Factors Influencing Utilisation of Community-Integrated Management of Childhood Illness Practices among Rural Nursing Mothers in Ogun State, Nigeria

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ABSTRACT
Community Integrated Management of Childhood Illness (C-IMCI) practices combine improved case management of childhood illness with aspects of nutrition, disease prevention, appropriate home care, normal growth and development of children who are less than five years old. This study assessed knowledge, attitudes, and factors influencing utilisation of C-IMCI practices among rural nursing mothers in Ogun state, Nigeria with a view to unraveling the dynamics involved in the utilisation of the programme. Multi stage sampling procedure was used to select 210 nursing mothers from Odeda and Obafemi-Owode Local Government Areas (LGAs) of the state during the monthly immunisation programme often held at the primary health centres. Data were collected with the aid of structured questionnaire and described using frequency and percentages while Pearson Product Moment Correlation coefficient was used to make some inferences. Results show that about 58.0% of the nursing mothers were between ages 21 and 30 years, with an approximate mean age of 28.0 years. Only 27.0% of the nursing mothers had secondary education. The mean monthly income of the mothers was ₦16,294.00k. Majority (90.5%) of the mothers were highly knowledgeable about C-IMCI practices just as the mothers' attitude towards patronage of hospital for post-natal services was highly favourable (mean=4.42). The most utilised C-IMCI recommended practices among the mothers were child immunisation (Mean=2.98) and the use of insecticide mosquito net (mean=2.97). Correlation analyses show positive significant relationship between attitude ($r = 0.25$, $p \leq 0.01$) of C-IMCI practices and its utilisation at 1.0% probability level. It was concluded that factors such as insufficient fund/cost of charges, drugs supplies and stock outs and poor quality of service significantly influenced C-IMCI utilisation among the nursing mothers. It was recommended that polices that would improve utilisation of C-IMCI practices among nursing mothers in rural areas of the State should be proposed by the appropriate stakeholders to the government for implementation.
Keywords: Community integrated, management, mothers, illness, childhood

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INTRODUCTON

Children under five years of age bear a disproportionate share of the global burden of disease. While major gains have been made in reducing childhood mortality during previous decades, stagnation or even reversals of trends have been observed recently in many countries. Children continue to face widespread regional disparities in their chances of survival. Sub-Saharan Africa remains the region with the highest under-five mortality rate in the world. In 2018, the region had an average under-five mortality rate of 78 deaths per 1,000 live births (United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME 2019). Over 70% of child mortality had been attributed to just five primary causes namely: pneumonia, diarrhea, malaria, measles and malnutrition (World Health Organisation, WHO 2004). In response to this challenge, the WHO and the United Nations International Children's Emergency Fund (UNICEF) developed Integrated Management of Childhood Illness practices (IMCI). C-IMCI practices is a broad strategy designed to reduce childhood mortality, morbidity and disability in developing countries, and to contribute to improved growth and development of children less than five years of age. The C-IMCI practices are made up of three components which are improving case management skills of health providers, improving the health system, and improving the family and community practices. The three components of the IMCI strategy are linked and support each other when implemented simultaneously. For example, components 1 and 2 support component 3 when health providers trained in IMCI counsel mothers on home care /management of sick children. In turn, when mothers seek treatment outside the home and receive quality care at the health facility, demand and utilisation of services increases. This demand can be met by having components 1 and 2 in place. In addition, community demand may facilitate outreach by facility-based health providers who can also supervise community health workers to provide quality care and reinforce health messages.

Child mortality has remained a national and global concern and its import in socio-economic rating of country's development cannot be overemphasised. A baby born in Nigeria is 30 times more likely to die before age five than one born in a developed country (NPC/UNICEF, 2001). Infant and child mortality rates are exceedingly high, and Nigeria ranks 2nd highest in the world and first in Africa among countries with high under-five mortality (NPC/UNICEF, 2001). Nearly, a quarter of a million newborn babies die each year. In an effort to address high child mortality rate in the country, Nigeria government implemented the Integrated Management of Childhood Illness (IMCI) strategy in 1997, seven years after the Programme was initiated in 1990.

Nigeria has been one of the least successful countries at improving child mortality with more than one million children still dying annually from preventable diseases such as malaria, malnutrition, diarrhea, acute respiratory infections, HIV/AIDS particularly in poor socio-economic environments in the rural areas where the socio-economic status of the people is low. In an effort to address high mortality rate in , Ogun state, the government implemented Community-Integrated Management of Childhood Illness Programme in 2007. The C-IMCI practices were incorporated into the Primary Health Centres (PHC's) across the State in order for the health providers and the nursing mothers to have easy accessibility and utilisation to the programme.

However, the utilisation of health service in the state by nursing mothers is grossly unknow but infant mortality rate is still on the high side in the State. Evidence shows that the State record high under-five mortality rate (U5M) of 113 (113 per 1, 000) and 17,000 annual number of under-five death and has not met up with the World Summit for Children (WSC) national goals for reducing U5MR (70/80 per 1,000) by one-third by 2000 (FMOH, 2011). The assumptions underlying this inquiry are that if nursing mothers are utilizing the C-IMCI practices, the rate of child mortality in the State should be low.

To further explain how utilisation of C-IMCI works, Andersen and Newman Framework (1973) of Health Services Utilisation was adopted. The framework was developed in the year 1973. The framework posited that an individual's access to and use of health services is considered to be a function of three factors: predisposing, enabling and needs factors. The purpose of this framework is to discover conditions that either facilitate or impede utilisation. The goal is to develop a behavioral model that provides measures of access to medical care. An individual's access to and use of health services is considered to be a function of three characteristics: predisposing, enabling and need factors. The predisposing factors are socio-cultural characteristics of individuals that exist prior to their illness. The predisposing factors in this study include the nursing mothers' age, education status, attitude and their knowledge towards C-IMCI Practices. Health belief, attitudes and knowledge that people have concerning and towards the health care system also affect their usage of the available service. Practices of C-IMCI are heavily influenced by the nursing mothers' knowledge and attitude. Nursing mothers with higher level of knowledge about the usefulness of C-IMCI tends to utilize C-IMCI services more compare with those that have low knowledge on the importance of C-IMCI services in the community. The enabling factors represent the logical aspect of obtaining care by the nursing mothers. The second component of the C-IMCI practices talks about the enabling factors. This includes availability of health care, health personnel and health facilities in the community. It is belief that where health systems are weak in terms of infrastructure and resources, individual attitudes and personal perceptions of the available health systems (C-IMCI services) can create barriers to the use of the services, therefore having a considerable impact on the eventual uptake of C-IMCI service in the area. The need factors addressed the third component of the C-IMCI practices. The need factors explained why the nursing mothers make use of C-IMCI practices. This represents how the nursing mothers view the health and function state of their children. The decision of whether the nursing mothers will seek care or not is dependent on the health status of the child and her perception of to what extent health care will improve health status and thereby increase utility. A reasonable assumption is that nursing mothers whose their children suffer from more severe illnesses have greater incentives to seek health care on C-IMCI practices. The model was adapted for making recommendations for the health-agriculture policy makers in packaging of health agricultural materials for farm-families in the study area. This will assist them take health decisions on how to take care of their children, live in healthy environment, how to take care of themselves as well as taking into cognizance the implications of ill-health on the children and also emotional effect on the women.

This study represents one of the few studies geared specifically towards understanding factors which are responsible for utilisation of health services and reasons for high under five mortality rates in Ogun state, Nigeria. Hence, to achieve the overall objective, this study specifically described the socio-demographic characteristics of the nursing mothers; assessed the attitude of the respondents towards C-IMCI practices, determined their knowledge and utilisation of C-IMCI practices among respondents, and identified factors influencing utilisation of C-IMCI practices.

METHODOLOGY

The study was conducted in Ogun state. Multi stage sampling procedure was used to select the respondents for the study. The selection procedure was as follows:

Stage one: Purposive selection of Odeda and Obafemi-Owode Local Government Areas out of the twenty (20) Local Government Areas in Ogun state due to high number of health centres and being the two largest rural Local Government Areas in the state. Stage two involved a proportionate selection of 40% of the ten (10) communities in Odeda LGA to give four (4) communities and selection of 25% of twelve (12) communities in Obafemi Owode LGA to give three (3) communities. Thus, a total of seven (7) communities were used for the study. The selected communities from the two (2) LGAs were Alabata, Olodo, Osiele, Orile-Ilugun, Ajebo, Obafemi, Ofada. Stage three involved a simple random selection of one primary health centre (PHC's) from each of the selected communities to make a total of seven (7) PHCs used in all. Stage four involved a simple random selection of thirty (30) nursing mothers from each of the selected PHC's during the monthly immunisation programmes. Therefore, a total of two hundred and ten (210) nursing mothers were selected and used for the study.

Attitude of the nursing mothers towards C-IMCI practices was measured at ordinal level on five-point Likert's typed scale of strongly agree (5), agree (4), undecided (3), disagree (2) and strongly disagree (1). Knowledge of C-IMCI practices was measured at interval level on two point rating scale of yes (1) and no (0). Utilisation of C-IMCI practices was measured at ordinal level on three-point rating scale of always (3), occasionally (2) and never (1). Factors influencing utilisation of C-IMCI practices was measured at ordinal level on three-point rating scale of major (3), minor (2) and not a factor (1).

Grand mean score was used as a benchmark to determine variables that significantly contributed to the study objectives. The grand mean for each scale was calculated by adding mean of each item in the scale divided by the number of items in each scale. Variables in each scale that had mean value equal to or above the grand mean score were considered to contribute significantly to the objective.

Data were collected with the aid of an interview guide and described using frequency counts, percentages, mean, standard deviation and Pearson Product Moment Correlation (PPMC) was used to analyse the data.

RESULTS AND DISCUSSION

Socio-economic characteristics of the respondents

Table 1 shows that a little above average (58.0%) of the respondents were between 21 and 30 years old, 24.0% were in the age group of 31-40 years and 15.0% were in the age group of less than 20 years. The mean

age of 28 years was obtained. This implies that majority of the respondents were still within their active, reproductive, productive age brackets and giving a healthy living condition they are still expected to be able to maximize and utilize C-IMCI practices to minimize infant mortality among their children. The finding also implies that the respondents would still be in their child-bearing age, thus, they would be using C-IMCI practices if they are knowledgeable about it. This is in line with Addai, (2000) and Kuzma, (2013) who posited independently that age positively influenced health care practices utilisation.

More so, the findings show that less than one-third (27.0%) of the respondents completed their secondary school education, 23.0% did not have formal education, 22.0% of the respondents had tertiary education, 10.0% of the respondents did not complete their secondary education, 9.0% of the respondents completed primary education, 8.5% did not complete their primary education, while 0.5% of the respondents have Islamic education. This implies that the respondents are fairly educated as education enhances the woman's knowledge of modern health-care facilities, improves her ability to communicate with modern health-care providers thereby increasing the value she places on good health, thus resulting in heightened demand for modern health-care services. This agrees with Agyemang and Asibey (2018) who posited that education influence healthcare utilisation. C-IMCI strategy identifies the education of the child's mother or care giver as an important factor in C-IMCI utilisation. This empowers them to know and understand how to give prescribed drugs, how to measure and prepare the Oral Rehydration Treatment (ORT) solution or prepare a cough mixture. This finding agrees with WHO (2006) report that education enhances the use of health services.

Attitude of the Nursing Mothers towards Utilisation of C-IMCI Practices

Attitude of the nursing mothers towards utilisation of C-IMCI practices were ranked according to the mean. The grand mean is 4.20, items with mean from 4.20 and above are considered high. I ensure I will take my child to hospital to receive vaccination ranked 1st (mean = 4.73), nursing mothers should follow health worker's advice about treatment ranked 2nd (mean = 4.68) and I go for adequate antenatal care services; the child should be taken to hospital when stooling ranked 3rd respectively (mean = 4.60). This implies that most of the respondents followed the guidelines of the programme. Use of vaccination and adherence to the instruction given by the health workers will reduce child mortality in the study area. This is in line with Jibo, Iliyasu, Abubakar, Umar and Hassan, (2014) who posited that the proportion of children that were fully immunised as recorded in their cards were higher in IMCI communities and has improved the health of the children.

Also, the child should be taken to hospital when there is high fever ranked 5th (mean = 4.57), the child should be taken to hospital when there is severe cough ranked 6th (mean = 4.62), the child should be taken to hospital when unable to eat well ranked 7th (mean = 4.43) and the child should be taken to hospital for postnatal care services ranked 8th (mean = 4.42). Taking the child to health centre for diagnosis and treatment will improve the quality of life and wellbeing of the child. This was similar to what was reported by Ebuehi (2009) that after implementation of IMCI, the prevalence of diarrhea and cough were reduced from baseline values of 13% and

29.9% to 9.5% and 18.6%, respectively, following IMCI introduction. This could have been contributed by the improved household practices like proper hand washing and improved personal hygiene practices in IMCI communities.

Furthermore, the child should be taken to hospital for regular checkups ranked 9th (mean=4.41) and the child should not be taken to hospital when unable to eat well ranked 10th (Mean = 4.20). Regular checkups and follow up will keep the children to be healthy. This finding is by Jibo, Iliyasu, Abubakar, Umar and Hassan, (2014) who found out that improved supported child health practices in communities where IMCI has been implemented over the last few years.

Respondents Knowledge on C-IMCI Practices

Table 3 shows that majority (72.0%) of the nursing mothers were highly knowledgeable of breastfeeding the child within one hour after birth. Many (62.5%) of them were knowledgeable of breastfeeding the child for two years while most (82.5%) of the mothers were knowledgeable that colostrum served as immunisation for the baby. Knowledge that nursing mothers have towards C-IMCI practices may affect their utilisation of the C-IMCI practices. This implies that nursing mothers that were highly knowledgeable on C-IMCI practices may tend towards utilisation and uptake of C-IMCI practices than those that have low knowledge on the practices.

Utilisation of C-IMCI Practices

The utilisation of C-IMCI practices among the nursing mothers was ranked according to mean. The grand mean of the scale is 2.89, items with mean value from 2.89 and above contributed highly to the subject matter. I ensure my children complete the full course of immunisation; I dispose the feaces safely, wash hands after the child has defecate; I follow the health worker's advice about treatment, follow up, and referral ranked 1st (mean=2.98). These practices fall under the care seeking practices of C-IMCI. Adherence to the components of C-IMCI practices will improve the health of the children. This help to reduce child mortality in the study area.

I use insecticide mosquito net to protect my children; I give children appropriate home treatment for infections; I take appropriate actions to prevent and manage child injuries and accidents; I go for antenatal care; I take the child to hospital to receive vaccination; I seek care from appropriate health providers ranked 4th (mean = 2.97). This practice falls under the third component of C-IMCI practices which aim to improve family and community practices by promoting those practices with the greatest potential for improving child survival, growth and development. For instance, protection of children in malaria-endemic areas by ensuring that they sleep under treated mosquito nets will help to prevent disease infection. This will help to decrease mortality and morbidity in children under five and enable children to develop and grow healthy. This agrees with Arifeen, Hoque, Akter, Rahman and Hoque (2009) who stated that implementation of IMCI led to improved family and community practices, translating into increased care seeking for illnesses.

Factors Influencing Nursing Mothers Utilisation of C-IMCI Practices

Results in Table 5 show the factors affecting the nursing mothers in utilizing C-IMCI practices. Insufficient fund/cost of charges was ranked first with the mean score of 1.61. This means that nursing

mothers that does not have sufficient fund may not be able to take their children to health centre when they are sick. This agrees with Hjortsberg, (2004) who reported that lack of fund and cost of access to health care are important determinants of health service utilisation.

Inadequate drug supplies was ranked second with mean score of 1.57 and poor quality of service was ranked third with the mean score of 1.50. Preliminary investigation and observation made during the data collection stage of the study shows that most of the Primary Health Care centre (PHCs') in the study area was not well equipped. State government should ensure that PHCs' are well equipped with all necessary health facilities. This will enhance the use of C-IMCI practices in the study area and the state at large.

Lack of service was ranked fourth with mean score of 1.47 while distance to the health centre was ranked fifth with mean score of 1.37. Most of the PHCs' in the study area were far apart. Some of the Nursing mothers' in the study areas needs to travel a long distance before getting to the available health centre. Government at all level should invest massively in building health centres near the people in order to encourage easy access to health care utilisation. This agrees with Obrist, Iteba and Lenger (2007) who posited that availability, accessibility, affordability, adequacy and acceptability of the health facility affect the individuals' utilisation of health services. O' Donnell, (2007) also reported that user charges, payment and distance affect the utilisation of health service. These factors when put together may affect the uptake and utilisation of the services by the nursing mothers.

Relationship between the nursing mothers' attitude and utilisation of C-IMCI practices

Result in Table 6 show that there is significant relationship between attitude ($r=0.25$; $p\leq0.05$ and utilisation of C-IMCI practices. Therefore, the null hypothesis is rejected. Health belief, and attitudes that people have towards the health care system affect their usage of the available service. Practices of C-IMCI are heavily influenced by the nursing mothers' attitude. This implies that the more favourable the attitude, the better the chance of utilisation of health service by the nursing mothers. Nursing mothers that had positive attitude towards C-IMCI practices are more likely to use the practices that those that had negative attitude in the community.

Decision criterion is Reject null hypothesis when $p<0.01$

CONCLUSION AND RECOMMENDATIONS

Overall, this study has made significant contributions to research work on factors affecting the utilisation of C-IMCI practices among rural nursing mothers in Ogun state. It was concluded that factors such as insufficient fund/cost of charges, drugs supplies and stock outs, poor quality of service, low reliability of point of care, lack of service and distance significantly influenced C-IMCI utilisation among the nursing mothers. Also, there is positive significant relationship between utilisation of C-IMCI practices and attitude of nursing mothers to C-IMCI practices. It is recommended that polices should be focused to address the factors impeding the use of C-IMCI practices and to improve utilisation of C-IMCI practices among nursing mothers in rural areas of the State.

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Table 1: Respondents socio-economic characteristics

Variables	F (%)	Field survey (2014)	S.D
Age (years)			
≤20	30 (15.0)		
21-30	116 (58.0)	**28 years**	**6 years**
31-40	48 (24.0)		
41 & above	6 (3.0)		
Marital status			
Single	-		
Married	199 (99.5)		
Widowed	1 (0.5)		
Divorced	-		
Educational status			
Non-formal	46 (23.0)		
Quranic education	1 (0.5)		
In-complete	17 (8.5)		
Primary education			
Complete primary education	18 (9.0)		
In-complete secondary education	20 (10.0)		
Complete secondary education	54 (27.0)		
Tertiary education	44 (22.0)		
Religion			
Christianity	143 (71.5)		
Islam	56 (28.0)		
Traditional	1 (0.5)		
Occupation			
Farming	41(20.0)		
Artisanship	54(27,1)		
Trading	66 (33.2)		
Animal husbandry	2 (1.0)		
Civil service servant	36 (18.1)		
Household size (persons)			
Less than or equal to 4	112 (56.0)		
5 – 9	83 (41.5)		
10 – 14	5 (2.5)		
Estimated annual income (₦)			
< 250,000	108 (54.0)		
250,000-499,000	82 (41.0)		
500,000-749,000	3 (1.5)		
750,000-959,000	5 (2.5)		
1 million and above	2 (1.0)		
Place of delivery			
Home	28 (14.1)		
Traditional birth attendance	1 (1.0)		
Community health centre	82 (41.2)		
Private hospital	80 (40.0)		
Religious centre	8 (4.0)		

I go for adequate antenatal care services	136(68.0)	58(29.0)	-	3

Field survey, (2014)
Note: Strongly agree (SA), Agree (A), Undecided (U), Disagree (D), Strongly disagree (SD). Grand mean score = 4.20

Table 2: **Respondents according to their attitude towards C-IMCI Practices**

Attitude on C-IMCI practices	**SA(%)**	**A (%)**	**U (%)**	**D (%)**	**SD(%)**	**MEAN**	**Rank**
I ensure I will take my child to hospital to receive vaccination	159(79.5)	34(17.0)	1(0.5)	7(3.5)	-	4.73	1st
I do not follow health workers advice about treatment	18(9.0)	13(6.5)	1(0.5)	98(49.0)	70(35.0)	3.95	15th
The child should not be taken to hospital when severe headache occurs	1 (7.5)	9(4.5)	1(0.5)	101(50.5)	74(37.0)	4.05	14th
I breastfeed my child exclusively for six months	71(35.5)	17(8.5)	1(0.5)	56(28.0)	55 (27.5)	2.97	19th
The child should be taken to hospital when there is high fever	133(66.5)	59(29.5)	-	5(2.5)	3 (1.5)	4.57	5th
I do not have time to exclusively breastfeed my baby	27(13.5)	17(8.5)	1(0.5)	99(49.5)	56 (28.0)	3.70	18th
The child should be taken to hospital when stooling	142(71.0)	48(24.0)	1(0.5)	5(2.5)	4 (2.0)	4.60	3rd
I do not go for antenatal care service	14(7.0)	7(3.5)	1(0.5)	96(48.0)	82 (41.0)	4.13	11th
The child should be taken to hospital for regular check ups	120(60.0)	63(31.5)	2(1.0)	10(5.0)	5 (2.5)	4.41	9th
The child should not be taken to hospital to receive vaccination	13(6.5)	10(5.0)	2(1.0)	89(44.5)	86(43.0)	4.13	11th
The child should not be taken to hospital when sudden weight occurs	12(6.0)	9(4.5)	3(1.5)	97(48.5)	79(39.5)	4.11	13th
The child should not be taken to hospital when unable to eat well	10(5.0)	5(2.5)	2(1.0)	101(50.5)	82(41.0)	4.20	10th
I take my child to hospital when severe headache occurs	93(46.5)	50(24.3)	1(0.5)	27(13.5)	29(14.5)	3.76	17th
The child should be taken to hospital for postnatal care services	115(57.5)	73(36.5)	1(0.5)	3(1.5)	8(4.0)	4.42	8th
The child should be taken to hospital when unable to eat well	119(59.5)	68(34.0)	1(0.5)	4(2.0)	8(4.0)	4.43	7th
The child should not be taken to hospital for postnatal services	24(12.0)	10(5.0)	3(1.5)	92(46.0)	71(35.5)	3.88	16th
The child should be taken to hospital when there is severe cough	124(62.0)	67(33.5)	1(0.5)	5(2.5)	3(1.5)	4.52	6th
Nursing mothers should follow health worker's advice about treatment	136(68.0)	64(32.0)	-	-	-	4.68	2nd

Table 3: Respondents Knowledge of C-IMCI practices

Knowledge on C-IMCI Practices	True (%)	False (%)
It is good to put the baby on the breast within one hour after birth.	*144 (72.0)	56 (28.0)
In order to have enough milk a mother needs to breastfeed every 4 hours (at least six times a day).	90 (45.0)	*110 (55.0)
Colostrums or first milk serves as the first immunisation for the baby.	*165 (82.5)	35 (17.5)
In the first six months, the infant needs water and/or other drinks in addition to breast milk.	128 (64.0)	*72 (36.0)
When breastfeeding, the baby's chin needs to touch the mother's breast.	*172 (86.0)	28 (14.0)
A malnourished infant and young child has more episodes of diarrhoea.	*175 (87.5)	25 (12.5)
Vitamin A supplementation is necessary only for children under 2 years.	156 (78.0)	*44 (22.0)
Breastfeeding benefits the baby, but not the mother.	115 (57.5)	*85 (42.5)
When a mother is HIV-positive, there are ways to decrease HIV transmission to the baby.	*165 (82.5)	35 (17.5)
Even if a mother believes she does not have enough breast milk, she can still be able to adequately breastfeed her baby.	*185 (92.5)	15(7.5)
A mother can prevent sore and cracked nipples by correctly positioning and attaching her baby at the breast.	*192 (96.0)	8 (4.0)
The most important thing a mother can do to produce sufficient breast milk is to breastfeed her baby frequently, both day and night.	*197 (98.5)	3 (1.5)
Infant formula contains antibodies that protect against diseases, especially against diarrhoea, respiratory and ear infections.	177 (85.9)	*23(11.2)
Mixed feeding (meaning breastfeeding and giving other foods and drinks) before six months can cause diarrhoea, respiratory and ear infections.	*119 (59.5)	81 (40.5)
Pregnant women can continue breastfeeding.	*24 (12.0)	176 (88.0)
Expressed breast milk can be stored in room temperature up to 1 day.	*120 (60.0)	80(40.0)
An HIV/AIDS infection increases energy and nutrients needs	*147 (73.5)	53(26.5)
A woman that is malnourished can still adequately breastfeed her baby	123 (61.5)	*77(38.5)
Do not feed leftover food that might be contaminated	*182 (91.0)	18 (9.0)
Antenatal care is needed for pregnant women	*192 (96.0)	8 (4.0)
Young children should be breastfed for 2 years	*125 (62.5)	75 (37.5)
Children 9-24 months old should eat 3-4 times in a day and have 1-2 snacks	*182 (91.0)	18 (9.0)
Mothers do not need support from the family or the community in order to feed their children	*141 (70.5)	59 (29.5)

Source: Field Survey 2014