

Full length research paper

Barriers and facilitators to the practice of exclusive Breast feeding among working class mothers: A study of female resident doctors in tertiary health institutions in Plateau State

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Health care workers are important in the promotion, protection and support of breast feeding. Their ability to do this may be influenced by their knowledge, personal experiences and work. The occupational status of women can be a significant barrier or facilitator to the practice of breastfeeding. A descriptive cross sectional study was conducted in all the tertiary health institutions in Plateau state among the female resident doctors between 14th January to 30th January 2013 to assess their knowledge and practice of EBF. Forty-seven female resident doctors in all the tertiary health institution in Plateau state participated in the study. All (100.0%) had good knowledge of EBF, (61.7%) indicated some medical reasons contradicting EBF, of this, (55.2%) to babies of HIV positive mothers. Twenty-nine practiced EBF. Failure to, about (62%) was due to resumption of work and family support/longer maternity leave and provision of crèches at places of work were most mentioned as potent motivators to EBF. Conducive atmosphere should be created at the work place to encourage the female professional to practice EBF on their children as they encourage other mothers to do same.

Key words: Exclusive breast feeding; resident doctors; knowledge; barriers; motivators

INTRODUCTION

A healthy nutrition is essential for normal growth and development during childhood and is central to establishing the foundation for healthy living (Sadoh et al., 2011; Levinienne et al., 2009). It is also widely agreed that breast milk is the ideal food for the human infant. World Health Organization (WHO) recommends that mothers worldwide should exclusively breastfeed for the child's first six months to achieve optimal growth, development, and health (WHO 2011). Thereafter, they should be given nutritious complementary foods and continue breastfeeding up to the age of two years or beyond. Breast feeding has benefits both for the mother and the baby (Egbonu et al., 2007; US Department of Health, 2010; Dermer, 2001).

The advantages include a lower risk of gastrointestinal infection for the baby, more rapid recuperation after birth, and delayed return of menstrual periods (a natural method of family planning). Breastfeeding also provides infants with superior nutritional content that is capable of improving the immunity and possible reduction in future health care spending (Dermer, 2001; WHO, 2000; WHO, 2001; Latham, 1991). No adverse effects on growth have been documented with Exclusive Breast Feeding (EBF) for six months. It was at the Innocenti Declaration in 1990, that the WHO/UNICEF called for policies that would cultivate a breastfeeding culture to encourage women to breastfeed their children exclusively for the first 6 months of life and then up to 2 years of age and beyond (Egbonu et al., 2007; WHO, 2007; Oparaocha et al., 2002; Mason, 1999; WHO/UNICEF, 2005). However, a recent estimate by WHO showed that worldwide only 35% of children between birth and their 5th month are exclusively breastfed (WHO, 2010).

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Based on the WHO Global data on Infant and Young Child Feeding in Nigeria, 22.3% of children were exclusively breastfed for less than 4 months, while 17.2% were exclusively breastfed for less than 6 months, in the year 2003. According to the Nigerian Demographic and Health Survey (NDHS), in 2008, 17% of children were exclusively breastfed for up-to 4 months, while 13% were exclusively breastfed up-to 6 months (NDHS, 2008; Agunbiade et al., 2012).

Despite the many benefits of breast feeding it has been shown that there are barriers to the practice of optimal breast feeding. Some of these barriers include hospital practices, advertisement of breast milk substitutes and lack of support for the breast feeding mother. Many women identify employment as a barrier to breast feeding. In a study on infant feeding practices among nursing personnel in Australia, returning to work was one of the main reasons women ceased breastfeeding, with 60 percent of women intending to breastfeed when they returned to work, but only 40 percent do so (Danielle et al, 2011). It is almost certain that women who go back to work before their babies are six months old will face challenges in adhering to the practice of EBF. In a study done on knowledge of breast feeding practice among female medical doctors in Nigeria, all respondents knew that babies should be exclusively breast fed for the first six months of life but only 60% knew that breast feeding should continue until two years. The practice of EBF among them was 11.1%. Before their babies were six months old, about 75% of respondents had resumed work whilst over 50% had started taking calls. Most could not breast feed during working or call hours (Mbwana, 2012). Work schedule was rearranged to allow breast feeding in only 27.3% of respondents. Evaluating the experience of this group of women is important as health care personnel have an important role to play in promoting breast feeding among mothers; they also ought to have time for such practice on their children.

In the medical profession, there are different cadre of doctors in the teaching hospital settings; the house officer who is under a one year tutelage after which he/she goes for the another year of service to the nation; the junior and senior resident doctor (training in specific specialist usually for a period of six years); consultants (specialist in different chosen fields of medicine and also often employed by a University as lecturer, may also be permitted to take years of sabbatical leave if they so desire). It is with this background that the study was focused on resident doctors as a case study of the female medical professionals; considering their duration of working in the hospital setting amidst tight schedule of job examination should have been passed before the end of their training. The study assessed their knowledge on EBF, prevalence and barriers to the practice of EBF and the identified factors that may motivate or promote the act among female medical professional.

METHODS

A descriptive cross sectional study was conducted in all the tertiary health institutions in Plateau state among the female resident doctors between 14th January to 30th January 2013 to assess their knowledge and practice of EBF. Married female residents doctors who have had one or more deliveries in the course of their professional practice were the study participants; selected from all the four tertiary health institutions in the state (Jos University Teaching Hospital, Plateau State Specialist Hospital, Our Lady of Apostle Jos and Bingham University Teaching Hospital). Verbal consent was sought and obtained from participants. In each of the health institutions visited, the Chief Resident Doctor were identified in all the departments and the semi-structured self administered questionnaire were given for the number of female residents present in the department that fulfill the criteria above. Filled questionnaires were collected between the stipulated dates from all the health institutions. Microsoft word Excel 2007 was used for data entry while SSPS version 16.0 was used for analysis. A confidence interval at 95% and significant p-value of <0.05 was established.

RESULTS

Knowledge on exclusive breast feeding

Forty-seven female resident doctors in all the tertiary health institution in Plateau state participated in the study; a hundred percent response rate was observed. All 47 (100.0%) knew what exclusive breast feeding was all about and its derivable benefits to the child, mother, the family and the nation at large. Twenty-nine (61.7%) indicated some medical reasons contradicting EBF while 18(38.3%) felt no medical reason contradicts the act. Of the (61.7%) that indicated some contraindication to EBF; (55.2%) to babies of HIV positive mothers, (10.3%) to women with mastitis and breast cancer, (10.3%) to mothers with breast cancer and TB, (6.9%) to mothers on cytotoxic drugs, (3.4%) to babies with HIV positive and intolerance to lactose etc.

Prevalence, barriers and motivators to Exclusive Breast Feeding

Twenty-nine (61.7%) of the resident doctors practiced EBF. Of the 18 (38.2%) that did not practice EBF, various reasons were stated that served as barriers. The highest proportion of 11(61.1%) was due to resumption of work; (22.2%) due to inadequate lactation and resumption of work; (5.6%) each were attributed to early resumption of work and other family demands; fear of contamination of milk if expressed and due to non-availability of steady supply of electricity in addition to resumption of work etc.

Table I: Socio-demographic profile and the practice of EBF (n=47)

| Variables | Exclusively breast fed for 6/12 | | | X | df | p |
|-------------------------------|---------------------------------|----------|----------|-------|----|-------|
| | Yes | No | Total | | | |
| Age group(yrs) | | | | | | |
| 25-29 | 2(6.9) | 2(11.1) | 4(8.5) | 2.273 | 4 | 0.741 |
| 30-34 | 16(55.2) | 9(50.0) | 25(53.2) | | | |
| 35-39 | 9(31.0) | 5(27.8) | 14(29.8) | | | |
| 40-44 | 1(3.4) | 2(11.1) | 3(6.4) | | | |
| 45-49 | 1(3.4) | 0(0.0) | 1(2.1) | | | |
| Department | | | | | | |
| Clinical | 22(75.9) | 12(66.7) | 34(72.3) | 0.459 | 1 | 0.498 |
| Non-clinical | 7(24.1) | 6(33.3) | 13(27.7) | | | |
| Religion | | | | | | |
| Christianity | 28(96.6) | 17(94.4) | 45(95.7) | 0.118 | 1 | 0.731 |
| Islam | 1(3.4) | 1(5.6) | 2(4.3) | | | |
| Residency type | | | | | | |
| Regular | 26(89.7) | 17(94.4) | 43(91.5) | 0.320 | 1 | 0.571 |
| Supernumerary | 3(10.3) | 1(5.6) | 4(8.5) | | | |
| Years of being married | | | | | | |
| 1-5 | 16(55.2) | 6(33.3) | 22(46.8) | 6.977 | 2 | 0.033 |
| 6-10 | 7(24.1) | 11(61.1) | 18(38.3) | | | |
| >10 | 6(20.7) | 1(5.6) | 7(14.9) | | | |
| Parity | | | | | | |
| 1-2 | 19(65.5) | 14(77.8) | 33(70.2) | 0.781 | 1 | 0.377 |
| >2 | 10(34.5) | 4(22.2) | 14(29.8) | | | |

However, certain factors were identified which will serve as motivators to the working to practice EBF; these are family support and longer maternity leave (25.5%), early closure from work (17.0%), prolongation of the maternity leave period and provide crèches at places of work (10.6%), perceived benefits to the child (10.6%), prolongation of maternity leave period alone (8.5%), provision of crèches at work place alone (6.4%), prolongation of the period of maternity leave and exemption of nursing mothers from taking calls (4.3%), etc (See Table 1).

Discussion

A good concept of EBF was recorded among all the participants which is the expected considering their field of professionalism. This is similar to the findings from a descriptive study conducted regarding breast feeding practice among female medical doctors in Nigeria. All respondents knew that babies should be exclusively breast fed for the first six months of life (Sadoh et al., 2011).

However, they tend to vary on contraindications to EBF. Breast feeding practice which was introduced about 23years ago at the Innocenti Declaration by

WHO/UNICEF was not devoid of cultural and religious oppositions at its inception. But as more enlightenment and awareness are continuously created in the media, hospitals etc the act was gradually adopted and practiced. In the health sector, other health issues also started emerging posing as challenges to exclusive breast feeding; using HIV as an example, the initial policy stipulates artificial infant feeding as one of the feeding options of the babies delivered of HIV positive mothers, but will review of this policy over the years the option of feeding includes EBF. This may partly be the reasons why varying opinion was observed among the resident doctors on whether or not there were medical contraindications to EBF. The period exposed to the training may also influence the response as those that had spent more time may be abreast with the current practice. In relating the socio-demographics to the prevalence of practice of EBF, a statistical significant association ($p=0.03$) was established between the number of years married years. Participants having the lowest duration of years of marriage had the highest frequency of practicing EBF on their babies. This may possibly be due to the increased awareness that have been created when compared to their counterpart who had their babies earlier than them. Though the doctor is expected to be buoyant enough to avoid artificial feeds,

but economic distress may also encourage the practice as this is at no cost to the mother or on the family when compared to the increasing cost of artificial feeds.

Breast feeding is a universal phenomenon common to all cultures. In the last 2 decades, there is a universal awareness of advantages of breast milk. In the western world, there have been increased trends of breast feeding in recent years (Afzal et al., 2002; Hanif et al., 2010). On the other hand; there has been a decline in the breast feeding in the developing countries. In this study, a low rate (61.7%) of practice was observed among the resident doctors; this is of concern considering that this cohort have a better knowledge of all the benefits of EBF, thus the practice among them ought to be higher than among the lay women. These are also the cohort of health personnel who the lay people see as a role model to this practice. In a similar study that investigated knowledge of and beliefs about breastfeeding among Chinese female physicians and nurses and their breastfeeding practices; a low exclusive breastfeeding rate was found among Chinese female physicians and nurses studied (Ouyang et al., 2010). Though medical profession is not without its challenge to the female gender, most of the response given by the doctors for failure to practice EBF despite its knowledge was due to work load. Other who complained of inadequate lactation, erratic power supply to store the expressed milk etc also indicated in addition to the above reasons demands from work.

A worker's morale can be enhanced to achieve the best expected output when the mental, economic, social among many other needs of the personnel are taken into consideration. According to Article 3 of Convention No. 183, by the International Labour Office on workers' rights and gender equality, stipulate that the breastfeeding worker should be provided with the right to one or more daily breaks or a daily reduction of hours of work to breastfeed her child. She should have the right to interrupt her work for this purpose, and such interruptions or reductions in daily hours of work should be counted as working time and remunerated accordingly (International Labour Office, 2007). The female medical personnel ought not to be denied these needs; which they themselves by virtue of their profession advocate for in their patients. They should serve as good example to other professional mothers if significant success is to be recorded in optimal child growth and development which EBF has been identified as one of the major child survival strategies. The suggested motivators that may encourage EBF practices by the participants should be implemented to encourage the act, with particular reference to the item most mentioned which is provision of crèches at work place. This will meet the health needs of the; baby as the breast milk source (i.e. the mother) is readily available, the mother as she has a sense of satisfaction that she is not only taking care of other people's children

but her own child is also being given the necessary attention. This is because, it will be much easier to dash to the crèche located within the hospital premises to breast feed than driving down to the house. In the hospital, the effect may be felt as workers output will be enhanced which may translate to better revenue yield for the hospital and the frequency of workers abandoning their duty posts to dash home in order to breast feed will be reduced. Other issues raised may need to be addressed by the government, such as the need to revise the maternity leave longer in order to allow the women enough time to practice EBF before she resumes work. This may possibly be the reason why the resident doctors with low parity (1-2 children) are more in number. A difficult previous experience exclusively breast feeding the children may also account for low practice and low parity though this was not asked in the questionnaire.

Conclusion

Doctors should be encouraged to practice EBF; they serve as role model to other professional women and women generally. They should not be mere educators of this thus promoting optimal growth in others at the detriment of their own offspring. Government, health institutions should provide crèches at places of work to encourage health personnel to practice EBF.

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