MedCrave
Step into the World of Research

Journal of Nutritional Health & Food Engineering

Research Article

Open Access

CrossMark

Socio-cultural practices and beliefs influencing infant and young child feeding in lubao sub-location Kakamega Country

Abstract

Background: Optimal feeding practices for children aged below 24months are important for the growth and Development and also for reducing childhood mortality and morbidity for this critical group. Social cultural beliefs and practices dictate behavior and practices of the people hence they influence feeding practices.

Objective: The purpose of this study was to find out how the socio-cultural beliefs and practices influence the feeding practices for children aged below 24months in Lubao sub location in Kakamega County.

Methods: This study was a cross-section study conducted between from January to March, 2016 in the rural western region amongst primary care givers of children aged below 2years. Random sampling technique was utilized to select the target sample and from a target population of 1000, a sample of 166 was calculated**.** Structured questionnaires were used to collect data on socio-cultural beliefs influencing the feeding practices.

Findings: The level of education and knowledge of forbidden foods had a positive correlation (rho-0.328) at (p>0.01). Approximately, 20(20%) reported foods recommended for the infants and young children while 80(80%) reported no specific foods recommended. Reasons associated with the recommended foods were; 4(20%) culture, 9(45%) lack of knowledge, 7(35%) due to other reasons.

Conclusion: Cultural beliefs and taboos i.e. food taboos/restriction, beliefs associated with certain foods, have a strong influence on infant feeding and undermines optimal infant feeding practices; breastfeeding and complementary feeding.

Keywords: socio-cultural practices, beliefs, infant and young child feeding

Volume 5 Issue 1 - 2016

Linet Njoki Karigi, Lucy Amanya Mutuli, Peter Bukhala

Msinde Muliro University of Science and Technology (MMUST), Kenya

Correspondence: Lucy Amanya Mutuli, Msinde Muliro University of Science and Technology (MMUST) 190-50100, Kenya, Tel +254721441183, Email amanyalucy@yahoo.com

Received: September 21, 2016 | **Published:** October 13, 2016

Abbreviations: CF, complementary feeding; BF, breast feeding; EBF, exclusive breast feeding; IYCF, infant and young child feeding; WHO, world health organization; UNICEF, united nations children's fund; NCD, non-communicable diseases; KDHS, Kenya demographic health survey; USAID, united states agency for international development; IBFAN, international baby food action network; MTCT, mother to child transmission

Background

Globally, only a third of breastfed infants 6-23months of age meet the criteria of dietary diversity and feeding frequency that are appropriate for their age.[1] Infant and young child feeding practices in 33 countries located in Africa, Asia, Latin America, and the Caribbean showed high rates of noncompliance with infant and young child feeding (IYCF) recommendations International Baby Food Action Network.[2] In Kenya, despite the adoption of a set of high impact IYCF policies and guidelines, only 39% of all children age 6-23months are fed in accordance with the recommendations. In Kenya, 61 percent of children less than sixmonths are exclusively breastfed. More than half of children in Kenya are still breastfeeding at age 20-23months (51percent). The proportion of breastfed children declines with age; breastfeeding is nearly universal in a child's first month of life, but the proportion breastfed drops to 61percent by the time a child is 18-23months. Under nutrition in the 6-24month age group in developing countries is a direct consequence of caregiver complementary feeding practices Kikafunda et al.,[3] in turn resulting in significant childhood morbidity and mortality since the surviving children have increased susceptibility to and have compromised physical growth, impaired cognitive development and reduced lifetime earnings.[4] Evidence shows that decline in length-for-age mainly occurs during the complementary feeding period, between 6 and 24months of age.[5] Indeed, poor complementary feeding has been identified as a risk factor associated directly with stunting.[6]

About 220 000 child lives could be saved every year with promotion of optimal breastfeeding and appropriate complementary feeding WHO.[1] Interventions promoting optimal complementary feeding could prevent up to 6% of deaths in countries with high mortality rates.[7,8] The complementary feeding period represents a significant window of opportunity when nutrition has the greatest effect on child health, growth and development.[9,10] There exists a significant gap in explaining why in spite of the adoption of high impact IYCF policies and guidelines in Kenya, there is still low compliance to the recommended practice. The gravity of nutritional outcomes during this period also underpins the urgency for contextualized evidence-based interventions

to prevent malnutrition in these children by targeting and improving complementary feeding practice. The description of the social cultural belief and practices on breastfeeding and complementary feeding practice will be an important step in facilitating the formulation of interventions to address situation. The complementary feeding period and associated practices play a significant role in health and development outcomes of infants and young children.[2,11] This period presents an opportunity within which appropriate interventions can result in tangible gains[9] as infant and young child feeding is a critical component of child survival and promotion of healthy growth and development. Taking into consideration the multifaceted and dynamic nature of infant and child feeding within the first two years and the scale of the study, four of the recently updated WHO IYCF core indicators were used as a guideline in describing complementary feeding practice. This was to facilitate the achievement of the study's aim of gathering and synthesizing information on the social cultural belief of complementary feeding practice among infants and young children aged 6-24months. The study intended to identify specific factors influencing complementary feeding practices thus highlight the factors promoting ideal and those leading to suboptimal infant feeding practices. Knowledge of feeding practices, their correlates and utilization of the modified WHO IYCF indicators will facilitate better monitoring of trends in the feeding practices and the design of locally appropriate interventions to increase the recommended feeding practices and thereby contribute to reducing malnutrition in the significant infant and young child population of. Overall the study will inform policy makers of appropriate evidence based interventions from the local level to the level of policy making to ensure optimal outcomes for this critical age group.

Methodology

This study was a cross-section study conducted between from January to March, 2016 in the rural western region amongst primary care givers of children aged below 2years. The rural region was purposively sampled due to the high impact of culture on children feeding practices. Random sampling technique was utilized to select the target sample and from a target population of 1000, a sample of 166 was calculated. Inclusion criteria were caregivers of children below 2years and care givers with children of chronic illnesses were excluded from the study. Before data collection, the respondents were informed of the objective and importance of the study to them, there after an informed consent was sought. Principles of ethics; beneficence, justice and non-malfeasance were maintained during the study. Data were collected using structured questionnaires with most of closed ended questions. Data from the questionnaire was entered into the computer design framework using excel. Data were then be exported to statistical package for social science (SPSS) for analysis Descriptive and statistics was used. Correlation was used to find out the association between cultural beliefs, breastfeeding and complementary feeding of infants and children.[12–20]

Results

A total of 100 participants met the eligibility criteria and were recruited to participate in the study. Of the sample size, 47(47%) were exclusively breastfed, while 53(53%) were mixed fed. Reasons for lack of exclusive breastfeeding included, 14(26%) of the 53 was as a result of lack of knowledge, 14(26%) cultural factors, 19(36%) mother's unavailability, and 5(9%) due to other reasons. Among the breastfed infants and young children, 44(44%) breastfeeding was initiated 30 min after birth, 40(40%) within 1-2hours, and 16(16%) initiation was done after 2hours and beyond. Reasons for late initiation of breastfeeding included sickness of the mother 10(10%), lack of knowledge 18(18%), culture 17(17%) and lack of breast milk 14(14%). Initiation of breastfeeding correlated positively (rho=0.32=98), but statistically insignificant ($p>0.01$) with the education level of the caregiver. Colostrums feeding frequencies were as follows; 91% of the study participants were fed on colostrums, and 9% were not. For this 9 not fed on colostrums, 6(67%) was due to cultural factors and 3(33%) was due to lack of knowledge. Among the 100 study participants, 11(11%), were given prelacteal foods and 89 (89%) did not receive prelacteal feeds. Introduction of these feeds was due to various factors; of the 11 who received prelacteal feeds, 4(36%) was due to culture, 5(46%) was due to lack of breast milk and 2(18%) was due to inadequate knowledge. Place of birth and introduction of prelacteal feeds were correlated both positively (rho=0.264) and highly significantly ($p<0.01$). Determinants of breastfeeding frequency included; child's demand 33(33%), mothers availability 57(57%) and other determinants contributed to 10%. Provider of breastfeeding education was as follows; 78(78%) received breastfeeding education from healthcare provider out of which only 37(47%) practiced EBF while 41(53%) did not practice EBF. 5 of the participants received BF education from their relatives but only 2 practiced BF. 7 of the participants who received BF education from their fellow women with children, 3(43%) did EBF while 4(57%) did not exclusively breastfeed. EBF positively correlated with the kind of breastfeeding education provider (rho=0.857) but insignificantly ($p>0.01$). Among the 100 participants, 47% were introduced to complementary feeds before 6months of age. 13 (25%) of this was due to lack of knowledge, 9(17%) cultural reasons and 22(41%) mothers unavailability and 9(17%) was due to other reasons. 31 of the participants reported forbidden foods for infants and young children and 69 reported there were no forbidden foods. Reasons associated with the forbidden foods were; 17(54%) were culture, lack of knowledge 7(23%) and 7(23%) was due to other reasons. The level of education and knowledge of forbidden foods had a positive correlation (rho-0.328) but insignificant ($p>0.01$). 20(20%) participants reported that there were foods recommended for the infants and young children while 80(80%) reported no specific foods recommended. Reasons associated with the recommended foods were; 4(20%) culture, 9(45%) lack of knowledge, 7(35%) due to other reasons. The relationship between early CF and recommended foods was positive but insignificant.

Discussion

The results of my study showed that social cultural practices and beliefs influenced feeding of feeding and young children. The social practices that influenced feeding were the demographic characteristics that ranged from level of education of care giver, the burden of responsibilities of the care giver. The cultural factors were the beliefs associated with certain foods, food taboos/restrictions and influence of the cultural custodians on the feeding of infant and young children. The introduction of prelacteal feeds, commonly water added sugar and salt and few using herbal drops significantly led to reduced prevalence of EBF. The prelacteal beliefs were associated with the cultural beliefs evidenced by the statements "opened up the infants intestines" and cleaned the stomach of the dirty contents by inducing vomiting. The cultural custodians especially the child's grandparents had a significant influence prelacteal feeding. Feeding of the prelacteal feeds delayed initiation of breastfeeding within the recommended 30minutes and this undermined suboptimal breastfeeding. Also maternal factors like

Citation: Karigi LN, Mutuli LA, Bukhala P. Socio-cultural practices and beliefs influencing infant and young child feeding in lubao sub-location Kakamega Country. *J Nutr Health Food Eng.* 2016;5(1):568–571. DOI: 10.15406/jnhfe.2016.05.00160

lack of breast milk, mothers' sickness and lack of knowledge led to prelacteal feeding. A small percentage of the respondents admitted not feeding their children with colostrumss. Customary it was believed that colostrums was "dirty milk" and "waste" from the mother hence should not be fed to infants. Also lack of knowledge lead the mothers not feeding their infants on colostrums. This made the children miss the opportunity of receiving the anti-infective property of colostrums milk hence undermining optimal infant feeding practices. In this study there was a noticeable practice of late initiation of breastfeeding, this was as a result as cultural beliefs held against colostrums where the colostrums had to be first expressed several times and discarded and this delayed breastfeeding and also prelacteal feeding delayed initiation of breastfeeding. The source of breastfeeding information by the relatives especially the respected members who were cultural custodians influenced EBF as evidenced in the study were some mothers who received breastfeeding information from their relatives did not practice EBF. According to the study the mother's unavailability influenced optimal breastfeeding where due to increased burden of responsibilities the mother had to introduce foods early to due reduced frequency of breastfeeding as a result of lack of time. This undermined the optimal BF practice due to mixed feeding. According to study the prevalence of early introduction of complementary feeds was quiet high, 47%. The reasons linked to the early introduction of feeds ranged from cultural influences, lack of maternal knowledge and increased maternal responsibilities. Increased maternal burden of responsibilities led to early introduction of other foods before 6months of age as the mothers could not afford time to adequately breastfeed the child. Lack of knowledge about child feeding as exampled in perception of "insufficient breast milk" by so many of the respondents led to early introduction of foods.

Various diet restrictions and food taboos imposed on infant feeding and also beliefs associated with certain foods influenced both EBF and CF. This study found a common taboo that most infants and young children were not fed on eggs as it was belief that the eggs made the "tongue heavy" hence would cause the child not be able to talk in the or would delay. This belief compromised appropriate CF as children missed on the nutrients provided by the eggs. Also customs regarding gender and food distribution in the households affected child feeding as care givers reported that men were served the large and better portions of food first before children and women, also there were some parts of meats especially organ meats that could not be eaten by children and women. There was a gap in knowledge as most mothers believed that protein foods like fish were not appropriate for their children.

A small number of the respondents reported a local belief of a practice that involved burning a certain kind of fish and a small amount of the ashes were fed to the infant or the young child. This helped soothe the baby to sleep as the baby would adapt the character of the fish which was asleep and it's dormant most times. Most caregivers had a high preference for feeding their infants on porridge as early as during the first month as many explained that porridge was good to make the child strong, this showed a large gap in child feeding knowledge.[20–43]

Conclusion

Several factors that undermine appropriate child feeding have a direct impact on the child's health, growth and development. The factors ranged from inadequate maternal knowledge, ignorance, socio factors, burdens and patterns of responsibilities, to cultural beliefs and taboos.

Cultural beliefs and taboos i.e. food taboos, restriction, beliefs associated with certain foods, have a strong influence on infant feeding and undermines optimal infant feeding practices; breastfeeding and complementary feeding.

Despite the guidelines and policies put in place to promote EBF and appropriate complementary feeding the prevalence of EBF and appropriate CF is still low due to many factors and one being socio cultural practices and beliefs.

Acknowledgements

None.

Conflict of interest

Author declares that there is no conflict of interest.

References

1. http://www.who.int/mediacentre/factsheets/fs178/en/.
2. International Baby Food Action Network. The state of breastfeeding in 33 countries 2010: Tracking Child and Young Child Feeding Policies and Programmes Worldwide, IBFAN. 2010.
3. Kikafunda J, Walker A, Tumwine J. Weaning foods and practices in central uganda: A cross-sectional study. *African Journal of Food, Agriculture, Nutrition and Development*. 2003;3(2).
4. Haas JD, Murdoch S, Rivera J, et al. Early nutrition and later physical work capacity. *Nutr Rev*. 1996;54 (2 pt 2):S41–S48.
5. Dewey KG, Huffman SL. Maternal, infant, and young child nutrition: combining efforts to maximize impacts on child growth and micronutrient status. *Food Nutr Bull*. 2009;30(2):S187–S189.
6. Bhutta ZA, Das JK, Rizvi A, et al. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *Lancet*. 2013;382(9890):452–477.
7. Jones G, Steketee RW, Black RE, et al. How many child deaths can we prevent this year? *Lancet*. 2003;362(9377):65–71.
8. Lozano R, Naghavi M, Foreman K, et al. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. *The Lancet*. 2012;380(9859):2095–2128.
9. http://siteresources.worldbank.org/INTWDR2006/Resources/477383-1127230817535/082136412X.pdf
10. Victora GD, Schwickert TA, Fooksman DR, et al. Germinal center dynamics revealed by multiphoton microscopy with a photoactivatable fluorescent reporter. *Cell*. 2010;143(4):592–605.
11. Agostoni C, Decsi T, Fewtrell M, et al. Complementary feeding: a commentary by the ESPGHAN Committee on Nutrition. *J pediatr Gastroenterol Nutr*. 2008;46(1):99–110.
12. Arora S, McJunkin C, Wehrer J, et al. Major factors influencing breastfeeding rates: Mother's perception of father's attitudes and milk supply. *Pediatrics*. 2000;106(5):E67.
13. Breastfeeding and the use of human milk. *Pediatrics*. 2012;129(3):e827–841.
14. Anderson J, Malley K, Snell R. Is 6months still the best for exclusive breastfeeding and introduction of solids? A literature review with consideration to the risk of the development of allergies. *Breastfeed Rev*. 2009;17(2):23–31.
15. Arifeen S, Black RE, Antelman G, et al. Exclusive breastfeeding reduces acute respiratory infection and diarrhea deaths among infants in Dhaka slums. *Pediatrics*. 2001;108(4):E67.

16. Arts M, Geelhoed D, De Schacht C, et al. Knowledge, beliefs, and practices regarding exclusive breastfeeding of infants younger than 6 months in Mozambique: a qualitative study. *J Hum Lact*. 2011;27(1):25–32.

17. Black RF, Blair JP, Jones VN, et al. Infant feeding decisions among pregnant women from a WIC population in Georgia. *J Am Diet Assoc.* 1990;90(2):255–259.

18. Ergenekon OP, Elmaci N, Ertem M, et al. Breastfeeding beliefs and practices among migrant mothers in slums of Diyarbakir, Turkey, 2001. *Eur J Public Health*. 2006;16(2):143–148.

19. Ford K, Labbok M. Who is breast-feeding? Implications of associated social and biomedical variables for research on the consequences of method of infant feeding. *Am J Clin Nutr*. 1990;52(3):451–456.

20. Gerrard JW, Perelmutter L. IgE-mediated allergy to peanut, cow's milk, and egg in children with special reference to maternal diet. *Ann Allergy*. 1986;56(4):351–354.

21. Jordan PL, Wall VR. Breastfeeding and fathers: illuminating the darker side. *Birth*. 1990;17(4):210–213.

22. Kakute PN, Ngum J, Mitchell P, et al. Cultural barriers to exclusive breastfeeding by mothers in a rural area of Cameroon, Africa. *J Midwifery Women's Health*. 2005;50(4):324–328.

23. Kalanda BF, Verhoeff FH, Brabin BJ. Breast and complementary feeding practices in relation to morbidity and growth in Malawian infants. *Eur J Clin Nutr.* 2006;60(3):401–407.

24. Kessler LA, Gielen AC, Diener-West M, et al. The effect of a woman's significant other on her breastfeeding decision. *J Hum Lact.* 1995;11(2):103–109.

25. Kier, Rajuan N, Goldberg MR, et al. Early exposure to cow's milk protein is protective against Ig-E mediated cow's milk protein allergy. *J Allergy Clin Immunol.* 2010;126(1):77–82.

26. Kimani Murage EW, Madise NJ, Fotso JC, et al. Patterns and determinants of breastfeeding and complementary feeding practices in urban informal settlements, Nairobi, Kenya. *BMC Public Health*. 2011;11:396.

27. Kramer MS, Kakuma R. *The optimal duration of exclusive breastfeeding: a systematic review*. Geneva: World Health Organization; 2001. 47p.

28. Sibeko L, Dhansay MA. Beliefs, Attitudes, and Practices of Breastfeeding Mothers From a Periurban Community in South Africa. *J Hum Lact.* 2005;21(1):31–38.

29. Littman H, Medendorp S, Goldfarb J. The decision to breastfeed: The importance of fathers' approval. *Clin Pediatr*. 1994;33(4):214–219

30. Maru Y, Haidaru J. Infant feeding practice of HIV positive mothers and its determinants in selected health institutions of Addis Ababa, Ethiopia. *Ethiopia Journal of Health development.* 2009;23(2):107–114.

31. Meyerink RO, Marquis GS. Breastfeeding initiation and duration among low- income women in Alabama: The importance of personal and familial experiences in making infant feeding choices. *J Hum Lact.* 2002;18(1):38–45.

32. Nwaru BI, Erkkola M, Ahonen S, et al. Age at the introduction of solid foods during the first year and allergic sensitization at age 5years. *Pediatrics*. 2010;125(1):50–59.

33. Oddy WH, Sly PD, de Klerk NH, et al. Breast feeding and respiratory morbidity in infancy: a birth cohort study. *Arch Dis Child.* 2003;88(3):224–228.

34. Omwega AM1, Oguta TJ, Sehmi JK. Maternal knowledge on mother-to-child transmission of HIV and breastmilk alternatives for HIV positive mothers in Homa Bay District Hospital, Kenya. *East Afr Med J*. 2006;83(11):610–618.

35. Rempel LA Rempel JK. Partner influence on health behavior decision-making: Increasing breastfeeding duration. *Journal of Social and Personal Relationships*. 2004;21(1):92–111.

36. Scott JA, Binns CW. Factors associated with the initiation and duration of breastfeeding: A review of the literature. *Breast feed Rev*. 1999;7(1):5–16.

37. Shirima R, Greiner T, Kylberg E, et al. Exclusive breastfeeding is rarely practiced in rural and urban Morogoro, Tanzania. *Public Health Nutr.* 2001;4(2):148–151.

38. Spencer RL. Research methodologies to investigate the experience of breastfeeding: a discussion paper. *Int J Nurs Stud.* 2008;45(12):1823–1830.

39. World Health Organization. *Infant and young child feeding: model chapter for textbooks for medical students and allied health professionals.* Geneva: World Health Organization; 2009.

40. World Health Organization. Summary of guiding principles for complementary feeding of the breastfed child. Geneva: World Health Organization. *Complementary feeding: report of the global consultation*. 2001. 5p.

41. Adejuyigbe E, Orji E, Onayade A, et al. Infant Feeding Intentions and Practices of HIV-Positive Mothers in South western Nigeria. *J Hum Lact.* 2008;24(3):303–310.

42. Subedi N, Paudel S, Rana T, et al. Infant and young child feeding practices in chepang communities. *J Nepal Health Res Counc.* 2012;10(21):141–146.

43. http://www.ifra-nigeria.org/IMG/pdf/Sika.pdf.