College of Medicine

Exploring determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district: An interpretive phenomenological analysis study

By

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A Dissertation Submitted to the College of Medicine in partial fulfilment of the Master of Science Degree in Global Health Implementation

23rd March 2022

DECLARATION

I, **Blessings Njolomole,** hereby declare that this thesis is my original work and has not been presented for any other awards at this University or any other university.

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DEDICATION

I dedicate this work to my late father and mother whose parental guidance and encouragement has enabled me to reach this far and to my wife Olive and sons, Dumilani, Zaithwa and Zizwani for their endurance, support and encouragement throughout my study period.

ACKNOWLEDGEMENT

I would like to express my sincere and deep appreciation to my supervisor Dr Isabel Kazanga Chiumia for her untiring support, guidance and mentorship throughout the study. I also acknowledge contributions made by faculty members and fellow students in the Department of Global Health Policy and Systems of the College of Medicine. Special thanks to my immediate family for their prayers support and best wishes.

ABSTRACT

Exclusive breastfeeding is the most widely known and effective intervention for preventing early childhood illnesses and deaths. Despite numerous global initiatives on breast-feeding, trend data show exclusive breast-feeding (EBF) rates have stagnated over the last two decades. In Malawi despite having some improvements in early initiation of exclusive breast feeding (EIBF), in the last decade there has been a decline in EBF and EIBF rates. EBF and EIBF rates have declined from 72% and 95 % in 2010 to 61% and 76% in 2016 respectively. The study aimed to explore determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district. Results for this study may help to inform evidence based planning and policy recommendations and interventions and may help managers and health workers in the district to come up with context specific interventions and strategies to promote EBF.

This was a qualitative interpretive phenomenological analysis (IPA) study. Purposive sampling technique was used to select breast feeding women with children 0-6 weeks and key informants while snowballing technique was used to recruit significant others. The sample size was 40 involving 18 women, 6 Spouses, 6 grandparents and 6 siblings of the women and key informants involving 2 maternity nurses and 2 clinicians and data was collected using focus group discussions (FGD) and in-depth interviews. The data was analyzed using thematic content analysis. The

study was conducted within a period of 12months. This period included proposal preparation, submission and approval, training of data collectors, pretesting of data collection tools, data collection, data analysis, report writing and dissemination of the findings.

Most of the women, sisters, spouses and grandparents were aware of the importance of exclusive breastfeeding but few were not aware. The source of information on the importance of EBF was nurses/doctors, friends, radio and care group volunteers. Women who were intrinsically motivated and those that had a good breastfeeding support system along the continuum of care practiced EBF. Availability of BFHI and EBF policies acted as cues for health workers to re-enforce EBF among women through health education talks. Some HCWs assumed that the women already knew how to breast feed as such they did not discuss with them about EBF and possible problems that could arise from breastfeeding such as sore nipples, failing to latch the baby to the breast, breast engorgement and the perception of breast milk insufficiency. Yet some HCW provided information based on their own biased intuition and not scientific professional knowledge. Nonetheless some women described EBF as an empowering experience and the best thing any woman can do to her child.

Findings of this study have shown that exclusive breastfeeding is not merely just an intuitive biological process based on the natural instinct of both the mother and her baby but rather that successful exclusive breastfeeding is dependent on a complex interplay of factors such as mothers agency, health care worker factors, socio-

economic factors and support from significant others. Furthermore HCW should provide reliable information based on scientific professional knowledge and not based on their own biased intuition and should provide practical demonstrations of breastfeeding and involve significant others when counselling a woman on exclusive breastfeeding during discharge from the postnatal ward.

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LIST OF ACRONYMS

COMREC: College of Medicine Research and Ethics Committee

DHO : District Health Officer

EBF : Exclusive Breast Feeding

EIBF :Early Initiation of Breastfeeding

FGD :Focus Group Discussion

GSIYCF :Global Strategy for Infant and Young Child Feeding

HCW :Health Care Workers

IDI :Infant and Young Child Feeding

IPA :Interpretive Phenomenological Analysis

IYCF :Infant and Young Child Feeding

MoHP :Ministry of Health and Population

WHA :World Health Assembly

WHO :World Health Organization

CHAPTER 1: INRODUCTION

1.1 Introduction

Exclusive breastfeeding (EBF) is defined as feeding an infant with only breast milk and no additional food, water, or other liquids during the first six months of life (1). EBF is the most widely known and effective intervention for preventing early-childhood deaths. Globally, 60% of infant and young children deaths occur due to inappropriate infant feeding practices and infectious diseases from which two-thirds of these deaths are attributable to sub-optimal breastfeeding practices (1). Inappropriate infant feeding practices could have negative effects on child growth and development, especially in developing countries where accessibility of basic health services is not sufficient (2). Optimum breastfeeding practices can prevent 1.4 million deaths worldwide among children under five every year. Suboptimal breastfeeding contributes to 45% of neonatal infectious deaths, 30% of diarrheal deaths and 18% of acute respiratory deaths among children under five in developing countries (1).

Globally, fewer than 35% of infants are exclusively breastfed. In Sub Saharan Africa exclusive breastfeeding ranges between 22 % and 33 % (3). Despite numerous global initiatives on breast-feeding, trend data show EBF rates have stagnated over the last two decades. Key challenges to EBF remain unaddressed through infant and young child feeding (IYCF) programming (4). A 2016 UNICEF report notes that 43% of newborn babies are fed prelacteal foods or liquids (feeds given to a newborn before breast-feeding is established), which can delay early initiation of breast-feeding, reduce a child's demand for breast milk and lead to difficulties in establishing breast-

feeding. In addition, most infants are introduced to other foods or liquids too early, prior to the recommended 6 months of age (5). Globally only 42 % (57 million) of mothers initiate Breastfeeding within the first hour after birth, about 35-36 % of babies less than four months are exclusively breastfed and 58 % continue breastfeeding up to the age of two years. Approximately half of the 10 million deaths of infants under 5 years old yearly are due to direct or indirect consequences of malnutrition and a greater proportion of these deaths are linked with improper breastfeeding practices [6]. Worldwide, under half of the newborns are breastfed within an hour of delivery. The proportion is even lower in the African region at 44% which is below the World Health Organization (WHO) desirable rate of 90–100%. The benefits of early initiation of breastfeeding (EIBF) for both mother and baby are well-documented, including reduced risk of postpartum hemorrhage, increased mother-baby bonding, increased colonization of the baby's enteric system by micro flora and reduced neonatal mortality. Despite these benefits, the rate of EIBF in most middle-income countries remains low including Namibia. EIBF rates are 30.8 and 41.9% in rural and urban Nigeria respectively with Algeria at 44.7% and Kenya at 58.7% [7].

During the Innocenti Declaration in 1990, the WHO and UNICEF called for policies that would cultivate breast feeding culture and encourage women to breast feed their infants exclusively for the first 6 months of life. Since then, a lot of effort has gone into scaling up breast feeding rates in several parts of the world including sub-Saharan Africa (SSA). However, the rates in most SSA countries are still low (8).In Malawi, despite implementing various initiatives and strategies to promote EBF its practice is on the decline. EBF rates have dropped by 11 percentage points from 72% in 2010 to 61% in 2016 (9). Additionally, Malawian children under the age of six months are exclusively breastfed for an average duration of 3.7 months only. This falls short of the recommendations by the World Health Organization as well as the Malawi Ministry of Health that

mothers exclusively breastfeed for all the first six months of the child's life (10). In Balaka district of Malawi EBF rates are at 57.9 % which is below the national average of 61% (11).This study therefore explored determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district.

1.2 Background

1.2.1 Trends in Exclusive Breast Feeding in Malawi

In 1993 the Malawi Ministry of Health and Population (MoHP) adopted the baby friendly hospital initiative (BFHI) launched by the WHO in 1991, as a strategy for promoting EBF in the country after the 1992 Malawi Demographic Health Survey revealed a dismal EBF rate of 3% (12). Since then the MoHP has taken other steps to promote and safeguard EBF through the launch of the Infant and Young Child Nutrition Policy and Guidelines as well as the Work Place Support and Breast Feeding Substitute Policy (13). As a result of these initiatives there were some improvements in EBF rates, rising from 3% in 1992 to 45% in 2004 and 72% in 2010.Likewise EIBF rates improved from 57% in 1992 to 70% in 2004 and 95% in 2010 [12]. Despite these achievements there has been a decline in EBF and EIBF rates in Malawi from 72% and 95 % in 2010 to 61% and 76% (Figure 1) respectively in 2016 [9]. Furthermore in Malawi, children under the age of six months are exclusively breastfed for an average duration of 3.7 months. This falls short of the recommendations by the World Health Organization as well as the Malawi Ministry of Health that mothers exclusively breastfeed for the first six months of the child's life (10). A cross-sectional nutritional baseline survey undertaken in Kasungu and Mzimba Districts of Malawi to assess the nutritional status of infants aged 0–6 months with regard to food intake found that prevalence of exclusive breastfeeding of infants 0-6 months was 43%. Exclusive breastfeeding

was less common in older infants, ranging from 81% in infants less than 1 month and 15% in infants aged 5 months, the study also revealed that children that were exclusively breastfed were on average 1·08 cm longer and 0·46 kg heavier than those that were not exclusively breastfed. Additionally the survey also revealed that only 4% of infants were exclusively breastfed for the entire 6 months and rates of diarrhea and fever were found to be higher among the non-exclusively breastfed infants [14].

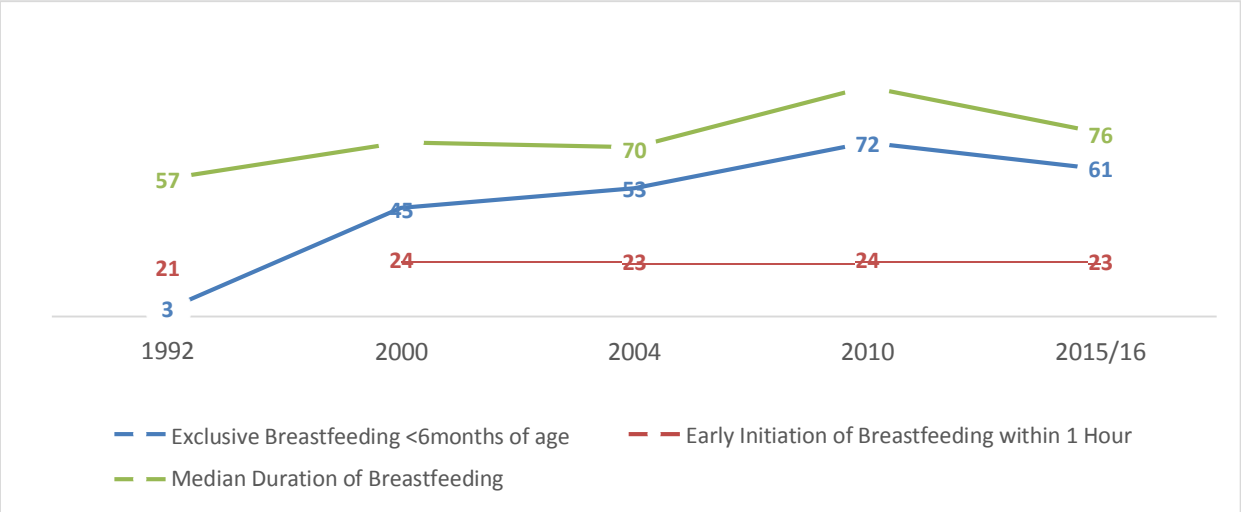

Figure 1: Exclusive Breastfeeding Trends In Malawi (Source Mdhs 2015/16

1.2.2 Breastfeeding practices in Malawi

A study conducted on breast and complimentary feeding practices in relation to morbidity and growth in Malawian infants found that the mean age at introduction of water was 2.5 months, complementary foods 3.4 months and solids 4.5 months. Over 40% of infants had received complementary foods by 2 months and 65% by 3 months. The proportion of exclusively breast- fed infants, which included those receiving supplemental water, was 13% at 4 months, 6.3% at 5 months and 1.5% at 6 months (15).

A cross section survey conducted in Mangochi district found that the proportion of mothers who thought that exclusive breastfeeding should last for 6 months and those that reported to have actually exclusively breastfed were 40.1% and 7.5% respectively. Of those that reported practicing exclusive breastfeeding for 6 months, 77.5% stated that exclusive breastfeeding should last for 6 months. Among the mothers who thought that exclusive breastfeeding should last for less than 6 months, 43.9% reported having been influenced in their opinion by health workers [16]. In another study conducted in northern Malawi on breastfeeding and mixed feeding practices, timing, reasons, decision makers, and child health consequences it was found that 65 % of the children were given food in their first month, and only 4% of the children were exclusively breastfed for 6 months. Mzuwula and dawale (herbal infusions), water, and porridge were common early foods. Grandmothers introduced mzuwula to protect the children from illness; other foods were usually introduced by mothers or grandmothers in response to perceived hunger. The early introduction of porridge and dawale, but not mzuwula, was associated with worse anthropometric status (17).These studies clearly show that the practice of EBF in Malawi is still a challenge with some mothers or care givers giving complementary feeds as early as one month due to perceived breast milk inadequacy and hunger of their children.

1.3 Problem Statement

Exclusive breastfeeding is a cornerstone of child survival and child health because it provides essential, irreplaceable nutrition for a child's growth and development (18). It serves as a child's first immunization providing protection from respiratory infections, diarrheal diseases, and other potentially life-threatening ailments (18). Despite all these benefits only fewer than 35 % of children are exclusively breast fed globally, while EBF ranges between 22-33% in Sub-Saharan Africa (3). Despite Malawi, implementing various initiatives and strategies to promote EBF its practice is on the decline. EBF rates have dropped by 11 percentage points from 72% in 2010 to 61% in 2016 (9). Additionally, Malawian children under the age of six months are exclusively breastfed for an average duration of 3.7 months only. This falls short of the recommendations by the World Health Organization (WHO) as well as the Malawi Ministry of Health that mothers exclusively breastfeed for all the first six months of the child's life (10).

Despite strong evidence on immediate and long term health benefits of optimal breastfeeding in children, as shown by different studies, its practice remains very low (1-5). In Balaka district of Malawi the percentage of children 0-5 months who were exclusively breast-fed in the past 24 hours dropped by 15.1 percentage points from 73% at baseline in 2013 to 57.9% at midline in 2016 (11). In some parts of Malawi, rates are as low as 19% at one month, and less than 5% at six months (19). This study therefore sought to identify the reasons for the decline in EBF rates among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district.

1.4 Broad Objective

To explore determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district

1.5 Specific Objective

i) To explore the level of knowledge of mothers with children aged 0-6 weeks on the importance of exclusive breastfeeding.

ii) To explore the perceptions of mothers with children aged 0-6 weeks towards exclusive breast feeding.

iii) To identify factors that promote exclusive breast feeding among mothers with children aged 0-6 weeks.

iv) To identify barriers of exclusive breastfeeding among mothers with children aged 0-6 weeks attending postnatal clinic services in Balaka district.

v) To describe the breastfeeding experiences of mothers with children aged 0-6 weeks.

CHAPTER 2 LITERATURE REVIEW

This section presents a review of literature on policy and historical context of exclusive breastfeeding and global impact and outcomes of the baby friendly hospital initiative on early initiation of breastfeeding and exclusive breastfeeding.

2.1 Policy and Historical Context of Exclusive Breastfeeding

The historical evolution of feeding for full-term infants includes wet nursing, the feeding bottle, and formula. Before the invention of bottles and formula, wet nursing was the safest and most common alternative to breastfeeding by the natural mother (20). In the 18th, 19th, and 20th centuries, advancements in chemistry and food preservation contributed to the increased replacement of breastfeeding by formulas, which were heavily advertised and considered a safe alternative. Currently, infant formula has a profound effect on the number of mothers who breastfeed their infants (20). Breastfeeding rates have decreased significantly in the 21st century, resulting in serious child hood health issues. Research suggests that breastfeeding prevents adverse health conditions, whereas formula-feeding is linked with their development. This evidence confirms breastfeeding is still the best source of infant nutrition and the safest method of infant feeding (20).

In July 1990, cognissant of the declining trends in breast feeding, government policy makers from more than 30 countries met in Florence, Italy and came up with and adopted the Innocenti Declaration which set an international agenda with ambitious targets for action on the protection, promotion and support of breastfeeding. The Innocenti Declaration was endorsed by the forty-fifth World Health Assembly (WHA) and the Executive Board of UNICEF in the same year (21). The

Innocenti Declaration reflected both the spirit and the support that was being mobilized for breastfeeding, and the recognition of the right of the infant to nutritious food enshrined in the Convention on the Rights of the Child. It captured the commitment as well as the practical vision of those who gathered in Florence to launch breastfeeding onto a higher public plane (21). Additionally, and pursuant to and in support of the Innocent Declaration the WHO and UNICEF globally launched the BFHI in 1991 as a strategy to promote, protect, and support breastfeeding in maternity and newborn facilities for the early initiation of breast feeding and promotion of EBF.BFHI was intended to aid countries to reach the fifth goal of the WHA Global Nutrition 2025 Targets, which aim to improve EBF rates to at least 50% globally (18).

In 2002, WHO member States unanimously endorsed the Global Strategy for Infant and Young Child Feeding (GSIYCF) in the 55th WHA and UNICEF's Executive Board adopted it in the same year. GSIYCF is the overarching framework for action by governments and all concerned parties to ensure that the health and other sectors are able to protect, promote and support appropriate infant and young child feeding practices. The GSIYCF reaffirms and builds on the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding that was adopted in 1990 and revitalized in 2005 (22).The Global Strategy reiterated the Innocenti Declaration call for countries to *"ensure that every facility providing maternity services fully practices all the Ten steps to successful breastfeeding."* The Second International Conference on Nutrition in 2014 recommended that countries *"Implement policies, programmes and actions to ensure that health services promote, protect and support breastfeeding, including the Baby-Friendly Hospital Initiative."* An indicator on the coverage of baby-friendly hospitals is included in the Global Nutrition Monitoring Framework adopted by the 2015 WHA. Thus, the global health community

continues to emphasize the importance of implementing the ten steps of the BFHI (23).Following the 1991 WHO and UNICEF endorsement and adoption of BFHI and the dismal national EBF rate of 3% reported in the 1992 Malawi Demographic and Health Survey. The Malawi Ministry of Health (MOH) adopted and launched the BFHI as a strategy to promote EBF and EIBF in the country with external funding in 1993 (12).

2.2 Global Impact and outcomes of the Baby Friendly Hospital Initiative on Early Initiation of Breastfeeding and Exclusive Breastfeeding

A systematic review of 58 studies in low, middle, and high- income countries demonstrated that BFHI led to increases in EIBF, EBF and breastfeeding duration in general with a dose–response relationship seen between the number of the Ten Steps a woman is exposed to and breastfeeding out-comes (23). These findings were also corroborated by another systematic review and meta-analysis of 195 studies in low, middle and high income countries evaluating the effects of the Ten Steps on breastfeeding outcomes which found that early initiation of breastfeeding less than one hour after birth increased by 25% with adherence to the BFHI (24).In Croatia EBF rates improved significantly from 8.9 % to 45.6 % following a national revitalization of BFHI in public hospitals (25). Furthermore, in Kuwait, implementation of BFHI resulted in a twofold improvement in early initiation of breastfeeding (23).

In Malawi the average rate of exclusive breastfeeding among infants aged less than 6 months increased from 3% to 71% between 1992 and 2010 respectively, representing an annual increase of approximately 4% per annum. The progress on raising rates of exclusive breastfeeding was

attributed to the implementation of the BFHI, strong leadership in support of infant and young child feeding at all levels of government ,well-articulated policies and guidelines; integrated services at the community level; providing infant and young child feeding support through multiple channels, national advocacy and intensive mass education to increase support for and knowledge of breastfeeding and links to programmes for prevention of mother to-child transmission of HIV (18)**.**Of late, despite Malawi implementing all the afore mentioned initiatives and strategies to promote EBF and EIBF its practice is on the decline. EBF rates have dropped by 11 percentage points from 71 % in 2010 to 61% in 2016 (9).

2.3 Previous Studies on Determinants of Exclusive Breastfeeding

2.3.1 Knowledge and perceptions of EBF

There are a number of factors that determine the practice of EBF by a lactating woman such as knowledge. A study conducted in Southern India on perceptions and practices regarding breastfeeding among postnatal women at a district tertiary referral government hospital found that 79.7 % of the postnatal women knew the importance of breastfeeding prior to delivery and this knowledge was imparted to them by doctors/nurses during antenatal visits and by their own mothers. [26]. A study conducted on breastfeeding knowledge and practices among mothers of children under 2 years of age living in a military barrack in Southwest Nigeria revealed that a majority (82.3%) of the women had knowledge about EBF and knew that a baby should not receive pre-lacteal feeds. About 88.2% of the respondents correctly acknowledged that colostrum should be fed to a baby. The knowledge score of the respondents was significantly associated with the use of pre-lacteal feeds, the practice of exclusive breastfeeding, and the use of a feeding bottle. A larger

proportion of those who gave pre-lacteal feeds and those using feeding bottles had fair breastfeeding knowledge while 5.9% of those using feeding bottles had good knowledge of breastfeeding (27). Another study on the determinants of exclusive breastfeeding among mothers of infants aged 6 to 12 months in Gwanda district, Zimbabwe found that the majority of women (89%) had knowledge of what exclusive breastfeeding is and were knowledgeable on EBF practices, nonetheless EBF rates were still low in the Gwanda community despite the women being knowledgeable. This finding was similar to a study in Nigeria where knowledge was high (82%) but the EBF rate was low (33.5%) (28). A study on determinants of breastfeeding practices among mothers in Malawi showed that knowledge and skills acquired during antepartum visits strengthen mothers' confidence and intention to breastfeed. During prenatal visits, Malawian mothers are routinely provided with breastfeeding education, and such educational sessions are associated with optimal breastfeeding outcomes (29).

A study conducted on perceptions and practices regarding breastfeeding among postnatal women at a district tertiary hospital in Southern India found that 96% of the mothers felt that breast milk is healthy for their babies, 17% agreed that breast milk protects babies from diseases while 49.4% opined that breast milk promotes bonding (26).Another study on the lived experiences of first time breastfeeding women found that women breastfed their children because they believed that breast milk provides immunity, good nutrition and improves the relationship between mother and child. (30). This study also showed that women associated exclusive breastfeeding with good motherhood. For most women, the activity of breastfeeding was acknowledged as a responsibility

and that breastfeeding helped them to fulfil their basic role as mothers (30). In a study on breastfeeding and mixed feeding practices in Malawi participants felt that the first milk (colostrum) was good for babies, as well as breast milk. They said that breast milk protects a baby from diseases, helps their bowels develop, and gives them energy. All women interviewed named breast milk as the primary source of food for babies, but several other foods could be given to a baby if it cried. The crying of a baby was seen as a sign of hunger and an indication that the baby was not getting enough food from breast milk thus exclusive breastfeeding was not widely practiced (31). Another study conducted in Ghana showed that previous experiences prior to breastfeeding by women who observed other female relatives breastfeed their own children reinforced the fact that the women would also breastfeed their babies after child birth (30).

2.3.2 Factors that promote EBF

Women's source of support and process of breastfeeding occurred within the context of their family and immediate society with partners as having the most positive influence. Women highly valued the support and advice they received from family members. This support was experienced at some points as enabling or encouraging successful breastfeeding (30). Other common influences that supported EBF were norms encouraging breastfeeding, postnatal support (from healthcare settings, community and households) and knowledge of breastfeeding benefits (32).

2.3.4 Barriers to exclusive breastfeeding

There are various factors that stand in the way of lactating women to exclusively breast feed their children. Such factors include lack of support from their husbands or other family members, medical conditions, failure to latch and HCW factors. A study on the influence of fathers' socioeconomic status and paternity leave on breastfeeding duration conducted in Sweden found that

fathers with low education and low social economic status did not support their wives in exclusive breast-feeding. The fathers used their role as family heads to control feeding practices in the family and the fathers believed that breast milk is mainly liquid and not heavy nor nutritious enough for the baby's optimal growth and development (33). A qualitative analysis nested in a randomized controlled trial on women's perceptions of breastfeeding barriers in early postpartum conducted in New York found that barriers to EBF included latch, medical, and medical staff, hospital practice and the perception of insufficient milk supply in the first few days (34).

A study on barriers to the practice of exclusive breastfeeding among HIV-positive mothers in Sub-Saharan revealed that HCWs would advise a woman to stop practicing EBF if they thought the woman was malnourished or if the woman was HIV positive. This is contrary to the WHO recommendation that HIV-exposed infants in low-resource settings be exclusively breastfed for 6 months and that EBF be combined with complementary feeding from age 6 to 12 months. Furthermore HCWs gave adapted messages based on what they believed to be the best feeding choice for mothers and that a significant number of HCWs, including those with relevant training, presented the possibility of mother to child transmission of HIV through breastfeeding as a certainty and not a risk, resulting in infant feeding counselling that downplayed EBF (35).

In the typical African context despite women having adequate understanding about EBF and its health benefits a woman's knowledge and understanding about EBF is not enough to enforce the practice of EBF because women did not have the 'power' to make independent decision to practice EBF. The women needed permission from their husbands or family heads. The paternal grandmother, grandfather, and father were the key decision makers (36). Furthermore other studies have shown that poor social economic status of women or women who were financially dependent

on a family member were more likely to practice mixed feeding (37). Another study in Malawi, found it was common for Malawian infants to be introduced to water, porridge, and herbal infusions before 6 months of age and that some Malawian fathers reportedly added formula to the infant's diet. A recent study discussed how Malawian health workers may provide insufficient advice or that mothers and fathers misinterpreted breastfeeding recommendations (38).

The literature reviewed in the preceding paragraphs confirms that breastfeeding is still the best source of infant nutrition and the safest method of infant feeding and revealed mixed results where by in some instances the knowledge score of the respondents was significantly associated with the use of pre-lacteal feeds, the practice of exclusive breastfeeding, and the use of a feeding bottle. In some instances knowledge of EBF did not always translate into the practice of EBF. The studies also revealed that knowledge and skills acquired during antepartum visits strengthen mothers' confidence and intention to breastfeed. It is also evident in the studies that women highly valued the support and advice they received from family members. This support was experienced at some points as enabling or encouraging successful breastfeeding (30). Other common influences that supported EBF were norms encouraging breastfeeding, postnatal support (from healthcare settings, community and households) and knowledge of breastfeeding benefits (32).

3. Conceptual Framework

3.1 Interpretive Phenomenological Analysis

This study was guided by the interpretive phenomenological analysis (IPA) framework. IPA is a contemporary qualitative methodology, first developed by psychologist Jonathan Smith in the 1990s. Whilst its roots are in psychology, it is increasingly being drawn upon by scholars in the human, social and health sciences and is committed to the systematic exploration of personal lived experiences. Its objective is to understand the lived experiences and explore how individuals make sense of their personal and social worlds. Through the two IPA complimentary commitments of 'giving voice' and 'making sense'. researchers seek to attain an 'insider perspective' of lived experiences (39). IPA is theoretically rooted in critical realism and the social cognition paradigm. Critical realism accepts that there are stable and enduring features of reality that exist independently of human conceptualization. Differences in the meanings individuals attach to experiences are considered possible because they experience different parts of reality. The social cognition paradigm is founded on the premise that human speech and behavior reflects these differences in meaning either directly or indirectly. Hence, analysis of interview data is considered to be a reasonable method of accessing and developing an understanding of these differences (40).

The IPA framework helps researchers to develop in-depth descriptions of human experiences. It can also be used to develop theories, models and explanations that help us understand human experiences. In 1936, Edmund Husserl one of the early philosophers of phenomenology rejected the view that empirical science is the basis for achieving an understanding of the world, stressing instead the importance of the 'life world' or lived experience. It is this thinking that has inspired much recent research in healthcare, in which the focus is on exploring individual 'lived

experiences' (40).Some critics of IPA asset that it is riddled with ambiguities as well as lacking standardization while others claim that it is mostly descriptive and not sufficiently interpretative enough. The most vigorous criticism of IPA is that the methodology suffers from four major conceptual and practical limitations (41).

Firstly, antagonists claim that IPA like many phenomenological studies gives unsatisfactory recognition to the integral role of language in their rebuttal of this criticism, protagonists accept that meaning making takes place in the context of narratives, discourse and metaphors which are always intertwined with language (42). Secondly, questions have been raised whether IPA can accurately capture the experiences and meanings of experiences rather than opinions of it. This may be particularly the case when interviewing people about sensitive issues such as mental illness. But the criticism could be seen as elitist, suggesting only those having access to the right level of fluency are allowed to describe their experiences (42). Thirdly, the fact that IPA, like other phenomenological inquiries focuses on perceptions is problematic and limiting to our understanding, because phenomenological research seeks to understand the lived experiences but does not explain why they occur. But, Smith et al have argued that IPA uses hermeneutic, idiographic and contextual analysis to understand the cultural position of the experiences(41). Finally, some critics assert that though IPA is concerned with cognition some aspects of phenomenology are not compatible with cognition and the role of cognition in phenomenology is not properly understood. However, Smith et al rebuff this by arguing that the IPA's prerequisite of sense-making and meaning-making which encompass formal reflection clearly resonates with cognitive psychology (42). IPA has three primary theoretical underpinnings namely; 1)

Phenomenology; 2) Hermeneutics and 3) Ideography (43).These have been described in 3.1.1, 3.1.2 and 3.1.3 below.

3.1.1 Phenomenology

Phenomenology is the study of phenomena or 'towards the things themselves'. Phenomenology is a discipline that focuses on peoples lived experiences and people's views of the world in which they live and what it means to them (30). Phenomenology is a philosophical approach to the study of experience in the things that matter to us and that constitute our lived world. The goal of phenomenology is to explore a lived experience. Phenomenological enquiry has two different approaches: descriptive phenomenology and interpretive phenomenology. IPA has its foundations in both (44). Descriptive Phenomenology aims to purely describe a lived experience without attempting to give meaning to it. Interpretive Phenomenology aims to reveal and interpret the embedded meaning in a lived experience and holds that there is no knowledge outside of interpretation and that knowledge of the lived world can only happen through interpretation grounded in the world of things, people, relationships, and language (44).

3.1.2 Hermeneutics

Hermeneutics (from the Greek word 'to interpret' or 'to make clear') is the theory of interpretation (45) .The three most important hermeneutic theorists for IPA are Friedrich Schleiermacher, Martin Heidegger, and Hans-Georg Gadamer. According to Schleiermacher interpretation involves both grammatical and psychological interpretation and is concerned with exact and objective textual meaning and is an art, involving the combination of a range of skills, including intuition and not just merely following mechanical rules, he further explains that hermeneutics offer meaningful

insights that potentially exceed and include the explicit claims of participants (44). Heidegger linked the interpretation of lived experiences with the attempt to make meaning from the experiences. The notion is that there is a phenomenon out there ready to be explored but requiring the detective work of the researcher to bring it to light using his/her prior experience, assumptions or preconceptions to make sense of the experience once it is revealed (46). Similar to Heidegger, Gadamer notes that one may only really get to know what his or her preconceptions are once the interpretation is underway. Thus the phenomenon (the thing itself) influences the interpretation, which in turn can influence the fore-structure, which can then itself influence the interpretation [44].

3.1.3 Idiography

Idiography is concerned with the particular, in that it is committed to the detailed analysis of a phenomenon under investigation. It takes great care of each case, offering detailed and nuanced analysis, valuing each case in its own merits before moving to the general cross-case analysis for convergence and divergence between cases with an understanding of how a particular experiential phenomenon (an event, process or relationship) has been understood from the perspective of particular people, in a particular context (44). See figure 2 IPA theoretical framework.

3.1.4 IPA Theoretical Framework: The three Phenomenological Underpinnings of IPA adapted from Smith et al., 2009

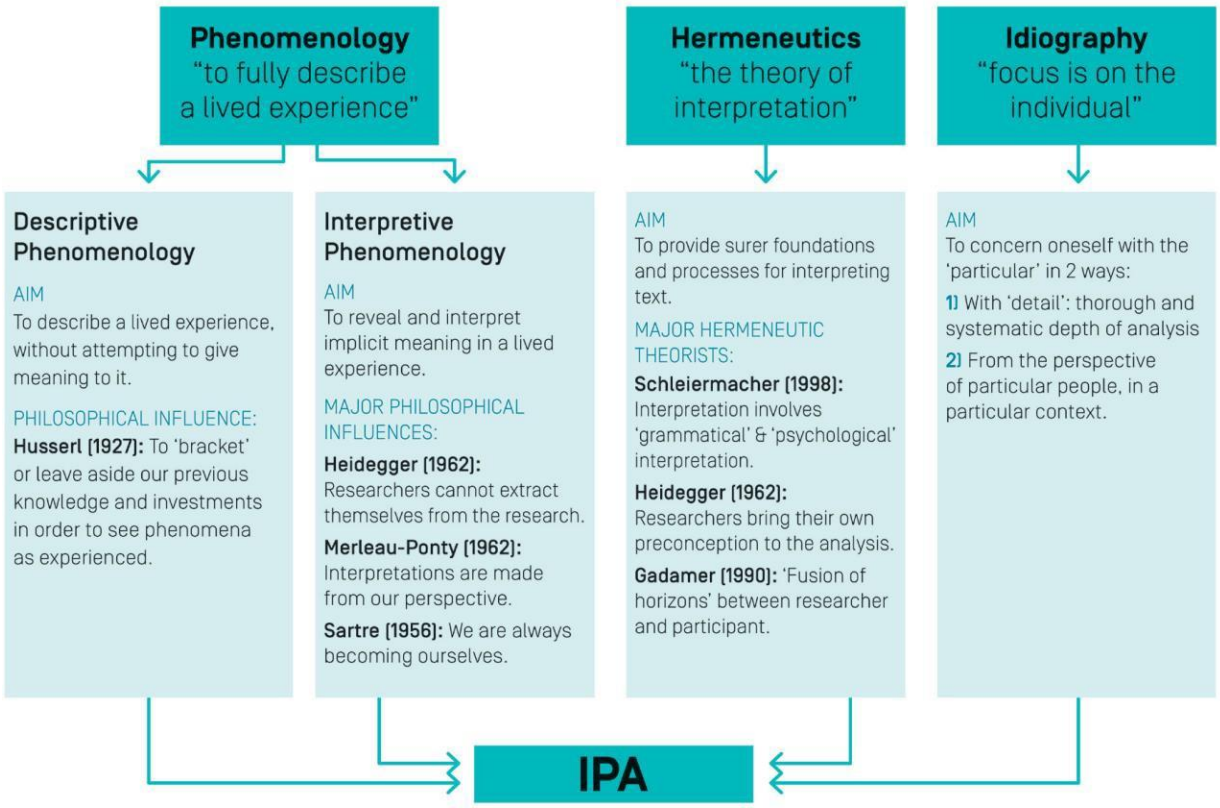

Figure 2: IPA Theoretical Framework

3.1.5 Rationale for using IPA conceptual framework

IPA resonates well with this study since IPA research explores and interprets major life lived experiences and keeps the focus locally, contextualized on a specific phenomenon while using broad knowledge principals and understand them in a local context highlighting what works in a local context setting, and not what works in 'most' or general settings. This study will explore people in a particular context who have shared a particular experience and make claims at a group level reflecting a specific focus. Additionally the IPA approach is particularly valuable because

the most effective policies and practices come from evidence-based research that also considers the individual and local context which is at the heart of IPA.

CHAPTER 3: METHODS

This chapter presents the research methods used in this study. It describes the study design, study place, study population, study period, inclusion and exclusion criteria, sample size, data collection, data management and analysis, ethical considerations and other practical issues related to fieldwork.

3.1 Study design

This was a qualitative interpretive phenomenological research design. Interpretive phenomenological analysis (IPA) was used in order to examine in detail individual lived experiences and how individuals make sense of that experience. IPA has three primary theoretical underpinnings namely phenomenology, hermeneutics, and ideography (43). IPA synthesizes ideas from phenomenology and hermeneutics resulting in a method which is descriptive because it is concerned with how things appear and letting things speak for themselves, and interpretative because it recognizes there is no such thing as an uninterpreted phenomenon. The third theoretical orientation which IPA relies upon is idiography. It refers to an in-depth analysis of single cases and examining individual perspectives of study participants, in their unique contexts. The fundamental principle behind the idiographic approach is to explore every single case, before producing any general statements (45). Thus IPA helped the researcher to explore the lived experiences of the participants and describe and interpret the embedded meaning in the lived experiences using phenomenological, hermeneutical and idiographic approaches (44).

IPA recognizes that analysis always involves interpretation, and is strongly connected to hermeneutics to garner an 'insider perspective' of experience thus IPA dictates the requirement for double hermeneutics: "Whereby the participant is trying to make sense of their personal and social world and the researcher is trying to make sense of the participant trying to make sense of their personal and social world'' Thus through phenomenology and hermeneutics the researcher was able to get an insider's view of the participants trying to make sense of their personal and social world. Through ideography the researcher got a detailed and in-depth examinations of how individual persons in their unique contexts made sense of a given phenomenon; by learning from each participant's individual story, and through a deep individualized analysis, the researcher got a more informative understanding of participants' thoughts, beliefs and behaviors. Each individual case is central to IPA (39).

3.2 Study Place

The study was conducted at Balaka District Hospital. Balaka District has a population of 438,379 representing 2.5% of the total population of Malawi (47). Balaka District Hospital serves a catchment population of 90,748. Balaka District is located in the Southern Region of the Republic of Malawi. Ntcheu borders it to the northwest, Mangochi to the north, Machinga to the east, Zomba to the southeast, Blantyre to the south, and Neno to the southwest. The district covers an area of 2,193 km^2 representing 2.4% of the total land area of Malawi. It is the 20th largest district in the country and the seventh largest in the Southern Region (48). The 2015-16 MDHS showed that 92.6 % of deliveries in Balaka were live births while 2.8 % and 4.1 % were still births and miscarriages respectively and 0.6 % were induced

abortions. Furthermore 87.2 % of women breastfed their children within one hour after birth while 1.5 % gave their children prelacteal feeds within the first three days of life. (9). Furthermore, in the period between 2016 and 2020 the rates for breastfeeding initiation within one hour have declined from 95.4 % in 2016 to 71.0 % in 2020 (57).

3.3 Study Period

Data was collected in the month of September 2020. Field data collection took approximately two weeks. Data was analysed in the month of October, 2020 and report writing started immediately thereafter

3.4 Study Population

The study population were women with children 0-6 weeks old attending 6 weeks postnatal clinic checkups at the maternity units of Balaka District Hospital as well as their spouses, siblings and grandparents.

3.5 Sample Size

Participants were recruited using purposive sampling technique to select 18 breast feeding women with children aged 0-6 weeks attending postnatal clinic services and four health care workers. Three focus group discussions (FGDs) of 6 women per group were conducted with these women. The FGDs provided a phenomenological and hermeneutical perspective focusing on participants lived experiences and their views of the world and what it means to them while conducting in- depth interviews with these women provided the idiographic perspective with an in-depth analysis of single cases and examining individual perspectives of the study participants, in their unique contexts exploring every single case, before producing any general statements

(44,45). Snowballing sampling technique was used to identify 18 significant others (6 spouses, 6 grandparents and 6 siblings). Snowball sampling is a purposive sampling method which is applied when it is difficult to recruit subjects in a study hence in this study the purposively selected (18)

Breastfeeding women were used to recruit their spouses, siblings and grandparents. [49]. The total sample size was forty.

3.6 Data Collection

Data was collected using semi structured interview guides for FGD and in-depth interviews. Semi- structured interview guides used open ended questions which provided an opportunity for the participants (who are considered the expert on the topic at hand) to talk in great detail about the elements of their experience that are of importance to them. Additionally semi structured interview guides, provided the interviewer with the flexibility to follow up on any answers given with further questions not necessarily on the original schedule (50).FGD/interviews took an average time of 45 minutes.

Both FGD and in-depth interviews were audio recorded and field notes were taken as well. The researcher trained interviewers, a recorder and an observer on how to document manage and record proceedings of the interviews. The Data collection tools were pre-tested at a health facility different from the one where this study was conducted. Three FGDs of 6 participants per group with women with children 0-6 weeks were conducted and 18 in-depth interviews with the same women were also conducted. In-depth interviews with significant others (Spouses, grandparents and

siblings of the women) and key informants involving 2 maternity nurses and 2 clinicians were conducted until no new substantive information was acquired or until saturation is was reached. Prior to enrollment of participants into the study, the researcher briefed the Balaka District Health Officer (DHO) about the study and sought authorization from him to conduct the study in the district.

3.7 Data Management and Analysis

3.7.1 Data Management

The researcher collected all the in-depth interview forms from all the interviewers and kept the guides, while audio recordings and transcripts of in-depth interviews and FGD were kept in safe and secure lockable drawers. Transcribed text were stored in word processing files on a password protected computer.

3.7.2 Data Analysis

All the data collected from the study was analyzed manually using content thematic analysis. After transcribing the researcher listened once more to the recording of the interview while reading the transcript. The researcher further familiarized himself with the data by reading and re-reading the transcripts to have a thorough understanding of the data. The researcher then generated initial codes by going through the data again and read and reread the transcripts and made notes and generated codes by identifying and highlighting data items that formed repeated patterns. After the data was coded and collated, the codes and collated data were sorted into themes, the themes were reread and reviewed in relation to the entire data set in order to ascertain whether the themes ‘work’. The themes were then collapsed into one theme or broken down into separate themes or were entirely removed

depending on the available supporting data set. For example, the codes: lack of knowledge, breast engorgement and sore nipples were collapsed into the theme ‘mothers agency’ (44, 49, 50, 51).

3.7.3 Trustworthiness

In IPA research the criteria to assess the trustworthiness of the research is founded on the principles of credibility, transferability, dependability and conformability. The researcher ensured credibility through prolonged engagement with the participants to identify and document recurrent and emerging features through adequate immersion and submersion in the research setting in order to enable recurrent patterns and themes to be identified and verified. Additionally credibility was enhanced through peer-debriefing and data triangulation. Additionally, participants were given an opportunity to verify the interpretations for accuracy and participants direct quotes have been included in the description of the findings.[30]. Transferability demonstrates the applicability of research findings to other populations. One strategy used to address the issue of transferability laid in the sample selection. In this case the researcher used the technique of purposive sampling whereby, informants living the experience under consideration were selected, leading to rich information and understanding of the phenomena under investigation to be applied to other populations (31, 52).

Dependability shows the consistency and the ability for the research to be repeated. Dependability has been achieved by providing a detailed report of the systematic process of the research with an audit trail, with raw data, data reduction and analysis products, data reconstruction and synthesis products, and process notes.

Confirmability which is the degree of neutrality or the extent to which the findings of a study are shaped by the respondents rather than the researcher's bias, motivation or interest were achieved by contextualizing the study within the broader literature on women's experience of exclusive breastfeeding (31,41).

3.7.4 Ethical Considerations

Ethics approval to conduct the study was obtained from the College of Medicine Research and Ethics Committee (COMREC) and the ethics number was P.03/20/3030. Permission was sought from Balaka DHO to conduct the study at his facility and allow his staff to participate in data collection.

3.7.8 Informed Consent and Confidentiality

The researcher sought informed consent from study participants. Informed consent is a 'process of negotiation' between the researcher and the study subjects, and not a 'one off action'. The consent seeking process was devoid of deception and exploitation. The study purpose, risks and benefits were explained (53). Participants were informed that participation in the study was voluntary and they signed a consent form for participation and were allowed to withdraw from the study at any time without any penalty. Additionally participants' information has been kept confidential and will not be used for any other purposes outside of this research project. Recorded interviews and filled interview guides were kept in a safe lockable drawer accessible only by the researcher.

3.7.9 Beneficence and Risks

Participants were informed that there are no direct or immediate benefits for taking

part in the study. It is however, envisaged that by studying the determinants of exclusive breastfeeding among women with children 0-6 weeks, this research's outcome may help to inform managers and health workers to come up with context specific interventions and strategies for promoting EBF in the district. Furthermore participants in the study were informed that the study entailed little or no risks at all for the subjects. There could have been little risk because some participants may have felt uncomfortable in sharing their lived or family breast feeding experiences with someone they did not know and especially that the researcher is male.

3.9.3 Participants Compensation

International guidelines and current best practice both indicate that structured remuneration of research participants is ethical and appropriate in Malawi. A review of the literature revealed that the underpinning rationale for remuneration is based on reimbursement of expenses and compensation for time and burden, but not as an incentive to participate (54). In 2018, researchers and regulators in Malawi proposed a standardized approach which used remuneration tables to calculate how much and for what purpose a participant should be compensated. The researcher remunerated participants based on those tables. Thus each participant got MK3, 700.00 broken down as follows subsistence MK1, 500.00, MK1, 000.00 of time in an 8 hour day (i.e MK1000/day and maximum contact time with participants is expected to be I hour) and transport amounting to MK 1,200.00 round trip for a 10 km distance (54).

CHAPTER 5 RESULTS PRESENTATION

5.1 Introduction

This chapter gives details of the results of this study. The results have been organized according to themes and begins with a brief description of key social demographic characteristics of the respondents. A total of forty respondents participated in the study. Table 1 presents socio demographic characteristics of the study participants. Most of the participants were females (n=32). Majority of the participants attended up to secondary education, two had no formal education and six had primary education whereas nurse/midwives and clinicians attended college education Table 1. The nurses and clinicians have worked at their post for more than a year. .

Table 1: Socio-Demographic characteristics of respondents

Characteristics	**Number**
Age	
Age range	17-62
Gender	
Male	8
Female	32
Marital Status	

Single	6
Married	28
Divorced	4
Widowed	2
Education	
None	2
Primary	6
Secondary	28
Tertiary	4
Tribe	
Chewa	9
Yao	14
Sena	1
Ngoni	7
Lhomwe	9
Religion	
Seventh Day Adventist	6
Roman Catholic	14
Islam CCAP	7 13

Table 2: Summary of results

Knowledge of exclusive breastfeeding	Most of the women, sisters, spouses and grandparents were aware of the importance of exclusive breastfeeding this was a good development because for the women to practice exclusive breastfeeding they had to be aware of the importance of exclusive breastfeeding. It was also very important for the sisters, spouses and grandparents to be aware of the importance of exclusive breastfeeding for them to be able to support the women. **"***My understanding of exclusive breastfeeding is that a woman should give her child breast milk only up until her child reaches six months. Breastfeeding should be frequent, don't wait for the child to cry first in order for you to breast feed him and don't allow many hours to pass without breastfeeding the child."* (Respondent 1, Breastfeeding Woman).
Perceptions towards exclusive breastfeeding	Participants, perceived breastfeeding as a natural thing to do. Most participants believed that exclusive breastfeeding is a must do natural thing for any woman who has given birth to a child. Respondents indicated having grown in a village where it is almost a cultural thing for a woman to breastfeed her child implying that breastfeeding was viewed as a social norm practiced and handed down from generation to generation with some thinking that there is no reason whatsoever that a woman should not exclusively breast feed her child *"Actually you can breast feed anytime and anywhere it doesn't matter, after all in my village all women breastfeed their children it is almost a natural thing for any woman to do so there*

is no reason whatsoever that a woman should not breast feed her child." (Respondent 8, Breastfeeding Woman)

Factors that promote exclusive breast feeding

The study found that women who were intrinsically motivated and those that had a good breastfeeding support system along the continuum of care practiced exclusive breastfeeding. The use of role models to motivate other women to practice EBF during health talks also motivated other women to practice EBF. Availability of BFHI and EBF policies acted as cues for health workers to re-enforce EBF among women. The breastfeeding support system in the continuum of care comprised of family members (Spouses, grandparents, mothers, sisters and health care workers)

"As a family we always support her to exclusively breast feed her child regardless of our religion and traditional beliefs. Actually religion and traditional beliefs do not hinder her from exclusively breastfeeding it's a thing of the past (for religion and traditional beliefs to hinder one from exclusively breast feeding." (Respondent 16, Sister)

Barriers to exclusive breastfeeding

Some of the respondents felt that HCWs assumed that they already knew how to breast feed as such they did not discuss with them about exclusive breastfeeding and possible problems that could arise from breastfeeding such as breast engorgement while others felt that breast milk was insufficient especially when one breast was engorged and the mother had to feed the child from one breast only. Some women did not know how to attach the baby to the breast resulting in poor

latching and sore nipples. This resulted in the women giving their children other foods and water within the six weeks period. HCWs also made decisions on behalf of the respondents on whether they should exclusively breast feed or not based on their own intuition about the condition of the mother and not necessarily based on professional knowledge. For example HCWs would advise a woman to stop practicing EBF if according to their assessment the woman was deemed malnourished or if the woman was HIV positive.

"At first I thought breastfeeding is a very simple thing to do I was not told that sometimes it can be a difficult thing to do. At the clinic they didn't tell me how to put my baby to the breast worse still when I put my baby to the breast there was no milk coming he kept sucking at the breast but there was no milk coming. To make matters worse my nipples became sore and my breast were getting engorged I didn't know what to do, nobody told me anything."(Respondent 22, Breastfeeding Woman)

Women's Experiences on Exclusive breastfeeding

Breastfeeding is considered as part of the biological process, where it is thought to be intuitive and based on the natural instinct of both the mother and her baby (30). This study found that the mothers determination, wanting to be a complete woman, the desire to strengthen the bond between the mother and her child as well as not knowing what to do when probably everyone else assumes that a mother should intuitively breastfeed as part of the natural process are some of the issues women go through in this apparently emotive biological journey of exclusive breastfeeding. The mothers described their feelings as happy, amazing and satisfying while others described their exclusive breastfeeding experience as the crowning jewel of motherhood that makes them feel complete as women

When I breastfeed my child I feel happy and enlightened the experience is very good, actually I made up my mind that I will exclusively breastfeed my child way before I even got pregnant. I do not have any physical, emotional or psychological problems that are interfering with breastfeeding even if I could have had physical, emotional or psychological problems I could still have exclusively breastfed my child." (Respondent 24, Breastfeeding Woman)

5.2 Knowledge of exclusive breastfeeding

Knowledge on the importance of exclusive breast feeding was assessed by asking the participants to explain what they know about exclusive breastfeeding. During the interviews, it was noted that most participants had knowledge of exclusive breastfeeding but some did not have or had obscure knowledge of exclusive breastfeeding. Most of the respondents heard about exclusive breastfeeding from nurses, other health workers, friends, care group volunteers and the radio. Some women were quoted as follows:

"*My understanding of exclusive breastfeeding is that a woman should give her child breast milk only up until her child reaches six months. Breastfeeding should be frequent, don't wait for the child to cry first in order for you to breast feed him and don't allow many hours to pass without breastfeeding the child."* (Respondent 1, Breastfeeding Woman).

"Exclusive breastfeeding means that the woman should not give water or any food to the child but breast milk only for 6 months after the six months have elapsed she should continue breastfeeding at the same time she should give the child additional foods and water because it is the child's right to be exclusively breastfed up to six months." (Respondent 2, Spouse)

Some few participants demonstrated lack of knowledge and had distorted information on the importance of exclusive breastfeeding were quoted as follow:

"Uuuuh uhuuuu I don't really know but I hear that it involves putting the child close to the mother so that the child's umbilicus should touch the mother's body while breastfeeding the child and the mother should not use soap when bathing the child and should also not use body lotion on the

child. This is what I did with my daughter when she was born she should also do the same with my grandson so that he should become healthy." (Respondent 3, Grandmother)

"Exclusive breast feeding means talking to the child and showing him love when he is breastfeeding so that he grows healthy actually it means the breast is the child's food ." Respondent 4, Grandmother)

5.3 Source of information

The study sought to establish the source of information about EBF. The study participants had different sources of information which included friends, nurses, and radio and care group volunteers. Some of the participants were quoted as follows.

*"I heard about exclusive breastfeeding from my friends who got pregnant and had children before me." (*Respondent 5, Breastfeeding Woman?)

"I heard about exclusive breastfeeding from care group volunteers in my village and nurses from the hospital." (Respondent 6, Breastfeeding Woman)

5.4 Perceptions towards exclusive breast feeding

The study assessed women's perception towards exclusive breastfeeding. The following three themes emerged from the data: A natural thing to do; the best thing a woman can do and; breastfeeding as beneficial.

5.4.1 A Natural thing to do

Most participants believed that breastfeeding is a natural thing for any woman who has given birth to do and that there is no reason whatsoever that a woman should not exclusively breast feed her child and that breast milk is clean and soothes the baby. Some of the women were quoted as follow: *"It is something natural and easy to do, you just latch the baby to the breast and you begin Breastfeeding."* (Respondent 7, Breastfeeding Woman)

"Actually you can breast feed anytime and anywhere it doesn't matter, after all in my village all women breastfeed their children it is almost a natural thing for any woman to do so there is no reason whatsoever that a woman should not breast feed her child." (Respondent 8, Breastfeeding Woman)

"I feel happy that I am breastfeeding because when my child breastfeeds and gets full he doesn't give me problems he sleeps soundly. Breastfeeding soothes him and breast milk is clean and hygienic." (Respondent 9, Breastfeeding Woman)

5.4.2 The best thing a woman can do

Some participants in the study believed that breastfeeding is the best thing a woman can do for her child since breast milk offers protection from diseases and helps the child to grow healthy and were quoted as follows:

"When I escorted my wife for antenatal clinic services during the pregnancy of our current child the nurse at the clinic said that we should give our child breast milk only for him to grow healthy

and be protected from diseases. So I think that exclusive breastfeeding is the best thing a woman can do for her child." (Respondent 10, Spouse)

5.4.3. Breast feeding as beneficial

Most participants viewed breastfeeding as beneficial for the child since breast milk is readily available, not contaminated and does not require rigorous preparation and that it provides immunity for the child. Other believed that exclusively breastfeeding a child for six month prevents the woman from getting pregnant and helps the child to grow very healthy and prevents stunting. Below are some quotes to support this view.

"I believe that exclusive breast feeding is good because during discharge from the postnatal ward the nurse told me that breast milk doesn't get contaminated or go bad ,breast milk is always readily available for use it doesn't require rigorous preparation it is the best food for the child. The first milk (Colostrum) that comes from the breast gives the child immunity to fight against diseases it's like immunizing the child against diseases."(Respondent 11, Breastfeeding Woman)

"Exclusive breastfeeding is good for the child because breast milk alone is adequate food for the child for the first six months. When we compare the children that are born now and those that were born in the past by our parents the current children are healthy and tall while those born in the past were stunted I think this is because the children being born now are exclusively breastfed un like those born in the past."(Respondent 12, Sister)

"During discharge of my granddaughter, the nurses at the post natal clinic told me that breast milk is adequate for the child's nutrition and that it has everything that the child needs for his growth, whatever we eat the child eats the same through breast milk it is warm and has vitamins and water necessary for the child's growth so I think exclusive breastfeeding is very good for my granddaughters son."(Respondent 13, Grandmother)

5.5 Factors that promote exclusive breast feeding

The study assessed the factors that promote EBF and three main themes emerged from the data. The themes are: Breast feeding support; mother's motivation; role modelling and policy as an enabler.

5.5.1. Breast feeding support

Some participants indicated that support from family members such as their mother, husband, sister, grandmother and nurses motivated them to practice EBF. Some women reported as follow:

"My mother is very supportive of me when I have a problem or when I am worried about exclusive breastfeeding she helps me with it. My mother is very experienced she breastfed all of us (her children) she teaches me how to put my child to the breast."(Respondent 14, Breastfeeding Woman)

"Nurses have been motivating me to exclusively breast feed actually when I have any problems related to breastfeeding I always consult the nurse. She is trained and well qualified to handle my issues."(Respondent 15, Breastfeeding Woman)

"As a family we always support her to exclusively breast feed her child regardless of our religion and traditional beliefs. Actually religion and traditional beliefs do not hinder her from exclusively breastfeeding it's a thing of the past (for religion and traditional beliefs to hinder one from exclusively breast feeding." (Respondent 16, Sister)

5.5.2 Mothers motivation

When probed on factors that motivate women to breastfeed most indicated that that they wanted the best for their child. One respondent explained:

"I am motivated to exclusively breast feed my child because I want the best for her I don't want her to be stunted .I was told during antenatal clinic services that children who are exclusively breastfed grow very healthy don't get stunted and become intelligent and strong." (Respondent 17, Breastfeeding woman)

"If a woman has been given quality EBF education including disadvantages of not practicing EBF she gets motivated to practice EBF but when the women are left alone and EBF education has not been done the women don't practice EBF."(Respondent 18, HCW)

5.5.3 Role models

One of the health workers when asked about what motivates women to practice exclusive breastfeeding had this to say:

"After teaching the women about EBF during health talks we ask other women who successfully practice EBF to witness or talk about how EBF has helped their children to grow healthy. The other women are then motivated to practice EBF after seeing and learning from their colleagues how EBF has benefitted them."(Respondent 19, HCW)

5.5.4 Policy as an enabler

When health workers were asked whether Balaka District Hospital as a designated BFHI facility has breastfeeding policies and guideline that support breastfeeding they indicated that the policies are available. Some of the respondents explained:

"Policies and guidelines are available in the consultation room, antenatal and postnatal wards, it starts with antenatal education when a woman is pregnant the woman is taught to start EBF before 30 minutes elapses after giving birth and when the woman is transferred to the postnatal ward from labor ward she is advised to continue practicing EBF without giving any other foods other than breast milk and upon discharge she is given the same guidance on EBF as was done during labor ward and postnatal ward and the same is repeated when the woman comes for postnatal checks after six weeks and she is reminded about EBF or she is asked about her EBF practices." (Respondent 20, HCW)

"We have BFHI and breastfeeding policies kept at the stores and antenatal .When the policies were introduced we read them to staff members but because of being busy I don't

think staff read the policies on their own. But after reading the policy to staff they picked what is new and they are teaching such things to the women. I am sure that staff are teaching women about EBF according

to the policy because when I do supervisions I hear staff teach women stuff that is in the policy."

(Respondent 21, HCW)

5.6 Barriers of exclusive breastfeeding

Regarding barriers to EBF five themes emerged: Mothers agency; lack of involvement of significant others; health care worker decisions; social economic factors and policy implementation.

5.6.1 Mothers agency

Some of the respondents felt that health care workers assumed that they already knew how to breast feed and attach their children to the breast as such they did not discuss with them possible problems that could arise from breastfeeding. Health care workers also made decisions on behalf of the respondents on whether they should exclusively breast feed or not. Some of the respondents had this to say:

"At first I thought breastfeeding is a very simple thing to do I was not told that sometimes it can be a difficult thing to do. At the clinic they didn't tell me how to put my baby to the breast worse still when I put my baby to the breast there was no milk coming he kept sucking at the breast but there was no milk coming. To make matters worse my nipples became sore and my breast were getting engorged I didn't know what to do, nobody told me anything."(Respondent 22, Breastfeeding Woman)

"She was breastfed but not exclusively because one of the breasts got swollen and we

thought milk from one breast is not enough therefore we started giving him other foods. Spouse 1
Lack of knowledge affects how a mother practices EBF greatly. If a person knows the importance of EBF it is easy for a woman to practice EBF."(Respondent 23, Breastfeeding Woman)

5.6.2 Lack of involvement of significant others

Some of the HCW interviewed believed that involving significant others including husbands in health education sessions or counselling during discharge of postnatal mothers would help in re- enforcing EBF practice at home and had this to say:

"I have never seen a male partner or husband being involved in EBF health education sessions during discharge of a postnatal mother where the spouse is counselled together with the woman on EBF even guardians of the postnatal women are not involved during counselling conducted at the time of discharge. During discharge the focus for EBF education is the postnatal woman anly nobody else is involved. Involving significant others would help to re-enforce EBF practice at home as the woman would be reminded to practice it." (Respondent 18, Health Care Worker)

5.6.3 Health Care Worker decisions

The study has demonstrated that HCWs sometimes make decisions based on their own intuition contrary to professional standards and guidelines. Some HCWs reported as follows:

"We ,the health workers decide whether the woman practices EBF or not depending on

our assessment of the condition of the mother for example during postnatal checkup when the woman is deemed malnourished we advise the woman to give the child other foods because the woman may not produce enough milk because she is malnourished so we advise the woman to give porridge to the child so too when the woman is HIV positive we tell the woman to give other foods to the child especially when the woman looks sickly and weak." (Respondent 20, HCW)

5.6.4 Socio-economic status

Poor socio-economic status of a breastfeeding mother including not having a partner influences her EBF behavior in the sense that she does not practice EBF since she also has to engage in other livelihood activities, one of the respondents had this to say:

*"I have also observed that single mothers do not practice EBF because they are engaged in other livelihood and household chores so it becomes difficult for the woman to focus on EBF but if the woman had a partner the partner would have been helping her with other chores including reminding her to do EBF." (*Respondent 18, HCW)

"Some women do not practice EBF because they have to do gardening and other chores to earn a living because of poverty hence they do not practice EBF." (Respondent 21, HCW)

5.6.5 Policy implementation

BFHI and breastfeeding policies are available but HCWs don't read and apply that knowledge in clinical practice. Furthermore BFHI trainings were conducted but implementation is poor. Some HCW reported as follows:

"We have both the guidelines and the policy, the policy is in form of a booklet both the policy and

guidelines are available in the ward. The guidelines are pasted on the walls in paper form but the challenge is that health workers don't utilize the policy and guidelines it is just like for decoration
people don't read them as such they don't apply what the policy and guidelines say in clinical practice." (Respondent 19, HCW)

"BFHI and breastfeeding policies are not being implemented despite the BFHI Coordinator training nurses and other cadres in various wards on the BFHI, its implementation has been difficult and ward in charges are not re-enforcing implementation of the policies. Policies are available and trainings have been conducted but implementation is poor. For one to know if things are on track and if mothers are complying to EBF standards there is need for regular ward supervision at least every two weeks to check how implementation is going on but this is not being done if there is supervision at all then it is after a very long period of time." (Respondent 18, HCW)

5.0 Women's experiences of breastfeeding

The study revealed four themes on women's experiences with EBF. The themes are: Self-determination; A sense of being complete; bonding and not knowing what to do. The themes demonstrate the women's individual emotional journey and description of their experience of breastfeeding.

5.7.1 Mothers determination

The study has demonstrated that a mother's determination is vital for effective EBF practices. One of the participants in the study had this to say:

"When I breastfeed my child I feel happy and enlightened the experience is very good,

actually I made up my mind that I will exclusively breastfeed my child way before I even got pregnant. I do not have any physical, emotional or psychological problems that are interfering with breastfeeding even if I could have had physical, emotional or psychological problems I could still have exclusively breastfed my child." (Respondent 24, Breastfeeding Woman)

5.7.2 A sense of being complete

For most women breastfeeding is acknowledged as a responsibility in fulfilling their basic role as mothers and caring for their children which makes them feel complete. Some women had this to say:

"Breastfeeding my child makes me feel complete as a woman actually breastfeeding is the crowning jewel of womanhood."(Respondent 25, Breastfeeding Woman)

"For me I think breastfeeding is the best for my baby. It's an opportunity for me to take care of him and I feel happy about that because I believe it's a good thing for him". (Respondent 26, Breastfeeding Woman)

"Breast feeding one's child is the best thing any woman can do. It is an empowering experience and it gives me feelings of contentment, I feel satisfied." (Respondent 27, Breastfeeding Woman)

5.7.3 Bonding

Breastfeeding has been known to promote bonding between a mother and her child and this has also been reflected in this study and one of the participants reported as follows:

"When I look at his face while breastfeeding him I feel very happy the bond between me and him grows strong each time I breastfeed him. It is amazing that you can actually feed

somebody else from your own body." (Respondent 28, *Breastfeeding Woman*)

5.7.4 Not knowing what to do

Although EBF is seen merely as an intuitive biological process based on the natural instinct of both the mother and her baby, the mother's knowledge and agency are vital for successful EBF

.Some of the respondents reported as follows:

"Immediately after my son was born the nurse put him on my chest and told me to hold him. I was afraid I didn't know what to do, it was my first time to give birth and I was very exhausted." (Respondent 29, Breastfeeding Woman)

CHAPTER 6: DISCUSSION OF RESULTS

This chapter discusses the findings of the study .The aim of this study was to explore the determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district and specifically sought to explore the level of knowledge of respondents on the importance of exclusive breastfeeding, perceptions towards exclusive breast feeding, factors that promote exclusive breast feeding, barriers of exclusive breastfeeding and to describe the breastfeeding experiences of mothers with children aged 0-6 weeks. A discussion of results will be presented according to themes.

6.1 Overarching themes

6.1.1 Exclusive breastfeeding support

The exclusive breastfeeding experiences of the respondents in this study was multifaceted. Drawing on the inductive approach of thematic analysis and idiographic, hermeneutic and phenomenological interpretations, the interpretive findings suggest that successful exclusive breastfeeding is dependent on a complex interplay of factors such as mothers agency, health worker factors, socio-economic factors and support from significant others (30,32,34,35,36,37). The women portrayed that if they can be supported along the continuum of care from the hospital to home through proper health education combining theory of EBF and practical lessons on how to attach and latch the baby to the breast and health education on potential problems associated with breastfeeding such as breast engorgement or sore nipples they could have practiced EBF since they would have known

how to prevent such problems from occurring and misconceptions of breast milk insufficiency would have been cleared. Additionally they have also demonstrated that emotional support and encouragement to practice EBF from family members, HCW enhances EBF practice (30, 32, 34, 35, 36, 37). Hence we can interpret that EBF support systems along the continuum of care are a critical success factor for women to practice EBF as an overarching theme clustering all the other themes (See appendix 15).

6.1.2 Knowledge of exclusive breastfeeding

Most of the women, sisters, spouses and grandparents were aware of the importance of exclusive breastfeeding this was a good development because for the women to practice exclusive breastfeeding they had to be aware of the importance of exclusive breastfeeding. It was also very important for the sisters, spouses and grandparents to be aware of the importance of exclusive breastfeeding for them to be able to support the women. These findings resonate well with studies from Pakistan, Nepal and India which showed that participants (sisters, spouses and grandparents) who had adequate knowledge about the importance of EBF viewed exclusive breastfeeding favorably (26).Some of the grandparents were not aware of the importance of exclusive breastfeeding to the baby and mother. This resonates with findings from another study conducted in Ghana on family belief systems and practices that influence exclusive breastfeeding where lack of knowledge had negative influences on EBF practices (36). This agrees with findings of a study on breastfeeding knowledge and practices among mothers of children under 2 years of age living in a military barrack in Southwest Nigeria which showed that knowledge was significantly associated with positive breastfeeding practices while little knowledge was associated with pre- lacteal and bottle feeding (27). However studies conducted in Gwanda

community in Zimbabwe showed that despite women being highly knowledgeable on EBF practices, its practice was very low. This finding was similar to a study in Nigeria where EBF knowledge was high (82%) but the EBF rate was low (33.5%).This finding shows that having the knowledge of EBF does not necessarily translate to EBF practice (28).

The source of information about exclusive breastfeeding was nurses/doctors, friends, radio and care group volunteers. Those who knew about EBF through nurses/doctors heard about EBF during antenatal clinic services and during postnatal discharge. The findings resonate with the Indian study on perceptions and practices regarding breastfeeding among postnatal women at a district tertiary referral government hospital (26) as well as the South African systematic review on exclusive breastfeeding policy, practice and influences (32).

6.1.3 Perceptions towards exclusive breastfeeding

From the narrative account of the participants, breastfeeding was identified as a natural thing to do. Most participants believed that exclusive breastfeeding is a must do natural thing for any woman who has given birth to a child. Respondents indicated having grown in a village where it is almost a cultural thing for a woman to breastfeed her child implying that breastfeeding was viewed as a social norm practiced and handed down from generation to generation with some thinking that there is no reason whatsoever that a woman should not exclusively breast feed her child. This line of thought resonates with findings of a study on the lived experiences of first-time breastfeeding women in Ghana (30). Some participants believed that exclusive breast feeding is the best thing that a woman can do for her child which resonates with the Ghanaian study mentioned in the preceding sentence where women associated exclusive breastfeeding with good

motherhood (30).Most participants viewed exclusive breastfeeding as beneficial for the child since breast milk is readily available, not contaminated and does not require rigorous preparation and that it provides immunity for the child while others said that exclusively breastfeeding a child for six month prevents the woman from getting pregnant and helps the child to grow very healthy and prevents stunting. The results are similar to findings of a study on perceptions and practices regarding breastfeeding among postnatal women at a district tertiary referral government hospital in southern India where the women believed that exclusive breastfeeding is nutritious protects the child from diseases and helps the child to grow very healthy (26).

6.2 Factors that promote exclusive breast feeding

The study found that women who were intrinsically motivated and those that had a good breastfeeding support system along the continuum of care practiced exclusive breastfeeding. The use of role models to motivate other women to practice EBF during health talks also motivated other women to practice EBF. Availability of BFHI and EBF policies acted as cues for health workers to re-enforce EBF among women. The breastfeeding support system in the continuum of care comprised of family members (Spouses, grandparents, mothers, sisters and health care workers).The results contradict findings from a study on the influence of fathers' socioeconomic status and paternity leave on breastfeeding duration in Sweden where fathers did not support their wives in exclusive breast-feeding but used their role as family heads to control feeding practices

in the family and fathers believed that breast milk is mainly liquid and not heavy nor nutritious enough for the baby's optimal growth and development (33).Results from this study however agree with findings from another study in Ghana on the lived experiences of

first time breastfeeding women which found that the women highly valued the support and advice they received from family members as enabling and encouraging successful exclusive breastfeeding practices (30). This also resonates with findings from another study on exclusive breastfeeding and family influences in rural Ghana where women who were supported by family, community support groups and nurses practiced EBF (56).The study also found out that the use of women who successfully practiced EBF (Role models) during EBF health education sessions motivates other women to practice EBF. This finding is consistent with findings from a systematic review of facilitators and barriers of exclusive breastfeeding practice in Sub-Saharan Africa where a mother becomes an advocator of exclusive breastfeeding and discourages other mothers from giving water during the first six months because from her own EBF experience her elder child fell ill often when she mixed exclusive breastfeeding and giving of other foods and water but when she gave breast milk only the child did not fall sick frequently. This motivated her to give breast milk only with no other substitute when she had her second child (37). This study also found out that after orienting staff on the BFHI and breastfeeding policies some health workers were teaching women about EBF according to the policy guidelines hence the policy acts as an enabler and cue for promoting EBF education for women attending postnatal clinic services which is consistent with findings of a study conducted in South Africa (32).

6.3 Barriers to exclusive breastfeeding

Some of the respondents felt that HCWs assumed that they already knew how to breast feed as such they did not discuss with them about exclusive breastfeeding and possible problems that could arise from breastfeeding such as breast engorgement while others felt

that breast milk was insufficient especially when one breast was engorged and the mother had to feed the child from one breast only. Some women did not know how to attach the baby to the breast resulting in poor latching and sore nipples. This resulted in the women giving their children other foods and water within the six weeks period. HCWs also made decisions on behalf of the respondents on whether they should exclusively breast feed or not based on their own intuition about the condition of the mother and not necessarily based on professional knowledge. For example HCWs would advise a woman to stop practicing EBF if according to their assessment the woman was deemed malnourished or if the woman was HIV positive. This is contrary to the WHO recommendation that HIV-exposed infants in low-resource settings be exclusively breastfed for 6 months and that EBF be combined with complementary feeding from age 6 to 12 months. The results of this study also echoes findings of another study on barriers to EBF among HIV-positive mothers in sub- Saharan Africa where it was found that HCWs gave adapted messages based on what they believed to be the best feeding choice for mothers and that a significant number of HCWs, including those with relevant training, presented the possibility of mother to child transmission of HIV through breastfeeding as a certainty and not a risk, resulting in infant feeding counselling that downplayed EBF (37).

Findings from this study were also consistent with findings of a study conducted in Sub-Saharan Africa on facilitators and barriers of exclusive breast feeding which showed that breast engorgement, sore nipples , perceptions of breast milk insufficiency and lack of knowledge on EBF lead to mothers giving their children other foods within the first six weeks of life (37).This study also revealed that despite having the BFHI and breastfeeding policies HCW don't read them and as such don't apply the policies in clinical practice.

This is consistent with finding of another study conducted in Sub-Saharan Africa where EBF policies are available but are not applied or HCW give contrary instructions to established guidelines (37).This study has also revealed that socio economic factors such as poverty and being a single mother contributes to failure for women to practice exclusive breast feeding as the women have to engage in other livelihood activities. This finding is consistent with results of another study on facilitators and barriers of EBF in Sub Saharan Africa which found that women who were financially dependent on a family member were more likely to practice mixed feeding (37).

6.4 Women's Experiences on Exclusive breastfeeding

Breastfeeding is considered as part of the biological process, where it is thought to be intuitive and based on the natural instinct of both the mother and her baby (30). This study found that the mothers determination, wanting to be a complete woman, the desire to strengthen the bond between the mother and her child as well as not knowing what to do when probably everyone else assumes that a mother should intuitively breastfeed as part of the natural process are some of the issues women go through in this apparently emotive biological journey of exclusive breastfeeding. The mothers described their feelings as happy, amazing and satisfying while others described their exclusive breastfeeding experience as the crowning jewel of motherhood that makes them feel complete as women. Yet others felt it was the best thing any woman can do and described the experience as empowering. The findings are similar to those of a study done on lived experiences of first-time breastfeeding women in Ghana (30). Feelings of being empowered or of being a complete woman or having a sense of satisfaction could have contributed to the women's determination to exclusively breastfeed their children while

the state of not knowing what to do when probably everyone else assumes that a mother should intuitively breastfeed as part of the natural process could have contributed to some women not exclusively breastfeeding their children.

6.5 Limitations

Participants were recruited from villages surrounding Balaka District Hospital within Balaka Township. This may have resulted in leaving out views, experiences and perceptions of populations in more remote areas of the district. Nonetheless the study being qualitative in nature provided an in-depth understanding of the determinants of exclusive breastfeeding in the district. There is no reason to believe that the study participants differed significantly from others in more rural areas of the district since Balaka district itself is generally considered a rural area as a whole.

CHAPTER 7 CONCLUSION AND RECOMMENDATION

This chapter presents the conclusions and recommendations of this study.

7.1 Conclusion

Exploring the determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district helped to identify themes and subthemes that offered insight into the phenomenon of exclusive breastfeeding. The findings have challenged the widely held notion that exclusive breastfeeding is merely an intuitive biological process based on the natural instinct of both the mother and her baby but rather that successful exclusive breastfeeding is dependent on a complex interplay of factors such as mothers agency, HCW factors, socio-economic factors and support from significant others. Hence we can conclude that the phenomenon conceptualizes that EBF support systems along the continuum of care are a critical success factor for women to practice EBF.

7.2 Recommendations

The results of this study have public health implications that are crucial for practice, policy and research for implementers and program planners seeking to promote optimal exclusive breastfeeding.

7.2.1 Recommendations for practice

- HCW should provide reliable information based on scientific professional knowledge and not based on their own biased intuition. This will help to reduce misinformation propagated by HCW which is counterproductive for practicing optimal EBF.
- Nurses, midwives and other HCWs should provide practical demonstrations of

breastfeeding in order to re-enforce theory on exclusive breastfeeding with practice. Evidence has shown that people remember more what they see and have practice on than when they just hear about something.

- Nurses, midwives and other HCWs should not assume that by just being a woman then a mother knows how to breastfeed and should also teach all mothers about possible exclusive breast feeding challenges that they may encounter along the way and how to handle the challenges .This will help to capacitate the agency of the women to handle such problems when they occur and seek health care promptly (43).
- Nurses, midwives and other HCWs should also involve significant others (either a spouse, sister, mother or grandparent) when counselling a woman on exclusive breastfeeding during discharge from the postnatal ward in order for the significant other to remind and assist the breastfeeding woman.
- Regular supervision should albe conducted in order to ensure implementation fidelity of the BFHI and breastfeeding policies in the clinical area (32, 36).

7.2.2 Recommendations for policy

- Strengthen community based support systems for breastfeeding by revamping community based maternal and newborn care initiatives and form or revamp mother care groups to follow up and provide health education support and counselling to the women during household visit which will be conducted when the women are pregnant and after they have delivered.
- Allocate more resources for outreach clinic services in hard to reach areas in order to increase access to services for breastfeeding women during which their challenges associated with EBF can be addressed.

- Link women to safety nets such social cash transfer and village banks to uplift their social economic status since studies have shown that women with poor socio-economic status fail to practice EBF (32, 56).

7.2.3 Recommendations for research

- Conduct more research on paternal support for exclusive breastfeeding in order to explore the perception of fathers towards supporting EBF in order to leverage the information in enhancing promotion of EBF.
- Conduct studies on effectiveness of EBF education during antenatal and the postnatal period in enhancing exclusive breastfeeding practices in order to use that information to re-design the approach and messaging if there will be gaps identified in such areas.
- Conduct implementation research on the implementation of BFHI and the breastfeeding policy to assess fidelity which will help to inform gaps or strengths which should be addressed or maintained respectively.

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APPENDICES

Appendix 1: FGD Informed Consent form English

My name is Blessings Njolomole; I am conducting this study in partial fulfillment of the requirements for the award of a Master's degree in Global Health Implementation. I seek your consent to participate in this study. The aim of the study is to explore determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka District. The information you will provide will be kept confidential and your identity will be kept anonymous. Recorded interviews and filled interview guides will only be used for purposes of this research and will be kept in safe lockable drawers accessible only by the researcher. No monetary incentives will be given for your participation in the research likewise you will not be penalized for refusing to participate or for withdrawing after enrolling in the study. There may be no direct benefits for taking part in this study. However, there is a possibility that information gained from the study will help to inform managers and health workers to come up with context specific interventions and strategies to promote EBF. The note taker will be recording information from our discussion so that we do not miss any important points. The interview may take about one hour. Are you willing to participate in the FGD?

(If Respondent agrees), Thank you so much for accepting. *(Ask respondent to sign below).*

Respondent Name.....Respondent Signature:…….

Name of Investigator:…….Signature of investigator: ……

Appendix 2: FGD Interview Guide for Women with Children 0-6 Weeks

My name is Blessings Njolomole, and I am conducting this study in partial fulfillment of the requirements for the award of a Master's degree in Global Health Implementation. The aim of the study is to identify barriers to exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district.

Please answer the questions truthfully and freely. All the information provided will be kept strictly confidential, and will be used for research purposes only. Your names are not required and multiple answers are allowed where applicable. Thank you.

Age…….Male……Female……Religion……

Part 1: Knowledge on the importance of Exclusive Breast Feeding

Now we will discuss about exclusive breastfeeding (EBF).

1. Tell me what you know about EBF.
2. What type of food did you give your child in the first three days after birth (Why)
3. For how long should a baby be exclusively breastfed? (Probe length of period and why)
4. What are the benefits of EBF?
5. Tell me how you knew about EBF and all the other information that you have provided

Part 2: Perceptions towards Exclusive Breastfeeding

We have just talked about EBF. Now I would like to ask you a few more questions just to understand better a few things that we already discussed as well as your perceptions on EBF.

1. Are you happy that you are exclusively breastfeeding your child?
2. In general, what can you say about EBF? (Probe for more Information)
3. What do you think is the best to give a newborn to eat? Probe why
4. What do you think about the first milk that comes? Probe should a nursing mother breast feed

her newborn child the first milk that comes? Probe for reasons why/why not)

5. Would you say that breast milk alone is adequate for a child's nutrition? Probe why

6. Is there any circumstance under which a mother should not exclusively breastfeed a baby?

Part 3: Factors that Promote Exclusive Breastfeeding

1. Think back to the instance you started EBF, what has been motivating you to exclusively breastfeed your baby? Probe for more information on family, social support systems and religion

2. Have you talked to anyone if you had a question or worry about exclusively breastfeeding your child? Probe more, who did you talk to, what did you talk about, what advise was given, did you take the advice and what did you say

3. Tell me who is the best person to talk to if you have a question or worry about exclusive breastfeeding? Probe who and why that person?

Part 4: Barriers to Exclusive Breastfeeding

We have discussed factors that promote EBF practices now I would like to learn more from you about what hinders you from practicing EBF

1. Explain to me in detail how your day was like yesterday (Probe more for mother's activities and length of time activities took 30 minutes, 1 hour, 2 hours etc, where was the baby during this time?).

2. Now tell me is there a point in time you felt you should not exclusively breastfeed (Probe more, what were the reasons for not exclusively breastfeeding?

3. Generally what would you say are the things that make it difficult for you to exclusively breastfeed? Probe more on family influences, social support systems, beliefs and religion.

4. Has anyone ever discouraged you or tried to prevent you from practicing EBF? (Probe

more- who is that person? What did they say or do to discourage her what did she do in response)

Appendix 3: IDI Guide on Exclusive breastfeeding experiences for Women with Children 0- 6 weeks

Now I would like you to tell me what you have experienced while breastfeeding your child (Probe more on her agency to breastfeed her child, any physical, emotional or psychological difficulties during breastfeeding? How does she feel about breastfeeding?)

Appendix 4: Chilolezo cha zokambilana za pa gulu kwa otenga Mbali mu Kafukufuku

Ine ndine Blessings Njolomole wophunzira pa sukulu ya za ukachenjede ku sukulu ya za udotolo ya College of Medicine.Ndikuchita kafukufuku yemwe cholinga chake ndi kufuna kuwunika zomwe zimachititsa kuti azimayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi ayamwitse mwakathithi.Zotsatira za kafukufukuyu zitha kuthandizira kupeza mayankho a zomwe zimalepheletsa kuti azimayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi alephere kuyamwitsa mwakathithi.

Kutenga nawo mbali mu kafukufukuyu sikokakamiza ndipo muli ndi ufulu kusiya kutenga nawo mbali nthawi ina ili yonse ngati mungafune kutero. Palibe chilango china chili chonse chomwe chingabwere chifukwa chokana kutenga nawo mbali mu kafukufukuyu. Zokambilanazi zilembedwa komanso kujambulidwa pa tepi ndi cholinga choti tisaphonye china chili chonse chomwe chinganenedwe. Zokambilara zonse zikhala zachinsinsi ndipo maina anu sazatchulidwa

kapena kulembedwa.Zokambilaranazi zitha kutenga ora limodzi.Mwavomera kutenga nawo mbali mu kafukufukuyu?

Ngati avomera athokozeni ndipo asayine mmusimu

Dzina la otenga mbali: …….. Saini ya otenga mbali ……..

Dzina la ochita kafukufuku: ……Saini ya ochita kafukufuku…….

Appendix 5: Namulondola wa Zokambilana za pa Gulu ndi Azimayi oyamwitsa

Ine ndine Blessings Njolomole, ndikuchita kafukufukuyu pokwaniritsa zofunikira pa maphunziro aza ukadaulo ndi cholinga chofuna kudziwa zimene zimalepheretsa amayi omwe ali ndi ana a masabata asanu ndi imodzi omwe amabwera ku sikelo ya katemera wa amayi omwe atha sabata zisanu ndi imodzi chibelekereni kulephera kuyamwitsa ana awo mwakathithi.

Chonde khalani omasuka kuyankha mafunso onse moonadi ndipo zonse zomwe tikambilane zisungidwa mwa chinsinsi ndipo zidzagwilitsidwa ntchito pa zinthu zokhudza kafukufuku basi sitilemba maina anu komanso funso limodzi likhoza kukhala ndi mayankho osiyana siyana.Zikomo kwambiri.

Zaka…….Mamuna……Mkazi……Chipembedzo……

Gawo Loyamba: Zomwe amadziwa za Kuyamwitsa Mwakathithi

Tsopano tikambilana za kuyamwitsa mwakathithi

1. Ndilongosoleleni zomwe mumadziwa za kuyamwitsa mwakathithi
2. Kodi mwana wanu munamupatsa chani masiku atatu oyambilira atangobadwa kumene nanga ndi chifukwa chani?
3. Kodi mwana amayenera kuyamwa mwakathithi kwa nthawi yaitali bwanji? Nanga ndi chifukwa chani amayenera kutero.
4. Nanga ubwino wa kuyamwitsa mwa kathithi ndi otani?
5. Kodi za kuyamwitsa mwa kathithi komanso zonse zimene mwalongosolazi munazidziwa kuchokera kwa ndani?

Gawo Lachiwiri: Malingaliro awo pa za Kuyamwitsa Mwakathithi

Tsopano ndi kufunsani mafunso okhudzana ndi mmene mumaonera nkhani zakuyamwitsa mwakathithi

1. Munganenepo chani zokhudzana ndi kuyamwitsa mwa kathithi?

2. Kodi ndiinu okondwa kamba koti mukuyamwitsa mwakathithi?

3. Kodi chakudya chabwino kumpatsa mwana ongobadwa kumenene ndi chiti? Nanga ndi chifukwa chani?

4. Nanga mkaka oyamba kutuluka mmawere mumauona bwanji?

4. Mukuganiza kuti mkaka wa mmawere ndiwokwanira kukhala chakudya chokhacho cha mwana wanu?

5. Kodi ndi pa zifukwa ziti zimene mayi sayenera kuyamwitsa mwana mwakathithi

Gawo Lachitatu: Zomwe zimathindizira kuti Mayi athe Kuyamwitsa Mwakathithi

1. Chiyambileni kuyamwitsa mwakathithi ndi ziti zomwe zakhala zikukulimbikitsani kuti muziyamwitsa mwakathithi? Fufuzani za zolimbikitsa zokhudza ku banja,anthu okhalanawo mu dera,chipembedzo ndi zikhulupiliro za anthu a mderalo

2. Kodi munalankhulanapo ndi munthu wina aliyense panthawi imene munali ndi mafunso kapena nkhawa zokhudzana ndi kuyamwitsa mwakathithi? Munamufunsa kapena munalankhulanapo ndi ndani? Munakambilana zotani?Anapeleka malangizo otani?Kodi nanga munamvera malangizowo?Nanga inu munanepo zotani pa nkhaniyi?

3. Mukuganiza kuti munthu oyenera kumufunsa kapena kulankhulana naye mukakhala ndi nkhawa zokhudza kuyamwitsa mwakathithi ndi ndani? Nanga mchifukwa ninji mungamufunse kapena kulankhulana ndi munthu ameneyo

Gawo Lachinayi: Zomwe zimalepheletsa kuti Mayi Asayamwitse Mwakathithi

Takambilana zina mwa zomwe zimakulimbikitsani kuyamwitsa mwakathithi tsopano ndikufuna kudziwa kuchokera kwa inu zina zomwe zimakulepheletsani kuti muyamwitse mwakathithi.

1. Ndikufuna mundilongosolere kodi kutangocha dzulo mumapanga/kugwira ntchito zanji? Funsitsitsani: Ntchitozo/kapena zimene amapangazo zinatenga nthawi yaitali bwanji- theka la ora, ora limodzi, ma ora awiri etc.

2. Kodi ilipo nthawi imene inu munaganizapo kuti musayamwitse mwakathithi? Funsitsitsani: Inali nthawi iti nanga zifukwa zake zinali zotani?

3. Tatiuzeni ndi zinthu ziti zomwe zimakulepheletsani kuti muyamwitse mwakathithi? Fufuzani za zimenene mayi amachita, akubanja,zikhulupiliro,chipembedzo)

4. Potsiliza ndikufuna kudziwa ngati alipo amene anakugwetsanipo mphwayi kapena kukuletsanipo/kuyesera kukulepheletsani kuti musayamwitse mwakathithi? Munthuyo ndi ndani?Analankhula kapena kuchita zotani kuti akugwetseni mphwayi kapena kukulepheletsani kuti musayamwitse mwakathithi.

Appendix 6: Namulondola wa Zokambirana ndi Azimayi Oyamwitsa Payekha payekha

Tsopano ndikufuna mundilongosolere momwe mwakhudzidwila kapena zomwe mwakumana nazo kamba kakuyamwitsa mwana wanu mwakathithi (Fufuzani za upangili ndi kuthekera kwawo pakuyamwitsa,fufuzaninso za zotsamwitsa zaku thupi komanso zokhumudwitsa za mmaganizo ndi zina.

Appendix 7: Informed Consent form for Significant Others' (Spouses, Grand Parents and Siblings) English

My name is Blessings Njolomole; I am conducting this study in partial fulfillment of the requirements for the award of a Master's degree in Global Health Implementation. I seek your consent to participate in this study. The aim of the study is to explore determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka District. The information you will provide will be kept confidential and your identity will be kept anonymous. Recorded interviews and filled interview guides will only be used for purposes of this research and will be kept in safe lockable drawers accessible only by the researcher. No monetary incentives will be given for your participation in the research likewise you will not be penalized for refusing to participate or for withdrawing after enrolling in the study. There may be no direct benefits for taking part in this study. However, there is a possibility that information gained from the study will help to inform managers and health workers to come up with context specific interventions and strategies to promote EBF. The note taker will be recording information from our discussion so that we do not miss any important points. The interview may take about one hour. Are you willing to participate in the IDI?

(If Respondent agrees), Thank you so much for accepting. (Ask respondent to sign below).

Respondent Name.....Respondent Signature:…….

Name of Investigator:…….Signature of investigator: ……

Appendix 8: In-Depth Interview Guide for Significant Others' (Spouses, Grand Parents and Siblings)

Good day. Welcome to this discussion, my name is Blessings Njolomole, a student at the College of Medicine of Malawi. I am conducting this study to explore barriers to exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka District. To achieve this purpose, I will interview you. The interview session will be audio recorded so that I capture everything. Shall we proceed?

Once the participant agrees, proceed as follows:

Age…….Male……Female……Religion……

Part 1: Knowledge on the importance of Exclusive Breast Feeding

Now we will discuss about exclusive breastfeeding (EBF).

1. Tell me what you know about EBF. /Describe EBF
2. For how long should a baby be exclusively breastfed? (Probe length of period and why)
3. What are the benefits of EBF?
4. Tell me how you knew about EBF and all the other information you have provided

Part 2: Perceptions towards Exclusive Breastfeeding

We have just talked about EBF. Now I would like to ask you a few more questions just to understand better a few things that we already discussed as well as your perceptions on EBF.

1. In general, what can you say about EBF? (Probe for more Information)
2. What do you think is the best to give a newborn to eat? Probe why
3. What is your opinion of the first milk that comes?
4. Would you say that breast milk alone is adequate for a child's nutrition? Probe why

5. Is there any circumstance under which a mother should not exclusively breastfeed a baby?

Part 3: Factors that Promote Exclusive Breastfeeding

1. Did your wife/Daughter/Sister breastfeed her youngest child? Probe who made that decision, how do you feel when you see your wife/Daughter/Sister breastfeed. What advice did you give?

2. You have mentioned of giving advice to your wife/Daughter/Sister does she follow the advice.

3. In your opinion what are the factors that motivate your wife/Sister/Daughter to exclusively breastfeed her baby? Probe for more information-family, social support systems, beliefs and religion

Part 4: Barriers to Exclusive Breastfeeding

We have discussed factors that promote EBF practices now I would like to learn more from you about what hinders your wife/Sister/Child from practicing EBF

1. Explain to me in detail how your wife's/Sisters/Daughters day was like yesterday (Probe more for mother's activities and length of time activities took 30 minutes,1 hour,2 hours etc ,where was the baby during this time?).

2. Now tell me is there a point in time you felt your wife/daughter/sister should not exclusively breastfeed (Probe more what were the reasons, for advising the wife/daughter/sister not to exclusively breastfeed? How did the wife/daughter/Sister respond to the advice?

3. Generally what would you say are the things that make it difficult for your wife/Sister/Daughter to exclusively breastfeed? Probe more on family influences, social support systems, beliefs and religion

4. Have you ever discouraged or tried to prevent your wife/Sister/Daughter from practicing EBF? Probe: What did you say or do to discourage her? What was her response?)

Appendix 9: Chilolezo cha Azimuna, Azigogo ndi Azichemwali a Azimayi Oyamwitsa omwe Akutenga nawo mbali mu Kafukufukuyu

Ine ndine Blessings Njolomole wophunzira pa sukulu ya za ukachenjede ku sukulu ya za udotolo ya College of Medicine.Ndikuchita kafukufuku yemwe cholinga chake ndi kufuna kuwunika zomwe zimachititsa kuti azimayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi ayamwitse mwakathithi.Zotsatira za kafukufukuyu zitha kuthandizira kupeza mayankho a zomwe zimalepheletsa kuti azimayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi alephere kuyamwitsa mwakathithi.

Kutenga nawo mbali mu kafukufukuyu sikokakamiza ndipo muli ndi ufulu kusiya kutenga nawo mbali nthawi ina ili yonse ngati mungafune kutero. Palibe chilango china chili chonse chomwe chingabwere chifukwa chokana kutenga nawo mbali mu kafukufukuyu. Zokambilanazi zilembedwa komanso kujambulidwa pa tepi ndi cholinga choti tisaphonye china chili chonse chomwe chinganenedwe. Zokambilara zonse zikhala zachinsinsi ndipo maina anu sazatchulidwa kapena kulembedwa.Zokambilaranazi zitha kutenga ora limodzi.Mwavomera kutenga nawo mbali mu kafukufukuyu?

Ngati avomera athokozeni ndipo asayine mmusimu

Dzina la otenga mbali: …….. Saini ya otenga mbali ……..

Dzina la ochita kafukufuku: ……Saini ya ochita kafukufuku…….

Appendix 10: Namulondola wa Mafunso a Azimuna, Azigogo ndi Azichemwali a Azimayi Oyamwitsa omwe Akutenga nawo mbali mu Kafukufukuyu

Muli bwanji .Khalani omasuka ku zokambirana zathu ine ndine Blessings Njolomole ophunzira ku sukulu ya za ukachenjede ya College of Medicine. Ndikuchita kafukufuku ofuna kupeza zimene zimalepheletsa amayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi omwe amabwera ku sikelo ya katemera wa amayi omwe atha sabata zisanu ndi imodzi chibelekereni kulephera kuyamwitsa ana awo mwakathithi kuno ku Balaka. Pa chifukwa ichi ndikufunsani mafunso ndipo zokambilana zathu zijambulidwa pa tepi zomwe zithandizire kuti zonse zomwe tikambilane zisungike bwino.Tingathe kuyambapo zokambilana zathu tsopano?

Ngati abvomeleza tsatilani ndondomeko ili mmusiyi.

Zaka…….Mamuna……Mkazi……Chipembedzo……

Part 1: Zomwe amadziwa za kuyamwitsa mwakathithi

Tsopano tikambilana za kuyamwitsa mwakathithi

1. Ndilongosoleleni zomwe mumadziwa za kuyamwitsa mwakathithi

3. Kodi mwana amayenera kuyamwa mwakathithi kwa nthawi yaitali bwanji? Nanga ndi chifukwa chani amayenera kutero.

4. Nanga ubwino wa kuyamwitsa mwa kathithi ndi otani?

5. Kodi za kuyamwitsa mwa kathithi komanso zonse zimene mwalongosolazi munazidziwa kuchokera kwa ndani?

Part 2: Malingaliro awo pa za kuyamwitsa mwakathithi

Tsopano ndi kufunsani mafunso okhudzana ndi mmene mumaonera nkhani zakuyamwitsa mwakathithi

1. Munganenepo chani zokhudzana ndi kuyamwitsa mwa kathithi?

2. Kodi chakudya chabwino kumpatsa mwana ongobadwa kumenene ndi chiti? Nanga ndi chifukwa chani?

3. Nanga mkaka oyamba kutuluka mmawere mumauona bwanji?

4. Mukuganiza kuti mkaka wa mmawere ndiwokwanira kukhala chakudya chokhacho cha mwana wanu?

5. Kodi ndi pa zifukwa ziti zimene mayi sayenera kuyamwitsa mwana mwakathithi

Part 3: Factors that Promote Exclusive Breastfeeding

1. Kodi akazi anu/mwana wanu/kapena chemwali anu amamuyamwitsa mwana wao wa mng'ono mwakathithi? Funsitsitsani: Anapanga chiganizo choti ayamwitse mwakathithi ndi ndani? Nanga inu mumamva bwanji pamene akazi anu/mwana wanu/chemwali anu akuyamwitsa mwakathithi? Mumawalangiza zotani?

2. Mwanena kuti mumawalangiza akazi anu/chemwali anu/mwana wanu nkhani zokhudza kuyamwitsa mwakathithi, kodi iwowo amatsatira zomwe inu mumawalangiza?

3. Ndikufuna mundilongosolere mwa mvemvemve ndi zinthu ziti zomwe zimawalimbikitsa akazi anu/chemwali anu/mwana wanu kuti aziyamwitsa mwakathithi? Funsitsitsani: zokhudza kubanja,zikhulupiliro,chipembedzo ndi anthu ena a mderalo

Part 4: Barriers to Exclusive Breastfeeding

Takambilana zina mwa zomwe zimawalimbikitsa akazi anu/chemwali anu/mwana wanu kuyamwitsa mwakathithi tsopano ndikufuna kudziwa kuchokera kwa inu zina zomwe zimawelepheletsa kuti ayamwitse mwakathithi.

1. Ndikufuna mundilongosolere kodi kutangocha dzulo akazi anu/chemwali anu/mwana wanu amagwira ntchito zanji/kapena amapanga chani? Funsitsitsani: Ntchitozo/kapena zimene amapangazo zinatenga nthawi yaitali bwanji- theka la ora, ora limodzi, ma ora awiri etc.

2. Kodi ilipo nthawi imene inu munaganizapo kuti akazi anu/chemwali anu/mwana wanu asayamwitse mwakathithi? Funsitsitsani: Inali nthawi iti nanga zifukwa zake zinali zotani, nanga akazi anu/chemwali anu/mwana wanu anayilandira motani nkhaniyi

3. Nanga inu Mukuganiza kuti ndi zinthu ziti zomwe zimalepheletsa akazi anu/chemwali anu/mwana wanu kuti asayamwitse mwakathithi?

4. Potsiliza ndikufuna kudziwa ngati munayamba mwawaletsapo akazi anu/chemwali anu/mwana wanu kuti asayamwitse mwakathithi? Funsitsitsani: Munawauza zotani nanga iwo nkhaniyi anailandira bwanji?

Appendix 11: Informed Consent form for Health Care Workers English

My name is Blessings Njolomole; I am conducting this study in partial fulfillment of the requirements for the award of a Master's degree in Global Health Implementation. I seek your consent to participate in this study. The aim of the study is to explore determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka District. The information you will provide will be kept confidential and your identity will be kept anonymous. Recorded interviews and filled interview guides will only be used for purposes of this research and will be kept in safe lockable drawers accessible only by the researcher. No monetary incentives will be given for your participation in the research likewise you will not be penalized for refusing to participate or for withdrawing after enrolling in the study. There may be no direct benefits for taking part in this study. However, there is a possibility that information gained from the study will help to inform managers and health workers to come up with context specific interventions and strategies to promote EBF. The interview may take about one hour. Are you willing to participate in the IDI?

(If Respondent agrees), Thank you so much for accepting. (Ask respondent to sign below).

Respondent Name.....Respondent Signature:…….

Name of Investigator:…….Signature of investigator: ……

Appendix 12: In-Depth Interview Guide for Health Care Workers

Good day. Welcome to this discussion, my name is Blessings Njolomole, a student at the College of Medicine of Malawi. I am conducting this study to explore barriers to exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka District. To achieve this purpose, I will interview you. The interview session will be audio recorded so that I capture everything. Shall we proceed?

Once the participant agrees, proceed as follows:

Age…….Male……Female……Religion……

In Malawi according to the 2015-16 Malawi Demographic Health Survey, the percentage of exclusive breastfeeding has fallen by 11 percentage points from 72% in 2010 to 61% in 2015-2016.In Balaka district the percentage of exclusive breast feeding is at 57.9% a drop of 15.1 percentage points.

1. Balaka District Hospital is a designated baby friendly hospital initiative (BFHI) facility what breastfeeding policies and guidelines do you have (Probe –show the policies)

2. In general what can you say about exclusive breast feeding practices among women in the district/hospital?

2. What antenatal and postnatal exclusive breast feeding education do you give to the women? Probe more on the type of information given.

3. Now tell me what motivates the women to practice EBF?

(Probe for family or social support systems)

4. What could be the reasons why some women do not practice EBF?

(Probe for family, social support systems, religious beliefs or mothers' activities)

5. We are towards the end of our discussion, let us talk about the challenges you are facing in your

work.

6. What challenges do you face in implementing the BFHI or breastfeeding policy?

Probe more on-the postnatal women, their partners, guardians, workmates and managers

7. Lastly, let us talk about areas you would want to see improvement.

a) If the Government of Malawi is to revise the social behavior change strategy and policy on exclusive breastfeeding and baby friendly hospital initiative what do you think should be done differently to improve the program? Please explain.

b) What can you or the managers do to promote and improve exclusive breast feeding practices among postnatal women in the district?

c) What other issues would you like to inform program planners?

Appendix 13 Chilolezo cha Anamwino ndi ma Dokotala ogwira ntchito Mchipatala omwe Akutenga nawo mbali mu Kafukufukuyu

Ine ndine Blessings Njolomole wophunzira pa sukulu ya za ukachenjede ku sukulu ya za udotolo ya College of Medicine.Ndikuchita kafukufuku yemwe cholinga chake ndi kufuna kuwunika zomwe zimachititsa kuti azimayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi ayamwitse mwakathithi.Zotsatira za kafukufukuyu zitha kuthandizira kupeza mayankho a zomwe zimalepheletsa kuti azimayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi alephere kuyamwitsa mwakathithi.

Kutenga nawo mbali mu kafukufukuyu sikokakamiza ndipo muli ndi ufulu kusiya kutenga nawo mbali nthawi ina ili yonse ngati mungafune kutero. Palibe chilango china chili chonse chomwe chingabwere chifukwa chokana kutenga nawo mbali mu kafukufukuyu. Zokambilanazi zilembedwa komanso kujambulidwa pa tepi ndi cholinga choti tisaphonye china chili chonse chomwe chinganenedwe. Zokambilara zonse zikhala zachinsinsi ndipo maina anu sazatchulidwa kapena kulembedwa.Zokambilaranazi zitha kutenga ora limodzi.Mwavomera kutenga nawo mbali mu kafukufukuyu?

Ngati avomera athokozeni ndipo asayine mmusimu

Dzina la otenga mbali: …….. Saini ya otenga mbali ……..

Dzina la ochita kafukufuku: ……Saini ya ochita kafukufuku…….

Appendix 14 : Namulondola wa Mafunso wa Anamwino ndi ma Dokotala ogwira ntchito Mchipatala

Muli bwanji .Khalani omasuka ku zokambirana zathu ine ndine Blessings Njolomole ophunzira ku sukulu ya ukachenjede ya College of Medicine. Ndikuchita kafukufuku ofuna kupeza zimene zimalepheletsa amayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi omwe amabwera ku sikelo ya katemera wa amayi omwe atha sabata zisanu ndi imodzi chibelekereni kulephera kuyamwitsa ana awo mwakathithi kuno ku Balaka. Pa chifukwa ichi ndikufunsani mafunso ndipo zokambilana zathu zijambulidwa pa tepi zomwe zithandizire kuti zonse zomwe tikambilane zisungike bwino.Tingathe kuyambapo zokambilana zathu tsopano?

Ngati abvomeleza tsatilani ndondomeko ili mmusiyi.

Zaka…….Mamuna……Mkazi……Chipembedzo……

1. Chipatala chino cha Balaka ndi chimodzi mwa zipatala zomwe ndi abwenzi a wana Kodi muli ndi ndondomeko zanji zothandira kuyamwitsa mwakathithi? Mungationetseko zina mwa ndondomeko zomwe muli nazo?

2. Tatiuzeni Kodi mboma lino la Balaka nkhani zokhudza kuyamwitsa mwakathithi zikuyenda bwanji? I n general what can you say about exclusive breast feeding practices among women in the district/hospital?

2. Nanga ndi maphunziro anji kapena uphungu wanji okhudzana ndi kuyamwitsa mwakathithi umene mumawapatsa azimayi panthawi yomwe ali oyembekezela komanso pamene abeleka mwana?

3. Mkuonakwanu ndi zinthu ziti zomwe zimawalimbikitsa azimayi kuti athe kuyamwitsa mwakathithi?

4. Nanga ndi zifukwa ziti zomwe zimapangitsa azimayi kuti asayamwitse mwakathithi? Fufuzani

zokhutsa banja, ntchito zimene mai amagwira, chipembedzo, zikhulupiliro.

Tsopano tikuyandikira mapeto a zokambilana zathu tiyeni tikambe za zovuta zomwe mumakumana nazo pogwira ntchito.

5. Ndi mabvuto anji omwe mumakumana nawo polimbikitsa kuti chipatalachi chipitilire kukhala bwenzi la wana kapena polimbikitsa ndondomeko zoyamwitsa mwakathithi? Fufuzani za mabvuto ochokera kwa azimayi omwe ali ndi ana osapitilira masabata asanu ndi imodzi, azimuna awo, oyang'anira azimayi ku chipatala, anzawo ogwira nawo ntchito komanso omwe amawayang'anira

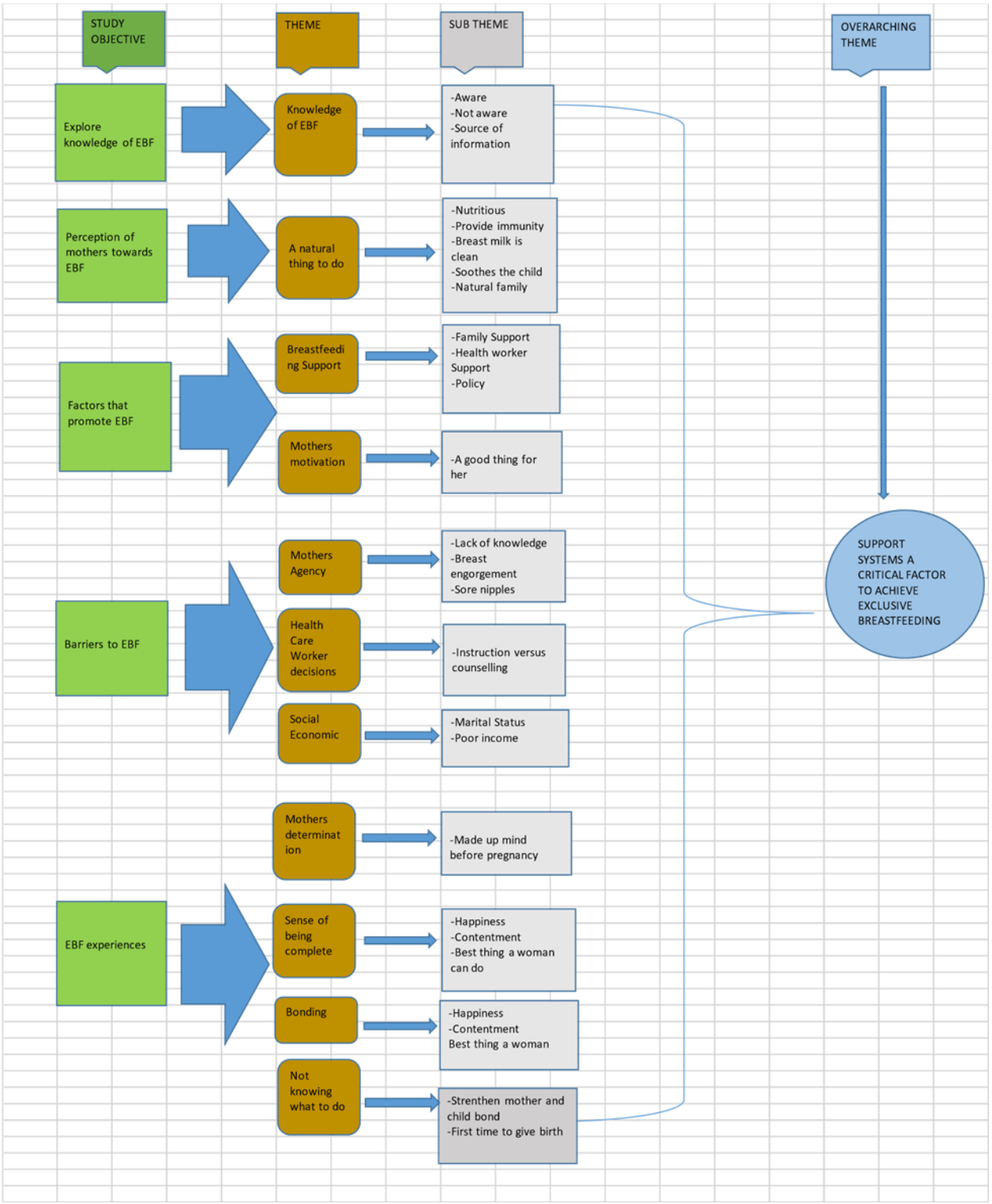
6. Potsiriza, tiyeni tikambe zomwe mukufuna zitakonzedwa.

i) Kodi boma la Malawi litafuna kuwunikanso ndondomeko zolimbikitsira kuti chipatala chino chipitilire kukhala bwenzi la wana kapena ndondomeko zolimbikitsa kuyamwitsa mwakathithi, ndi zinthu ziti zomwe mukanakonda Zitakonzedwa? Longosolani/Tambasulani

ii) Nanga ndi zinthu ziti zomwe inu kapena okuyang'anilani mungachite kuti mulimbikitse komanso kupititsa patsogolo ndondomeko zoyamwitsa mwa kathithi kuno ku Balaka

iii) Ndi zinthu zina ziti zomwe mukufuna opanga malamulo ndi ma pologalamu atadziwa?

Appendix 15: Themes



Appendix 16: Manuscript

Exploring determinants of exclusive breastfeeding among women with children 0-6 weeks attending postnatal clinic services in Balaka District

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Abstract

Introduction: Exclusive breastfeeding is the most widely known and effective intervention for preventing early childhood illnesses and deaths. Despite numerous global initiatives on breast-feeding, trend data show exclusive breast-feeding (EBF) rates have stagnated over the last two decades. So too in Malawi, despite implementing various initiatives to promote exclusive breast feeding (EBF), its practice has been declining in the last decade. This study aimed to explore determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district of Malawi.

Methods: This was a qualitative interpretive phenomenological analysis (IPA) study. Purposive sampling technique was used to select breast feeding women with children 0-6 weeks and key informants while snowballing technique was used to recruit significant others. The sample size was 40 and data was collected using focus group discussions (FGD) and in-depth interviews. The data was analyzed using thematic content analysis.

Results: Overall determinants of exclusive breastfeeding included participants knowledge of EBF, mothers perception of healthy benefits of EBF, mothers agency, determination and motivation to breastfeed, socio-economic factors and breastfeeding support from family members and significant others as well as availability of policies and guidelines on EBF and health care worker (HCW) decisions and advice which influenced whether a woman practiced EBF or not.

Conclusion: Findings from this study have shown that EBF is dependent on a complex interplay of factors such as mothers agency, HCW factors, socio-economic factors and support from significant others. Hence EBF support systems along the continuum of care are a critical success factor for women to practice EBF and not just merely an intuitive biological process based on the natural instinct of both the mother and her baby.

Keywords: Determinants, Exclusive breastfeeding, women, postnatal clinic, children 0-6 weeks

Introduction

Exclusive breastfeeding (EBF) is the most widely known and effective intervention for preventing early-childhood deaths. Globally, 60% of infant and young children deaths occur due to inappropriate infant feeding practices and infectious diseases from which two-thirds of these deaths are attributable to sub-optimal breastfeeding practices [1]. Optimum breastfeeding practices can prevent 1.4 million deaths worldwide among children under five every year. Suboptimal breastfeeding contributes to 45% of neonatal infectious deaths, 30% of diarrheal deaths and 18% of acute respiratory deaths among children under five in developing countries [1].Globally, fewer than 35% of infants are exclusively breastfed. In Sub Saharan Africa exclusive breastfeeding ranges between 22 % and 33 % [2].Despite numerous global initiatives on breast- feeding, trend data show EBF rates have stagnated over the last two decades [3]. In Malawi, despite implementing various initiatives and strategies to promote EBF its practice is on the decline. EBF rates have dropped by 11 percentage points from 72% in 2010 to 61% in 2016 [4] with EBF rates dropping by 15.1 percentage points in Balaka district [5]. Additionally, Malawian children under the age of six months are exclusively breastfed for an average duration of 3.7 months only while EBR rates in some parts of Malawi are as low as 19% at one month, and less than 5% at six months [6]. This falls short of the recommendations by the World Health Organization as well as the Malawi Ministry of Health that mothers exclusively breastfeed for all the first six months of the child's life [7].

Previous studies on EBF show that knowledge determines whether a woman practices EBF or not and the knowledge is usually imparted to them by doctors/nurses during antenatal visits and by their own mothers [8] .Studies conducted in Zimbabwe and Nigeria showed that despite women being knowledgeable about EBF not all practiced EBF [9,10]. Furthermore, other studies have

revealed that women who perceive breast milk as healthy for their babies [11] or believed that breast milk protects babies from diseases or provides immunity; is nutritious and promotes bonding between the mother and child breastfed their children exclusively [12]. Another study conducted in Ghana showed that women who received support from their husbands, other family and community members during the postnatal period practiced EBF and viewed the support as enabling or encouraging EBF [13].Additionally, the studies have also shown that previous experiences prior to breastfeeding by women who observed other female relatives breastfeed their own children reinforced the fact that the women would also breastfeed their babies after child birth [11].Other studies have shown that a woman's agency and healthcare worker (HCW) factors also affected EBF practices of some women and that a woman's inability to latch the baby to the breast and the perception of breast milk supply insufficiency lead to some women not practicing EBF [14].Additionally, some HCW would advise a woman to stop practicing EBF if they thought the woman was malnourished or if the woman was HIV positive contrary to the WHO recommendations [15].Furthermore, HCWs gave adapted messages based on what they believed to be the best feeding choice for mothers and that a significant number of HCWs, including those with relevant training, presented the possibility of mother to child transmission of HIV through breastfeeding as a certainty and not a risk, resulting in infant feeding counselling that downplayed EBF [15].

Despite strong evidence on immediate and long term health benefits of optimal breastfeeding in children, as shown by different studies [1-5] and Malawi implementing various initiatives and strategies to promote EBF its practice is on the decline with EBF rates dropping by 11 percentage points from 71 % in 2010 to 61% in 2016 [4] while in Balaka district of Malawi the rates dropped by 15.1 percentage [5]. This study therefore seeks to explore determinants of exclusive

breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district.

Methods

Type of research

This was a qualitative interpretive phenomenological research study. Interpretive phenomenological analysis (IPA) was used in order to examine in detail individual lived experiences and how individuals made sense of their experiences through focus group and in-depth analysis of the phenomena under study [16]. Focus group discussions and in-depth interviews were conducted in order to get an insider's view of the participants making sense of their personal and social world in their unique contexts [17]. IPA allowed the researcher to use broad knowledge principals about the phenomena being investigated to understand and interpret participants lived experiences while keeping the focus locally contextualized highlighting what works in a local context setting, and not what works in 'most' or general settings [18].

Study Place

The study was conducted at Balaka District Hospital. Balaka District has a population of 438,379 representing 2.5% of the total population of Malawi [19].The district is located in the Southern Region of the Republic of Malawi. Ntcheu borders it to the northwest, Mangochi to the north, Machinga to the east, Zomba to the southeast, Blantyre to the south, and Neno to the southwest. The district covers an area of 2,193 km^2 representing 2.4% of the total land area of Malawi. It is the 20th largest district in the country and the seventh largest in the Southern Region [20]. Balaka District Hospital serves a catchment population of 90,748 .The facilities provide the essential health package comprising reproductive maternal newborn and child health services, vaccine preventable diseases, malaria, integrated management of child hood illnesses, community health package

,neglected tropical diseases, HIV/AIDS, nutrition, neglected tropical diseases, non-communicable diseases, oral health services and tuberculosis treatment. Staff at the hospital consists of Medical Officers, Clinical Officers, State Registered Nurses, Nurse Midwife Technicians, Pharmacy Technicians, Radiographer Technicians and Dental Technicians. The hospital attends to both outpatients and inpatients [20,21].

Study Period

Data was collected in the month of September 2020. Field data collection took approximately two weeks. Data was analysed in the month of October, 2020 and report writing started immediately thereafter.

Study Population

The study population were women with children 0-6 weeks old attending 6 weeks postnatal clinic checkups at the maternity units of Balaka District Hospital as well as their spouses, siblings and grandparents who were identified through snowballing technique.

Sample Size

Participants were recruited using purposive sampling technique to select 18 breast feeding women with children aged 0-6 weeks attending postnatal clinic services and four health care workers. Three focus group discussions (FGDs) of 6 women per group were conducted with these women. Literature on FGD indicates that participant size of between 4 and 12 is adequate with the ideal size being between 5 and 10 participants [22]. The FGDs provided a phenomenological and hermeneutical perspective focusing on participants lived experiences and their views of the world and what it means to them while conducting in-depth interviews with these women provided the idiographic perspective with an in-depth analysis of single cases and examining individual perspectives of the study participants, in their unique contexts exploring every single case, before

producing any general statements [15, 16**].**Snowballing sampling technique was used to identify 18 significant others (6 spouses, 6 grandparents and 6 siblings). Snowball sampling is a purposive sampling method which is applied when it is difficult to recruit subjects in a study hence in this study the purposively selected 18 breastfeeding women were used to recruit their spouses, siblings and grandparents [23].The total sample size was forty.

Data Collection

Data was collected using semi structured interview guides for FGD and in-depth interviews. Semi-structured interview guides used open ended questions which provided an opportunity for the participants to talk in great detail about the elements of their experience that are of importance to them. Additionally semi structured interview guides, provided the interviewer with the flexibility to follow up on any answers given with further questions not necessarily on the original schedule [24].

Both FGD and in-depth interviews were audio recorded and field notes were taken as well. The researcher trained interviewers, a recorder and an observer on how to document manage and record proceedings of the interviews. The Data collection tools were pre-tested at a health facility different from the one where this study was conducted. Three FGDs of 6 participants per group with women with children 0-6 weeks were conducted and 18 in-depth interviews with the same women were also conducted. In-depth interviews with significant others (Spouses, grandparents and siblings of the women) and key informants involving 2 maternity nurses and 2 clinicians were conducted until no new substantive information was acquired or until saturation was reached. Prior to enrollment of participants into the study, the researcher briefed the Balaka District Health Officer (DHO) about the study and sought authorization from him to conduct the study in the

district.

Data Management

The researcher collected all the in-depth interview forms from all the interviewers and kept the guides, while audio recordings and transcripts of in-depth interviews and FGD were kept in safe and secure lockable drawers. Transcribed text were stored in word processing files on a password protected computer.

Data Analysis

All the data collected from the study was analyzed manually using content thematic analysis. After transcribing the researcher listened once more to the recording of the interview while reading the transcript. Thereafter the researcher read and reread the transcripts and made notes and generated codes [25] After the data was coded and collated, the codes and collated data were sorted into themes, the themes were reread and reviewed in relation to the entire data set in order to ascertain the themes. The themes were then collapsed into one theme or broken down into separate themes or were entirely removed depending on the available supporting data set [14,20,23].

Trustworthiness

In IPA research the criteria to assess the trustworthiness of the research is founded on the principles of credibility, transferability, dependability and conformability. The researcher ensured credibility through prolonged engagement with the participants to identify and document recurrent and emerging features through adequate immersion and submersion in the research setting in order to enable recurrent patterns and themes to be identified and verified. Additionally credibility was enhanced through peer-debriefing and data triangulation. Additionally, participants were given an opportunity to verify the interpretations for accuracy and participants direct quotes have been

included in the description of the findings [9]. Transferability demonstrates the applicability of research findings to other populations. One strategy used to address the issue of transferability laid in the sample selection. In this case the researcher used the technique of purposive sampling whereby, informants living the experience under consideration were selected, leading to rich information and understanding of the phenomena under investigation to be applied to other populations [10,26]

Dependability shows the consistency and the ability for the research to be repeated. Dependability has been achieved by providing a detailed report of the systematic process of the research with an audit trail, with raw data, data reduction and analysis products, data reconstruction and synthesis products, and process notes. Confirmability which is the degree of neutrality or the extent to which the findings of a study are shaped by the respondents rather than the researcher's bias, motivation or interest were achieved by contextualizing the study within the broader literature on women's experience of exclusive breastfeeding [10,27].

Ethical Considerations

Ethics approval to conduct the study was obtained from the College of Medicine Research and Ethics Committee (COMREC). Permission was sought from Balaka DHO to conduct the study at his facility and allow his staff to participate in data collection.

Informed Consent and Confidentiality

The researcher sought informed consent from study participants. Informed consent is a 'process of negotiation' between the researcher and the study subjects, and not a 'one off action'. The consent seeking process was devoid of deception and exploitation, the study purpose, risks and benefits were explained [28]. Participants were informed that participation in the study was voluntary and

they signed a consent form for participation and were allowed to withdraw from the study at any time without any penalty. Additionally participants' information has been kept confidential and will not be used for any other purposes outside of this research project. Recorded interviews and filled interview guides were kept in a safe lockable drawer accessible only by the researcher.

Beneficence and Risks

Participants were informed that there are no direct or immediate benefits for taking part in the study. It is however, envisaged that by studying the determinants of exclusive breastfeeding among women with children 0-6 weeks, this research's outcome may help to inform managers and health workers to come up with context specific interventions and strategies for promoting EBF in the district. Furthermore participants in the study were informed that the study entailed little or no risks at all for the subjects. There could have been little risk because some participants may have felt uncomfortable in sharing their lived or family breast feeding experiences with someone they did not know and especially that the researcher is male.

Participants Compensation

International guidelines and current best practice both indicate that structured remuneration of research participants is ethical and appropriate in Malawi. A review of the literature revealed that the underpinning rationale for remuneration is based on reimbursement of expenses and compensation for time and burden, but not as an incentive to participate [29]. In 2018, researchers and regulators in Malawi proposed a standardized approach which used remuneration tables to calculate how much and for what purpose a participant should be compensated. The researcher remunerated participants based on those tables. Thus each participant got MK3, 700.00 broken down as follows subsistence MK1, 500.00, MK1, 000.00 of time in an 8 hour day (i.e MK1000/day

and maximum contact time with participants is expected to be I hour) and transport amounting to MK 1,200.00 round trip for a 10 km distance [30].

Results

Demographic characteristics of participants

A total of 40 participants were interviewed and comprised of 18 breastfeeding women 4 HCW 6 spouses, 6 siblings and 6 grandmothers of the breastfeeding women. The majority of the participants were female. Twenty eight participants attended up to secondary education, two had no formal education and six had primary education whereas the nurse/midwives and clinical officers attended college education Table 1. The nurses and clinicians had worked at their post for more than a year.

Table 1: Socio-Demographic characteristics of respondents	
Characteristics	**Number**
Gender	
Male	8
Female	32
Marital Status	
Single	6
Married	28
Divorced	4
Widowed	2
Education	
None	2
Primary	6
Secondary	28
Tertiary	4
Tribe	
Chewa	9
Yao	14
Sena	1
Ngoni	7
Lhomwe	9
Religion	
Seventh Day Adventist	6
Roman Catholic	14
Islam	7
CCAP	13

Knowledge of exclusive breastfeeding

Knowledge on the importance of exclusive breast feeding was assessed by asking the participants to explain what they know about exclusive breastfeeding. During the interviews, it was noted that most participants had knowledge of exclusive breastfeeding but some did not have or had obscure knowledge of exclusive breastfeeding. Most of the respondents heard about exclusive breastfeeding from nurses, other health workers, friends, care group volunteers and the radio. Some participants were quoted as follows:

"Exclusive breastfeeding means that the woman should not give water or any food to the

child but breast milk only for 6 months after the six months have elapsed she should continue breastfeeding at the same time she should give the child additional foods and water because it is the child's right to be exclusively breastfed up to six months." (Respondent 2, Spouse)

Some few participants demonstrated lack of knowledge and had distorted information on the importance of exclusive breastfeeding and one was quoted as follow:

"Uuuuh uhuuuu I don't really know but I hear that it involves putting the child close to the mother so that the child's umbilicus should touch the mother's body while breastfeeding the child and the mother should not use soap when bathing the child and should also not use body lotion on the child. This is what I did with my daughter when she was born she should also do the same with my grandson so that he should become healthy." (Respondent 3, grandmother)

Source of information

The study sought to establish the source of information about EBF. The study participants had different sources of information which included friends, nurses, and radio and care group volunteers. Some of the participants were quoted as follows.

*"I heard about exclusive breastfeeding from my friends who got pregnant and had children before me." (*Respondent 5, Breastfeeding Woman?)

"I heard about exclusive breastfeeding from care group volunteers in my village and nurses from the hospital." (Respondent 6, Breastfeeding Woman)

Perceptions towards exclusive breast feeding

A Natural thing to do

Most participants believed that breastfeeding is a natural thing for any woman who has given birth to do and that there is no reason whatsoever that a woman should not exclusively breast feed her child and that breast milk is clean and soothes the baby. One of the woman was quoted as follows:

> *"Actually you can breast feed anytime and anywhere it doesn't matter, after all in my village all women breastfeed their children it is almost a natural thing for any woman to do so there is no reason whatsoever that a woman should not breast feed her child."* (Respondent 8, Breastfeeding Woman)

The best thing a woman can do

Some participants in the study believed that breastfeeding is the best thing a woman can do for her child since breast milk offers protection from diseases and helps the child to grow healthy and were quoted as follows:

> *"When I escorted my wife for antenatal clinic services during the pregnancy of our current child the nurse at the clinic said that we should give our child breast milk only for him to grow healthy and be protected from diseases. So I think that exclusive breastfeeding is the best thing a woman can do for her child."* (Respondent 10, Spouse)

Breast feeding as beneficial

Most participants viewed breastfeeding as beneficial for the child since breast milk is readily available, not contaminated and does not require rigorous preparation and that it provides immunity for the child. Others believed that exclusively breastfeeding a child for six month prevents the woman from getting pregnant and helps the child to grow very healthy and prevents stunting. Below are some quotes to support this view.

> *"I believe that exclusive breast feeding is good because during discharge from the*

postnatal ward the nurse told me that breast milk doesn't get contaminated or go bad ,breast milk is always readily available for use it doesn't require rigorous preparation it is the best food for the child. The first milk (Colostrum) that comes from the breast gives the child immunity to fight against diseases it's like immunizing the child against diseases."(Respondent 11, Breastfeeding Woman)

"Exclusive breastfeeding is good for the child because breast milk alone is adequate food for the child for the first six months. When we compare the children that are born now and those that were born in the past by our parents the current children are healthy and tall while those born in the past were stunted I think this is because the children being born now are exclusively breastfed un like those born in the past."(Respondent 12, Sister)

"During discharge of my granddaughter, the nurses at the post natal clinic told me that breast milk is adequate for the child's nutrition and that it has everything that the child needs for his growth, whatever we eat the child eats the same through breast milk it is warm and has vitamins and water necessary for the child's growth so I think exclusive breastfeeding is very good for my granddaughters son."(Respondent 13, Grandmother)

Factors that promote exclusive breast feeding

Breast feeding support

Some participants indicated that support from family members such as their mother, husband, sister, grandmother and nurses motivated them to practice EBF. Some women reported as follow:

"My mother is very supportive of me when I have a problem or when I am worried about exclusive breastfeeding she helps me with it. My mother is very experienced she breastfed all of us (her

"Nurses have been motivating me to exclusively breast feed actually when I have any problems related to breastfeeding I always consult the nurse. She is trained and well qualified to handle my issues."(Respondent 15, Breastfeeding Woman)

"As a family we always support her to exclusively breast feed her child regardless of our religion and traditional beliefs. Actually religion and traditional beliefs do not hinder her from exclusively breastfeeding it's a thing of the past (for religion and traditional beliefs to hinder one from exclusively breast feeding." (Respondent 16, Sister)

Mother's motivation

When probed on factors that motivate women to breastfeed most indicated that that they wanted the best for their child. One respondent explained:

"I am motivated to exclusively breast feed my child because I want the best for her I don't want her to be stunted .I was told during antenatal clinic services that children who are exclusively breastfed grow very healthy don't get stunted and become intelligent and strong." (Respondent 17, Breastfeeding woman)

Role models

One of the health workers when asked about what motivates women to practice exclusive breastfeeding had this to say:

"After teaching the women about EBF during health talks we ask other women who successfully practice EBF to witness or talk about how EBF has helped their children to grow healthy. The other women are then motivated to practice EBF after seeing and learning from their colleagues how EBF has benefitted them."(Respondent 19, HCW)

Policy as an enabler

When health workers were asked whether Balaka District Hospital as a designated baby friendly hospital initiative facility has breastfeeding policies and guideline that support breastfeeding they indicated that the policies are available. One of the respondents explained:

> *"Policies and guidelines are available in the consultation room, antenatal and postnatal wards, it starts with antenatal education when a woman is pregnant the woman is taught to start EBF before 30 minutes elapses after giving birth and when the woman is transferred to the postnatal ward from labor ward she is advised to continue practicing EBF without giving any other foods other than breast milk and upon discharge she is given the same guidance on EBF as was done during labor ward and postnatal ward and the same is repeated when the woman comes for postnatal checks after six weeks and she is reminded about EBF or she is asked about her EBF practices."* (Respondent 20, HCW)

Barriers of exclusive breastfeeding

Mother's agency

Some of the respondents felt that health care workers assumed that they already knew how to breast feed and attach their children to the breast as such they did not discuss with them possible problems that could arise from breastfeeding. Some of the respondents had this to say:

> *"At first I thought breastfeeding is a very simple thing to do I was not told that sometimes it can be a difficult thing to do. At the clinic they didn't tell me how to put my baby to the breast worse still when I put my baby to the breast there was no milk coming he kept sucking at the breast but there was no milk coming. To make matters worse my nipples became sore and my breast were getting engorged I didn't know what to do, nobody told*

me anything."(Respondent 22, Breastfeeding Woman)

Lack of involvement of significant others

Some of the HCW interviewed believed that involving significant others including husbands in health education sessions or counselling during discharge of postnatal mothers would help in re-enforcing EBF practice at home and had this to say:

> *"I have never seen a male partner or husband being involved in EBF health education sessions during discharge of a postnatal mother where the spouse is counselled together with the woman on EBF even guardians of the postnatal women are not involved during counselling conducted at the time of discharge. During discharge the focus for EBF education is the postnatal woman anly nobody else is involved. Involving significant others would help to re-enforce EBF practice at home as the woman would be reminded to practice it."* (Respondent 18, Health Care Worker)

Health Care Worker decisions

The study has demonstrated that HCWs sometimes make decisions based on their own intuition contrary to professional standards and guidelines. These decisions affect whether women will exclusively breastfeed or not. One HCW reported as follows:

> *"We ,the health workers decide whether the woman practices EBF or not depending on our assessment of the condition of the mother for example during postnatal checkup when the woman is deemed malnourished we advise the woman to give the child other foods because the woman may not produce enough milk because she is malnourished so we advise the woman to give porridge to the child so too when the woman is HIV positive we tell the woman to give other foods to the child especially when the woman looks sickly and*

weak." (Respondent 20, HCW)

Socio-economic status

Poor socio-economic status of a breastfeeding mother including not having a partner influences her EBF behavior in the sense that she does not practice EBF since she also has to engage in other livelihood activities, one of the respondents had this to say:

> *"I have also observed that single mothers do not practice EBF because they are engaged in other livelihood and household chores so it becomes difficult for the woman to focus on EBF but if the woman had a partner the partner would have been helping her with other chores including reminding her to do EBF." (*Respondent 18, HCW)
>
> *"Some women do not practice EBF because they have to do gardening and other chores to earn a living because of poverty hence they do not practice EBF."* (Respondent 21, HCW)

Policy implementation

BFHI and breastfeeding policies are available but HCWs don't read and apply that knowledge in clinical practice. Furthermore BFHI trainings were conducted but implementation is poor. Some HCW reported as follows:

> *"We have both the guidelines and the policy, the policy is in form of a booklet both the policy and guidelines are available in the ward. The guidelines are pasted on the walls in paper form but the challenge is that health workers don't utilize the policy and guidelines it is just like for decoration people don't read them as such they don't apply what the policy and guidelines say in clinical practice."* (Respondent 19, HCW)

"BFHI and breastfeeding policies are not being implemented despite the BFHI Coordinator training nurses and other cadres in various wards on the BFHI, its implementation has been

difficult and ward in charges are not re-enforcing implementation of the policies. Policies are available and trainings have been conducted but implementation is poor. For one to know if things are on track and if mothers are complying to EBF standards there is need for regular ward supervision at least every two weeks to check how implementation is going on but this is not being done if there is supervision at all then it is after a very long period of time." (Respondent 18, HCW)

***Women's experiences of* breastfeeding**

Mothers' determination

The study has demonstrated that a mother's determination is vital for effective EBF practices. One of the participants in the study had this to say:

"When I breastfeed my child I feel happy and enlightened the experience is very good, actually I made up my mind that I will exclusively breastfeed my child way before I even got pregnant. I do not have any physical, emotional or psychological problems that are interfering with breastfeeding even if I could have had physical, emotional or psychological problems I could still have exclusively breastfed my child." (Respondent 24, Breastfeeding Woman)

A sense of being complete

For most women breastfeeding is acknowledged as a responsibility in fulfilling their basic role as mothers and caring for their children which makes them feel complete. One participant explained:

"Breastfeeding my child makes me feel complete as a woman actually breastfeeding is the crowning jewel of womanhood."(Respondent 25, Breastfeeding Woman)

"Breast feeding one's child is the best thing any woman can do. It is an empowering experience and it gives me feelings of contentment, I feel satisfied." (Respondent 27,

Breastfeeding Woman)

Bonding

Breastfeeding has been known to promote bonding between a mother and her child and this has also been reflected in this study and one of the participants reported as follows:

> *"When I look at his face while breastfeeding him I feel very happy the bond between me and him grows strong each time I breastfeed him. It is amazing that you can actually feed somebody else from your own body."* (Respondent 28, *Breastfeeding Woman*)

Not knowing what to do

Although EBF is seen merely as an intuitive biological process based on the natural instinct of both the mother and her baby, the mother's knowledge and agency are vital for successful EBF .The quote below illustrates this:

> *"Immediately after my son was born the nurse put him on my chest and told me to hold him. I was afraid I didn't know what to do, it was my first time to give birth and I was very exhausted."* (Respondent 29, Breastfeeding Woman)

DISCUSSION OF RESULTS

This chapter discusses the findings of the study .The aim of this study was to explore the determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district and specifically sought to explore the level of knowledge of respondents on the importance of exclusive breastfeeding, perceptions towards exclusive breast feeding, factors that promote exclusive breast feeding, barriers of exclusive breastfeeding and to describe the breastfeeding experiences of mothers with children aged 0-6 weeks. A discussion of results will be presented according to themes.

Knowledge of exclusive breastfeeding

Most of the women, sisters, spouses and grandparents were aware of the importance of exclusive breastfeeding this was a good development because for the women to practice exclusive breastfeeding they had to be aware of the importance of exclusive breastfeeding. It was also very important for the sisters, spouses and grandparents to be aware of the importance of exclusive breastfeeding for them to be able to support the women. These findings resonate well with studies from Pakistan, Nepal and India which showed that participants (sisters, spouses and grandparents) who had adequate knowledge about the importance of EBF viewed exclusive breastfeeding favorably [31].Some of the grandparents were not aware of the importance of exclusive breastfeeding to the baby and mother. This resonates with findings from another study conducted in Ghana on family belief systems and practices that influence exclusive breastfeeding where lack of knowledge had negative influences on EBF practices [32]. This agrees with findings of a study on breastfeeding knowledge and practices among mothers of children under 2 years of age living

in a military barrack in Southwest Nigeria which showed that knowledge was significantly associated with positive breastfeeding practices while little knowledge was associated with pre-lacteal and bottle feeding [33]. However studies conducted in Gwanda community in Zimbabwe showed that despite women being highly knowledgeable on EBF practices, its practice was very low. This finding was similar to a study in Nigeria where EBF knowledge was high (82%) but the EBF rate was low (33.5%).This finding shows that having the knowledge of EBF does not necessarily translate to EBF practice [9].

The source of information about exclusive breastfeeding was nurses/doctors, friends, radio and care group volunteers. Those who knew about EBF through nurses/doctors heard about EBF during antenatal clinic services and during postnatal discharge. The findings resonate with the Indian study on perceptions and practices regarding breastfeeding among postnatal women at a district tertiary referral government hospital [8] as well as the South African systematic review on exclusive breastfeeding policy, practice and influences[13].

Perceptions towards exclusive breastfeeding

From the narrative account of the participants, breastfeeding was identified as a natural thing to do. Most participants believed that exclusive breastfeeding is a must do natural thing for any woman who has given birth to a child. Respondents indicated having grown in a village where it is almost a cultural thing for a woman to breastfeed her child implying that breastfeeding was viewed as a social norm practiced and handed down from generation to generation with some thinking that there is no reason whatsoever that a woman should not exclusively breast feed her breastfeeding child. This line of thought resonates with findings of a study on the lived experiences of first-time breastfeeding women in Ghana [11]. Some participants believed that

exclusive breast feeding is the best thing that a woman can do for her child which resonates with the Ghanaian study mentioned in the preceding sentence where women associated exclusive breastfeeding with good motherhood [11].Most participants viewed exclusive breastfeeding as beneficial for the child since breast milk is readily available, not contaminated and does not require rigorous preparation and that it provides immunity for the child while others said that exclusively breastfeeding a child for six month prevents the woman from getting pregnant and helps the child to grow very healthy and prevents stunting. The results are similar to findings of a study on perceptions and practices regarding breastfeeding among postnatal women at a district tertiary referral government hospital in southern India where the women believed that exclusive breastfeeding is nutritious protects the child from diseases and helps the child to grow very healthy [8].

Factors that promote exclusive breast feeding

The study found that women who were intrinsically motivated and those that had a good breastfeeding support system along the continuum of care practiced exclusive breastfeeding. The use of role models to motivate other women to practice EBF during health talks also motivated other women to practice EBF. Availability of BFHI and EBF policies acted as cues for health workers to re-enforce EBF among women. The breastfeeding support system in the continuum of care comprised of family members (Spouses, grandparents, mothers, sisters) and health care workers[15].The results contradict findings from a study on the influence of fathers' socioeconomic status and paternity leave on breastfeeding duration in Sweden where fathers did not support their wives in exclusive breast-feeding but used their role as family heads to control feeding practice in the family and fathers believed that breast milk is mainly liquid and not heavy

nor nutritious enough for the baby's optimal growth and development [34].Results from this study however agree with findings from another study in Ghana on the lived experiences of first time breastfeeding women which found that the women highly valued the support and advice they received from family members as enabling and encouraging successful exclusive breastfeeding practices [11].This also resonates with findings from another study on exclusive breastfeeding and family influences in rural Ghana where women who were supported by family, community support groups and nurses practiced EBF [28].The study also found out that the use of women who successfully practiced EBF (Role models) during EBF health education sessions motivates other women to practice EBF [35].

This finding is consistent with findings from a systematic review of facilitators and barriers of exclusive breastfeeding practice in Sub-Saharan Africa where a mother becomes an advocator of exclusive breastfeeding [35] and discourages other mothers from giving water during the first six months because from her own EBF experience her elder child fell ill often when she mixed exclusive breastfeeding and giving of other foods and water but when she gave breast milk only the child did not fall sick frequently. This motivated her to give breast milk only with no other substitute when she had her second child [15,29]. This study also found out that after orienting staff on the BFHI and breastfeeding policies some health workers were teaching women about EBF according to the policy guidelines hence the policy acts as an enabler and cue for promoting EBF education for women attending postnatal clinic services which is consistent with findings of a study conducted in South Africa [32].

Barriers to exclusive breastfeeding

Some of the respondents felt that HCWs assumed that they already knew how to breast as such they did not discuss with them problems that could arise from breastfeeding such as breast engorgement while others felt that breast milk was insufficient especially when one breast was engorged and the mother had to feed the child from one breast only. Some women did not know how to attach the baby to the breast resulting in poor latching and sore nipples. This resulted in the women giving their children other foods and water within the six weeks period because of lack of support from HCW [36] or because HCWs made decisions on behalf of the respondents on whether they should exclusively breast feed or not based on their own intuition about the condition of the mother and not necessarily based on professional knowledge [37]. For example HCWs would advise a woman to stop practicing EBF if according to their assessment the woman was deemed malnourished or if the woman was HIV positive. This is contrary to the WHO recommendation that HIV-exposed infants in low-resource settings be exclusively breastfed for 6 months [38] and that EBF be combined with complementary feeding from age 6 to 12 months [39]. The results of this study also echoes findings of another study on barriers to EBF among HIV-positive mothers in sub- Saharan Africa where it was found that HCWs gave adapted messages based on what they believed to be the best feeding choice for mothers and that a significant number of HCWs, including those with relevant training, presented the possibility of mother to child transmission of HIV through breastfeeding as a certainty and not a risk, resulting in infant feeding counselling that downplayed EBF [15].

Findings from this study were also consistent with findings of a study conducted in Sub Saharan Africa on facilitators and barriers of exclusive breastfeeding which showed that engorgement, sore

nipples , perceptions of breast milk insufficiency and lack of knowledge on EBF lead to mothers giving their children other foods within the first six weeks of life [35] .This study also revealed that despite having the BFHI and breastfeeding policies HCW don't read them and as such don't apply the policies in clinical practice. This is consistent with finding of another study conducted in Sub-Saharan Africa where EBF policies are available but are not applied or HCW give contrary instructions to established guidelines [13].This study has also revealed that socio economic factors such as poverty and being a single mother contributes to failure for women to practice exclusive breast feeding as the women have to engage in other livelihood activities. This finding is consistent with results of another study on facilitators and barriers of EBF in Sub Saharan Africa as well as another study conducted in Malawi which found that women who were financially dependent on a family member were more likely to practice mixed feeding [15,22].

Women's Experiences on Exclusive breastfeeding

Breastfeeding is considered as part of the biological process, where it is thought to be intuitive and based on the natural instinct of both the mother and her baby [11]. This study found that the mothers determination, wanting to be a complete woman, the desire to strengthen the bond between the mother and her child as well as not knowing what to do when probably everyone else assumes that a mother should intuitively breastfeed as part of the natural process are some of the issues women go through in this apparently emotive biological journey of exclusive breastfeeding. The mothers described their feelings as happy, amazing and satisfying while others described their exclusive breastfeeding experience as the crowning jewel of motherhood that makes them feel complete as a woman. Yet others felt it was the best thing that any woman can do and described the experience as empowering. The findings are similar to those of a study done on lived experiences of first-time breastfeeding women in Ghana [11]. Feelings of being empowered or of

being a complete woman or having a sense of satisfaction could have contributed to the women's determination to exclusively breastfeed their children while the state of not knowing what to do when probably everyone else assumes that a mother should intuitively breastfeed as part of the natural process could have contributed to some women not exclusively breastfeeding their children.

Limitations

Participants were recruited from villages surrounding Balaka District Hospital within Balaka Township. This may have resulted in leaving out views, experiences and perceptions of populations in more remote areas of the district. Nonetheless the study being qualitative in nature provided an in-depth understanding of the determinants of exclusive breastfeeding in the district. There is no reason to believe that the study participants differed significantly from others in more rural areas of the district since Balaka district itself is generally considered a rural area as a whole.

Conclusion

The study aimed at exploring determinants of exclusive breastfeeding among women with children aged 0-6 weeks attending postnatal clinic services in Balaka district from the perspectives of the women themselves, their spouses, sisters, grandparents and health care workers and identified themes and subthemes that offered insight into the phenomenon of exclusive breastfeeding. The findings have challenged the widely held notion that exclusive breastfeeding is merely an intuitive biological process based on the natural instinct of the mother and her baby but rather that successful exclusive breastfeeding is dependent on a complex interplay of factors such as mothers agency, HCW factors, socio-economic factors and support from significant others. Hence we can conclude that the phenomenon conceptualizes that EBF support systems along the continuum of care are a critical success factor for women to practice EBF and not just merely an intuitive

biological process based on the natural instinct of both the mother and her baby.

Implication for future research

The study explored the determinants of EBF among women with children 0-6 weeks at Balaka district hospital only. More studies need to be conducted at a large scale in other health facilities in rural settings in the district.

Study limitations

Participants were recruited from villages surrounding Balaka District Hospital within Balaka Township. This may have resulted in leaving out views, experiences and perceptions of populations in more remote areas of the district.

Declarations

Ethics approval and consent to participate: All ethical principles for medical research involving human subjects were followed including confidentiality and the principles of doing good while minimizing harm and participants compensation were dealt with in line with acceptable international guidelines and practice.

Consent for publication: Not applicable.

Data availability: Thematic chart is available upon request

Conflict of interest: The authors declare that they have no conflict of interest.

Funding: This study was self-funded hence there was no external influence in this study.

Author Contributions: Blessings Njolomole conceived the idea, designed, collected and analysed data, and wrote the manuscript, Dr Isabel Kazanga Chiumia guided and reviewed the draft manuscript and design.

Acknowledgements: The author would like to sincerely thank Dr Isabel Kazanga Chiumia for her untiring support, guidance and mentorship throughout the development of this manuscript and

contributions by faculty members and fellow students in the Department of Global Health Policy and Systems of the College of Medicine. Special thanks to my immediate family for their prayers support and best wishes.

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