Is competence enough to enable Kenyan mothers to make good infant and young child feeding decisions?

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Abstract
The aim of this study was to explore factors associated with maternal infant and young child feeding motivation in urban and rural Kenya. We conducted 18 focus group discussions with mothers of children 0 to 23 months of age and healthcare workers. The data were transcribed, translated, and explored following the principles of content analysis. We first explored and coded the data inductively and categorized it according to emerging themes representing the most relevant topics for young child feeding. After this, these themes were theorized into an explanatory framework. Finally, the results yielded seven themes integrated into self-determination theory’s three basic motivation-building pillars: autonomy, competence, and relatedness. We found that maternal intrahousehold autonomy on child feeding was substantial. However, this autonomy was lost for a period of time while in close contact with the healthcare staff. The authority of the healthcare workers was at its peak when the child was born and faded gradually as the child grew. Building maternal competence is important for child-feeding outcomes, but our data showed that the health education methods used by the healthcare workers were inadequate to improve maternal motivation. The competence of Kenyan healthcare workers should be improved in the area of complementary feeding counseling, and they should be trained to provide practical and emotional support as a way of increasing maternal motivation on infant and child feeding.

KEYWORDS
competence, feeding practices, Kenya, maternal autonomy, self-determination theory, social support

1 | INTRODUCTION

Poor infant and young child-feeding practices are widely documented in Kenya. Exclusive breastfeeding is at 61% nationwide (Kenya National Bureau of Statistics, 2015), but only at 2% in some of the slum areas of Nairobi (Kimani-Murage et al., 2011). 80% of children aged 6 to 8 months have been started on complementary foods (United Nations Children’s Funds, 2016), and only 39% of children aged 6 to 23 months were fed according to WHO recommendations in 2004 (WHO Nutrition Landscape information system, NLis, 2005). 11% of children under the age of 5 years are underweight and 26% stunted or chronically malnourished (Kenya National Bureau of Statistics, 2015; United Nations Children’s Funds, 2016).

Imdad, Yakoob, and Bhutta (2011) reviewed interventions that included education and support on breastfeeding and were targeted at mothers. They found these successful in improving exclusive breastfeeding rates at both 4 to 6 weeks, when prenatal counseling had the greatest impact, and at 6 months postpartum, when the combination of prenatal and postnatal counseling had the highest impact. The impact was strongest in developing countries. Meanwhile, Wood, Woods, Blackburn, and Sanders (2016) were more hesitant about the effects of breastfeeding promoting interventions in their review of six studies conducted in developed countries, three of which were conducted prenatally and three postpartum. They found that despite acquired knowledge, mothers were unable to translate it into real-life behaviors. They concluded that the most important components in enhancing breastfeeding were improved knowledge and skills, emotional support by healthcare workers, and breastfeeding self-efficacy. Continuing on to complementary feeding, Dewey and Adu-Afarwuah (2008) indicated that although positive results on weight and linear growth
were seen in studies conducted in developing countries, neither educational nor food-providing interventions adequately improved complementary feeding outcomes in many of the 42 studies reviewed.

The primary goal of most interventions is to achieve behavioral change, which is difficult, as it requires major renewal of both thinking and action (National Research Council, US Panel on Race, Ethnicity, and Health in Later Life, Anderson, Bulatao & Cohen, 2004). Mere transmission of knowledge seems insufficient (Dewey & Adu-Afarwuah, 2008), whereas better outcomes have been achieved by supporting ownership of the information and desired practices (Horii et al., 2016). One’s self-efficacy and inner motivation have been shown to improve results for interventions promoting weight loss (Teixeira, Silva, Mata, Palmeira, & Markland, 2012), tobacco abstinence (Williams et al., 2011), and diabetes care (Williams, Freedman, & Deci, 1998). Motivation seems to be an important factor in determining the adherence to promoted health behavior in general (Ng et al., 2012).

As lack of motivation may constitute one of the reasons why interventions targeted at infant and young child feeding fail to substantially change feeding practices in many cases, we aimed to study what factors affect maternal feeding motivation in Kenya. As there was little related information available in the African context, we opted for an explorative study where we conducted focus group discussions (FGDs) among primary caretakers and healthcare workers in urban and rural Kenya.

2 | METHODS AND THEORETICAL FRAMEWORK

We conducted 18 FGDs in Ruraka subcounty in Nairobi county and Masinga subcounty in Machakos county, Kenya, in September 2015 to explore community experiences and attitudes towards infant and young child feeding in the two regions. Ruraka is a densely populated urban slum area attached to the city of Nairobi, with healthcare centers located at a distance of 5 to 15 km from families, and Masinga is a more sparsely populated rural area consisting of smaller villages separated from each other by dirt roads, where families live within a 10 to 20 km radius of the nearest health center.

We selected six mother and child health centers (MCHCs) by convenience sampling, three in Nairobi and three in Machakos. These MCHCs were public and run by the government, and included variations in socioeconomic status and geographic location. We held three FGDs in each MCHC: a group of primary caretakers discussed breastfeeding, another complementary feeding, and finally a group of healthcare workers discussed child-feeding and child-caring practices. Caretakers with children in the age range of 0 to 9 months participated in the breastfeeding FGD and those with children aged 6 to 23 months in the complementary feeding FGD. Lists of all caretakers with children within the appropriate age groups, attending the health center on the day of the study, were compiled. From these, eight caretakers were randomly selected for each of the two FGDs. The final number of caretakers in each discussion ranged from 5 to 7, as some refused to participate. The total number of refusals was 23, and the most common reason was the need to get back home to her other children. All available healthcare workers were included, the group size varying from 3 to 4. Altogether, 92 informants participated in the FGDs. The participant characteristics are described in Table 1.

The Amref Health Africa ethical committee approved the study (ESRC P111/2014).

Two pairs of Kenyan nutritionists who spoke the local languages conducted the FGDs based on discussion guides developed by the researchers. The guide for breastfeeding included topics like exclusive breastfeeding and breastfeeding problems. The guide for complementary feeding included appropriate and inappropriate complementary foods and problems in providing balanced diets. The healthcare workers discussed young child-feeding practices within their communities, their opinions on why mothers were successful or unsuccessful in following guidelines, and what could be done to improve maternal motivation. Prior to the discussions, the moderator, one of the local nutritionists, explained the purpose of the study to the participants who filled in an informed consent form. The discussions lasted approximately 1 hr and were recorded. The participants were offered light refreshments after the discussions. The moderator and the note taker transcribed the recordings with the support of the notes taken and translated the transcripts into English. These were checked and approved by two local researchers.

2.1 | Data analysis and the self-determination theory (SDT) as the theoretical framework

We analyzed the data using Carney’s “the ladder of analytical abstraction” approach, presented by Miles and Huberman (1994, p. 92). First, we explored and coded the data following the principles of inductive content analysis (Krippendorff, 1980), keeping the data from each of the three FGD types and the geographic areas separate. Second, we searched for relationships within the data and found the topics most relevant to young child-feeding practices. Thereupon, we categorized the data as follows: (a) delivery and breastfeeding initiation, (b) initiation of complementary feeding, (c) support and information sources for breastfeeding, (d) support and information sources for complementary feeding, (e) breastfeeding problems, and (f) acceptable and

Key messages

- Interventions to improve infant and young child-feeding practices should go beyond building maternal competence.
- Mothers should be offered more social support, and their competence should be built in encouraging ways throughout their pregnancy, childbirth, breastfeeding, and complementary feeding.
- The competence of the healthcare workers should be strengthened in the area of complementary feeding to allow them to correctly and proficiently advice mothers.
TABLE 1  Participant characteristics

<table>
<thead>
<tr>
<th>Caretakers</th>
<th>Nairobi, n (%)</th>
<th>Machakos, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfeeding FGD</td>
<td>Complementary feeding FGD</td>
</tr>
<tr>
<td>Mother</td>
<td>18 (100)</td>
<td>18 (95)</td>
</tr>
<tr>
<td>Father</td>
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</tr>
<tr>
<td>Grandmother</td>
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<td>0 (0)</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
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<tr>
<td>17–20</td>
<td>1 (6)</td>
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<td>21–30</td>
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<td>31–40</td>
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</tr>
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<td>40&lt;</td>
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<tr>
<td>Number of children</td>
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<td></td>
</tr>
<tr>
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<tr>
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<td>3</td>
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<td>3 (16)</td>
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<td>4≤</td>
<td>2 (11)</td>
<td>1 (5)</td>
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<tr>
<td>Age of youngest child (months)</td>
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<td>14 (74)</td>
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<tr>
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<td>5 (26)</td>
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<td>Healthcare worker FGD</td>
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<td>2 (20)</td>
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<tr>
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<td>1 (10)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30–39</td>
<td>3 (30)</td>
<td>5 (50)</td>
</tr>
<tr>
<td>40–47</td>
<td>7 (70)</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Number of children</td>
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<tr>
<td>4</td>
<td>1 (10)</td>
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</table>

Note: FGD = focus group discussion.
recommended complementary foods. Third, these themes were theorized into an explanatory framework, and it became evident that the results could be integrated into the SDT (Ryan, Patrick, Deci, & Williams, 2008). The relationships between SDT and the themes are presented in the 3 section and summarized in supplementary Table 1.

Two researchers (LS & SO) read the transcripts and were in agreement about the interpretations.

The SDT strives to explain people’s behavior by studying what motivates them. It describes three basic psychological needs (autonomy, competence, and relatedness) that need to be met in order for a person to lead a fulfilled life and be capable of changing her behavior. Autonomy, or the decision making power of an individual, is the first crucial step in behavior change. This is contrasted by external regulation, or the use of authority. When individuals are allowed to act in health-promoting ways on their own terms, they are likely to keep up positive behavior. Competence means having the tools and skills to act in desired ways. According to SDT, competence is aided by autonomy, as a person who is highly motivated to change is also eager to learn. Good child-feeding practices can be adopted by women who are autonomous in their decision-making but who are also aided in strengthening their competence to make correct decisions and have the practical skills to perform these actions. The third important element of the SDT is the sense of relatedness or social support. (Ryan et al., 2008)

3 | RESULTS

3.1 | Autonomy

3.1.1 | Intrahousehold autonomy

The women perceived their autonomy within the home substantial and regarded themselves as sole deciders when it came to making child-feeding decisions, both during breastfeeding and complementary feeding. They diminished the importance of men, with the explanations that fathers did not know how to take care of children or what food to buy. The women felt they were more competent than men for two reasons: first, they spent more time at home with the children; and second, because they had been educated by the healthcare workers.

*The mother knows how to take care of the child not the father. The man looks for the money and brings for you to decide what the family will eat.—Mother 34, Nairobi*

The women reported asking for advice from their mothers and mothers-in-law but felt autonomous in respect to them also. Most importantly, the women felt that they could make decisions about child feeding without having to ask anyone else.

3.1.2 | Extrahousehold autonomy

Although the woman was the main decision maker at home, her autonomy was weak in relation to healthcare workers. While at the hospital for childbirth, her decision making power was almost fully overtaken by the healthcare staff. The mothers trusted in the knowledge and experience of the doctors and did not question anything that was done, though some mothers confessed feeling anxious when they did not know where their newborn babies were or what was being done to them. At this time, no mother in the study felt autonomous, and all were completely subject to decisions of the healthcare workers.

When in the ward after delivery, most mothers felt autonomous in their decision to breastfeed the child and were motivated to do so understanding the benefits of breastfeeding. Despite of this, many women heavily depended on the healthcare workers, to the extent that some felt it was the healthcare workers who made the decisions about breastfeeding, as expressed by a mother (13) in Nairobi: “Breastfeeding depends on the doctor. Some are told to stop at 6 months and others at 1 year.” The healthcare workers’ authority derived mostly from the respect that the mothers had for their education and knowledge, as well as experiences with getting help at the health facility. Still, some mothers followed the given instructions out of fear of the healthcare workers.

*Some mothers whose children are not growing well are not confident in bringing the child to the facility but instead send their relatives to bring the child.—Healthcare worker 2, Machakos*

In Machakos, the authority of the healthcare workers was not as strong as in Nairobi during the first month of a child’s life. While the mothers listened to advice from the healthcare workers, they also took advice from others, especially older women in the villages. Despite of this, not even the elderly had authority over the mothers, who could decide whether or not to heed to the advice given.

As the child grew, the mothers gradually became less and less dependent on the healthcare workers. Although the breastfeeding education provided at the health centers had clearly been successful in increasing the mothers’ knowledge and improving practices, the same could not be said about complementary feeding. Despite of information provided, there was a tendency to ignore it.

*I practiced exclusive breastfeeding for eight months before starting complementary feeding although the health worker had advised me to initiate feeds after six months.—Mother 10, Machakos*

The stronger maternal autonomy at this point manifested itself as a desire to find the best ways possible to feed her child. Many mothers, especially in Nairobi, still sought the assistance and knowledge of the healthcare workers, but most women, especially in Machakos, turned to neighbors and relatives for information. Some women even sought for information from the Internet, as they actively wanted to improve their own competence.

3.2 | Competence

The concept of competence manifested itself in two forms: as the feelings of ability and opportunity at act. The perceived ability was based on knowledge and know how, and the strongest influence on opportunity seemed to be perceived financial situations.

3.2.1 | Competence and knowledge of mothers

Many of the mothers reported feeling competent when it came to breastfeeding. These feelings were often associated with the practical ability to breastfeed. However, a number of mothers felt unable to
produce enough breast milk to satisfy the child. The beliefs related to this were mostly associated with the baby crying as a result of inadequate breast milk, but the healthcare workers pointed out the many possible reasons for a baby crying: “Crying is the usual and only way a baby can communicate since it cannot talk. Maybe the child is sleepy, feeling hot and is sweating or getting irritated by the napkin.” (Healthcare worker 5, Nairobi). Despite the strong belief within the communities that not enough breast milk was produced, some women especially in the Nairobi area had a good understanding of how to increase milk production and improve positioning of the child to the breast. “Stress causes milk not to be produced. It is good if a mother has peace and is calm. It is also good to eat well…” (Mother 7, Nairobi).

In addition to the perceived insufficiency of breast milk, most women experienced problems with breastfeeding, more specifically cracked nipples, swollen breasts, and pain. These were not directly associated with competence as they were considered normal and were quickly solved, either with the help of healthcare workers or relatives.

“I had adequate milk production although my breasts were painful and my mother told me that it was normal.—Mother 9, Machakos

The mothers felt competent with complementary feeding also. However, the actual knowledge about complementary feeding was weak compared to breastfeeding. Especially, the importance of timely initiation of complementary feeding was lost to many women, who thought that breast milk would provide their children with complete nutrition even well beyond 6 months. “She started [eating] at 9 months. She was breastfeeding first then I gave her porridge.” (Mother 23, Nairobi). There were also issues with proper knowledge about suitable and nonsuitable complementary foods, sufficient amounts of food, and feeding frequencies. “Avocados are not good for children, they cause chest infections and have too much fat” (Mother 25, Machakos). Though all mothers claimed to know what a balanced diet was and were under the impression that they were providing their children with such, the interpretations were often far from recommendations. Nutritionally, the most concerning beliefs were that small children can only take fluids and should not be offered any meat products. “If I cook food that has soup like beef or fish, I give her the soup to drink” (Mother 20, Nairobi). These beliefs were related to the child not being able to chew, the digestive system not being able to handle protein, and the child growing too big. The growth and reaction of the child to foods were often seen as proof of something being good, and encouraged the mother to continue what she was doing.

“She does not like Ugali because it disturbs her digestive system. She likes bananas so I decided to give her that.—Mother 24, Nairobi

3.2.2 Competence and knowledge of the healthcare workers

The healthcare workers were generally very knowledgeable on breastfeeding, though there was room for improvement. The competence of the healthcare workers reflected directly on the competence of the mothers. In fact, when the healthcare workers were well informed and confident in their message, the mothers felt competent and practiced what was being taught, as demonstrated by the feeding of colostrum, practiced by all mothers in the study population.

Still, some of the healthcare workers were at times unable to provide reliable information that was scientifically correct. One common issue was the misinterpretation of skin-to-skin contact after birth, which was confused with kangaroo care of preterm infants. “It is practiced but only for those children who are pre-terms” (Healthcare worker 3, Machakos). Some used old recommendations for breastfeeding where mothers were HIV positive. “Breastfeeding is done immediately after birth except for those mothers who are HIV positive” (Healthcare worker 4, Machakos).

The counseling on complementary feeding was not to the level of that on breastfeeding. Here, some healthcare workers were knowledgeable, but all instructions given did not follow recommendations. Old beliefs guided them in their work and as an interesting phenomenon, so did commercials.

“We were taught during the clinics that it is good to give Weetabix and milk.—Mother 6, Nairobi

When the mothers got sufficient explanations and thus a better understanding and were, in addition, allowed the opportunity to in practice observe the preparation of complementary foods, improvements were seen.

“We have cooking lessons. /.../ Then we give counseling and there is normally a great change.—Healthcare worker 5, Nairobi

3.2.3 Opportunity

Poverty was associated with perceived incompetence both with breastfeeding and complementary feeding. This presented itself as feelings of being unable to produce enough milk to practice exclusive breastfeeding, not having enough money to provide proper complementary foods, and also as a pressure to return to school or work and thus stop breastfeeding and leave feeding decisions to the child’s caretaker.

Although the healthcare workers considered the return to school or work as a common problem, they tended to disagree with poverty being the actual cause for improper feeding practices. They regarded these as psychological restrictions and suggested that reallocating food budgets would lead to improved feeding practices.

“From the 30 shillings they use to buy starchy foods /.../ they would be able to buy beans for ten shillings, potatoes for ten shillings and vegetables for ten shillings. They still prefer to go for plantains, pumpkins and potatoes for ten shillings each.—Healthcare worker 5, Nairobi

3.3 Relatedness

3.3.1 Social support

Social support was divided into professional support and support from family and friends. Both elements were found in the study, although to a rather small extent. Professional support was most noticeable after
childbirth at the hospital, though many mothers were left to tend to themselves after the birth if the child was healthy. If the baby needed medical care, the mother was excluded from decisions, and the condition of the baby was not explained to her. Despite of this, a number of mothers reported that they had been helped with breastfeeding positioning and attachment. One weakness in the advisory system was that the mothers were not supported in their own decision-making and competence.

The healthcare workers expressed that there was a need for more social support to the mothers, which could not be provided because of the lack of time and resources. The mothers, who would have liked the opportunity to ask more questions and have more practical assistance, echoed their concerns.

The women seemed to get slightly more support from family and friends, though many expressed a need for more support in taking care of their work, household, and childcare duties to be able to provide better diets for their children. The role of the husbands in being supportive towards their spouses was noted as important in this context.

At its best, social support manifested itself in women who were deeply concerned with the wellbeing of their peers. These mothers advised and helped each other through concrete acts, like encouraging mothers with malnourished children to attend the health center and accompanying them there.

You will find mothers whose children are severely malnourished and are enrolled in the feeding program and recover. They become our ambassadors; if they see a neighbor whose child is suffering from the same, they will come along with that mother and child.—Healthcare worker 5, Nairobi

3.3.2 | Social acceptance

A sense of belonging in the community was important to the women, and both family and neighbors were major sources of information and support. However, the relationships were not authoritative, and most of the women felt like they could easily decline the advice offered by others without compromising relationships. “You will get a lot of advice but you are the one who decides” (Mother 12, Nairobi). Despite of this, there were mothers who heeded to the advice from relatives and friends.

There was a mother with a young baby who had a stomachache. She gave the baby herbal medicine as advised by others and the situation got worse.—Mother 7, Nairobi

Moreover, in multiple instances, it became clear that traditions were followed just for the sake of them, even if there was no apparent gain for the mother or belief that it would be beneficial for the child. The foods that were considered good complementary foods varied between tribes.

4 | DISCUSSION

We found that elements of all three core feelings of SDT occurred in the data collected. Furthermore, for all of these, 2 to 3 factors affected the actualization of the feelings. None of the core feelings stand alone but are interlinked, with one supporting the actualization of the other (Figure 1).

The factors affecting maternal autonomy were relationships within and outside the home. Within their homes, the mothers were autonomous and there were distinct roles between husband and wife, as demonstrated by Kwambai et al. (2013). The men were portrayed as providers and the women as homemakers who had the decision-making power about child feeding. Maternal intrahousehold authority is considered beneficial, as an association has been found between increased maternal autonomy and improved nutritional status and overall health of children (Carlson, Kordas, & Murray-Kolb, 2015; Hirani & Olson, 2016). However, a study conducted in Kenya found no such association for children below 3 years of age (Brunson et al., 2009). Increased maternal autonomy usually materializes as increased power over family income or the ability to have one’s own income (Rahman & Rao 2004; Anderson & Eswaran, 2009). However, in the urban settlements of Nairobi, women’s employment outside the home has been argued to be one of the main factors for early cessation of breastfeeding (Kimani-Murage et al., 2015), illustrating that the generally considered indicators of maternal autonomy may not always be beneficial for child feeding practices.

Although there has been much focus on gender roles and intrahousehold power relationships, research on maternal autonomy outside the home is scarce in the African context. Hirani and Olson (2016) discuss the effect of the settings on a woman’s autonomy, stating that although she may be autonomous at home, she might lack...
the same control in public, like at the hospital. We found that the women completely lost their autonomy when submitted to the hospital for childbirth, but slowly regained control as the child grew. There was a stark contrast in the authority of the healthcare workers and the dependence of the mothers upon them, when comparing breastfeeding to complementary feeding. During breastfeeding, the healthcare workers were the strongest influence on the mothers’ feeding decisions, and most mothers strictly followed their advice. During complementary feeding, this authority faded. One possible explanation could be a lack of confidence and unity in complementary feeding messages provided by the healthcare workers, reflecting on the motivation of the mothers to seek advice from them or act according to it. Likewise among Kenyan women, Maina, Karanja, and Kombich (2013) found that perceptions of the quality of health services greatly affected mothers’ decisions to bring children to the health center. The relationships between mothers and healthcare workers require further research, as they seem to contribute to child feeding.

The beliefs related to complementary feeding (i.e., thinking that small children do not need animal products and should only be given liquids) were similar to those found in other cultures (Montero-Rosa, Pelto, Frongillo, & Rasmussen, 2012) and could be one of the reasons for rapid growth faltering at the time when complementary feeding is started (Shrimpton et al., 2001). Here, the inaccurate feeling of competence resulted in negative outcomes for the children, although feelings of incompetence could have lead to information seeking behavior and improved feeding practices.

The competence of healthcare workers and friends had direct consequences on maternal behavior, as they relied so heavily on these. Similarly, Chaturvedi, Nakkeeran, Doshi, Patel, and Bhagwat (2014) found a direct linkage between the knowledge of Anganwadi (healthcare) workers and child feeding practices in India. Where the counseling was not convincing, mothers turned to other information sources. This could reflect the healthcare workers’ weaker knowledge and lack of confidence in complementary feeding recommendations.

Elsewhere, poor quality of counseling has been linked to a lack of knowledge and skills among healthcare workers (Ashworth, Shrimpton, & Jamil, 2008; Pelto et al., 2004), which could be due to the more complex nature of the complementary feeding recommendations compared to breastfeeding or the lack of training. Furthermore, mothers are less likely to attend services if the health center is far away, if there is a need for transportation involving a cost and if the visit interferes with other family duties (Ashworth et al., 2008). This could be one of the explanations for why many mothers especially in the Machakos area tended to seek for advice from neighbors and relatives. Another explanation could be the seeking of social acceptance, as individuals are less likely to adopt behaviors that are not accepted in their community and would label them as outsiders (Ryan et al., 2008). Cultural customs often affect infant and child feeding, as seen in Uganda (Nankumbi & Muliira, 2015) and South Africa (Kruger & Gericide, 2003).

Although financial restrictions directly affected mothers’ choices, they seemed to have an even greater restrictive impact on the mothers’ perception of her competence to provide accurate diets for her children. Webb-Girard et al. (2012) found that Kenyans who lived in food-insecure households were more likely to believe that breast milk was not enough to satisfy a baby younger than 6 months compared to those living in food-secure households. Kimani-Murage et al. (2015) reported similar findings from Nairobi slums. Poverty and the lack of food limit food choices, and studies have shown poverty to be associated with insufficient complementary feeding and poor child nutritional status (Issaka, Agho, Burns, Page, & Dibley, 2015; Gewa & Yandell, 2012).

Many interventions on infant and child feeding focus on educational pursuits to build maternal competence (Imdad et al., 2011; Dewey & Adu-Afarwua, 2008). It was evident also in our study that building maternal competence is important for child feeding outcomes. However, the methods for education could be revised to improve the motivation of the mothers. It has been indicated that students are able to internalize information and become intrinsically motivated when teachers and parents show interest in their education are present and give assistance (Deci et al., 1991). This advocates need for increased professional social support, as Raj and Plichta (1998) parallelize social support with educational assistance. Social support enables mothers to achieve their goals on breastfeeding (Hirani & Olson, 2016) or complementary feeding. Practical and emotional support could be the missing component of interventions to improve maternal motivation. Poor support (both from families and professionals) has been found to be one of the factors negatively affecting child feeding in Nairobi slums (Kimani-Murage et al., 2015). Shim et al. (2016) state that social support, or giving concrete examples and involving women in hands on work rather than merely giving theoretical advice, could increase competence. In our study, professional support was to a large extent limited to help with breastfeeding positioning, but could have beneficial effect if extended beyond that. Support from family and friends is also important for child health outcomes, as involving and educating fathers and grandmothers to provide support to mothers have positive effects on child feeding practices (Mukuria, Martin, Egondi, Bingham, & Thuita, 2016). In addition, the children of women who have good supportive networks and accept help when needed have been found to be healthier than the children of isolated women who do not get help (Myntti, 1993). Furthermore, Buchanan (2004) has argued that the primary goal of health-promoting interventions should not be the quantitative change in people’s behavior but rather their perceived improved ability to make decisions about their own behavior. Thus, understanding the perceived autonomy, competence and relatedness of mothers could help design interventions that would support women in their decision making, promote wellbeing, and aid in permanently changing child-feeding behavior on their own terms.

One of the strengths of this study is that the informants were those primarily making child-feeding decisions, thus capable of providing valuable insights. Furthermore, the inclusion of healthcare workers allowed for another viewpoint on the same subject. As two distinct areas were included, we were able to acquire data from both urban and rural settings, which differed only slightly. Reflecting these findings on the SDT allowed us to highlight the issues affecting maternal motivation the most. Furthermore, this provides theoretical evidence to the argument that these themes are related to motivation. All the interpretations were made transparent, and the
analysis was confirmed by two authors. The key limitation in this study was the consistency and precision of documentation during the FGDs.

5 | CONCLUSIONS AND RECOMMENDATIONS

Interventions to improve infant and young child-feeding practices should go beyond building maternal competence. First, it would be important to support mothers in their ability to make choices that are beneficial for their children. Allowing them room to make these decisions themselves is important for intrinsic motivation and the lasting change induced by ownership. To achieve such, the autonomy of mothers should be supported throughout their pregnancy, childbirth, breastfeeding, and complementary feeding. They should be offered more social support, and their competence should be built in encouraging ways. It would be important for the mothers to have a trusting and familiar relationship to the healthcare workers to allow them to seek information from these professionals rather than friends, commercials, and the Internet. Additionally, the competence of the healthcare workers should be strengthened in the area of complementary feeding so they could correctly and convincingly advise the mothers.

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CONFLICTS OF INTEREST

The authors declare that they have no conflict of interest.

CONTRIBUTIONS

LS designed the study, coded and analyzed the data, wrote the manuscript, and approved the manuscript for submission.

SO designed the study, analyzed the data, reviewed the manuscript, and approved the manuscript for submission.

JK organized and supervised the fieldwork, reviewed the manuscript, and approved the manuscript for submission.

CL supervised the fieldwork, reviewed the manuscript, and approved the manuscript for submission.

MM designed the study, reviewed the manuscript, and approved the manuscript for submission.

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