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**THE UNIVERSITY OF ZAMBIA  
SCHOOL OF MEDICINE  
DEPARTMENT OF POST BASIC NURSING**

**A STUDY TO DETERMINE KNOWLEDGE, ATTITUDE AND PRACTICE OF ANTE-NATAL MOTHERS TOWARDS HIV TRANSMISSION THROUGH BREASTFEEDING IN LUSAKA URBAN DISTRICT.**

**BY**

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**Abbreviations used in the Study**

1.	A.I.D.S	.....	Acquired Immuno Deficiency Syndrome
2.	A.R.I.	.....	Acute Respiratory Infections
3.	B.F.H.I.	.....	Baby Friendly Hospital Initiative
4.	D.H.S.	.....	Demographic Health Survey
5.	H.I.V.	.....	Human Immuno Deficiency Virus
6.	I.B.F.A.N.	.....	International Baby Food Action Network
7.	L.D.H.M.T.	.....	Lusaka District Health Management Team
8.	KAP	.....	Knowledge, Attitude and Practice
9.	M.C.H.	.....	Maternal Child Health
10.	M.T.C.T.	.....	Mother-To-Child-Transmission
11.	NGO	.....	Non-Governmental Organisation
12.	O.R.T.	.....	Oral Rehydration Therapy
13.	S.T.I.	.....	Sexually Transmitted Infections
14.	U.N.A.I.D.S	.....	United Nations Programme for Aids
15.	UNICEF	.....	United Nations International Children's Emergency Fund
16.	UTH	.....	University Teaching Hospital
17.	V.C.T.	.....	Voluntary Counselling and Testing
18.	W.A.B.A.	.....	World Alliance for Breastfeeding Action
19.	WHO	.....	World Health Organisation

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**DECLARATION**

I hereby declare that the work presented in this study for the Bachelor of Science in Nursing Degree has not been presented wholly or in part for any other degree nor is it being currently submitted for any other degree.

SIGNED: *Amr Conere* 10.01.2000 .....

(CANDIDATE)

APPROVED BY: *M. Saleh* 10.1.2000 .....

(SUPERVISING LECTURER)

**STATEMENT**

I hereby certify that this study is entirely the results of own independent investigations. The various sources of information to which I am indebted are clearly indicated in the paper and in the references.

SIGNED: LANB Caree 10.01.2000

## **DEDICATION**

I dedicate this study to my husband, Mr. H.C. Kanene, and my children Muleya, Kunda and Chilala for what they have gone through as a result of my absence during my study.

My sister Catherine Mwape Banda for her patience, understanding and support both materially and financially.

My late father Reverend Peter Elijah Banda, my mother and all the Banda family for their encouragement and support.

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Lastly but not the least, to all the respondents for allowing me to interview them.

**MAY GOD BLESS YOU ALL**

**ABSTRACT**

The aim of the study was to determine the knowledge, attitude and practice of antenatal mothers on HIV transmission through breastfeeding. The study was conducted in Lusaka Urban District Health Centres, in October, 1999.

Review of literature revealed the factors influencing HIV transmission through breastfeeding as inadequate information, educational level, maternal age, maternal parity, occupation, source of knowledge and knowledge and attitude of health care provides.

A descriptive type of study was used. The sample consisted of fifty (50) antenatal mothers from five (5) health centres in which ten (10) respondents were chosen using simple random sampling technique.

Data was collected using structured interview schedule. It was sorted, categorized, coded and it was analysed systematically.

The study revealed that although most respondents attained some form of education, there were some respondents who had never been to school. The study also revealed that the respondents knowledge on HIV transmission through breastfeeding was inadequate though the majority were aware of HIV/AIDS.

Regarding attitude and practice, the study revealed that most of the respondents had a negative attitude towards breastfeeding when one became HIV positive. Most of the mothers were against 'wet' nursing.

# **CHAPTER ONE**

## **INTRODUCTION**

## 1.0. INTRODUCTION

### 1.1 BACKGROUND INFORMATION

Mother to Child transmission (M.T.C.T.) means that the immediate source of the child's infection lies within the mother. It means that the infant acquired the Human Immune Virus (HIV) during pregnancy (in utero), labour, during delivery or breastfeeding. The proportion of routes is unclear. It is believed that in developing countries the percentage of infants born to HIV infected mothers who become infected is about thirty four (34%) percent. Out of those infected it is believed that fourteen (14%) percent are infected through breastfeeding. This study therefore will enable us to know how much knowledge the antenatal mothers have with regards to HIV transmission through breastfeeding.

In the past a number of child survival initiatives were established to improve the lives of children the world over. These included:

- **Breastfeeding and Child survival**

Reproductive health is a broad concept which embraces among other issues family planning and maternal and child health (MCH/FP). Reproductive health is concerned with the health of all the people especially the vulnerable groups in the society, for example, the children and women. Safe motherhood is one of the components of MCH/FP which is more concerned with the mother and child issues. It encompasses antenatal care, safe and clean delivery, family planning and breastfeeding.

Breastfeeding is being recommended throughout the world because of its health benefits both for the mother and baby.

According to Cohen, J. et al (1992) exclusive breastfeeding for six (6) months and continuing breastfeeding up to two (2) years and beyond, has proved that it can save for about four thousand (4,000) babies a day from deaths due to diarrhoea and acute respiratory infections caused by early

introduction of formula and other food substitutes to a baby. This fact is supported by a Unicef Statement (1994) which states that “exclusively breastfed children are at a lower risk of infection than infants who receive complementary feeds earlier than six (6) months.” Babies who have complementary food prepared under unhygienic conditions and poor sanitary conditions will be more prone to diarrhoeal diseases.

Breastmilk has many advantages compared to alternatives to breastmilk. It has been said that breastmilk provides unique protection against infections and allergies and it also contains many anti-inflammatory properties. According to Arke, J. (1992) breastmilk enhances the baby’s immune system and it also satisfies both the baby’s nutritional and fluid needs. Offering of complementary feeds to infants below six (6) months reduces breastmilk intake, interferes with full absorption of the nutrients and exposes the infant to the danger of contamination.

- **Baby Friendly Hospital Initiatives**

This is another initiative which promotes child survival initiatives. Baby Friendly Hospital Initiative (BFHI) strategies are based on the ten (10) steps to successful breastfeeding. The initiative was implemented in Zambia following the Innocent Declaration (1990) a WHO/UNICEF joint statement on protecting, promotion and supporting breastfeeding. The strategies are aimed at increasing exclusive breastfeeding rates and continued breastfeeding among others by encouraging early bonding of the baby and the mother, reducing unnecessary separation by encouraging ‘rooming in’ concept. The strategies also aim at improving the health care providers’ knowledge and skill by training them in breastfeeding management.

Community breastfeeding support groups and social mobilization activities have been incorporated to promote breastfeeding so as to reduce childhood problems. To facilitate the BFHI activities in Zambia the

Nutrition Commission has a national policy on breastfeeding. The goal of the policy is to facilitate child survival, growth development and psychosocial wellbeing. This can be achieved through exclusive breastfeeding for the first food supplements for two (2) years and beyond.

Since the introduction of BFHI guidelines in 1993 when UNICEF/WHO initiated guidelines on implementation of BFHI activities to address breastfeeding issues fifty four (54) health facilities have attained the status of BFHI in Zambia. These strategies aim at facilitating child survival and growth development through exclusive breastfeeding with appropriate supplements.

**STATEMENT OF THE PROBLEM**

The world's child problems raised global concern in the past because of the increase in infant morbidity and mortality caused by diseases such as acute respiratory infections, malnutrition and diarrhoea. Most of these diseases can be prevented by early detection and prompt treatment. To reduce the infant morbidity and mortality rates the World Health Assembly (1978) came up with strategies for child survival. These strategies include growth monitoring, oral rehydration therapy (ORT) breastfeeding and immunization.

However, despite these strategies for child survival being in existence, statistics show that infant mortality rates have continued to rise. According to the DHS (1996) document, infant mortality has risen to one hundred and nine deaths per every thousand (109/1000) live births as compared to D.H.S. 1992 which had revealed 107 deaths per 1000 live births.

The advances made in child survival are being eroded by HIV/AIDS. The pandemic now presents a challenge to the survival of the child the world over. According to the UNAIDS report (1998), there are about 590,000 children under fifteen (15) who were newly infected with the virus HIV in 1997 while 40,000 died the same year. There are 1.1 million children under the age of fifteen (15) years up to today living with AIDS; and the total is 2.7 million. As can be seen HIV/AIDS is contributing substantially to the rising child mortality rates in many of the developing countries.

HIV/AIDS has brought a dilemma in the campaign for breastfeeding in the child's survival strategies especially in developing countries where the majority of the people are believed to be living in poverty. This means introducing alternatives to the children in these countries without provision of safe water, improved sanitation, morbidity and mortality rates would increase due to diarrhoeal diseases.

Mother to child transmission is a new concept hence there is need to offer more knowledge to mothers on HIV transmission through breastfeeding. Education will empower the mothers to make informed choices and decisions on the practices of infant feeding should they be found HIV positive. There are several factors that may affect the knowledge, attitude and practice of antenatal mothers on HIV transmission through breastfeeding. These will be discussed under the following sub headings:-

- Maternal factors
- Source of knowledge
- Service factors
- **Maternal factors**

There are several maternal factors that may affect the knowledge, attitude and practice of antenatal mothers on HIV transmission through breastfeeding. These include:-

- Level of education.

It has been said knowledge is power. Education empowers mothers to decide on what is right or wrong for themselves. There is need to educate antenatal mothers so that they will be able to read relevant literature, interact with colleagues who are enlightened so that they will learn.

With education antenatal mothers may be better informed on issues related to HIV transmission through breastfeeding. While with little or no education mothers would be more vulnerable to manipulation from their male counterparts. Educated antenatal mothers may have access to various sources of information relating to HIV transmission through breastfeeding and hence may be more knowledgeable than uneducated colleagues.

- **Occupation**

Antenatal mothers who are in employment may be exposed to various contacts such as clients and colleagues at their working places from whom they can learn.

Through discussions, reading papers and other articles the mothers may be able to exchange information on educational issues and experiences that are beneficial. Mothers who are not working have limited exposure to information. They are always found in the same environment and interacting with the same people, hence their knowledge will be limited.

- **Maternal age**

In Zambia most girls are married off at a tender age. As a result the young mothers may easily be influenced by their older counterparts because they lack experience and knowledge hence they may be ignorant in most issues relating to antenatal. This may make the young mother more vulnerable to wrong advice and influence, this may affect her knowledge and attitude towards HIV transmission through breastfeeding. When a young antenatal mother is given the right advice and information in relation to antenatal issues and HIV transmission through breastfeeding both the mother and the baby may benefit.

- **Maternal parity**

It is assumed that a mother who had breastfed before is more likely to breastfeed her children during subsequent deliveries. Because of having been exposed to the health care providers, antenatal mothers may continue to acquire knowledge on HIV transmission and breastfeeding practices from the health providers. The antenatal mothers attitude and practice may be influenced by the information from the health providers. A mother who had breastfed before may be aware of the benefits of breastfeeding both to her and her baby as a result she may want to continue breastfeeding all her babies.

- **Source of knowledge**

Credibility of source of information may affect an antenatal mother's knowledge and practice towards HIV transmission through breastfeeding. When the mother is adequately informed she may make better informed decisions and choices.

- Peer influence.

An antenatal mother who is enlightened on issues relating to HIV transmission and breastfeeding may influence others by sharing knowledge with them. Antenatal mothers may learn more from mothers who may be getting antenatal care.

- **Health personnel**

According to safe motherhood in Zambia (1996) attendance of mothers for antenatal care in urban areas is about 92%. This means the majority of mothers in urban areas especially, can benefit from the I.E.C. activities that are offered by health personnel in the clinics.

Health personnel who are knowledgeable, with better skills in breastfeeding management and HIV transmission may be able to impart knowledge to the mothers during antenatal mothers. Hence the antenatal mothers knowledge, attitude and practice may be affected by the health personnel's knowledge on HIV transmission through breastfeeding.

- **Media**

Data from D.H.S. (1996) on access to media, showed that over 60% of women listened to the radio, in the urban areas. This means a lot of mothers may be reached through the media. The media need to disseminate quality information because the mothers attitude and practice towards HIV transmission and breastfeeding may largely depend on the information received. Good quality information may affect the mothers knowledge on HIV transmission through breastfeeding and mothers attitude may be positive. When the quality of information is poor mothers may not gain anything.

- **Service factors**

Survey done by D.H.S (1996) showed that fifty three percent of mothers source of knowledge were the health centres. This means that health centres need to be environmentally friendly towards mothers. Unconducive environmental may enable the mother abandon antenatal visits hence she wont learn much.

Rigid schedules should be minimized for example having antenatal mothers only once a week. This means that when a mother misses her antenatal appointment for that week she wont be seen till the following week. This may affect the mothers' attitude and practice.

### 1.3. **PURPOSE OF THE STUDY**

The purpose of the study is to assess the knowledge, attitude and practice that antenatal mothers have towards HIV transmission through breastfeeding.

The findings from the study will enable the health care providers reassess themselves with regards to the I.E.C. activities that they offer in health centres. Adjustments will be made in areas which need emphasis when giving I.E.C. in issues relating to HIV/AIDS and exclusive breastfeeding.

The findings from the study will also help the health personnel to disseminate proper and adequate information, education and communication on HIV transmission through breastfeeding to both antenatal mothers and health workers.

1.4. **HYPOTHESIS**

The knowledge that mothers have towards HIV transmission through breastfeeding has an effect on attitude and practice.

1.5. **OBJECTIVES**

**MAIN OBJECTIVE**

To determine the knowledge, attitude and practice of mothers with regards to HIV transmission through breastfeeding in order to make recommendations to relevant authorities on formulation of strategies that encourage positive breastfeeding attitude and practices among mothers despite their HIV status.

**SPECIFIC OBJECTIVE:**

- To establish the level of knowledge that mothers possess in relation to exclusive breastfeeding.
- To establish the level of knowledge that mothers possess in relation to HIV transmission through breastfeeding.
- To determine the attitude that mothers have towards HIV transmission through breastfeeding.
- To find out how the mothers would feed their infants if they were found to be HIV positive.
- To make recommendations to policy makers with regards to HIV transmission through breastfeeding and the mothers knowledge, attitude and practices.

1.6.

**DEFINITION OF TERMS**

- a) Knowledge - Aware of something.
- b) Attitude - Manner of feeling and behaviour towards something.
- c) Practice - Actual use or performance.
- d) Exclusive Breastfeeding - Feeding the infant on breast milk only from birth to six (6) months of age.
- e) Mother to Mother Support Group - A community based interest group which has gone through an orientation of lactation management and successfully breastfed their infant. They give support and advice to breastfeeding mothers in the community they live.
- f) Morbidity - The ratio of the number of diseases to the total population.
- g) Mother-to-Child - transmission - Baby gets the HIV infection from the mother during pregnancy or delivery or during breastfeeding
- h) 'Wet' nursing - Allowing another person especially a relative to breastfeed a baby when the mother is sick and is unable to do it herself.
- i) Rooming in - Mother and the baby are kept in the same room so that she can breast-feed on demand.
- j) Infant - A baby who is under 1 year of age.

1.7.

**VARIABLES**

The variables that are going to be investigated in this study include:-

(a) **Dependent variables**

- Knowledge
- Attitude
- Practice

(b) **Independent variables**

Maternal parity, maternal age, educational level, occupation source of knowledge and knowledge and attitude of the care providers.

**INDICATORS AND CUT OFF POINTS FOR THE VARIABLE**

<b>VARIABLES</b>	<b>INDICATORS</b>	<b>CUT OFF POINTS</b>
Knowledge	Knowledgeable	2 - 4
	Not knowledgeable	0 - 1
Attitude	Positive Attitude	2 - 4
	Negative Attitude	0 - 1
Practice	Practice	1
	Would not practice	0

**CRITERIA FOR INDICATORS AND CUT OFF POINTS**  
**KNOWLEDGE ON EXCLUSIVE BREASTFEEDING**

1. Have heard about exclusive breastfeeding.
2. Mention that exclusive breastfeeding is feeding the baby on breast milk only from birth up to six (6) months.
3. Know that exclusive breastfeeding is good for baby and makes baby grow well.
4. Mention at least one benefit of exclusive breastfeeding.

Knowledgeable - 2 - 4 points

Not knowledgeable - 0 - 1 points

**KNOWLEDGE ON HIV/AIDS**

1. Should have heard of HIV/AIDS.
2. Should know HIV/AIDS is transmitted both in adults and children.
3. Mention at least one (1) way through which children get infected.
4. Should know that there is no cure for HIV/AIDS.  
Knowledgeable - Should meet 2 - 4 points  
Not knowledgeable - should meet 0 - 1 points

**ATTITUDE AND PRACTICE TOWARDS BREASTFEEDING**  
**AND HIV/AIDS POSITIVE**

1. Should believe that breastfeeding is good regardless of the mother's HIV status.
2. Mention at least one reason for breastfeeding in an HIV positive mother.
3. She would breastfeed her baby even when found HIV positive.
4. Would not give her baby for wet nursing
5. Should mention at least one (1) disadvantage of wet nursing  
Knowledgeable - respondents should meet 3 - 5 points  
Not knowledgeable - respondents should meet 0 - 2 points

**CHAPTER TWO**

**LITERATURE REVIEW**

## LITERATURE REVIEW

### INTRODUCTION

Throughout the world breastfeeding has been accepted as perfect food for infants. Breastfeeding is being recommended because of its benefits. The International Baby Food Action Network (IBFAN) is a worldwide coalition of Non Governmental Organisation Committee for the improvement of mother and child through better infant nutrition and promotion, protection and support of breastfeeding. The World Alliance for Breastfeeding Action (WABA), brings all breastfeeding advocates together throughout the world. WABA monitors and assesses the impact of breastfeeding at the national level. WHO/UNICEF supports breastfeeding through financing programmes which could result in positive changes in breastfeeding, for example the annual breastfeeding week. It is for this reason that WHO and many governments including Zambia adopted the Innocent Declaration at the WHO/UNICEF policy makers meeting on breastfeeding in 1990. This was a global initiative on the promotion, protection and support breastfeeding.

In Zambia in order to promote, protect and support breastfeeding, a national policy was initiated and developed. This is a guide to private sectors and Non Governmental Organisations (NGO) in support of breastfeeding. The goal of the policy is to facilitate child survival, growth development and psychosocial wellbeing through exclusive breastfeeding for the first six (6) months and continue thereafter with appropriate food supplements for two (2) years and beyond.

However, the World Bank Assessment report estimated that two thirds ( ) of the population in developing countries are said to be living below the poverty datum line and 69% live in households in which basic needs are not being met. In view of this the alternatives to breastfeeding

would be expensive to most people. Alternatives given to the babies under conditions of poor hygiene can lead to diarrhoea, malnutrition and eventually death.

There are studies that have been done that show that optimal breastfeeding to infants below the age of 2 years with timely complementary feeds can greatly contribute to the reduction of acute respiratory infections diarrhoeal diseases, malnutrition and also reduce cases of fatality of childhood illness. Bier, J.A. etal (1997) did a study in a rural community in Bangladesh on diarrhoea and breastfeeding. The study showed that exclusive breastfed infants were protected from diarrhoea that was due to E. Coli. Roberta J. etal (1995) did another in Honduran on benefits of breastfeeding in poor populations. They concluded that chances of infants dying from respiratory tract infections and diarrhoea are less in poor populations when babies are exclusively breastfed the first four to six ( 4 —6 ) months.

However, there has been threats to the strategies that protect, promote and support breastfeeding since the coming of the HIV/AIDS epidemic in the world today. The HIV/AIDS pandemic represents a tragic set back in the progress made on child welfare. “The pandemic is threatening to reverse the success gained through promotion of child survival programmes like immunizations, control of diarrhoeal diseases and the promotion of breastfeeding.” UNAIDS report 1998.

2.2.

### **GLOBAL HIV/AIDS PREVALENCE**

The June 1998 UNAIDS report estimates indicate that by the beginning of 1998 over thirty 30 million people were infected with HIV, the virus that causes AIDS and that 11.7 million people around the world had already lost their lives to the disease. The virus continues to spread causing 16,000 new infection a day. In 1997 alone 2.3. million people died of AIDS during the course. Nearly 600,000 children were infected with HIV in 1997 mostly through their mothers before or during birth or during breastfeeding. The number of children under 15 fifteen (15) who have lived or are living with HIV since the start of the epidemic has reached around 3.8 million. Unless a cure is found or life prolonging therapy can be made more widely available, the majority of those now living with HIV will continue dying.

2.3.

### **SUB SAHARAN AFRICA HIV/AIDS PREVALENCE**

Over two thirds of all the people now living with HIV in the world nearly twenty one (21) million men, women and children are in the sub Saharan Africa. HIV in Sub Sahara Africa has mostly spread through heterosexual transmission. This means that women are more heavily affected in Africa than in other regions where the virus was initially spread most quickly among men through homosexuality or drug injecting. Bonena and Rolden (1987) found that wives bargaining power in marriage was lowest in the area of deciding on and when to have sexual intercourse. This increases the vulnerability of women to HIV/AIDS. Four out of five HIV positive women in the world live in Africa. A presentation on HIV/AIDS by Dr. Simpungwe on 16<sup>th</sup> October, 1999 at Libala SDA Church revealed that Zambia was among the top 3 with the highest rates of HIV in the sub Saharan countries. Zimbabwe being the first followed by Botswana and Zambia is third.

### THE ZAMBIAN SITUATION

According to the UNAIDS (1998) report 770,000 adults and children were infected with the HIV virus in Zambia. Sichone M. (1996) reported that as of March 1996 nearly 34,000 Cumulative AIDS cases had been reported to the Ministry of Health. This figure he said was a serious under estimate of the actual number of cases due to the under reporting. This means the actual numbers of the AIDS disease will only be known when the reporting system improves.

There are two (2) HIV transmission mechanisms which account for most new infections in Zambia, through heterosexual contact and perinatally. The majority of infections are transmitted through heterosexual contact in adults while many children get the infections through perinatal transmission.

Since the HIV epidemic started more and more women are becoming infected. UNAIDS (1998) estimates, reports that 12.2 million women in child bearing age (15 – 49 years) are infected, with 9.9 million from Sub Saharan Africa.

Jacobson, J.L. (1991) in his study showed that the female to male ratio was estimated to be 6 women infected for every 4 men. It is therefore clear that HIV/AIDS is still an increasing important problem in general and for women in particular because of the vulnerability and impact it has on women compared to men.

Although most babies with HIV will have contracted it from their mothers, little is known about the precise mechanism or timing of transmission. It is said that 30 – 40% babies are infected through mother to child transmission. There is evidence that infection can occur as early as the first 12 – 15 weeks gestation but proportion of fetuses who are infected this early or during the birth process is unknown. Of the 30 – 40%

infected with HIV, 14% may get infected through breastfeeding. There are studies that have been done that confirm mother to child transmission. The study revealed that HIV in breast milk does not necessarily mean that breastfeeding is a route of transmission evidence from case reports points in that direction. Another study by Nicoll, A. etal (1995) on infant feeding policy and practice in the presence of HIV supported breastfeeding as still being the best food for infants.

A study done in Zambia by Mpabalwani M. etal (1993) examined the role of breastfeeding in transmission of HIV. They concluded that although breastfeeding may be an important mode of HIV transmission in children who are breastfed by seropositive mothers, there are other factors that need to be studied to evaluate postnatal transmission. Most of the studies done do not really state how much infection the infants get from the mothers solely from breastfeeding.

It is reported that a woman in a developing country may choose to breastfeed even if she knows about her infection and knows that she might pass it on through breast milk. This is why breastfeeding has been known to protect the infant against a range of other infections as earlier mentioned. It is a convenient approved by most cultures and it is free. By choosing artificial feeding a woman may avoid passing on HIV virus to her baby.

But while the water supply is unsafe she may expose her child to other deadly diseases. Since prolonged breastfeeding is believed to have a natural contraceptive effect, she may also expose herself to pregnancy again if she is not using any other contraceptive.

In most developing countries a seropositive mother will stretch the family's budget. According to the UNAIDS report (1998) a year's supply

of artificial milk for infants will cost a Vietnamese family more than the country's per capita G.D.P. and this is the same elsewhere in the developing world. This would add on to the family's budget burden. On the other hand if bottle feeding becomes a norm for all seropositive mothers, the women may expose themselves to stigmatization and end up being rejected from communities especially where there is low knowledge in the modes of HIV transmission.

## **KNOWLEDGE, ATTITUDE AND PRACTICE ON HIV TRANSMISSION THROUGH BREASTFEEDING**

In the past knowledge, was acquired within the community through interactions with adults. Traditional practices involved passing of knowledge, beliefs values and norms from older generations to the young generations. In Zambia breastfeeding has been considered a tradition and an acceptable norm. Information and advice on pregnancy to would be mothers is usually given during initiation ceremonies or just before marriage.

These days many mothers especially in urban areas get the information and advice on pregnancy and all related issues from the healthcare providers and media. Demographical Health Survey (1992) results showed that 92% of mothers attend antenatal clinics.

This means antenatal mothers would benefit from the clinics if the health care providers would use the opportunities to teach and give advice to the mothers on various issues related to pregnancy, delivery and postnatal period. Friends, P. (1991) did a study which revealed that almost all mothers who breastfeed their children lacked knowledge especially on exclusive breastfeeding. This is supported by a study done by Mwala, C. (1993) to determine the knowledge, attitude and practice amongst working mothers with regards to breastfeeding in Lusaka Urban which revealed that despite the fact that most mothers attended antenatal clinics during pregnancy not every mother received advice on breastfeeding.

Hence the need to intensify information, education communication (I.E.C) activities in health care settings to antenatal mothers so that they are given adequate knowledge especially on new concepts such as exclusive breastfeeding and HIV transmission. This will enable antenatal mothers have adequate knowledge and be able to make informed decisions and

choices regarding infant feeding.

This knowledge will also empower the women to decide on the appropriate feeding practices with regards to HIV transmission through breastfeeding.

**CHAPTER THREE**  
**RESEARCH METHODOLOGY**

### 3.0.

## **METHODOLOGY**

### **3.1. RESEARCH DESIGN**

The purpose of the study was to determine knowledge, attitude and practice of antenatal mothers towards HIV transmission through breastfeeding. The researcher decided to use the survey research design to collect data for the study. "a survey is a mode of verbal inquiry that heavily relies upon the validity of verbal reports. It combines a distinct method of data collection. (interviews and questionnaires) with a special form of data analysis by statistical means". (Seaman and Verhomick 1982 p 163). Combining the questionnaire and the interview in the same study quite often enhances a research investigation. The interviewer had decided to use the interview because it has a lot of advantages. There were more chances of using all the data from each interview because there were few blank items, misunderstandings, late arrival and incorrect completions. Depth of response was assured, since the researcher was able to pursue any question of special interest. The interviewer was able to ask respondents questions that were not included initially but that would add to the richness of the interview content, such information was added to the data, recorded by the interviewer for her own understanding of the situation.

### **3.2. RESEARCH SETTING**

The study was conducted in Lusaka Urban District. The district has a population of about 1.2. million including those in the child bearing age. The district has a total of 23 peri urban clinics which are divided into 8 zones.

### **3.3. STUDY POPULATION**

The population consisted of all antenatal mothers who were in the clinics at the time of the study. A sample of fifty (50) respondents from the total population of antenatal mothers was used.

### **3.4. SAMPLE SELECTION AND APPROACH**

The sample frame list of all the clinics was taken from LDHMT offices along Makishi Road. Five (5) clinics were selected by simple random sampling method. Each subject of the sample was selected on the basis of chance. The selection of the subjects in the sample did not depend upon judgement of the researcher rather chance alone decided which subjects were to be included. The lottery, one of the simple random method was used. All the clinics were numbered on small and identical slips of paper which were folded and mixed together. The papers were of the same size, colour and shape. A blindfold selection was made of the number of slips which was required to constitute the sample of five (5) clinics. Slips numbering 1 to 23 were made and mixed thoroughly and one by one a blindfold selection of the slips were made till the number of five (5) was reached. The selected clinics catered for both high and low density areas. The clinics sampled included Matero Reference, Chipata, Civic Centre, Chilenje and Kalingalinga Clinics.

### **3.5. SAMPLE SIZE**

The researcher used a sample of fifty (50) subjects selected from the total population of antenatal mothers. Ten (10) mothers were drawn from each of the five (5) selected clinics.

### **3.6. SAMPLING METHOD**

The researcher used a simple random sampling method. This method ensured that all mothers in the population had an equal chance of being included in the sample. The five (5) clinics were selected from sampling frame list of twenty three (23) clinics by the lottery method.

A systematic sampling method was used to draw a sample of 10 mothers from each of the selected five (5) clinics. The sampling frame list was the antenatal mothers in the clinic at that time. A sampling sample interval was obtained for each of the clinic by dividing the total number of the mothers by the sample size of 10 per clinic.

### **3.7. DATA COLLECTION**

Data collection was done between 11<sup>th</sup> to 18<sup>th</sup> October, 1999. The respondents were interviewed personally by the interviewer. Data collection technique used was the structured interview schedule. The questions on the questionnaires and their wording were fixed and identical to those given to all respondents such that the responses one got were a result of the different respondents who had different views and tastes. The instrument comprised of a series of questions that were both open and close ended. All the responses were filled in by the interviewer. This method of data collection had been selected because it had a lot of advantages and also combining the questionnaire and interview enhanced a research investigation.

An interview was used to elicit information from a broader group of individuals since the respondents did not have to know how to read or write. Both verbal and non verbal cues that did not appear on the questionnaire were noted during the interviews. If the interviewee did not understand any one of the questions it could be repeated. By rewarding the item the researcher made the questions more meaningful to the other interviewees. The interviewer was more sure that all the questions were answered because no items were overlooked during the interview. As a result this method had low non response rate.

This instrument may have limitations such as not giving accurate answers by the interviewee because of the interviewer's presence. This problem was addressed by creating good relationship and rapport with the respondents. Respondents were assured that all the information was confidential. Interviews were costly both in time and money because the interviewer had to spend a certain number of hours interviewing each participant separately. This method is not practical where field of investigation is vast and informants are scattered.

### **3.8. ETHICAL CONSIDERATION**

A letter asking for permission to conduct the study in Lusaka Urban clinics was sent to the Lusaka District Management Team. Permission to carry out the study was granted on 1<sup>st</sup> October. Consent from the respondents to interview them was obtained at the beginning of the session. Anonymity of all the respondents was maintained. The interview schedule was serially numbered.

### **3.9. PILOT STUDY**

A pilot study was done at Kabwata clinic with a small scale of respondents to test the accuracy and suitability of the tool. The pilot study helped the researcher to make readjustments to the questionnaire. Some of the questions were removed from the questionnaire because of repetitions in the responses, while in some, phrasing of the questions was corrected. Some questions were included to the questionnaire to source for more information for the study. Lastly some questions were re-arranged in a logical sequence.

## **CHAPTER FOUR**

# **DATA ANALYSIS AND PRESENTATION OF FINDINGS**

## **PRESENTATION AND ANALYSIS OF DATA**

Data collected and presented in this chapter was obtained from fifty (50) respondents. Data was sorted out according to the tool used; a Structured interview schedule. Data collected was checked for completeness and then tallied on a master sheet. Responses from open ended questions were categorized and suitable terms to bring all such related data together were used and then entered on the master sheet.

Descriptive statistics and percentages were used in tabulating data. Cross tabulation, a pie chart and frequency tables were used. It was found suitable to use tables because they summarize results in a meaningful way, enabling the reader to understand the author's intentions in the study. Cross tabulations of variables was done to show relationships among variables and to draw meaningful inferences from the sample.

**Table 1**

**RESPONDENTS AGE DISTRIBUTION IN RELATION TO EDUCATION**

<b>AGE</b>	<b>NONE</b>	<b>PRIMARY</b>	<b>SECONDARY</b>	<b>COLLEGE UNIVERSITY</b>	<b>TOTAL</b>
15 – 19	1(2%)	3(6%)	6(12%)	-	10(20%)
20 – 24	2(4%)	8(16%)	9(18%)	2(4%)	21(42%)
25 – 29	1(2%)	2(4%)	4(8%)	3(6%)	10(20%)
30 - 34	1(2%)	3(6%)	2(4%)	3(6%)	9(18%)
<b>TOTAL</b>	<b>5(10%)</b>	<b>16(32%)</b>	<b>21(42%)</b>	<b>8(16%)</b>	<b>50(100%)</b>

Majority of respondents 21(42%) have attained secondary education followed by primary education 16(32%). Meanwhile 5(10%) of the respondents never went to school. The majority 21 (42%) were in the reproductive age group of 20 – 24 years.

**Table 2**

**SOCIO DEMOGRAPHIC DATA**

<b>RESIDENTIAL PLACE</b>	<b>NO. OF RESPONDENTS</b>	<b>PERCENTAGE</b>
Low Density	11	22%
Medium Density	16	32%
High Density	23	46%
<b>TOTAL</b>	<b>50</b>	<b>100%</b>

The majority of the respondents 23 (46%) live in high density areas, while 11 (22%) live in low density.

**Table 3**

**RESPONDENTS EDUCATION IN RELATION TO OCCUPATION**

<b>EDUCATION</b>	<b>OCCUPATION</b>		
	<b>WORKING</b>	<b>NOT WORKING</b>	<b>TOTAL</b>
Never been to School	-	<b>5(10%)</b>	<b>5(10%)</b>
Primary School	-	16(32%)	16(32%)
Secondary School	3(6%)	17(34%)	20(40%)
College/University	7(14%)	2(4%)	9(18%)
<b>TOTAL</b>	10(20%)	40(80%)	50(100%)

Majority of the respondents (80%) were not working and the majority of the respondents 40% attained Secondary education while (10%) had never been to school.

**Table 4**

**RESPONDENTS PARITY IN RELATION TO MARITAL STATUS**

<b>MARITAL STATUS</b>	<b>0 - 2</b>	<b>3 - 5</b>	<b>6 - 8</b>	<b>TOTAL</b>
<b>SINGLE</b>	3(6%)	-	-	3(6%)
<b>MARRIED</b>	30(60%)	11(22%)	2(4%)	43(86%)
<b>DIVORCED</b>	2(4%)	-	-	2(4%)
<b>WIDOW</b>	-	2(4%)	-	2(4%)
<b>TOTAL</b>	35(70%)	13(26%)	2(4%)	50(100%)

The majority of the respondents 43(86%) were married and 35(70) had 0 - 2 children . Only 2(4%) mothers had more than 5 children.

**Table 5**

**HUSBANDS' EDUCATION IN RELATION TO OCCUPATION**

**OCCUPATION**

**EDUCATION**

	<b>PRIMARY</b>	<b>SECONDARY</b>	<b>COLLEGE UNIVERSITY</b>	<b>DON'T KNOW</b>	<b>TOTAL</b>
<b>FORMAL EMPLOYMENT</b>	4(8%)	15(30%)	11(22%)	3(6%)	33(66%)
<b>INFORMAL EMPLOYMENT</b>	1(2%)	7(14%)	3(6%)	-	11(22%)
<b>UNEMPLOYED</b>	1(2%)	-	-	-	1(2%)
<b>TOTAL</b>	6(12%)	22(44%)	14(28%)	3(6%)	45(90%)

Majority of the respondents husbands 33(66%) were engaged in formal employment, while 1 (2%) were unemployed. 22 (44%) of the husbands had attained secondary education followed by 14(28%) with college/university level of education. 3(6%) of the respondents did not know the husbands' level of education.

**Table 6**

**KNOWLEDGE**

**RESPONDENTS WHO HAVE HEARD OF EXCLUSIVE BREASTFEEDING**

<b>HEARD OF EXCLUSIVE BREASTFEEDING</b>	<b>NO. OF RESPONDENTS</b>	<b>PERCENTAGE</b>
<b>YES</b>	36	72
<b>NO</b>	11	22
<b>NONE</b>	3	6
<b>TOTAL</b>	50	100

Majority of the respondents 36 (72%) had heard about exclusive breastfeeding. Meanwhile 3(6%) respondents had never heard about exclusive breastfeeding.

**Table 7**

**WHAT MOTHERS UNDERSTOOD ABOUT THE MEANING OF EXCLUSIVE BREASTFEEDING**

RESPONSES	NO. OF RESPONSES	PERCENTAGE
KNOWLEDGEABLE	19	38
NOT KNOWLEDGEABLE	31	62
<b>TOTAL</b>	<b>50</b>	<b>100</b>

19(38%) of the respondents knew the correct definition of exclusive breastfeeding while the majority 31 (62%) did not know.

**Table 8**

**WHEN DID RESPONDENTS HEAR OF EXCLUSIVE BREASTFEEDING**

PERIOD	NO. OF RESPONDENTS	PERCENTAGE
Present Pregnancy	13	26
Previous pregnancy	23	46
Never heard	14	28
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Majority of the respondents 23 (46%) had heard about exclusive breastfeeding during the previous pregnancies while 14 (28%) had never heard about it.

**Table 9****RESPONDENTS KNOWLEDGE TOWARDS BREASTFEEDING IN RELATION TO SOURCE OF INFORMATION**

<b>SOURCE OF INFORMATION</b>	<b>KNOWLEDGEABLE</b>	<b>NOT KNOWLEDGEABLE</b>	<b>TOTAL</b>
FRIENDS	3(6%)	1(2%)	4(8%)
RELATIVES	1(2%)	2(4%)	3(6%)
HEALTH PERSONNEL	23(46%)	2(4%)	25(50%)
MEDIA	2(4%)	-	2(4%)
MEDIA AND HEALTH PERSONNEL	1(2%)	-	1(2%)
RELATIVES AND HEALTH PERSONNEL	1(2%)	-	1(2%)
N/A	-	14(28%)	14(28%)
<b>TOTAL</b>	<b>31(62%)</b>	<b>19(38%)</b>	<b>50(100%)</b>

Majority of the respondents 23(46%) got the information about exclusive breastfeeding through the health personnel with 7(14%) from friends.

**Table 10**

**KNOWLEDGE OF RESPONDENTS ON HIV/AIDS**

<b>KNOWLEDGE</b>	<b>NO. OF RESPONDENTS</b>	<b>PERCENTAGE</b>
<b>KNOWLEDGEABLE</b>	50	100
<b>NOT KNOWLEDGEABLE</b>	0	0
<b>TOTAL</b>	50	100

All the respondents 50(100%) were knowledgeable on HIV/AIDS.

**Table 11**

**RESPONDENTS KNOWLEDGE ON MODES OF TRANSMISSION OF HIV**

**A. IN ADULTS**

RESPONSES	NO. OF RESPONDENTS	PERCENTAGE
YES	48	96
NO	2	4
TOTAL	50	100

The majority of the respondents 48(96%) knew how HIV is transmitted in adults while 2(4%) did not know.

**B. IN CHILDREN**

RESPONSES	NO. OF RESPONDENTS	PERCENTAGE
YES	44	88
NO	6	12
TOTAL	50	100

The majority of the respondents 44 (88%) were knowledgeable on how children get infected while 6(12%) were not.

**Table 12**

**RESPONDENTS SOURCE OF INFORMATION ON HIV/AIDS**

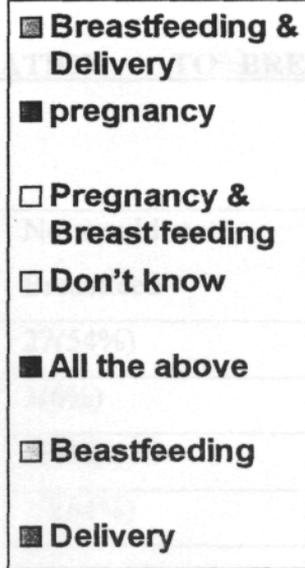
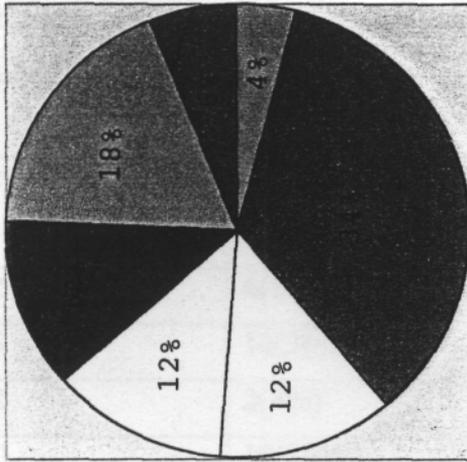
SOURCE	NO. OF RESPONDENTS	PERCENTAGE
FRIENDS	7	14
RELATIVES	3	6
HEALTH PERSONNEL	20	40
MEDIA	4	8
ALL THE ABOVE	11	22
MEDIA/HEALTH PERSONNEL	3	6
RELATIVES/HEALTH PERSONNEL	1	2
MEDIA/SCHOOL	1	2
TOTAL	50	100

Majority of the respondents 20(40%) got the information about HIV/AIDS through the health personnel with 7(14%) from friends.

## PIE CHART 13

### RESPONDENTS KNOWLEDGE ON DIFFERENT WAYS OF HOW CHILDREN GET INFECTED

Table 14



Majority of respondents 34% know that HIV can be transmitted through pregnancy and 12% don't know how a child gets infected.

**Table 14**

**RESPONDENTS PARITY IN RELATION TO BREASTFEEDING IF BECAME HIV POSITIVE**

Parity	Yes would breastfeed	No would not Breastfeed	Total
0 – 2	6(12%)	27(54%)	33(66%)
3 – 5	10(20%)	3(6%)	13(26%)
6 – 8	2(4%)	2(4%)	4(8%)
Total	18(36%)	32(64%)	50(100%)

The majority of respondents 27 (54%) who would not breastfeed if they became HIV positive had 0 – 2 children, meanwhile majority 10(20%) of those who would breastfeed had 3 – 5 children.

**Table 15**

**ATTITUDE OF RESPONDENT TOWARDS 'WET' NURSING**

RESPONSES	NO. OF RESPONDENTS	PERCENTAGE
YES	19	38
NO	23	46
N/A	8	16
TOTAL	50	100

The majority of the respondents 23(46%) were not willing to have their infants to be breastfed by a relative while 19 (38%) were willing.

## CHAPTER FIVE

### DISCUSSION OF FINDINGS

## **5.0 DISCUSSION OF THE FINDINGS**

### **INTRODUCTION**

The research study was aimed at establishing the knowledge, attitude and practice of antenatal mothers towards HIV transmission and breastfeeding in Lusaka peri urban clinics.

### **SOCIO DEMOGRAPHIC DATA**

All the mothers were within the reproductive age group of 15 – 49 years the majority (42%) were in the age group of 20 – 24 years. (Table 1) Page 28. The majority had attained some form of education and 10% never went to school. (Table 1) page 28. Considering the small sample size of 50, 10% of respondents who have never gone to school is significant. Illiteracy rates among women in Zambia have been documented as being quite high. For the literate respondents it was necessary to know their knowledge, attitude and practice towards HIV and breastfeeding as one would presume they would have heard or read about the concepts somewhere.

The study revealed that 46% of the respondents live in the high density area. (Table 2) page 29. This is in line with the fact that the study site was in Lusaka which is one of the fastest growing cities in the region. The study also revealed that 60% of the respondents were not working and only 20% were working. (Table 3) page 30. This means mothers have limited exposure to information. The more exposure one has, the more knowledge one gains. It is worse for those women who were not working and have never been to school, since they have little interaction with those who are enlightened. Most of the respondents 83% were married and had 0 – 2 children. (Table 4) page 31. Since the mothers are still in the childbearing age, there is need for them to have adequate and necessary information on infant feeding and HIV transmission, through breastfeeding so that

they are able to make informed choices. There were only 4% of the mothers who had 6 – 8 children. (Table4) page 31. This may suggest that mothers have reduced the number of children they would want. This could either mean that people have been educated on family planning services and are practicing it or the families are not able to support big families both economically and socially. (Table 4) page 31. Though 66% of the respondents' husbands were engaged in some form of formal employment (Table 5) on page 32, the majority had low paying jobs. This attributes to most of them being found in the high density areas. Since most of the mothers were not working and majority of the husbands were engaged in low paying jobs, appropriate alternatives to breast milk would be too expensive for these families. It is interesting to note that 6% of the mothers did not know their husbands level of education.

### **KNOWLEDGE OF ANTENATAL MOTHERS TOWARDS EXCLUSIVE BREASTFEEDING**

The findings of the study on knowledge revealed that a total of 72% respondents had heard about exclusively breastfeeding, while 6% had never heard of it. (Table 6) on page 34. However, only 38% of the respondents knew the correct meaning of exclusive breastfeeding with 62% who did not know (Table 7) page 35. The findings further revealed that 46% of the respondents heard of exclusive breastfeeding during the previous pregnancies (Table 8) on page 35.

This suggests that the health care providers have slackened in the dissemination of information. Though many antenatal mothers attend antenatal clinics health workers are not utilizing the opportunity to teach and advise mothers about exclusive breastfeeding. Though the antenatal mothers were aware of exclusive breastfeeding the findings suggests that their level of awareness is inadequate. Freund P.J. (1995) did a study which revealed that almost all mothers who breastfeed their children, many lacked knowledge especially on exclusive breastfeeding.

The study revealed that 50% of respondents got the information about exclusive breastfeeding through the health personnel, followed by 14% from friends (Table 9) on page 35. These findings indicate that peer education is still an effective way of disseminating information in most of the programmes. Hence there is need to support peer education among antenatal mothers.

The study also revealed that all mothers (100%) were knowledgeable on the issue of HIV/AIDS (Table 10) on page 36. This suggests that the majority of the mothers are knowledgeable of the pandemic of HIV/AIDS. However not all mothers were aware of the modes of HIV transmission in adults, 96% were aware while 4% were not. (Table 11) page 37. Where as only 88%, were aware of how children get infected (Table 11B) page 37. This means there is still need to continue educating the people on HIV transmission. The findings on the source of information revealed that the majority 40% got the information from health personnel while 14% got it from friends (Table 12) page 38. Though 34% of the respondents knew that HIV can be transmitted through pregnancy, there were still 12% who did not know any of the different modes of transmission of HIV in children (Pie Chart 13) page 39. The findings suggests that there is need to educate the mothers on how a child gets infected and the chances of the child not being infected even when the mother is HIV positive.

## **ATTITUDE AND PRACTICE OF THE ANTENATAL MOTHERS TOWARDS HIV TRANSMISSION THROUGH BREASTFEEDING**

The study revealed that 54% of the mothers who felt they would not breast feed if they became HIV positive had 0 - 2 children (Table 14) page 40; while the majority who thought they would breastfeed, had 3 – 5 children. The findings suggest that because of the knowledge of HIV/AIDS the young mothers thought they would not breastfeed their babies despite the benefits to both the mother and the baby, for fear of infecting the baby. On the other hand the multipara mothers felt they would breastfeed despite their HIV status, may be due to the previous breastfeeding experiences they would have had with the other children. Most of the respondents 46% felt they would not give their babies to be breastfed by a relative while only 38% were willing to give their children to be breastfed by a relative. (Table 15) page 41. Traditionally most people used to give their babies to be breastfed by a relative especially a sister or grandmother, it was an acceptable norm. Now with the knowledge of HIV/AIDS people have changed their practices towards breastfeeding. The findings approve the hypothesis which states that the knowledge antenatal mothers have on HIV transmission breastfeeding will influence their attitude and practice. The study revealed that the majority of the respondents had negative attitude towards HIV transmission and breastfeeding and most of them, especially young mothers, felt they would not breastfeed their babies if they became HIV positive.

### **5.1. IMPLICATIONS ON HEALTH SYSTEMS**

The study revealed that ante natal mothers were aware of HIV transmission and breastfeeding. However, the mothers' awareness on exclusive breastfeeding and its benefits was not adequate. Majority of mothers got their information on both exclusive breastfeeding and HIV/AIDS from health centres. Hence the need to intensify the dissemination of information in the centres so that new concepts such as exclusive breastfeeding are understood by all the antenatal mothers. The second highest source of information was friends, this indicates that there is need to encourage peer education. All the health centres should have active breastfeeding mothers support groups. The drama group that perform at some health centres and in the communities to disseminate information should be strengthened and given all the support by the stake holders, that is the health personnel, the community, the civil leaders, the politicians and the non governmental organisations.

Orientation of health workers especially nurses on current knowledge on HIV transmission and breastfeeding should be done routinely.

### **5.2. SUMMARY**

The study has shown that there is great need for health care providers to disseminate information on exclusive breastfeeding and HIV/AIDS. It has been proven that mothers have knowledge gaps on exclusive breastfeeding and modes of HIV transmission. Lastly the high illiteracy rates among women will continue to retard their participation in programmes such as exclusive breastfeeding.

### **5.3. CONCLUSION**

The study was aimed at determining the knowledge, attitude and practice towards

HIV transmission breastfeeding in Lusaka urban district. Data was collected by use of structured interview schedule. The sample consisted of fifty (50) antenatal mothers who were randomly selected.

The study revealed that most mothers got information on breastfeeding and HIV/AIDS from health workers followed by others who got the information from friends in the community. This indicates that peer education is one of the most effective way of disseminating information. Though all mothers were knowledgeable of HIV/AIDS, there were still few who did not know how it is transmitted in both adults and children. The study showed that the mothers' attitude towards breastfeeding in HIV positive. This is in line with the hypothesis that states that the knowledge the mothers have towards HIV transmission through breastfeeding has an effect on their attitude and their practices.

#### **5.4. RECOMMENDATIONS**

The following are the recommendations made as a result of the findings of the study:-

1. All health centres should have free voluntary counselling and testing services for antenatal mothers. There is need for all the midwives to be trained in counselling.
2. Existing breastfeeding mother support groups should be strengthened in all the communities and where they do not exist they should be initiated.
3. There should be frequent monitoring and evaluation of standards in all health centres with BFHI status by the Nutrition Commission in conjunction with UNICEF so that standards are maintained.
4. There should be frequent updating of knowledge on reproductive health especially safe motherhood to health workers through in service,

workshops and seminars.

5. Dissemination of information in the community through drama and sketches should be encouraged and supported so that illiterate mothers can contribute.
6. There is need for organisations to provide supportive services especially nutrition to the mothers who would want to breastfeed their babies even when they are positive.
7. There is need for educating the communities and families on the importance of giving moral, nutritional and spiritual support to a mother who decides to breastfeed despite being HIV positive.
8. In view of the low economic status of most antenatal mothers there is need to do another study to establish whether mothers can afford alternatives to breast milk in this era of HIV/AIDS.

#### **5.5. LIMITATIONS OF THE STUDY**

1. It was difficult to obtain adequate literature on HIV transmission through breastfeeding in antenatal mothers, because not much has been documented yet especially in Zambia.
2. Time was inadequate in which to complete the study.
3. The research was not funded hence the resources to carry out the study was inadequate.

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**APPENDIX 1**

No.:.....

**QUESTIONNAIRE**

**STRUCTURED INTERVIEW SCHEDULE**

**NAME OF INTERVIEWER**

**INSTRUCTIONS**

1. The title of the study is Determination of knowledge and attitude towards HIV/AIDS transmission through breastfeeding.
2. Introduce yourself to the client and explain the purpose of your visit.
3. Please assure the client that the information from the study will be treated in strict confidence and that no names will be used.
4. Please tick the appropriate answer and write the comments in the space provided.
5. Thank the respondents at the end of the interview.

**SECTION A**

FOR OFFICIAL USE ONLY

**DEMOGRAPHIC INFORMATION**

1. How old are you?

- i) 15 - 19 yrs
- ii) 20 - 24 yrs
- iii) 25 - 29 yrs
- iv) 30 - 34 yrs
- v) 35 - 39 yrs
- vi) 40 and above

2. What is your level of education?

- i) Never been to school
- ii) Primary School
- iii) Secondary School
- iv) College/University

3. Where do you live?

- i) Low density
- ii) Medium density
- iii) High density

4. What is your Religion?

- i) Moslem
- ii) Christian
- iii) Hindu
- iv) Budhist

5. Are you working?

- i) Yes
- ii) No

6. If yes to question 5 what do you do?

.....

7. What is your marital status?

i) Single

ii) Married

iii) Divorced

iv) Widowed

8. How many children do you have?

i) 0 - 2

ii) 3 - 5

iii) 6 - 8

iv) 9 and above

9. What is your Husband's education level?

i) Primary School

ii) Junior Secondary

iii) Senior Secondary

iv) College/University

v) I do not know

10. What is your Husband's occupation?

.....

**SECTION B**

**QUESTIONS ON KNOWLEDGE**

FOR OFFICIAL USE

10. Have you ever heard of exclusive breastfeeding:

i) Yes

ii) No

12. If yes when did you hear about it?

.....

13. Who told you about it?

i) Friends

ii) Relatives

iii) Health Personnel

iv) Media Personnel

v) Others specify

14. What do you understand by exclusive breastfeeding?

.....

15. Do you think exclusive breastfeeding is good for your baby?

i) Yes

ii) No

16. If yes what are the benefits?

.....

17. Have you ever heard of HIV/AIDS?

i) Yes

ii) No

18. If yes to question 17 from whom did you hear about HIV/AIDS?

- i) Friends
- ii) Relatives
- iii) Health Personnel
- iv) Others specify

19. Do you know how HIV is transmitted?

- i) Yes
- ii) No

20. Do you know how children get infected?

- i) Yes
- ii) No

21. If yes explain how they get infected?

.....

22. Is there a cure for HIV?

- i) Yes
- ii) No

23. If your answer to question 20 above is yes explain?

.....

**QUESTIONS ON ATTITUDE AND PRACTICE**

24. Is it good to breastfeed a baby when the mother is HIV Positive?

- i) Yes
- ii) No

25. Give reasons for your answer to question 24?

.....

26. Would you breastfeed your baby if you were found to be HIV positive?

- i) Yes
- ii) No

27. If your answer is No to question 26 would you give Your baby to be breastfed by a relative who is HIV Negative?

- i) Yes
- ii) No

28. Give reasons if your answer to 27 above is No?

.....

29. What alternatives would you give to your child instead of breastmilk if you could afford?

- i) Powdered Milk
- ii) Goats Milk
- iii) Fresh cow's milk
- iv) Porridge
- v) Other specify

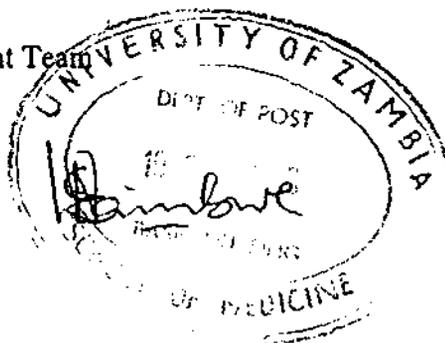
30. What type of help would you like to be given to a mother who wants to exclusive breastfeed her baby even when she is HIV positive?

**END OF INTERVIEW. THANK YOU!**

# APPENDIX II

Leah B. Kanene  
School of Medicine  
Department of Post basic Nursing  
P.O. Box 50110  
LUSAKA.

The Director  
Lusaka District Health management Team  
P.O. Box  
LUSAKA.



u.f.s Head – Post Basic Nursing

Dear Sir/Madam,

RE: STUDY PROJECT

I am a final 4<sup>th</sup> year Post Basic student at the above mentioned school currently pursuing a degree course in Nursing. I am required to conduct a research study in partial fulfillment of this course. I am interested in determining the **Knowledge, attitude and practice of ante-natal mothers in HIV transmission through breastfeeding in Lusaka Urban District.**

I hope that the findings of the study will help to disseminate proper and adequate information, education and communication on HIV transmission through breastfeeding to the mothers and the public at large.

The purpose of this letter is to kindly request for your permission to let me collect data from Lusaka Urban District Clinic from September to October 1999 for a period of (2) two weeks.

I shall be most grateful if permission will be granted for me to conduct this research study from (5) five randomly selected sample of clinics in Lusaka Urban District.

Thanking you in anticipation for your cooperation and consideration.

Yours faithfully,

A handwritten signature in black ink that reads 'Leah B. Kanene'.

Leah B. Kanene

P. O. Box 50877  
Lusaka  
Tel: 011 253 831  
Fax: 253 8196



In reply please quote  
No

# MINISTRY OF HEALTH

## LUSAKA DISTRICT HEALTH MANAGEMENT BOARD

DATE: 1<sup>st</sup> October, 1999

The In-charge

----- clinic  
LUSAKA.

### Re: Research study at your Health centre.

This serves to introduce Leah B. Kanene who is a student at School of Medicine – Department of Post Basic Nursing, and wishes to undertake a research study in Knowledge, Attitude and Practice of Antenatal mothers in HIV transmission through Breast-feeding in Lusaka Urban District.

Kindly assist her/him during her/his studies.

  
**E. C. MUSONDA**  
**MANAGER ADMINISTRATION**  
**For/District Director of Health**

c.c. Acting Manager Planning and Development.

# INNOCENTI DECLARATION

## On the Protection, Promotion and Support of Breastfeeding

### RECOGNISING that

Breastfeeding is a unique process that:

- provides ideal nutrition for infants and contributes to their healthy growth and development;
- reduces incidence and severity of infectious diseases, thereby lowering infant morbidity and mortality;
- contributes to women's health by reducing the risk of breast and ovarian cancer, and by increasing the spacing between pregnancies;
- provides social and economic benefits to the family and the nation;
- provides most women with a sense of satisfaction when successfully carried out; and that

Recent research has found that:

- these benefits increase with increased exclusiveness<sup>1</sup> of breastfeeding during the first six months of life, and thereafter with increased duration of breastfeeding with complementary foods, and
- programme interventions can result in positive changes in breastfeeding behaviour;

The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers' meeting on "Breastfeeding in the 1990s: A Global Initiative", co-sponsored by the United States Agency for International Development (A.I.D.) and the Swedish International Development Authority (SIDA), held at the Spedale degli Innocenti, Florence, Italy, on 30 July - 1 August 1990. The Declaration reflects the content of the original background document for the meeting and the views expressed in group and plenary sessions.

### WE THEREFORE DECLARE that

As a global goal for optimal maternal and child health and nutrition, all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively on breast milk from birth to 4-6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond. This child-feeding ideal is to be achieved by creating an appropriate environment of awareness and support so that women can breastfeed in this manner.

Attainment of the goal requires, in many countries, the reinforcement of a "breastfeeding culture" and its vigorous defence against incursions of a "bottle-feeding culture." This requires commitment and advocacy for social mobilization, utilizing to the full the prestige and authority of acknowledged leaders of society in all walks of life.

Efforts should be made to increase women's confidence in their ability to breastfeed. Such empowerment involves the removal of constraints and influences that manipulate perceptions and behaviour towards breastfeeding, often by subtle and indirect means. This requires sensitivity, continued vigilance, and a responsive and comprehensive communications strategy involving all media and addressed to all levels of society. Furthermore, obstacles to breastfeeding within the health system, the workplace and the community must be eliminated.

Measures should be taken to ensure that women are adequately nourished for their optimal health and that of their families. Furthermore, ensuring that all women also have access to family planning information and services allows them to sustain breastfeeding and avoid shortened birth intervals that may compromise their health and nutritional status, and that of their children.

All governments should develop national breastfeeding policies and set appropriate national targets for the 1990s. They should establish a national system for monitoring the attainment of their targets, and they should develop indicators such as the prevalence of exclusively breastfed infants at discharge from maternity services, and the prevalence of exclusively breastfed infants at four months of age.

National authorities are further urged to integrate their breastfeeding policies into their overall health and development policies. In so doing they should reinforce all actions that protect, promote and support breastfeeding within complementary programmes such as prenatal and perinatal care, nutrition, family planning services, and prevention and treatment of common maternal and childhood diseases. All healthcare staff should be trained in the skills necessary to implement these breastfeeding policies.

<sup>1</sup>Exclusive breastfeeding means that no other drink or food is given to the infant; the infant should feed frequently and for unrestricted periods.

<sup>2</sup>World Health Organisation, Geneva, 1989.

### OPERATIONAL TARGETS:

All governments by the year 1995 should have:

- appointed a national breastfeeding coordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations;
- ensured that every facility providing maternal services fully practises all ten of the *Ten Steps to Successful Breastfeeding* set out in the joint WHO/UNICEF statement<sup>2</sup> "Protecting, promoting and supporting breastfeeding: the special role of maternity services";
- taken action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety; and
- enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.

We also call upon international organizations to:

- draw up action strategies for protecting, promoting and supporting breastfeeding, including global monitoring and evaluation of their strategies;
- support national situation analyses and surveys and the development of national goals and targets for action; and
- encourage and support national authorities in planning, implementing, monitoring and evaluating their breastfeeding policies.