.019	0.000
Married	113 (37.7)	64 (56.6)	49 (43.4)		
Divorced/ Separated	45 (15.0)	33 (73.3)	12 (26.7)	32.304	0.000
Widowed	35 (11.6)	8 (22.9)	27 (77.1)		
Cohabiting	51 (17.0)	29 (56.9)	22 (43.1)		
Occupation					
Employed	65 (21.7)	59 (90.8)	6 (9.2)		
Unemployed	235 (78.3)	89 (37.6)	146 (62.1)		
Area of residence					
Urban formal	32 (10.7)	24 (75.0)	8 (25.0)	9.441	0.002
Urban informal	268(89.3)	124 (46.3)	144(53.7)		

The findings in table 3 show majority, 121 (40.3%) respondents were aged 25 years and above and 60.3% (73) of them practiced breastfeeding while only 27% (20) mothers aged 18 years or less practiced breastfeeding. There was a significant relationship between mother's age and infant feeding practices ($p= 0.000$). This could be due to the fact that teenagers are least exposed to peer and emotional support, experience in motherhood as well as guidance and counseling which can help them identify with the required infant care. These findings were synonymous with Park, Meier & Song (2003) as well as Tucker, Wilson & Samandari (2011).

A few, 86 (28.7%) mothers were educated up to primary school level and less than half 46.5% (40) breastfed whereas 50 (16.7%) had secondary education and 74% (37) of them breastfed. The level of education was thus a significant factor for infant feeding practices ($p= 0.000$). Similarly, Shwetal et al (2012) found that the rate of breastfeeding initiation was higher in literate compared to illiterate mothers. However, Odu & Dotun (2007) found no significant difference in breastfeeding patterns of both literate and illiterate mothers.

Married respondents comprised a majority 113 (37.7%) respondents, 56.6% (64) gave breast milk as the feeding method of choice compared to their unmarried counterparts. There was a significant relationship between marital status and infant feeding practices ($p= 0.000$). These findings were similar to Papp (2012) that partners provide a significant and unique source of emotional and instrumental source of support during the early weeks of breastfeeding.

Majority mothers, 235 (78.3%) were unemployed and comprised majority 62.1% (146) of those who did not give breast milk as the infant feeding choice while 59 (90.8%) of the 65 employed practiced breastfeeding. Maternal occupation had a significant relationship with infant feeding practices ($p= 0.000$). This could be due to the fact that most employed mothers could afford to pay for house helps or bring family members to carry out household duties while they cared for their infants. Employed mothers were probably more likely to express breast milk and leave at home. These findings were similar to Poduval & Poduval (2008) whose study suggested that nonworking family members fulfill the need for childcare when the mother is at work hence providing her necessary support to perform her dual role

efficiently. The area of residence had a significant relationship with infant feeding practices ($p= 0.002$).

More than half of respondents 89.3% (293), resided in the urban informal settlement and 53.7% (144) of them bottle fed with cow's or formula milk compared to 8 (25.0%) of those in urban formal settlements. In this study, mothers residing in the slum were least likely to breastfeed and comprised the largest proportion of those practicing mixed feeding, discarding colostrums and giving prelacteal feeds. Mothers in the slum also reported history of recent illness in their children more than those in urban formal settlements. This could be attributed to the fact that in slums it is easier to access these commodities in small quantities at affordable prices. The lack of sufficient water and sanitation facilities prevented proper hygiene. Similarly Roy, Dasgupta & Pal (2009) and Swamy (2010) revealed discarding colostrums and giving prelacteals as common practice in slums. Kimani-Murage et al (2010) revealed that slum children are most affected health wise than any other sub-group including rural areas.

4.4 Culture

The respondents were asked questions intended to establish how different cultural practices impact on infant feeding practices.

Table 4: Cultural factors affecting infant feeding practices

Variable	N%	Infant feeding practices		χ^2	P-value
		Yes	No		
Do you think culture affects your decision to feed your child?					
Yes	67 (22.3)	44 (65.7)	23		
(34.3)	9.213	0.002			
No	233(77.7)	104 (44.6)	129(55.4)		
Do the cultural practices have a negative effect for you and your child?					
Yes No	82 (27.3%)	59 (72.0%)	23 (28.0%)	23.095	0.000
	218 (72.7%)	89 (40.8%)	129(59.2%)		
Is breastfeeding in public acceptable in the community you reside?					
Yes No	268(89.3%)	135(50.4%)	133 (1.087%)	0.297	
	32 (10.7%)	13 (40.6%)	19(59.4%)		

Most, 233 (77.7%), respondents thought culture did not affect their decision to feed their children. 55.4% (129) of these mothers practiced bottle feeding with cow's or formula milk. There was a significant relationship between culture and infant feeding practices ($p= 0.002$). In this study some respondents discarded colostrums and gave prelacteal feeds to their infants. Others practiced the use of herbs and introduced other foods too early. Most mothers believed that breast milk is not fully satiating and that traditional family foods were more nutritious. These findings are indicative of culture's significance in the choice of infant feeding and are similar to Nankunda et al (2006), Singh (2010) and Weber (2012). Contrary to Agnew et al (1997) who attributed breastfeeding in public as unacceptable, most respondents in this study had a universal consensus that breastfeeding in public is acceptable in their communities of residence. This could probably be due to the difference in geographical locations of both studies.

Table 5: Other factors affecting infant feeding practices

Variable	N (%)	Infant feeding practices		χ^2	P-value
		Yes	No		
Health education material or counseling on infant feeding practices					
Yes	296(98.7)	146 (49.3)	150(50.7)	0.001	0.979
No	4 (1.3)	2 (50.0)	2 (50.0)		
Does media affect infant feeding					
Yes	31 (10.3)	22 (71.0)	9 (29.0)	6.474	0.011
No	269(89.7)	126 (46.8)	143(53.2)		
Does your work environment, conditions at home and partner's source of income affect your feeding choices?					
Yes	239(79.7)	87 (36.4)	152(63.6)	78.638	
No	61 (20.3)	61 (100)	0 (0.0)		
Do you think living in a place other than where you are now would influence your choice of feeding?					
Yes	83 (27.7)	54 (65.1)	29 (34.9)	11.354	0.001
No	217(72.3)	94 (43.3)	123(56.7)		
Workload					
5 hours or less	40 (13.3)	17 (42.5)	23 (57.5)	0.862	0.353
More than 5 hours	260 (86.7)	131 (50.4)	129 (49.6)		
Do you get time to rest and breastfeed?					
Yes	154 (51.3)	90 (58.4)	64 (41.6)	10.503	0.001
No	146 (48.7)	58 (39.7)	88 (60.3)		
Attendance of Antenatal Care					
Yes	155 (51.7)	112 (72.3)	43 (27.7)	67.427	0.000
No	145 (48.3)	36 (24.8)	109 (75.2)		
Is breastfeeding good for you and child?					
Yes	281 (93.7)	8 (52.7)	33 (47.3)	19.751	0.000
No	19 (6.3)	0 (0.0)	19 (100)		

Greater than half, 296 (98.7%) of respondents had received health education material or counseling on infant feeding practices. However, 50.7% (150) of the mothers did not practice breastfeeding for their infants. There was no statistical significance between health education and infant feeding practices. ($p= 0.979$).

Most, 269 (89.7%), of respondents had no media exposure and as such 53.2% (143) mothers did not practice breastfeeding as the infant feeding method of choice. There was a significant relationship between media exposure and infant feeding relationship ($p= 0.011$).

Many of the respondents, 239 (79.7%), agreed that work environment, conditions at home and partners source of income affected their feeding choices. As such, 63.6% (152) of them gave formula or cow's milk to their infants as opposed to breast milk. There was a statistical relationship ($p= 0.000$) between socio-economic status and infant feeding practices.

A greater proportion, 217 (72.3%), of respondents did not think a different place of residence would influence their feeding practices. 56.7% (123) mothers would still practice bottle feeding with cow's or formula milk. There was a significant relationship between place or residence and infant feeding practices (0.001).

Majority, 260 (86.7%) experienced more than 5 hours workload a day and 50.4% (131) gave breast milk while only 42.5% who worked less than 5 hours gave breast milk to their infants. There was no statistical significance between infant feeding practices and maternal workload ($p=0.353$).

Half of the respondents, 155 (51.7%), attended antenatal clinics. 72.3% (112) of them gave breast milk as the infant feeding choice compared to 24.8% of those that did not. Antenatal clinic attendance had a significant relationship with infant feeding practices ($p= 0.000$).

Most respondents, 281 (93.7%), demonstrated adequate knowledge on breastfeeding and 52.7% (148) gave breast milk as the infant feeding choice. There was a statistical significant relationship between knowledge of breastfeeding and infant feeding practices ($p= 0.000$).

CHAPTER FIVE
SUMMARY OF THE FINDINGS, CONCLUSIONS AND
RECOMMENDATIONS

5.1 Conclusion

Findings from the study indicates the feeding practices of mothers of infants aged zero to six, months are being exclusively breastfed. The study therefore likely to establish the relationship between social-demographic factors have a significant effect on infant feeding practices. The risk groups include younger adolescent mothers, the uneducated and those that resided in the informal settlements. Culture is significantly related to infant feeding practices. Infant factors are significantly related to infant feeding practices.

As such, the study concludes that social-demographics, culture and infant characteristics are factors affecting feeding practices of mothers with children zero to six months in Sunyani Zongo Community.

5.2 Recommendations

On the basis of general findings of this study, the researcher recommends the need to implement the various infant feeding policies by the government working hand in hand with the help of medical personnel as soon as infants are born and follow-up to at least six months.

The government should strive to make available social amenities and necessary infrastructure for slum dwellers mostly health centers, safe water and toilet facilities and in turn residents should maximise these facilities accordingly to ensure health maintenance is a continuous process.

Communities should be urged that even as they uphold and respect their cultural practices to put the need for health first.

Public health sectors should offer more information on proper feeding practices and hospitals should adopt the Baby Friendly Hospital Initiative (BFHI), so as to encourage proper breastfeeding initiation and successful exclusive breastfeeding for six months.

The WHO's 10 steps to successful breastfeeding should be availed to mothers in each facility providing maternity services and care for newborn infants. The researcher recommends the assessment of the effect of other factors like religion and tribe/ethnicity on infant feeding practices.

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APPENDIX A

Informed Consent Form for mothers participating in the study

Assessing the factors affecting the feeding practices of mothers with children zero to six months Dear respondent,

You are kindly invited to participate in a research on factors affecting the feeding practices of mothers with children zero to six (0-6) months of age. The research is being conducted by Batinge Gladys Adorlo of AMMUSTED in partial fulfilment for the requirement of the award of M-Tech in Catering and Hospitality. The research will help you identify your problems with infant feeding and is also expected to suggest significant policy statements through its recommendations on age appropriate feeding practices for your infant. As such, it could enable policy formulation in the country that will sustain the recommended standards of infant feeding.

Please note that all information gathered from this study will remain private and confidential. It will be used to enhance knowledge of the common good in a bid to improve infant feeding practices and reduce child morbidity and mortality. Ethical measures will be undertaken to ensure privacy and anonymity. You are free to withdraw consent and discontinue participating in the study although your full participation will be highly appreciated.

QUESTIONNAIRE

SUNYANI GOVERNMENT HEALTH CENTRE

This questionnaire is intended to assess the factors affecting the feeding practices of mothers with children 0-6 months.

SECTION A: BIODATA

1. Age of mother: 18 years { } 19- 24 years { } 25 years and above
2. Level of education No education { } Nursery { } Primary { }
Secondary { } Tertiary { }
3. a. Marital status: Single { } Married { } Divorced/ Separated { }
Widowed { } Cohabiting { }
Other please specify.....
- b. If married, at what age did you marry?
18 years { } 19-24 years { }
Other (please specify).....
4. a. Occupation: Employed { } Unemployed { }
b. If employed, what work do you do?
5. a. Husband's occupation: Employed { } Unemployed { }
b. Husband's level of education?
.....
6. Residence: Urban formal settlement { } Urban informal settlement { }
7. a. How many children do you have?
.....
- b. What age/ ages are they?
.....

- c. What birth order is your current child?
- d. What age is your current child?
- 8. a. Whom do you live with?
 Husband { } Maternal relatives { } Paternal relatives { }
 Other (Please Specify)
- b. How many people live in your household?

SECTION B: MATERNAL FEEDING PRACTICES

- 9. a. How do you feed your infant?
 Breastfeed only { } Bottle feed with breast milk { }
 Bottle feed with cow's milk { } Bottle feed with formula { }
- b. Do you think it is the best method for feeding your infant?
 Yes { } No { }
- c. If breastfeeding, how often do you breastfeed?

- d. i) What else do you give apart from breast milk?

- ii) How long will you breastfeed your infant?

- e. i) If bottle feeding, why?

- ii) How do you prepare the milk before giving your infant?

- iii) How do you clean the bottle you use for feeding your child?

10. Do you have any knowledge concerning antenatal and maternity care?

Yes { }

No { }

11. a. Did you attend antenatal clinics during your pregnancy?

Yes { }

No { }

b. If yes, how many times did you attend?

.....

c. If no, why?

.....

12. a. Is breastfeeding good for you and your child?

Yes { }

No { }

b. If yes, why?

.....

c. If no, why?

.....

13. Where did you get information about breastfeeding?

.....

14. a. How many hours a day do you work?

.....

b. Do you get some time to rest and breastfeed?

Yes { }

No { }

c. Who takes care of your child when you are off to work?

.....

d. Does breastfeeding interfere with your work?

.....

Yes { }

No { }

di. If yes, how?

e. Do you have anyone to help around with housework while you are away?

Yes { } No { }

f. Are you given time off from work to go and nurse your baby?

Yes { } No { }

SECTION C: SOCIO-CULTURAL FACTORS

15. a. Have you ever received any health educational material or counseling on infant feeding practices?

Yes { } No { }

b. If yes, where was it and did you find it helpful?

Yes { } No { }

16. a. Does the media affect your choice of feeding?

Yes { } No { }

b. If yes, how?

17. a. Does your work environment, conditions at home and partner's source of income affect your feeding choices?

Yes { } No { }

b. If yes, how do they affect your feeding choice?

.....

c. What do you think could be done differently to improve these choices?

.....

18. a. Do you think living in a place other than where you are now would influence your choice of feeding?

Yes { } No { }

- b. If yes, how will it affect your feeding choice?
- c. If no, why?
19. a. Do you think culture affects your decision to feed your child?
- Yes { } No { }
- b. How does culture affect your feeding choices?
- c. Do you think it would cause a problem for you if you did not obey?
- d. Do the cultural practices have a negative effect for you and your child?
- Yes { } No { }
- e. If yes, what are they?
- f. Do you think they are harmful? Given a chance would you engage in these practices?
-
- g. What other attitudes and beliefs do people in your community have regarding breastfeeding or other methods of feeding the infant?.....
- h. Is breastfeeding in public acceptable in the community you reside?
- Yes { } No { }
- h. i. If no, why?

SECTION D: INFANT CHARACTERISTICS

20. What was your infant's birth weight?.....
21. At what gestational age did you go into labour?.....
22. How was the progress of labour?
- Normal { } Prolonged { } Complicated { }
23. What was the method of delivery?
- Spontaneous Vaginal delivery { } Induced vaginal delivery { }
- Planned caesarean section { } Emergency caesarean section { }
- Others please specify).....

24. a. Has the infant had any feeding problems?

Yes { }

No { }

b. What are they?.....

c. What do you do to ensure your baby still feeds?.....

25. a. Has the baby suffered from any recent illness?

Yes { }

No { }

b. Has the illness affected the baby's feeding?.....

c. What did you do to ensure the baby still feeds?.....

d. What did you do after the baby got well?.....

Thank you for your cooperation