

# Socio-Economic and Attitudinal Barriers to Exclusive Breast Feeding Uptake in Zimbabwe and Possible Migratory Mechanisms

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## Abstract

Child mortality rate in Zimbabwe which stands at 97 deaths per 1,000 is horrendous and it poses a huge threat to the realization of Millennium Development Goal number 4 which is to reduce under five mortality. Exclusive breast feeding which has been found as one of the major remedies to the pandemonium is largely underutilized in Zimbabwe. The study investigated the socio-economic and attitudinal barriers to exclusive breast feeding with the objective of influencing the increase in the uptake of this noble intervention. This empirical study utilized a mixed research methodology. It was noted that factors such as negative attitudes, low income, gender inequalities, social influence, and traditional practices were hindering the uptake of exclusive breast feeding. The study put forth recommendations to trigger the utilization of exclusive breast feeding.

**Keywords:** Exclusive Breast Feeding, Socio –economic, mortality, barriers

## 1.1 Introduction

A death of one child is one too many, incontrovertibly infant mortality rate in Zimbabwe which is at 97 deaths per 1,000 is horrific and quite disturbing (Ministry of Health and Child Welfare, 2010). Paradoxically one of the proposed solution to this social catastrophe which is recommended, free, accessible, sustainable and safe (Moland et al, 2010) is not far of reach for many rural women but is being underutilised (Jenkins et al, 2011).

A large body of evidence demonstrates the benefits of exclusive breastfeeding infant feeding practice for child survival, growth, and development (Jenkins et al, 2011). This is premised on its high immunological, nutritional and hygienic value as compared to other liquids, solids and bottled infant milk formulas (World Health Organisation, 2003). Lack of exclusive breast feeding is associated with high incidences of diseases such as diarrhoea, pneumonia, bacterial meningitis, bacteraemia, respiratory tract infection, necrotizing enterocolitis and malnutrition. These in turn are responsible for morbidity and mortality, in the lifelong associated with poor school performance, impaired intellectual and social development (World Health Organisation, 2003: Jones et al, 2003: Jenkins et al, 2007).

The World Health Organisation defines 'Exclusive breastfeeding' as giving breast milk only to infants from 0-6 months, and not feeding any food or liquid, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicine as only recommended by the health workers (World Health Organisation, 2001)

The 2003 Lancet series on child survival identified the promotion of exclusive breastfeeding infant feeding practice during the first 6 months of life and continued breastfeeding to 12 months as the single most effective preventive public health intervention for reducing mortality among children aged, 5 years (Jones, 2003). More recently, the 2008 Lancet series on maternal and child under nutrition estimated that 1.06 million child deaths (ten percent of all mortality in children aged, 5 years) are attributable to non-exclusive breastfeeding in the first 6 months of life (Jenkins et al, 2011).

The Ministry of Health and Child Care in Zimbabwe recommends and promotes exclusive breast feeding as the most appropriate infant feeding practice for children from 0-6 months of age. Despite efforts by the respective ministry to increase the exclusive breast feeding uptake its practice is still very low (Jenkins et al, 2011). According to the National Nutrition Survey (2010) the current national exclusive breast feeding rate stands at a staggering rate of 5 percent. The Multiple Indicator Monitoring Survey of 2010 provides a higher national rate of 21%, with a higher proportion of 29 percent in urban areas being exclusively breast fed compared to 26 percent in rural areas (Multiple Indicator Monitoring Survey, 2009). This is quite disconcerting considering the established value of exclusive breast feeding and government target of 100 percent uptake.

Breastfeeding is a complex process governed by psychological and physiological factors, which in turn are conditioned by a wide spectrum of environmental, socioeconomic and cultural circumstances (Greiner et al, 2001). In the view that exclusive breast feeding is a physiological process which transpires in a specific socio-economic milieu, this research labours to investigate the socio-economic factors that might be militating against the uptake of exclusive breast feeding in rural Zimbabwe.

## 1.2 Theoretical Framework

The theoretical standpoint by Icek Ajzen which is the theory of planned behaviour, based on the research by

Fishbein and Ajzen (1975), provides a conceptual framework for this study. The theory has the strength of understanding people's behavior and its psychological determinants. According to the theory of planned behavior human action is guided by three factors:

1. Behavioural beliefs, which are beliefs about probable outcomes of behaviour and the evaluations of those outcomes.
2. Normative beliefs, which are beliefs about the normative expectations of others and motivation to comply with those expectations.
3. Control beliefs, which are beliefs about the presence of factors that may aid or hinder performance of behaviour and the perceived power of those factors (Ajzen, 2006).

Each of these beliefs produces certain attitudes or perceptions. Behavioural beliefs create a particular attitude regarding behaviour, while normative beliefs result in perceived subjective norms, and control beliefs create perceived behavioural control. Attitude toward behaviour, perceived subjective norms, and perceived behavioural control contribute to the intention to perform an action (Ajzen, 2006). If understanding behaviour is the primary objective, then the factors determining the intention to perform that behaviour must be specified (Fishbein & Ajzen, 1975). It is the factors that predict the intention to breastfeed that are the focus of this study.

The theory of planned behaviour explains the relationship between the intention to breastfeed, the act of exclusive breastfeeding and the factors that affect a women's decision regarding breastfeeding. Knowledge alone is not sufficient to change behaviour. Attitudes, subjective norms and perceived behavioural control regarding behaviour, all influence the intention to perform a certain behaviour, which in turn predicts the likelihood of a particular behaviour taking place.

The theory of planned behaviour not only provides a framework for this study, it also serves as a guide to identify the influence of the significance others in determining behaviour change and adoption on new health behaviours.

The attitude of women towards breastfeeding is one of the most important indicators in the of the possible infant feeding choice by the mother and these can often be strongly influenced by partners, relatives, culture, friends, co-workers, and healthcare providers. For women who have the positive support of their partners and relatives, the decision to exclusively breastfeed up to 6 months is a daily battle. Jenkins et al (2011) notes that older women and in-laws are perceived by mothers as good advisors, because of their knowledge of existing social norms and in this sense, they influence the mothers infant feeding choices. This can be explained by the theory of planned behaviour that attitudes are determined by the society's perception of the desirability of one's action.

Healthcare workers are in a unique position as well to influence women's attitudes, since they are often viewed as experts. The expectations, client education, and support provided by healthcare personnel heavily impacts women's attitudes and actions regarding exclusive breast feeding (Jenkins, 2009).

Subjective norms are the perceived social pressure to perform or not perform certain behaviour such as breastfeeding (Ajzen, 2006). Some of this pressure is overt and some is covert. Overt pressure can take many forms such as advice, attitudes, policies, laws, and educational material. Covert pressure is very subtle, it includes being in an environment where a particular infant feeding practice is dominant. In a Zimbabwean rural setup are raised in cultures in which there are clear expectations put on their behaviour (Gelfand, 1979). Breastfeeding is one such behaviour that is influenced by subjective norms. Women who are raised and live in segments of society in which children are not exclusively breastfed they are not likely to breastfeed. Gelfand (1979) in rural Zimbabwe discovered that the infant feeding practices were largely influenced by the existing social norms which were inculcated mostly by in-laws and grandmothers.

Perceived behavioural control is one's belief as to the ease and likelihood of success in performing certain behaviours (Ajzen, 2006). If women believe that exclusive breastfeeding is difficult, constraining, not very much helpful and socially unacceptable, they will typically not choose to breastfeed.

### **1.3 Methodology**

The research methodology is of mixed research methods. The Concurrent nested model of mixed methods was utilised and was identified by its use of one data collection phase, during which both quantitative and qualitative data are collected simultaneously.

### **1.4 Location of the study**

The study was carried out in Mataga Ward, Mberengwa District at Mataga Rural Health Centre, and Midlands's province in Zimbabwe. Mataga Rural Health Centre is one of the health centres in the District which cascades health services such as Voluntary Counselling and Testing, Provider Initiated Counselling and Testing, immunisation and exclusive breast feeding.

### 1.5 Target Population

The target population was 50 mothers who have infants from 0-6 months of age. Records from Mataga Rural Health Centre and Village Health Workers indicated that there are approximately 50 mothers at a given months who have infants at this stage under Mataga Rural Health Centre catchment area. The nurses and Village Health Workers at Mataga Rural Health Centre constituted key informants.

### 1.6 Sampling.

Accidental sampling method was used to select 20 (40 %) of 50 mothers target population from Mataga Rural Health Centre. Purposive sampling was utilised used to select the key informants which are Nurses and Village Health Workers.

### 1.7 Data Collection Techniques.

The researcher used interview schedules designed in English which were translated to vernacular Shona and translated back to English. An interview schedule was used to collect data from the study respondents and an interview guide was used for the key informants. The interview schedule was composed of both closed and open ended questions.

### 1.8 Data Analysis

Quantitative data was analysed using the Statistical Package for Social Scientists, descriptive analysis was done to describe the distribution of the different variables such as age, employment status, economic status and educational level. Qualitative data was analysed manually using themes to answer objectives of the study.

## 2.0 Demographic Characteristics of Respondents

### 2.2 Distribution of mothers respondents by Age

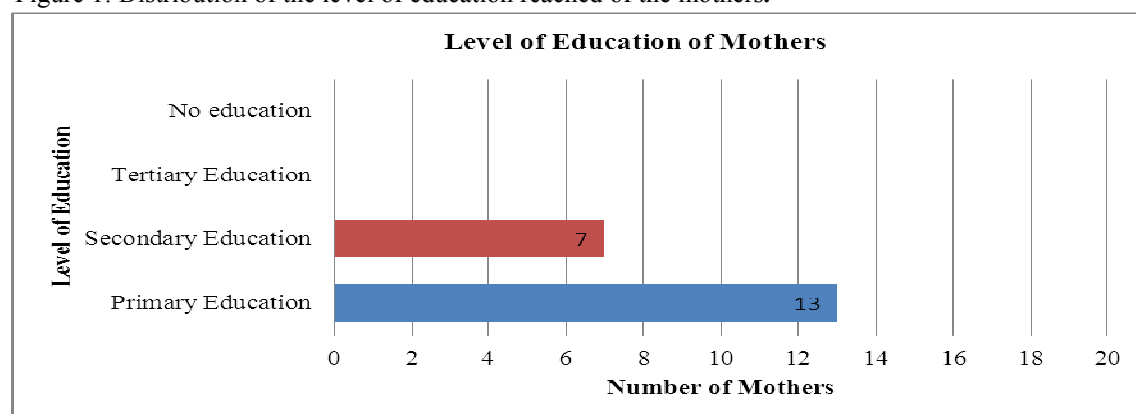
**Table 1: Statistical distribution of mothers respondents by age**

Age Groups	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 15-19	3	15.0	15.0	15.0
20-25	9	45.0	45.0	60.0
26-30	3	15.0	15.0	75.0
31-35	2	10.0	10.0	85.0
36 +	3	15.0	15.0	100.0
<b>Total</b>	<b>20</b>	<b>100.0</b>	<b>100.0</b>	

The above table 1 exhibits the age distribution of mothers who participated in the study. Out of the 20 (100%) mothers interviewed, 9 (45%) the largest proportion of mothers are from the 20-25 age range. 3 (15%) respondents were within 15-19 age range ,while age groups 26-30 and 36+ had 3 respondents each. 2 (10%) respondents belonged to the 31-35 age group. The high composition of mothers in the 20-25 age groups confirms the findings of the Zimbabwe Demographic Health Survey (2011) which reported a high fertility rate among women from the age of 20-25.

### 2.3 Level of Education of the respondents.

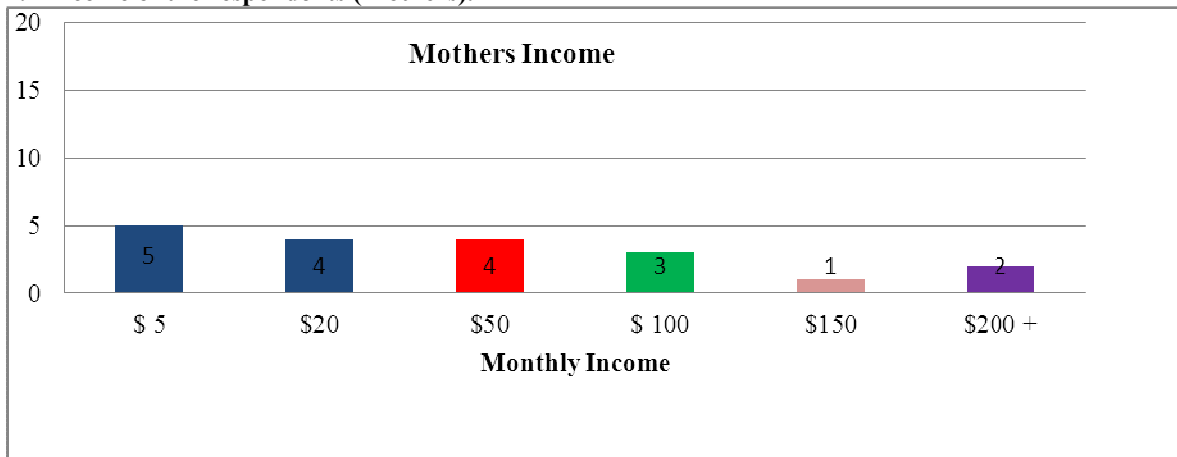
Figure 1: Distribution of the level of education reached of the mothers.



A large proportion of respondents 13 (65%) managed to reach primary level. A total of 7 (35%) mothers managed to reach secondary level. The primary school attendant rate in this study tallies the findings of

the Multiple Indicator Monitoring Survey (2009) which recorded a 99 % primary education net attendance of the girl child in Zimbabwe. The Multiple Indicator Monitoring Survey (2009) highlighted that education of the mothers influences the uptake of exclusive breast feeding.

**2.4 Income of the respondents (Mothers).**



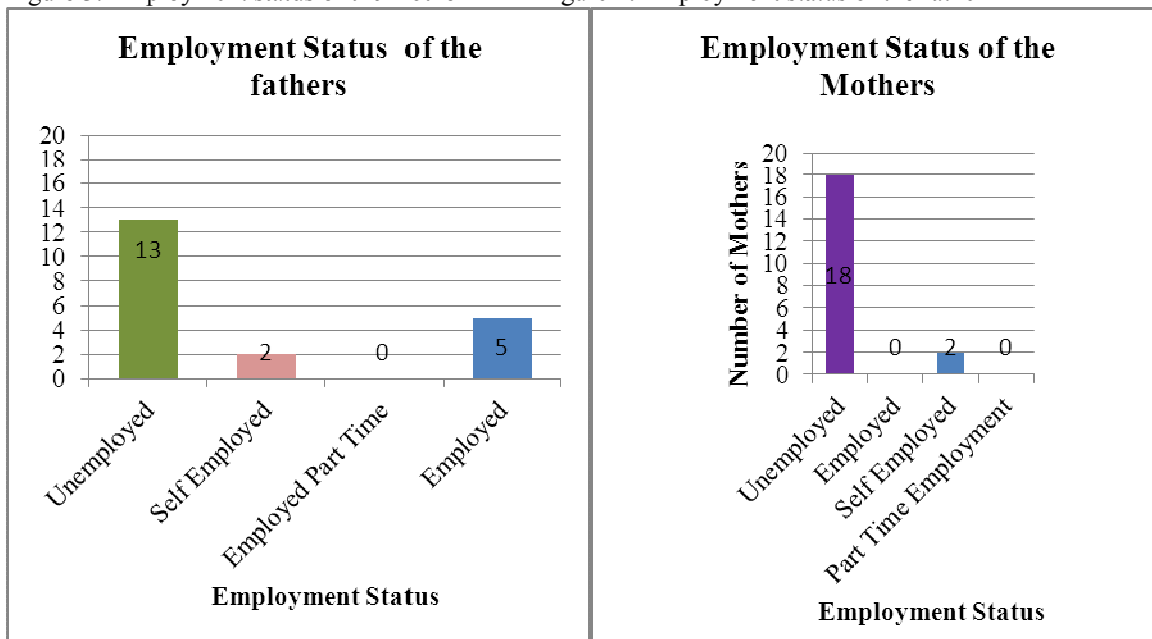
Women in Zimbabwe have limited access to the means of production hence their income and economic status is low. As illustrated by figure 2 above there are very few women who earn more than \$ 50 per month in Mataga. Among the 20 (100%) mothers who were interviewed 5 (25%) had an income estimate of \$ 5, 4 (20%) mothers earns an estimate of \$ 20, 4 (20%) mothers earns an estimate of \$ 50, 3 (15%) mothers earns \$100 ,while a paltry 2 (10%) mothers earns more than \$100.

These findings corresponds UNICEF (2009) views that many women in rural areas are living far below the poverty datum line and agriculture which is the main source of livelihood in rural areas has been hampered by vagaries of weather. According to the Multiple Indicator Monitoring Survey (2009) wealth quintile or income influences the uptake of exclusive breast feeding.

**2.5 Employment Status of Mothers and the fathers.**

Figure 3: Employment status of the mother

Figure 4: Employment status of the father



Unemployment is thriving in this study. 18 (90%) mothers and 13(65) fathers reported that they are not employed. 2 (10%) mothers reported that they were self-employed. This confirms UNICEF (2009) which notes high unemployment rate among rural women in Zimbabwe. On a comparative note of figure 3 and 4 unemployment rate was higher among the mothers than husbands with a margin of 24%. The employment status is imperative in analysing the income and wealth quintiles of the family and its implications on exclusive breast feeding uptake.

### 3.0 Exclusive Breast feeding rates among the 20 mothers in Mataga Ward

Exclusive breast feeding rates in Zimbabwe are very low and this is recurring in rural areas (Multiple Indicator Monitoring Survey, 2009). 6 (30%) respondents confirmed that there were practicing exclusive breast feeding. 14 (70%) respondents reported. that they were not exclusively breast feeding their children. This study noted a 30% exclusive breast feeding rate in Mataga Ward. This closely corresponds with information provided by nurses at Mataga Health Centre of 32 exclusive breast feeding rate. Mataga Ward exclusive breast feeding rate is substantially higher than national results of 29% (Multiple Indicator Monitoring Survey, 2007). This rate is still very low considering the Ministry of Health and Child Welfare is ideally targeting a 100 % uptake.

### 3.1 Knowledge and understanding about exclusive breast feeding among respondents.

The respondents (mothers) exhibited extensive knowledge and understanding of the meaning of exclusive breast feeding. The knowledge of exclusive breast feeding was measured through enquiring from mothers the meaning of exclusive breast feeding. Fifteen (70%) mothers provided Very satisfactory responses with regard to their knowledge of the meaning exclusive breast feeding. 5 (25%) mothers showed satisfactory knowledge of exclusive breast feeding. In summary all the mothers had information on what constituted exclusive breast feeding and the recommended period. The study noted no much significant correlation between this knowledge of the meaning of exclusive breast feeding and the actual practice by the mothers. Out of the fourteen (70%) of the mothers who exhibited extensive knowledge of exclusive breast feeding, only 5(25 %) percent of the mothers managed to exclusively breast feed. This sheds light that the knowledge of exclusive breast feeding does not translate to the active uptake of exclusive breast feeding. These results can be elucidated by the theory of planned behaviour that knowledge alone is not sufficient to change behaviour but attitudes, subjective norms and perceived behavioural control regarding behaviour, all influence the intention to perform certain behaviour.

### 4.0 Factors that influences the practice of the exclusive breast feeding in rural Zimbabwe

#### 4.1 Mothers attitudes towards exclusive breast feeding

The mother's attitudes towards exclusive breast feeding was measured through enquiring if the mothers perceives that exclusive breast feeding alone was enough for their babies. The 13 (65%) respondents pointed out that mother's milk alone was not enough for the baby and there is need to give supplementary feeding. These 13 (65%) of the mothers constitute 93 % of the mothers that were not exclusively breast feeding. Only one respondent who was not exclusive breast feeding mentioned that exclusive breast feeding was enough, this is despite that she was not practicing it herself. Respondent number 5 was probed why she thinks that breast feeding alone was not enough for the baby, she said in vernacular shona that '*mwana anenge anenzara nenyota saka anotoda porridge nemvura,*' and translated in English as 'the baby would be hungry and thirsty and would need porridge'. The argument the baby would be thirst cannot be justified because 88 % of breast milk is water (Linkages, 2004).

#### 4.2 Association between level of Education and exclusive breast feeding practice

Thirteen (65%) respondents as reflected by Figure 4 have only managed to reach primary education. Seven (35%) have reached secondary school education. The level of education seems to have a bearing on the infant feeding practice choices by mothers. 4 (30%) of the seven mothers who had secondary education managed to exclusively breast feed. Only 1 mother who had secondary education who did not exclusively breast feed her child. Eleven (55%) mothers who had no primary education only did not exclusively breast feed. Only two mothers with primary education managed to practice exclusive breast feeding. This trend is exhibited in the table below.

**Table 3: Relationship between education levels and the practice of exclusive breast feeding**

Level of Education	Exclusive Breast Feeding Frequency	Non – Exclusive Breast Feeding Frequency
Primary Education	2	11
Secondary Education	4	1

The table above shows that there is a higher prevalence of exclusive breast feeding among respondents with secondary education than with primary education. These results confirm other studies that acknowledged a high uptake of exclusive breast feeding among mothers with high education and a lower uptake among those with little education. Furthermore this study established that there is a correlation between level of education and understanding of the benefits of exclusive breast feeding. Respondents with secondary education posed a deeper understanding of the benefits of exclusive breast feeding. The influence of education was also shared by the nurse key informant that she noted a high prevalence among mothers who have secondary education. This can be justified by the fact that mothers who are better educated have a better understanding of issues and they can distance their personal attitudes and perceptions from fact.



### 4.3 Traditional practices that hinders exclusive breast feeding practice (Nhova Treatment)

In a Zimbabwean rural setup children are treated of a condition called *Nhova (fontanel)*. *Nhova (fontanel)* is a condition whereby the upper top of the infant's head subsides into the child's head. Traditionally this condition is attributed to evil spells. From a scientific perspective the fontanel condition is a symptom of dehydration. Out of the 14 (70%) mothers who were not practicing exclusive breast feeding, 12 mothers informed the study that had treated their child *nhova* while 2 mothers said that they had not treated their children *nhova*. Out of the 12 mothers who had treated their children *nhova* 10 mothers confirmed that they had treated their children *nhova* through giving their children different foods and medicines to eat and drink such as trees barks juices, roots, herbs, cooking oil and wild fruits. The foods and liquids that were given are believed to repel potential evil spirits which causes *nhova*. Out of the 6 mothers who were practicing exclusive breast feeding 4 mothers were not treating their children *nhova* and the other 2 mothers had treated their children *nhova* but not through giving the children foods to eat but smearing cooking oil and salt on top of the child's head. These results show that the belief of *nhova* is wide spread in rural areas. These results tally with findings from Kenya that infants are given various herbs to treat *nhova* which in Kenya is *ndabele* (Ministry of Health Kenya, 2011). This constitutes defaulting of exclusive breast feeding as the standards of the practice stipulate that only medicines and vitamins prescribed by the doctor can be given to the infant.

### 4.4 Societal influence/barriers

#### 4.4.1 The influence of the mother in law

Significant others such grandmothers, in laws and husbands influences the infant feeding practices pursued by mothers. In an African culture older persons are regarded as a fountain of knowledge and younger persons tap knowledge from them. Most of the advice that came from the mothers in law discouraged exclusive breast feeding in favour of mixed infant feeding practice. The mother in law as the mother of the husband is usually powerful to influence the decisions in her daughter in law and son. According to respondent number 2 the mother in law gave the infant porridge a day after delivery and in vernacular shona she said '*vamwene vakapa mwana porridge zuva randakabva nemwana kuchipatarara, vaitaura kuti rudzi rwemwana uyu vanodyisa saka ano tozvara ane nzara*'. In English '*the baby was given porridge the day she came home by the mother in law, she argued that the tribe which the child hails from they eat a lot and they are born hungry*'. Respondents 6 and 12 expressed that when they had left their children with the mother in law the child they found that she had already given porridge to the child. This finding can be explained by the theory of planned behaviour which envisages that people's behaviour is influenced by normative beliefs, which are beliefs about the normative expectations of others and motivation to comply with those expectations. To this end mothers follow the advice of the mother in law so that she can meet the expectations and she is motivated towards compliance.

#### 4.4.2 Gender Inequalities

In an African rural milieu all major decisions are made by the husbands and they are the head of the family. Eighteen (90%) respondents noted that they had been advised by their husbands on infant feeding. Two (10%) mothers said that their husbands had not said or advised them anything about infant feeding. Indications are that 13 (65%) of the 18 fathers were against exclusive breast feeding as they argued that the child should be given porridge as breast milk was not enough for the baby, that's why the baby is always crying. Respondent number 4 informed the researcher that the husband is the one who bought peanut butter and margarine so that we can prepare porridge for the baby. She further said in shona her husband said '*wakamboonepi iwe mwana anongorarama nemukaka chete asina chimwe chanodya*', translated in English as '*where have you seen a child just surviving on mother's milk alone*'. This shows that husbands poses a great barrier for exclusive breast feeding uptake whilst when they are in support it presents an opportunity for exclusive breast feeding. It is however unfortunate that many fathers are not supportive of exclusive breast feeding as noted by (Jenkins et al, 2011).

#### 4.4.5 Decision makers with regard to infant feeding practices in the household

The will of the persons who makes decisions at household level is the one that usually takes its course with regard to the feeding of the infants (Jenkins et al (2011). 16 (80%) mothers informed this study that the husband was the one who makes decisions with regard to infant feeding, 4 (10%) mothers said that they are the ones that makes decisions on the feeding patterns of their children. The mother in law was established as one of the major decision maker with regard to infant feeding, 14 (70%) mothers pointed out the mother in law as one another decision maker with regard to infant feeding. The mothers pointed both the husband and the mother in law, which shows that they all concurrently exert influence. Grandmothers and relatives were also pointed out as some of the persons who make the decision on the infant feeding of the baby however their frequencies are very minimal. This corresponds with FJeld (2008) findings in Malawi that the influence of the mother in law and husband was one of the greatest barriers to exclusive breast feeding uptake in Malawi.

### 4.5 Limited income

Lack of milk was noted as one of the main reasons why the mothers were not practicing exclusive breast feeding.

Many of the mothers who were not practicing exclusive breast feeding confirmed that lack of milk was one of the reasons they decided to introduce supplementary feeding. The reasons for lack of food were established as responsible for the low supply milk. This can be linked to low income of the mothers who are experiencing challenges in acquiring food. High prevalence of exclusive breast feeding was noted among mothers who had an income above \$ 100, 4 (66%) of the 6 (100%) mothers who were practicing exclusive breast feeding had an income above \$ 100. Only 2 mothers who were practicing exclusive breast feeding had an income which is below \$ 100. 14 (70%) mothers who were not exclusive breast feeding had incomes below 100%. As illustrated by Figure 6 18 (90%) mothers were unemployed and only 5 (25%) fathers are gainfully employed while 2 (10%) were self-employed. These results correspond with findings from a Kenya study that exclusive breast feeding was low among women with low incomes as they produce little milk which compels them to introduce supplementary feeds (Ministry of Health Kenya, 2008). The nurse informant number 2 informed the study that many mothers are failing to practice exclusive breast feeding because they are producing not enough milk. The nurse further explained that without enough balanced food it is hard to produce enough milk. This can be further validated by the Zimbabwe Vulnerability Assessment Committee which found out that 39 – 45 percent of the people in Mberengwa were food insecure (Zimbabwe Vulnerability Assessment Committee, 2012).

#### 4.6 Gender of the child

This study could not directly establish the influence of the gender the child on exclusive breast feeding as the number of the male child was significantly very low to the number of girls. 13(65) mothers confirmed that they had a girl child while 7 (35%) mothers confirmed that they had a boy child. However many mothers informed the study on the challenges that are faced in exclusive breast feeding that the boy child eats more than the girl child and hence mother's milk is not enough for the baby. Respondent number 16 informed the study that '*boys far outweighs boys in terms of food consumption hence reason why she decided to give complimentary feeding*'. Village Health Worker respondent number 2 concurred with respondent number 16 that boys eat very much and that mother's milk might not be enough for the boy child. However nurse respondent number 1 and village health worker respondent number 3 denied that boys eat more than girls at this tender age, it was raised that these are some of the beliefs that are held by communities that impedes the exclusive breast feeding uptake. All the Village Health Workers 4 (100) confirmed that this was a wide belief that boys eat very much and it is impossible for them to be satisfied by mother's milk alone.

#### 5.0 Conclusion

This study has unearthed that there are usually many impediments that confronts the mothers against adopting exclusive breast feeding. It is therefore pertinent that efforts to upscale exclusive breast feeding should be holistic so that it reaches all areas that determine the mothers to breast feed exclusively.

#### 6.0 Recommendations

A number of recommendations can be noted especially in increasing the uptake of exclusive breast feeding in rural areas.

- There is need for the Ministry of Health and Child Welfare to strengthen its Village Health Worker Programme. Village Health Workers are critical for mobilizing communities to practice exclusive breast feeding. As evidenced by the results of this study that there is a high uptake of exclusive breast feeding among mothers that were reached by Village Health Workers.
- The respective Ministry should ensure increased male involvement in health programmes that targets families. Males influence poses a barrier to the practice of exclusive breast feeding hence it is imperative that they accompany their wives to clinics so that they are educated on the recommended infant feeding practices.
- Community awareness on exclusive breast feeding should be scaled up and they should not only target mothers but should be extended to members of the extended family such as grandmothers and mothers in law. This can be done through the utilization of village meetings, church meetings and other community gatherings. Church leaders, politicians should be romped in the community as they are many of positions and people pay heed to their advice.
- Behaviour change awareness programmes targeting mothers and other community members should be initiated, these seek to change the attitudes of the mothers and community members towards exclusive breast feeding. The programme should target attitudes such as that mother's milk alone is not enough for the baby. Behaviour change awareness can also address cultural beliefs that exist that discourage exclusive breast feeding.
- The government need to avail food to members of the community that are in hunger ,the food may not be necessary in the context of the exclusive breast feeding programme but any food relief programme will positively impact exclusive breast feeding. The study unveiled that many could not exclusive breast feed

because they were producing little milk owing to lack of food.

- Nurses needs to be oriented with enough information pertaining to exclusive breast feeding. This is critical for them to deliver adequate and up to date information pertaining .Many mothers had no or very little information about exclusive breast feeding, which might also be a signal that they did not get enough information from the nurses.
- This study was done on a small sample but it's an eye opener to future studies in this area, there is need to do more and extensive research in the area of institutional capacity of the Ministry of Health and Child Welfare ,this study have not dwell much analyzing the current efforts of the respective ministry.

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