Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 6 No. 3 (2025): March 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i3.1548
Original Article

BARRIERS TO EXCLUSIVE BREASTFEEDING PRACTICES AMONG HIV-POSITIVE MOTHERS ATTENDING POSTNATAL CLINIC AT KAJJANSI HEALTH CENTRE IV, WAKISO DISTRICT. A CROSS-SECTIONAL STUDY.

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Abstract

Background

Exclusive breastfeeding is critical for infant health, particularly among HIV-positive mothers. This study aimed to assess the barriers to exclusive breastfeeding among HIV-positive mothers attending a postnatal clinic at Kajjansi Health Center IV.

Methodology

A descriptive cross-sectional study design was employed to select 40 mothers. A simple random sampling method was used, and data was collected using a semi-structured researcher-administered questionnaire with both open and close-ended questions. Microsoft Excel was used for data analysis.

Results

40 respondents participated in this study; the majority, 28(70%) of the respondents, were between 18-25 years of age, while only 01(2.5%) was above 35 years. 75% of the respondents knew that exclusive breast milk is important for HIV-positive mothers. However, 37.5% of the mothers were not sure whether taking ARVs during pregnancy and after childbirth reduces the chances of HIV transmission to the born baby, and 37.5% of them also mentioned replacement feeding as the ideal baby feeding method in the first 6 months. 62% of the respondents reported having sufficient breast milk for EBF. However, 65% of them reported sometimes having support from their partners to EBF, and 20% were not sure whether EBF is culturally accepted. Half of the mothers never got breastfeeding counseling during ANC, and 75% were not advised on EBF for the first 6 months at the health facility.

Conclusion

The study found good knowledge among most of the respondents. However, socioeconomic and health facility factors greatly contributed to barriers to EBF among HIV-positive mothers.

Recommendation

The government, through the Ministry of Health, should expand breastfeeding education during antenatal care and postnatal visits, emphasizing the health benefits of EBF beyond HIV transmission alone.

Keywords: *Exclusive breastfeeding practices, HIV positive mothers, Kajjansi health Centre iv, Wakiso district.*
Submitted: *2025-01-10* ***Accepted:*** *2025-02-20* ***Published:*** *2025-03-01*

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Background of the study

Exclusive breastfeeding (EBF) refers to the feeding of an infant on only breast milk and no other liquids or foods except medication and mineral supplements (Penugonda et al., 2022). EBF is very crucial for HIV-positive mothers since the practice is shown to reduce the risk of HIV transmission from mother to child, as well as provide numerous other health benefits for both the mother and her child (Modjo & Amanda, 2015). It further strengthens the infant's immune system, promotes healthy growth and development, and is also very important in fostering a strong bond between the mother and her child. While breastfeeding is a natural and beneficial practice, it is also important to appreciate that it can pose risks for HIV-positive mothers who may inadvertently transmit the virus to their infants through breast milk if proper guidelines are not followed (Blackshaw et al., 2021).

The first WHO guidelines on the use of ARVs in pregnancy and infant feeding were released in 2000 to curb mother-to-child transmission (Govender & Coovadia, 2014). However, major changes concerning infant feeding in the subsequent WHO guidelines of 2006 and 2010 reflect consecutive updates based on scientific evidence on HIV and infant feeding (WHO, 2016).

World Health Organization (WHO) recommends that HIV-positive mothers exclusively breastfeed their infants for the first six months of life (Olorunfemi & Dudley, 2018). Thereafter, they can introduce appropriate complementary foods and continue breastfeeding for the first 12 months of life. These HIV-positive mothers should then consider stopping breastfeeding at 12 months if they are

able to provide a nutritionally acceptable and safe diet without breast milk. Nevertheless, mothers living in food-

insecure regions need to continue breastfeeding beyond 12 months to achieve an adequate diet (McCoy et al., 2015).

Globally, there are an estimated 1.3 million women and girls living with HIV who become pregnant each year where in the absence of intervention, the rate of transmission of HIV from a mother to her child during pregnancy, labor, delivery, or breastfeeding ranges from 15% to 45% (Kassa, 2018). It should, however, be noted that 1.2 million deaths and 2.5 million HIV infections have been prevented courtesy of prevention of mother-to-child transmission (PMTCT) and Elimination of mother-to-child transmission (EMTCT) programs (Oyebanji, 2022).

In sub-Saharan Africa, exclusive breastfeeding has been shown to significantly reduce the risk of HIV transmission from mother to child while also providing essential nutrients and immunological benefits for the infant (Pretorius, 2020). Hence, improving exclusive breastfeeding rates among HIV-positive mothers has contributed to the overall goal of eliminating new HIV infections in children and keeping mothers alive and healthy (Ritchie et al., 2019).

Uganda has made significant progress in reducing its HIV/AIDS burden, but the country still faces challenges in addressing mother-to-child transmission of the virus (Mustapha et al., 2018). Despite the availability of antiretroviral therapy and PMTCT/EMTCT services, exclusive breastfeeding rates remain sub-optimal among HIV-positive mothers (Ski, 2016). Hence, various barriers to EBF, including cultural beliefs, lack of knowledge, inadequate support from healthcare providers or communities, and economic factors, have compelled mothers to seek alternative feeding options in Uganda.

This study aimed to assess the barriers to exclusive breastfeeding among HIV-positive mothers attending a postnatal clinic at Kajjansi Health Center IV.

Methodology

Study Design and Rationale

The study employed a descriptive cross-section design employing a quantitative approach. This design was selected because data was to be collected at one point in time among the HIV-positive mothers.

Study Setting and Rationale

The study was conducted at Kajjansi Health Center IV, Wakiso district and Central region of Uganda. The health Center is located along Entebbe-Kampala Road, about 24 kilometers southwest of Mulago National Referral Hospital. The health facility has a bed capacity of about 50 beds and offers services like Outpatient services, Inpatient services, maternity services, and Elimination of mother-to-children services EMTCT services. This study area was selected due to the increasing number of HIV-positive mothers reporting to prefer feeding their babies on replacement feeds.

Study Population

The study targeted all the HIV-positive mothers at postnatal clinic Kajjansi Health Center IV.

Sample Size Determination

The study employed 40 HIV-positive mothers from postnatal clinics to provide better information about the study. According to Kish and Leslie (survey sampling, 1965), statistical formulae for surveys:

N0 = (z2pq)/d2

No representative sample for proportions

z= standard normal deviation (1.96) at 95% confidence interval p= proportion of the target population 50 % (0.5)

q= 1-p

d= degree of occurrence desired (0.05) Therefore No = (1.962*0.5*0.5)/0.052 No =384 People

Following the above, the study sample was calculated using the following formula;

n=No / (1+No/N); where

n= sample size

No=the representative sample for proportions

N= population size

Hence, the study sample size was;

n=384/ (1+384/45)

n= 40

Therefore, the desired sample size was 40 respondents.

Sampling Procedure

A convenience sampling method was used to identify the participants' information for this study. This was done by reaching out to all HIV-positive mothers present on that day who are easily accessible to ask for their participation. On each visit, the researcher sampled four respondents for 10 days to reach a sample size of 40 to participate in the study.

Inclusion Criteria

All the HIV-positive mothers who were present that day and consented to participate in the study.

Dependent variable;

Barriers to exclusive breastfeeding.

Independent variables;

Knowledge regarding Exclusive breastfeeding among the HIV positive mothers Socio-economic barriers to exclusive breastfeeding among HIV-positive mothers

Hospital Barriers to Exclusive Breastfeeding Among the HIV positive Mothers

Research Instruments

The study used a semi-structured, administered questionnaire with both open and close-ended questions. The questionnaire contained three sections: section A, which consisted of the demographic data of the respondents; section B, which consisted of the knowledge of the respondents; section C, which consisted of the socio-economic barriers and the Hospital barriers to EBF among HIV-positive mothers. The questionnaire was

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formulated in English and was translated into the local language for illiterate respondents
to easily understand it.

Data Collection Procedure

The researcher was introduced to the mothers by the in charge of the postnatal clinic, then thoroughly explained to the respondents the purpose of the study and the possible risks that would be involved. Consent was sought from the respondents, and then a questionnaire was issued to the participants, ensuring that all the respondents who could not interpret the questionnaire were helped to interpret. The time to answer the questionnaire was 15-20 minutes to avoid losing the respondents' concentration.

Data Management and Presentation

Data from the study was thoroughly checked and validated for completeness and stored in a database established using Microsoft Excel. A password was used to prevent unauthorized access to the database. The data was also backed up on a flash and hard disk before and after analysis.

Data on the questionnaire was kept under lock and key while electronically stored data was password protected.

Data Analysis

The data was first cleaned, organized, and checked for any gaps, after which it was changed into codes and later transferred to Microsoft Excel 2017 and SPSS computer programs for the presentation of tables and figures. Responses for open-ended questions were summarized and given themes before tallying them for analysis.

Ethical Considerations

After the approval of the proposal by the school research committee, an introductory letter was given to the researcher, introducing her to be allowed to carry out the study. An introductory letter was taken to the Charge Kajjansi Health Center IV to seek permission; the researcher introduced herself to the

In-charge postnatal clinic and then introduced to the respondents, explaining the purpose of the study as well as the objectives. The consent was obtained from the respondents. Respondents' contact identities were kept anonymous throughout the study to ensure that the researcher used codes to identify the respondents but not their names. Furthermore, no one else except the researcher had access to the completed research instruments for confidentiality.

Results

Table 1: Showing demographic characteristics of the respondents, n=40

Age group	Frequency (f)	Percentage (%)
18-25 years	28	70
26-30 years	9	22.5
31-35 years	2	5
Above 35 years	1	2.5
Religion		
Catholic	17	42.5
Muslims	10	25
Protestant	7	17.5
Born again	6	15
Tribe		
Muganda	29	72.5
Munyankole	7	17.5
Musoga	3	7.5
Gishu	1	2.5
Level of Education		
Secondary	21	52.5
Tertiary	15	37.5
Primary	4	10
Number of pregnancies		
One	16	42.5
Two	10	25
Three	9	22.5
More than three	5	12.5
Occupation		
Self-employed	21	52.5
Employed	12	30

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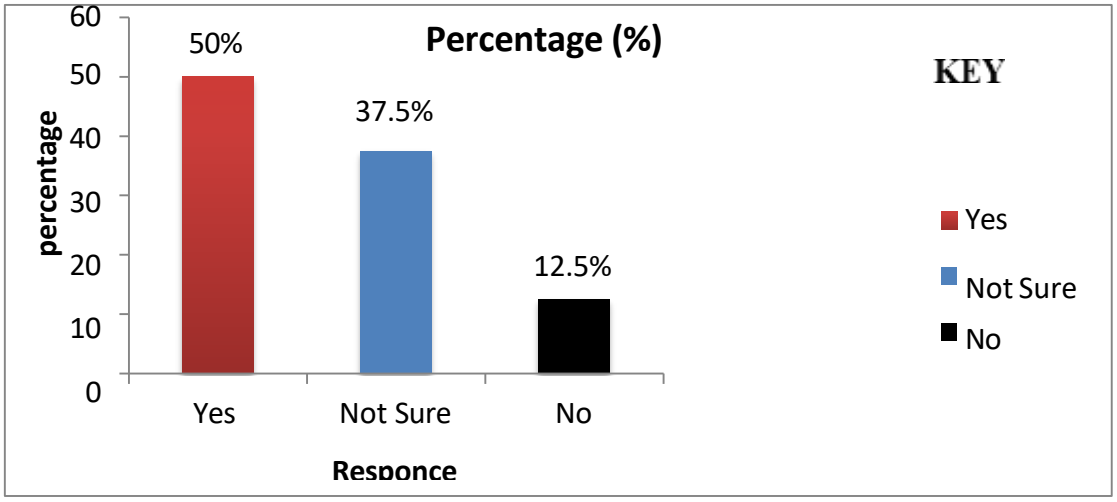
Housewife	07	17.5
Total	**40**	**100**

N = 40, primary data (2024)

Table 1 indicates that the majority, 28(70%) of the respondents were between 18-25 years of age, while only 01(2.5%) was above 35 years. Regarding religion, 17(42.5%) of the respondents were Catholics, while at least 06(15%) of them were born-again Christians. Concerning the tribe, the majority of 29(72.5%) of the respondents were Baganda, while only 01(2.5%) was a Gishu. More than half of 21(52.5%) of the respondents were at a secondary level of education, while the least 04(10%) were at a primary level. In terms of the Number of pregnancies, 16(42.5%) of the respondents had one child, while the least 05(12.5%) of them had more than three children. Concerning Occupation, more than half 21(52.5%) of the respondents were self-employed while the least 07(17.5%) were housewives.

Knowledge regarding Exclusive Breast Feeding

Figure 1: Showing whether taking ARVs during pregnancy and after childbirth reduces the chances of HIV transmission to the born baby, n=40



According to Figure 1, half 20(50%) of the respondents knew that taking ARVs during pregnancy and after childbirth reduces the chances of HIV transmission to the born baby, while the least 05(12.5%) did not know.

Figure 2: Showing whether breast milk protects the baby from other illnesses.

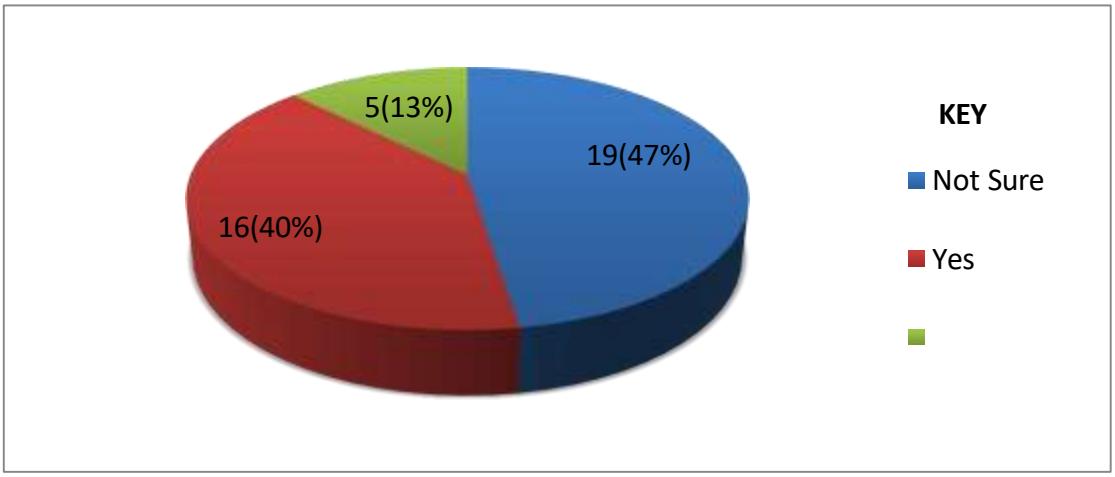


Figure 2 indicates that almost half of 19(47%) of the respondents were not sure whether breast milk protects the baby from other illnesses, while the least 05(13%) did not know.

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Table 2: Showing response on the ideal baby feeding method in HIV-positive mothers in the first 6 months.

Response	Frequency (f)	Percentage (%)
Exclusive breastfeeding	17	42.5
Replacement feeding	15	37.5
Mixed feeding	08	20
Total	**40**	**100**

Source: Primary data 2024

Table 2 shows that 17(42.5%) of the respondents mentioned EBF as the ideal baby feeding method in HIV-positive mothers in the first 6 months, while at least 08(20%) of them mentioned mixed feeding.

Figure 3: Showing whether exclusive breastfeeding is important for HIV-positive mothers.

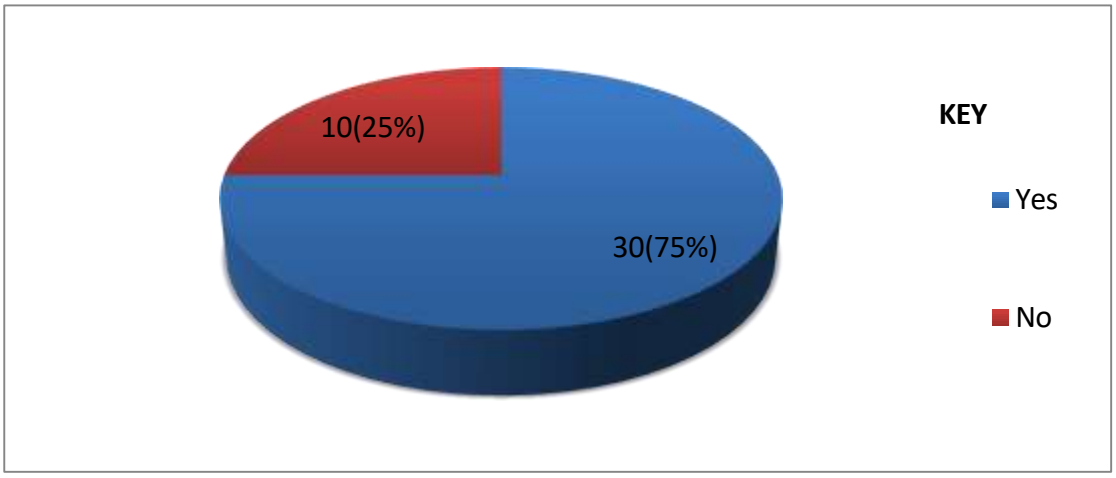
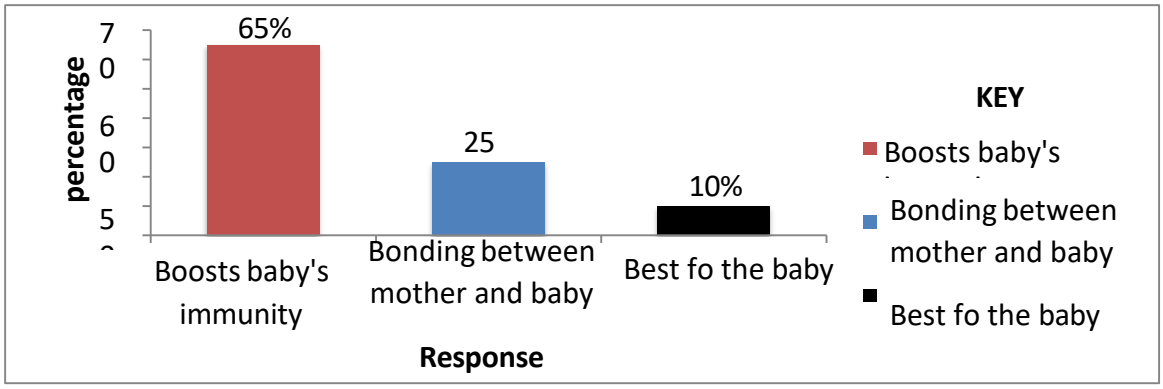


Figure 3 indicates that the majority, 30(75%) of respondents, believed exclusive breastfeeding was important for HIV-positive mothers, while the rest, 10(25%), did not find it important.

Figure 4: Showing the reasons why exclusive breastfeeding is important for HIV-positive mothers



Results from Figure 4 indicate that the majority, 26(65%) of the respondents, mentioned boosting the baby's immunity as the importance of breast milk for HIV-positive mothers, while the minority, 04(10%), mentioned that it is the best for the baby.

Socio-economic Barriers to Exclusive Breastfeeding among HIV Positive Mothers.

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Table 3: Showing whether the respondents disclosed their HIV status to their partner, n=40

Response	Frequency (f)	Percentage (%)
Yes	32	80
No	08	20
Total	**40**	**100**

Source: Primary data 2024

Table 3 shows that the majority, 32(80%) of the respondents reported disclosing their HIV status to their partner while the rest 08(20%) did not.

Table 4: Showing the reasons for not disclosing the HIV status to the partner, n=10

Response	Frequency (f)	Percentage (%)
Not yet ready	05	50
Fear of family breakup	04	40
Fear of violence	01	10
Total	**10**	**100**

Source: Primary data 2024

Table 4 shows that half 05/10(50%) of the respondents did not disclose their HIV status to their partner because they felt not ready, while only 1/10(10%) feared violence.

Figure 5: Showing response on who influences the respondents' feeding method, n=40

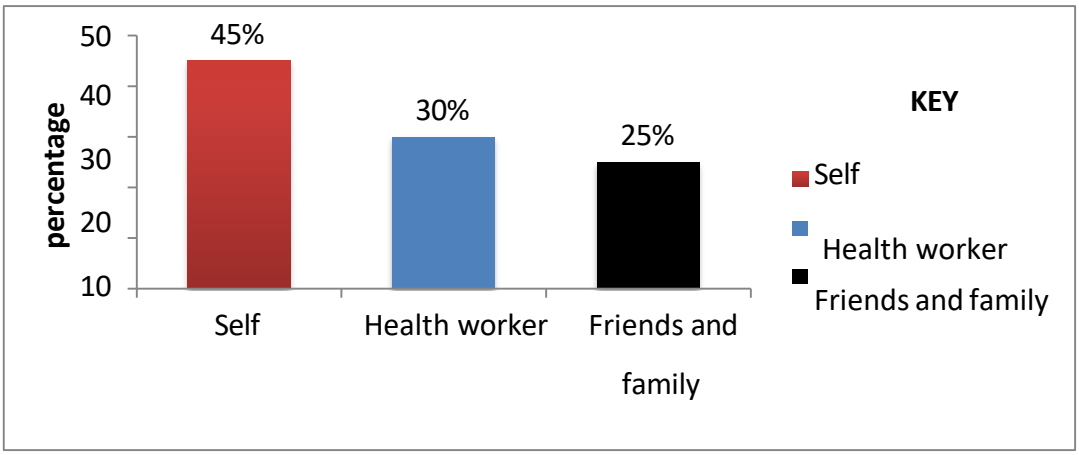

Figure 5 shows that 18(45%) of the respondents reported being influenced by themselves regarding breastfeeding methods, while the least 10(25%) reported friends and family.

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Figure 6: Showing whether respondents believe their breast milk is sufficient to do EBF, n=40

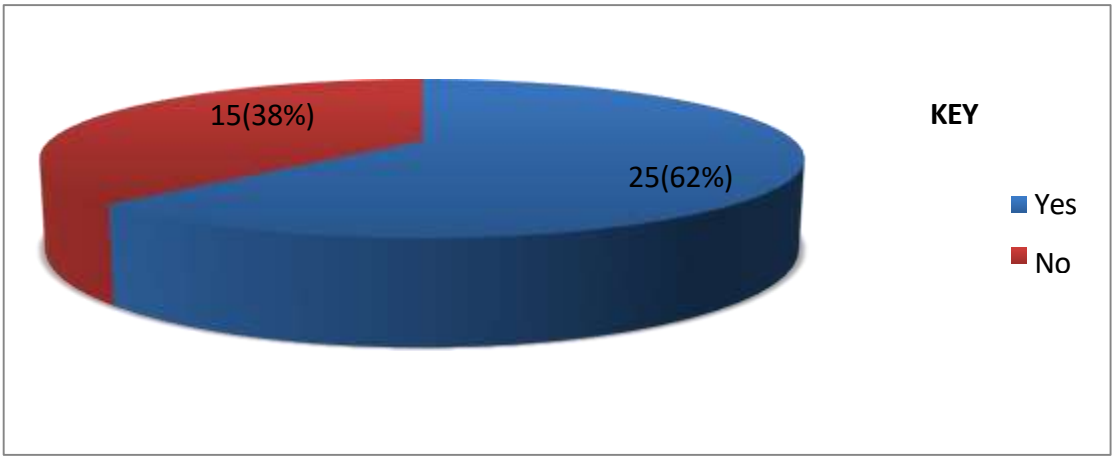

Figure 6 indicates that most 25(62%) of the respondents believed their breast milk was sufficient to do EBF, while the rest 15(37.5%) of them said no.

Table 5: Showing reason why respondents believe their breast milk is not sufficient to do EBF n=15

Response	Frequency (f)	Percentage (%)
The small size of the breast	07	46.7
Lack of confidence to breastfeed exclusively	06	40
Fear of exposing the baby	02	13.3
Total	**15**	**100**

Source: Primary data 2024

Table 5 shows that most 07/15(46.7%) of the respondent's small size of the breast was the reason for not believing to have sufficient breast milk to do EBF, while the least 02/15(13.3%) feared exposing the baby.

Table 6: Showing whether the respondents get enough support from their partner to practice EBF, n=40

Response	Frequency (f)	Percentage (%)
Some times	26	65
Always	10	25
Never	4	10
Total	**40**	**100**

Source: Primary data 2024

Table 6 shows that most 26(65%) of the respondents reported sometimes getting enough support from their partners to practice EBF, while the rest 4(10%) Never get it at all.

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Figure 7: Showing whether EBF is culturally accepted in the respondents' community, n=40

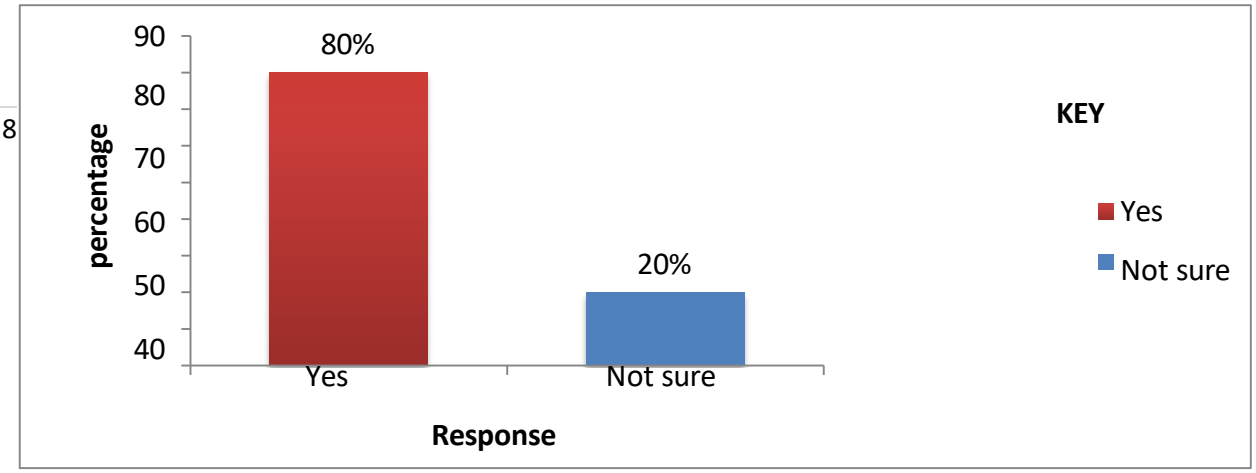

Figure 7 indicates that the majority, 32(80%) of the respondents, said that EBF is culturally accepted in their community, while the rest, 08(20%), were not sure.

Health Facility Barriers to Exclusive Breastfeeding among HIV Positive Mothers.

Figure 8: Showing whether the respondents received breastfeeding counseling at the health facility during ANC

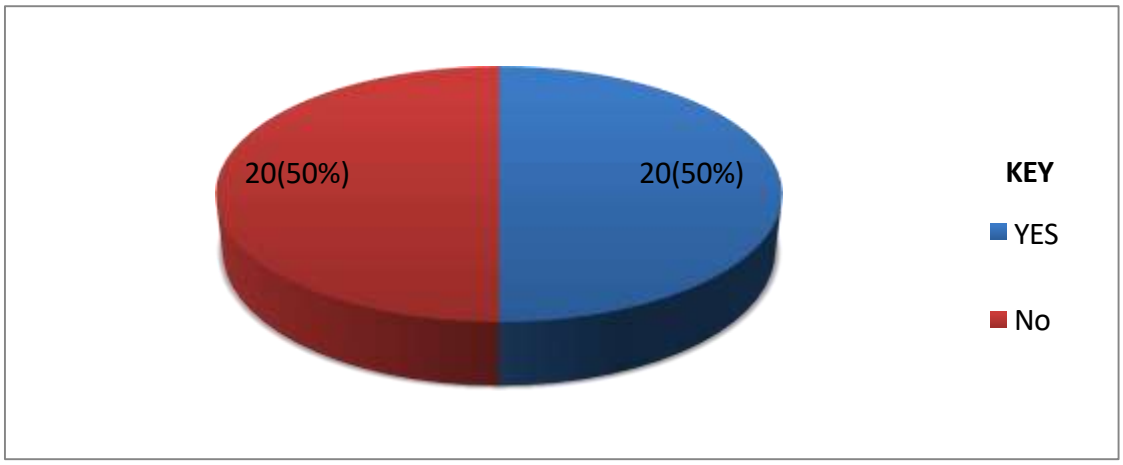

Figure 7 indicates that half, 20(50%) of the respondents, reported receiving breastfeeding counseling at the health facility during ANC, while the other half, 20(50%), did not.

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Figure 9: Showing those who received breastfeeding counseling whether the follow-up mechanisms are clear, n=20

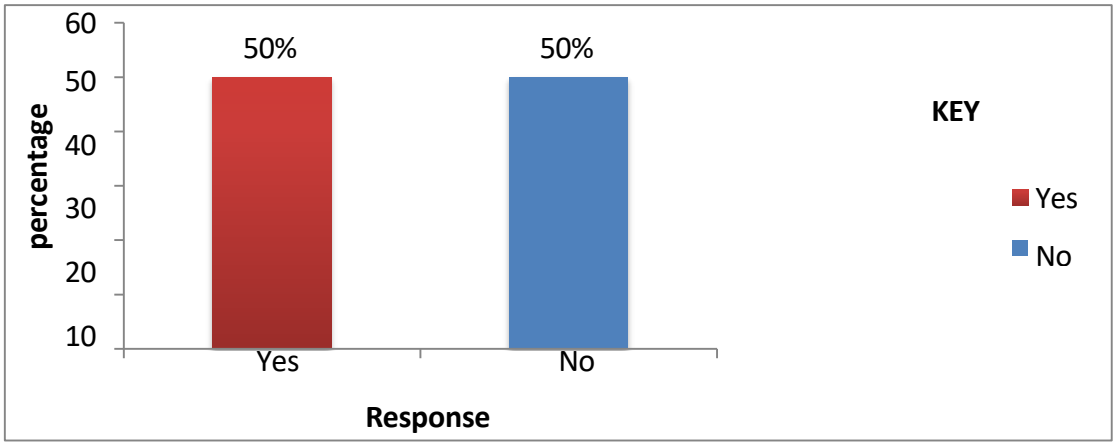

Figure 8 shows that half 10/20(50%) of the respondents said that the follow-up mechanisms are clear, while the other half 10/20 (50%) said they were not clear.

Table 7: Showing reasons for not receiving breastfeeding counseling at the health facility during ANC, n=2

Response	Frequency (f)	Percentage (%)
Long Waiting time	15	75
Fear of stigma	05	25
Total	**20**	**100**

Source: Primary data 2024

Table 7 shows that the majority, 15/20(65%) of the respondents, did not receive breastfeeding counseling because of the long waiting time, while the rest, 05/20(25%), was because of fear of stigma.

Table 8: Showing the respondents were advised on EBF for the first 6 months at the health facility, n=40

Variables	Frequency (f)	Percentage (%)
No	30	75
Yes	10	25
Total	**40**	**100**

Source: Primary data 2024

Table 8 shows that the majority, 30(75%) of the respondents, were advised on EBF for the first 6 months at the health facility, while the least 10(25%) were not.

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Figure 10: Showing recommendations to improve PMTCT services, n=40

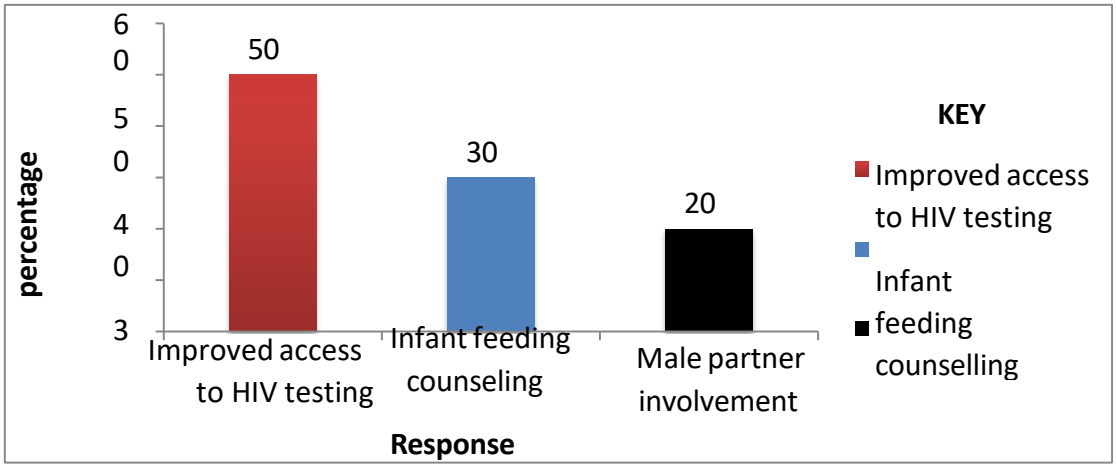

Figure 10 indicates that half 20(50%) of the respondents recommended improved access to top HIV testing as a way to improve PMTCT services, while the least 8(20%) of them recommended male partner involvement.

Discussion

Demographic Data of the Respondents.

Results of this study showed that the majority, 28(70%) of the respondents were between 18-25 years of age, which could be because young adults are the most dominant proportion of the population in Uganda. Regarding religion, most 17(42.5%) of the respondents were Catholics, which could be attributed to the dominance of catholic religion in Uganda. Concerning the tribe, the majority, 29(72.5%) of the respondents were Baganda, which could be due to the dominance of the Baganda ethnic group in the study area since it is in the Buganda region. More than half of 21(52.5%) of the respondents were secondary level education, which could be due to the introduction of universal education up to secondary. In terms of the Number of pregnancies, 16(42.5%) of the respondents had one child, which could be because young adults are the majority of participants in the study, and concerning Occupation, more than half 21(52.5%) of the respondents were self-employed which could be due to the rampant unemployment in Uganda.

Knowledge regarding Exclusive Breast Feeding

The findings of the study indicated that half 20(50%) of the respondents knew that taking ARVs during pregnancy and after childbirth reduces the chances of HIV transmission to the born baby. This is consistent with studies in South Africa, where 77.2% of participants had similar awareness about the role of ARVs in reducing mother-to-child transmission (Dlamini & Mokoboto-Zwane, 2019).

Awareness levels suggest a reasonable understanding of ARVs, but a need for more widespread education remains. Results of the study showed that almost half of 19(47%) of the respondents were not sure whether breast milk protects the baby from other illnesses. Similar studies in Tanzania also found limited awareness about the protective role of breast milk, especially in preventing infections like diarrhea (Ngarina et al., 2014). This indicates a need for enhanced education on the health benefits of breast milk beyond HIV transmission.

The findings of the study showed that 17(42.5%) of the respondents mentioned EBF as the ideal baby-feeding method in HIV-positive mothers in the first 6 months. This aligns with findings in South Africa and Nigeria, where mothers also acknowledged the importance of EBF for infant nutrition (Horwood et al., 2019; Coetzee et al., 2017). This indicates a positive recognition of EBF, though the proportion suggests that awareness could be further strengthened.

Results of the study revealed that the majority, 30(75%) of respondents believed exclusive breastfeeding is important for HIV-positive mothers. Findings are in line with results from Ethiopia and other African countries, where respondents viewed EBF as crucial for the health of HIV-exposed infants (Mebratu, 2020). This strong belief in the value of EBF underscores the importance of leveraging this awareness to improve EBF practices.

This study indicated that the majority, 26(65%) of the respondents, mentioned boosting a baby's immunity as the importance of breast milk for HIV-positive mothers. This is consistent with studies from Nigeria and Ethiopia, where mothers recognized the immune-boosting benefits of breast milk (Coetzee et al., 2017; Mebratu, 2020). This understanding supports efforts to promote EBF, though continued education on the broader benefits of breast milk is necessary.

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Socio-economic Barriers to Exclusive Breastfeeding among HIV-Positive Mothers

The findings of the study showed that the majority, 32(80%) of the respondents reported disclosing their HIV status to their partner, which is higher than in some studies where disclosure rates were lower. Reasons for not disclosing for half of the respondents because they felt unready (Belay & Wubneh, 2019). However, the remaining respondents who had not disclosed their status due to feeling unready reflect the ongoing stigma and fear surrounding HIV.

Results of the study indicated that 18(45%) of the respondents reported being influenced by themselves regarding breastfeeding methods. Findings are in line with results in Uganda and Malawi, where self-efficacy in decision-making has been reported, and mothers with strong self-belief were more likely to adhere to EBF despite external pressures (Flax, 2017). Similarities in the findings could be due to the strong beliefs of mothers in their values.

Results of the study showed that 25(62%) of the respondents believed their breast milk was sufficient to do EBF. This is similar to findings in Zambia, where mothers who believed in the adequacy of their breast milk were more likely to practice EBF (Hazemba et al., 2016). Most 07/15(46.7%) of the respondents who doubted their milk sufficiency cited small breast size as a reason, a cultural and personal perception also noted in South Africa, where household norms and misconceptions influenced breastfeeding decisions (Modjadji, 2023).

The findings of the study showed that 26(65%) of the respondents reported sometimes getting enough support from their partners to practice EBF, which could be due to the knowledge deficit of partners about the benefits of EBF. This aligns with a study in Ethiopia, where partner involvement was shown to positively influence EBF practices (Belay & Wubneh, 2019; Operto, 2020).

This study showed that the majority, 32(80%) of the respondents, said that EBF is culturally accepted in their community, which could be due to the widely known benefits of breast milk to the baby and the mother.

This mirrors findings from studies in Uganda, Malawi, and South Africa, where cultural norms supported EBF, but external pressures to supplement feeding were also prevalent (Flax, 2017; Modjadji, 2023).

Health Facility Barriers to Exclusive Breastfeeding among HIV-Positive Mothers

The findings of the study indicated that half 20(50%) of the respondents reported receiving breastfeeding counseling at the health facility during ANC, which is lower than in some studies where breastfeeding counseling rates were higher, such as in Tanzania, where 75.2% received counseling across multiple stages (Rasheed et al., 2018). This gap indicates a need for more consistent and widespread counseling services.

The findings of the study showed that half 10/20(50%) of the respondents said that the follow-up mechanisms are clear, which could be due to the friendly services on ART. In contrast, a study in Zimbabwe highlighted the lack of structured follow-up mechanisms and continuity of care, leading to lower adherence to EBF (Sibanda et al., 2018).

Results of the study indicated that the majority, 15/20(65%) of the respondents, did not receive breastfeeding counseling because of the long waiting time, which could be due to the shortages of staff in most of the public facilities. This barrier was also noted in South Africa, where long waiting times and poor health facility management discouraged mothers from attending ANC services (Ramoshaba, 2017).

This study indicated that the majority, 30(75%) of the respondents, were advised on EBF for the first 6 months at the health facility. This is consistent with the South African findings where breastfeeding counseling during ANC facilitated successful EBF (Dlamini & Mokoboto-Zwane, 2019). However, as noted in Uganda, the quality and consistency of the advice given can vary significantly depending on the knowledge and experience of individual healthcare providers (Operto, 2020).

This study showed that half 20(50%) of the respondents recommended improved access to top HIV testing as a way to improve PMTCT services. This recommendation aligns with global strategies for improving maternal and child health outcomes through better access to testing and HIV care (Suryavanshi, 2018).

Conclusion.

In conclusion, the study findings revealed good knowledge among most of the respondents. However, the socio-economic and health facility factors contributed to barriers to EBF among HIV-positive mothers.

Recommendations

Expanding breastfeeding education during antenatal care (ANC) and postnatal visits, emphasizing the health benefits of EBF beyond HIV transmission.

Developing programs aimed at educating partners on the importance of EBF so they can offer more consistent support. Partner involvement has been shown to positively influence breastfeeding practices.

Promotion of community-based awareness campaigns to highlight the cultural acceptance of EBF and dispel myths that may hinder mothers from adhering to EBF, such as concerns about breast size and milk adequacy.

Implication to Nursing Practice.

The findings of this study will be very important to nursing practice as it will help nurses to be aware that there is a growing need to include partners in health education sessions, especially during ANC visits, to foster an understanding of the importance of supporting EBF.

Acknowledgment
I wish to extend my sincere gratitude to the Ministry of Education and Sports, Mildmay School of Nursing and Midwifery, my supervisor (Mr Bukenya Bonny), plus all my tutors.
My heartfelt appreciation goes to my loving parents and siblings, who have helped me towards the completion of this report.

List of Abbreviations
AIDS: Acquired immunodeficiency syndrome
ANC: Antenatal Care
ARVs: Anti- retro Viral
DME: Diploma in Midwifery Extension
EBF: Exclusive Breast Feeding
EMTCT: Elimination of Mother-to-Child Transmission
HIV: Human Immunodeficiency Virus
KHCIV: Kajjansi Health Center IV
PMTCT: Prevention of Mother to Child Transmission
WHO: World Health Organization

Source of funding
The study was not funded.

Conflict of interest
The author declares no conflict of interest.

Author contributions
Victoria Namyalo was the principal investigator.
Bonny Bukenya, the research supervisor.

Data availability
Data is available upon request.

Informed consent
All the study participants consented to the study.

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Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol. 6 No. 3 (2025): March 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i3.1548
Original Article

PUBLISHER DETAILS:

Student's Journal of Health Research (SJHR)
(ISSN 2709-9997) Online
(ISSN 3006-1059) Print
Category: Non-Governmental & Non-profit Organization
Email: studentsjournal2020@gmail.com
WhatsApp: +256 775 434 261
Location: Scholar's Summit Nakigalala, P. O. Box 701432, Entebbe Uganda, East Africa