

Scaling Up Exclusive Breastfeeding among Mothers in Enugu East Local Government Area Nigeria- A Health Intervention Study

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Abstract: Background: Breastfeeding promotion is an important component of the child survival strategies and also optimizes growth of Low Birth Weight (LBW) babies. The main strategy for the promotion of EBF in Nigeria is the WHO/UNICEF baby friendly hospital initiative. However, available evidences show that EBF is hardly practiced by lactating mothers globally. Objective: The study therefore aimed to examine the behavioural pattern of mothers to exclusive breastfeeding using informal health workers as educators. Methods: The study was a cluster-randomized intervention design involving mothers attending antenatal clinics and who brought their babies to the health centres for routine immunization. A total of 400 mothers were recruited for the study [400 mothers in each cluster selected]. A multistage sampling technique involving four stages was used to select the study sample. Intervention was designed to improve mothers' knowledge and practice of EBF in group A while group B served as control. Results: Mothers in this study, for both intervention and control were mostly aged 35-39yrs (32.6% and 31.4%) respectively. Results showed that in both intervention and control groups, the source of information were mostly health talk given by the health workers at the facilities (44.8% and 45.8%) respectively. The women seemed to know that breast milk is the best food for the baby before the study and this was more in the control group than intervention group. Follow up intervention on the mother to ensure breast feeding is initiated yielded positive results. Available data indicated that breastfeeding was initiated earlier by mothers. Most (50.2%) mothers initiated breast feeding within 30 minutes of delivery due to the intervention given to them as against 30% who do such before the intervention. Conclusions: The study suggest that health policies that legitimize and acknowledge the practice of informal health workers [IHWs] and integrating them into specific health programmes in the Nigerian healthcare delivery system can be adopted. There is need for registration of all IHWs so they can be better organised and easily accessed.

Keywords: Exclusive breastfeeding, scale up, health education, intervention, Nigeria

1. Background

According to the World Health Organisation (WHO), infants should be exclusively breastfed (in which water, milk and other liquid or solid foods are not allowed) for 4-6 months¹. Breastfeeding promotion is an important component of child survival strategies and also optimizes growth of Low Birth Weight (LBW) babies^{2,4}. Exclusive breastfeeding (EBF) reduces the risk of infection, atopic diseases and recently infantile hypertrophic pyloric stenosis and hence infant morbidity and mortality^{5,7}. However, available evidences show that EBF is hardly practiced by lactating mothers globally⁸.

The main strategy for the promotion of EBF in Nigeria is the WHO/UNICEF baby friendly hospital initiative (BFHI)⁹. However this initiative fails to reach most mothers in the rural and peri-urban areas¹⁰. Also, studies have shown that a good number of Nigerian women attend Antenatal clinic, but most deliver outside health care facilities¹¹. This implies that even in the urban areas, some mothers may not benefit from the baby friendly hospitals.

Studies show that health education to mothers on the benefits of EBF increased the duration of EBF in infants aged 4-6 months, by inducing positive behavioural changes in the mothers^{12,13}. However, most of the health educators used in those studies were formal health care workers, that

were based in the hospitals^{9,14}. In Nigeria like in most sub-Saharan African countries where the majority of people lack access to hospitals, using entirely hospital-based health education campaigns may not be ideal for scaling-up exclusive breastfeeding¹⁵. Strategies that can substantially reach both users and non-users of hospitals, and that can provide ready information to the rural and peri-urban mothers are needed, especially as infant mortality rate in Nigeria is higher in these areas when compared to the urban areas¹⁵.

Therefore an additional (to hospital-based intervention) breastfeeding promotion strategy, that can ensure cost-effective and sustainable scaling-up of EBF as part of Integrated Management Of Childhood Illness (IMCI) will be through the use of both formal (hospital-based) and informal (community-based) health care workers. This strategy would reach mothers who deliver at home, provide an opportunity to involve other family members and continue support 6 months after child birth. It has noted that EBF rate in Nigeria is low and well below the WHO recommendation of 90% coverage²³. Antenatal care was strongly associated with EBF. Intervention studies, including peer-counselling, to support breastfeeding using cluster-randomized controlled trials are required to increase EBF in Nigeria and appropriate infant-feeding practices in each geopolitical region will also be needed if Nigeria is to attain the child survival-related Millennium Development Goal (MDG) of

reducing infant mortality from about 100 deaths per 1,000 livebirths to 35 deaths per 1,000 live births by 2015²⁴. The study therefore aims to examine the behavioural pattern of mothers to exclusive breastfeeding using informal health workers as educators.

2. Methods

Study Area

The study was conducted in the urban area of Enugu state in South-East Nigeria. Health workers both formal and informal exist here due to the presence of health facilities e.g. the University of Nigeria Teaching Hospital Enugu, Parklane Specialist Hospital, cottage hospitals and Primary Health Care Centers. Enugu state has an estimated population of 3,257,298 people⁷² and consists of 17 LGAs, 4 of which are urban while the remaining 13 are rural. Enugu urban has 4 Local Government Areas (LGA) namely Enugu-East, Enugu North, Enugu South and Nsukka. The 2006 population of each of the LGAs listed is, 279,089, 244,852, 198,723 and 309,633 respectively out of which the females are 146,273, 123,227, 104,262 and 160,392 respectively. The occupation is mainly farming and civil service. The housing condition was poor. The drainage and waste disposal system are also very poor. Portable water supply was irregular and usually from municipal sources distributed through water tankers and common taps. The study lasted for 4 months.

Study Design

The study was a cluster-randomized intervention study involving two communities in the Local Government Area (LGA).

Study Population

Mothers attending antenatal clinics and who brought their babies to the health centres for routine immunization. These mothers had been living in the study area for the past twelve months and were selected irrespective of their socio-economic status, culture, religion, tribe, educational level or occupation.

Sample Size and Sampling Technique

The minimum sample size was determined using the formula for sample size for a definite population considering 0.234 as the proportion of the target population exclusively breastfeeding, power of 80%, confidence interval of 95% and 0.05 as the absolute sampling error that can be tolerated. A total of 400 mothers were recruited for the study [400 mothers in each cluster selected]. A multistage sampling technique involving four stages was used as described below.

Enugu North LGA was purposively selected to ensure that both the formal and informal health workers were represented and because the area is typically urban compared to neighboring LGAs which has greater part of it as rural.

Secondly Enugu North LGA has 27 health facilities scattered across seven [7] communities and the communities include: Iva valley, GRA, New heaven, Asata, Ogbete, Ogui New Layout and Independence Layout.

Iva valley, Independence layout, New haven and Ogui New Layout have health facilities with Informal Health Workers while G.R.A, Ogbete and Asata have facilities with Formal Health Workers and met the criteria for inclusion. Ogui New layout and Ogbete health facilities were chosen by simple random sampling technique without replacement.

Thirdly, out of the 12 health facilities in New layout and Ogbete, simple random sampling technique was used to select Asata Health Centre in Ogui New layout as the intervention facility while Mother of Christ in Ogbete community was selected as the control facility.

Fourthly, in each of the clusters [Asata health center in Ogui New layout and Mother of Christ in Ogbete], 120 mothers with children aged 0-24 months were randomized, both in the intervention and the control facilities by simple random sampling. This was done by selecting the mothers as they arrive for routine immunization until the sample size of 400 was attained in both the study and control sites i.e. 800 altogether. A baseline study was conducted to examine the behavioural pattern of mothers to exclusive breastfeeding with pre-tested interviewer-administered questionnaires. The results informed the intervention design.

3. Description of the Intervention

Randomization

A listing of all the Patent Medicine Dealers (PMDs) in both the intervention and control community was conducted to yield 25 and 14 respectively [total=25 PMDs]. Also a listing of all the Village Health Workers (VHWs) in both sites was conducted to yield 10 and 6 respectively [total=16 VHWs]. The PMDs and the VHWs or Traditional Birth Attendants (TBAs) both made up the Informal Health Workers (IHWs) while the Formal Health Workers were recruited from the Primary Health Care centres. In any community without the IHWs, the community development committee was encouraged to nominate persons to be recruited and trained as a VHW following the Federal Ministry of Health guidelines for establishing and training VHWs⁷³. The PMDs, VHWs and the Formal Health Workers (FHWs) all make up the Baby Friendly Focal Agents (BAFFA). The BAFFA represented a core group of exclusive breastfeeding counsellors. For the intervention cluster, 2 FHWs, 2 VHW and 2 PMD were recruited and trained, while in control, only 2 FHW were recruited for the study. On the whole there were 4 FHWs and 4 Informal Health Workers (IHWs) for both intervention clusters. Training the BAFFA was a participatory implementation research involving the community members in the design, implementation and monitoring of the research through meetings and discussions. In the intervention facility, the following combination of focal agents was assigned:

Strategy 1: 2 FHWs + 2 VHW + 2 PMD (intervention)

Strategy 2: 2 FHWs only (control)

The selection of the BAFFA took into account, the different villages in the study community to ensure all were given equal chances of being selected.

Trainings of the BAFFAs

The BAFFA was trained using parts of the WHO/UNICEF breastfeeding counselling course and results of the baseline survey as a guide⁷⁴ and adapted to suit the local needs. The training was given over 28 hours (4 hours a day for 7 days) by breastfeeding counsellors (Health Educators) drawn from various institutions including the state ministry of health, the health visiting unit of University of Nigeria Teaching Hospital Enugu and Enugu State University Teaching Hospital Park lane.

Counselling skills was taught by demonstrations, role plays and included listening to mothers, learning about their difficulties, assessing the position and attachment of babies during a breastfeed, building mother's confidence, giving support and providing relevant information and practical help when required. The training was done in batches considering their various educational backgrounds. The BAFFA was expected to be responsible for 10-15 mothers residing in the same community. This took about 3 sessions in each community with IHWs.

Counselling Session

All pregnant mothers in the last month of their last trimester were recruited in the health facilities for counselling. Using interviewer-administered pre-tested questionnaire, baseline information was sought from the recruited mothers. The BAFFAs except the FHW visited all the recruited mothers at home. A minimum of 12 visits per mother was made; 2 in the last trimester of pregnancy, 1 within 48 hours of delivery, 1 between day 7 and day 14 and 1 during days 24-28. There after they were visited every 2 weeks between the months of 2 and 6. The BAFFA in addition was free to make or receive additional contacts if required. Counselling was given at home and key family members were included. The duration of each visit was between 30 minutes and 1 hour. The FHW at the facility level counseled the pregnant mothers during antenatal and post-partum visits only for the study communities.

Referrals of sick infants

All sick children being breastfed and mothers encountering problems of breastfeeding were referred to the health centres for management by both the clinicians in the study team, the health educators and the formal health workers. The mothers in all the groups were asked to record the number of suckling episodes (during the day and night) and the days when the infant had diarrhoea or a respiratory illness. At each visit, the breastfeeding pattern and the infant's medical condition were noted.

Quality assurance and follow up

The performance of each BAFFA was monitored at least every 2 weeks over the study period by the researchers and supervisors to ensure they were conversant with the UNICEF/WHO's recommendations for breastfeeding. In addition, unannounced visits were made to the mothers at least once a month. Each visit was followed with a counselling session to the nursing mother.

Inclusion and exclusion criteria

- Mothers with children aged 0-24 months attending health centres (who gave informed consent) were selected.
- Excluded from the study were mothers whose babies were admitted into the newborn special care unit for any reason, those with orofacial deformities, oesophageal atresia and other feeding difficulties. Children with identifiable chronic conditions like congenital heart disease, cerebral palsy were also excluded.
- Mothers who did not give consent for any reason were excluded from the study.

4. Data Collection

Instrument for data collection was a pre-tested interviewer administered questionnaire translated into the local language and with identification numbers to aid respondents' identification subsequently. The questionnaire was prepared in English Language and was carefully explained to the mothers and guided by the interviewers to fill out the forms without difficulty. Information was sought on the respondents' socio-demographic data, knowledge, perception, attitude and experience of exclusive breastfeeding. Addresses of households and respondents phone numbers were written down in a separate paper different from the questionnaire to aid getting back to the household members during health education and post intervention interview while still maintaining confidentiality.

Pre and post survey was conducted in both intervention and control groups. The health education intervention was given to the study group only by the BAFFA and same questionnaire administered post intervention. The health education sessions took place on Saturday evenings so as not to interfere with their work. The proposed duration of health education was three weeks and in three sessions. The respondents were in a group of forty (40) for each session of health education. This means that there was 3 groups and 3 sessions of health education each in the intervention and control groups.

Data analysis

The primary outcome variable was the proportion of lactating mothers that adopted exclusive breast-feeding at the end of 4 months. Data was statistically analysed using EPI INFO software. The chi-square and student's t-test were used to determine the relationship variables and to compare means respectively.

Ethical Considerations

Approval for the study was obtained from the ethical committee of the University of Nigeria Teaching Hospital, Enugu. Individual consent was obtained in written form from all respondents before start of the study. The same type of health education given to the intervention group was offered to the control group after the end of the study.

Political acceptance and community participation was sought for the study; advocacy visits were paid to the traditional rulers of the chosen communities and their cabinets to elicit community support. Also leaders of the different women groups in the community (market, church, cooperatives), in both the study and control communities

were solicited for as well. This was achieved by visiting them to explain clearly the purpose of the study and the various interventions designed for the study.

5. Results

Socio-demographic characteristics of the mothers

A total of 393 respondents were interviewed out of 400 recruited for the intervention group giving a response rate of 98.25% while in the control group 395 respondents were interviewed out of 400 in the control group giving a response rate of 98.75%.

Mothers in this study, for both intervention and control were mostly aged 35-39yrs (32.6% and 31.4%) respectively. This study found that there were still mothers who were between 45-49yrs who delivered babies at the time of the study in both intervention and control groups [see table 1]. Majority of the mothers had at least primary education across the intervention and control groups (51% and 43%) respectively. The mothers in both groups were mostly Christians (63.4% and 70.9%), and also were mostly farmers (49.6% and 46.1%) respectively. Although majority were married (68.7% for intervention group and 66.3% for control), it is worth mentioning that there were numerous single mothers in both groups who were delivered of their babies during the study period, although this was higher in the control group 80(20.3%) as against 73(18.6%) in the intervention group [table 1].

Knowledge and practice of exclusive breastfeeding among breast feeding mothers

The mothers in the study were asked about their sources of knowledge about exclusive breastfeeding. Results showed that in both intervention and control groups, the source of information were mostly health talk given by the health workers at the facilities (44.8% and 45.8%) respectively. Good number of the mothers also heard about EBF through mass media campaigns (42.2% and 38.2%), while others heard about EBF through their friends (13% and 15.9%) respectively. Knowledge about whether breast milk alone is enough for the first 6 months was elicited. Findings indicated that women in the control group was more knowledgeable that breast milk was enough for the first 6 months in both before and after the intervention (56.2% and 55.2%) respectively as against the intervention group (48.9%) and 50.9% respectively. The women seemed to know that breast milk is the best food for the baby before the study and this was more in the control group than intervention group. Follow up intervention on the mother to ensure breast feeding is initiated yielded positive results. Available data indicated that breastfeeding was initiated earlier by mothers. Most (50.2%) mothers initiated breast feeding within 30 minutes of delivery due to the intervention given to them as against 30% who do such before the intervention [figure 1].

6. Discussion

The age range that mostly participated in this study was 35-39years. There is a limitation as did not seek to find the association between mothers age and knowledge and practice of exclusive breastfeeding. The finding that there

were still mothers who were between 45-49yrs who delivered babies at the time of the study was encouraging as this would likely strengthen health workers trust and confidence in advising who are expecting to be pregnant after long years of marriage.

The study found good proportion of young single mothers delivered of babies. This implies high rate of single parenthood. Care need to be taken to ensure that these sect of mothers are reached with appropriate interventions to encourage exclusive breastfeeding.

It was expected that almost all the women would indicated health workers at the facilities as their source of information about exclusive breastfeeding. The proportion which indicated to have heard from the health workers was not encouraging. This implies that health workers need to scale up strategies for communicating breastfeeding messages. Other strategies for communicating breastfeeding messages like mass media should be scaled up if the objectives of the EBF would be achieved in Nigeria.

Although Knowledge about whether breast milk alone is enough for the first 6 months was above average, there seemed to be no difference between the intervention group and control group. However, care should be taken to generalize this finding, and it is suggested that more intensive intervention studies should be carried out to determine barriers to knowledge.

The findings showed that the women seemed to know that breast milk is the best food for the baby before the study. The proportion was not encouraging and calls for appropriate strategies to scale up EBF initiative in Nigeria. Follow up intervention on the mother to ensure breast feeding is initiated yielded positive results. Available data indicated that breastfeeding was initiated earlier by mothers, as most mothers initiated breast feeding within 30 minutes of delivery due to the intervention given to them as against where there was no intervention at all. It is advised that such measure should be sustained to encourage other nursing women to keep the tempo. The follow up strategy deployed to encourage the mothers initiate breastfeeding earlier in this study should be replicated to other settings to help scale up EBF initiative in Nigeria.

7. Conclusions

The study suggest that health policies that legitimize and acknowledge the practice of informal health workers [IHWs] and integrating them into specific health programmes in the Nigerian healthcare delivery system can be adopted. There is need for registration of all IHWs so they can be better organised and easily accessed.

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Appendix

Table 1: Distribution of Mothers By Age

Age (Years)	Intervention Group		Control Group	
	Number	%	NUMBER	%
15-19	6	1.5	8	2.0
20-24	36	9.2	42	10.6
25-29	72	18.3	61	15.4
30-34	92	23.4	111	28.1
35-39	128	32.6	124	31.4
40-44	52	13.2	41	10.4
45-49	7	1.8	8	2.0
TOTAL	393	100	395	100

Table 2: Socio-Demographic Characteristics Of Mothers

S.No	Variables	Study Group N(%)	Control Group N(%)
1.	LEVEL OF EDUCATION		
	No formal education	144 (36.6)	154 (39.0)
	Primary	201 (51.1)	173 (43.8)
	Secondary	42 (10.7)	40 (10.1)
	Tertiary/University	6 (1.5)	28 (7.1)
	TOTAL	393 (100)	395 (100)
2.	RELIGION		
	Christianity	249 (63.4)	280 (70.9)
	Islam	0 (0.0)	0 (0.0)
	Traditional	92 (23.4)	73 (18.5)
	No religion	52 (13.2)	42 (10.6)
	TOTAL	393 (100)	395 (100)
3.	OCCUPATION		
	House wife	38 (9.7)	40 (10.1)
	Teacher/Lecturer	27 (6.9)	25 (6.3)
	Trader	82 (20.9)	84 (21.3)
	Farmer	195 (49.6)	182 (46.1)
	Unemployed	22 (5.6)	31 (7.8)
	Self employed	17 (4.3)	19 (4.8)
	Civil servant	12 (3.1)	14 (3.5)
	Others (specify)	0 (0.0)	0 (0.0)
	TOTAL	393 (100)	395 (100)
4.	MARITAL STATUS		
	Single	73 (18.6)	80 (20.3)
	Married	270 (68.7)	262 (66.3)
	Widowed	32 (8.1)	23 (5.8)
	Separated/Divorced	18 (4.6)	30 (7.6)
	TOTAL	393 (100)	395 (100)
5.	How did you hesar about EBF		
	-Friends	51 (13.0)	63 (15.9)
	-Health talk	176 (44.8)	181 (45.8)
	-Mass media	166 (42.2)	151 (38.2)
	TOTAL	393 (100)	395 (100)

Table 3: Showing Influence of Mothers' Knowledge on EBF

S/No	VARIABLES	Pre-Intervention Number (%)		Post-Intervention Number (%)	
		GROUP 1	GROUP 2	GROUP 1	GROUP 2
1.	Breast milk alone is enough for the first 6 months.				
	-Yes	192 (48.9)	201 (50.9)	221 (56.2)	218 (55.2)
	-No	201 (51.1)	194 (49.1)	171 (43.8)	177 (44.8)
	TOTAL	393 (100)	395 (100)	393 (100)	395 (100)
2.	Breast milk is the best food for the baby				
	-Yes	296 (75.3)	262 (66.3)	311 (79.1)	271 (68.6)
	-No	97 (24.7)	133 (33.7)	82 (20.9)	124 (31.4)
	TOTAL	393 (100)	395 (100)	393 (100)	395 (100)
3.	Colostrum is good milk				
	-Yes	205 (52.2)	271 (68.6)	231 (58.8)	289 (73.2)
	-No	188 (47.8)	124 (31.4)	162 (41.2)	106 (26.8)
	TOTAL	393 (100)	395 (100)	393 (100)	395 (100)

CHART 1 Showing Commencement Of Breast Feeding Post Intervention

