

The practice of breastfeeding by healthcare workers in the Federal Teaching Hospital, Abakaliki, south-eastern Nigeria

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Background. Optimal breastfeeding practices include exclusive breastfeeding (EBF) for the first 6 months of life, followed by continued breastfeeding with adequate complementary foods on to at least 2 years of age. This is expected to be well known and practised by healthcare workers (HCWs) who are in the position to educate the community.

Objective. To determine the actual breastfeeding practices of HCWs in a tertiary hospital in south-eastern Nigeria.

Methods. We conducted a cross-sectional, descriptive study among female HCWs at the Federal Teaching Hospital, Abakaliki, south-eastern Nigeria, using a self-administered, semi-structured questionnaire.

Results. One hundred HCWs were recruited, including doctors, nurses, pharmacists and other HCWs. Only 3% practised EBF with all their children, their cited reasons being a busy work schedule (61.8%), EBF being too stressful (18.4%), ignorance of benefits of EBF (13.2%) and lack of family support (3.9%). Only 1% breastfed their babies up to 2 years. The reasons for failing to do so included refusal of the child to breastfeed (32.6%), another pregnancy (30.4%), feeling it was shameful (10.9%) and feeling that the baby was too old (8.7%).

Conclusion. There are obvious shortcomings in breastfeeding practices among HCWs. They need to be empowered and supported to promote and support breastfeeding among their patients in particular and society in general.

S Afr J CH 2014;8(2):55-58. DOI:10.7196/SAJCH.668



Breastfeeding is a way of providing ideal nutrition for the healthy growth and development of infants.^[1] The importance of breastfeeding to child health has been documented repeatedly. The United Nations Children's Fund (UNICEF) included breastfeeding as one of the child survival strategies during the World Health Organization (WHO) WHO/UNICEF policymakers' meeting on 'Breastfeeding in the 1990s: A Global Initiative', held in Italy on 30 July - 1 August 1990.^[2] The Innocenti declaration was then produced and adopted, calling on nations and international organisations to draw up action strategies for the protection, promotion and support of breastfeeding.^[2]

Healthcare workers (HCWs) have a great influence on infant feeding practices,^[3,4] because the importance of healthy nutrition to the normal growth and development of children is well known to them.^[4] It is expected that they impart their knowledge of the advantages of breastfeeding to the baby, the mother and society, to their clients. Based on this, we postulate that female HCWs would practise and promote what is ideal for their own babies. In a study of paediatricians and the promotion/support of breastfeeding, it was reported that respondents who had personal experience with breastfeeding were 2.3 times more likely to report supportive policies.^[4] It is therefore our expectation that HCWs who have good breastfeeding practices will most likely promote what they believe in and practise.

Optimal breastfeeding practices include exclusive breastfeeding (EBF) for 6 months and continuing thereafter with adequate complementary feeds until 2 years of age and beyond.^[5] However, despite the many known benefits of optimal breastfeeding, many barriers to breastfeeding exist. Some of these barriers are lack of support for the breastfeeding mother, advertisements of infant formula and early return to employment.^[6,7] Working women have

identified their return to work as a major barrier to breastfeeding,^[8-11] proving that facilities to support breastfeeding at the workplace should be encouraged.

The female HCW is at the helm of the campaign and support for breastfeeding, and because the role of HCWs in getting breastfeeding off to a good start and maintaining it can be decisive, it is critically important that their attitudes and personal experiences with its practice are described. It is for this reason that the authors decided to describe the experience and the actual practice of breastfeeding by HCWs in a tertiary hospital in south-eastern Nigeria.

Methods

We carried out a hospital-based, cross-sectional, descriptive study among female HCWs of the Federal Teaching Hospital Abakaliki (FETHA), south-eastern Nigeria, which is a designated baby-friendly institution and the major tertiary health institution in its state, Ebonyi.

A consecutive convenience sample of 100 female HCWs met the inclusion criteria of being in practise within a baby-friendly tertiary hospital setting for at least 2 years, having one or more children and willingness to participate after due information. Those who were unwilling (20 participants), did not have a child (5 participants) or had not worked for 2 years in a tertiary hospital (7 participants) were excluded. Data were collected using a self-administered, semi-structured questionnaire. The questionnaire surveyed information on demographic characteristics such as occupation, age, religion, tribe and the number of children the participant had. Structured questions about EBF practice and continued breastfeeding until 2 years were included. EBF was defined as giving the baby breastmilk only for 6 months with no prelacteal feeds and no other fluids. Questions on reasons for not practising correct breastfeeding were left open so that

respondents responded in their own words. Their responses were subsequently categorised.

Analysis was done using SPSS (version 17) and Epi Info (version 12.1). Descriptive statistics were used to summarise the data. Differences between groups were tested using the Pearson χ^2 test or Fisher's exact test where the frequency was <5. The level of significance was set at p -value <0.05.

Ethical approval for the study was obtained from the FETHA research and ethics committee. Written consent was sought from every participant.

Results

Participant sociodemographics are presented in Table 1. Most (45%) belonged to the 36 - 40-year age group; 38% were aged 31 - 35 years; and the mean±standard deviation age was 35±6.2 years (range 21 - 42). The majority were nurses (40%) and doctors (27%). All participants were Christians, mostly Roman Catholic (42%). Most were of the Igbo tribe (86%), 2% each were of the Hausa and Yoruba tribes while the remaining 10% consisted of one individual each from 10 other tribes. Sixty-eight per cent of the respondents had three or more children with a mode of 3. Married respondents accounted for 63%, 12% were separated, 15% had never married (single mothers) while 10% were divorced. There were no widows.

Twenty-five per cent had exclusively breastfed at least one of their children for 6 months, while only 3% had practised EBF for all their children. The majority (75%) of those who had breastfed at least one baby exclusively for 6 months had done so for their first child. Most (61.8%) of those who had not practised EBF for 6 months at all attributed this to having had to resume a busy work schedule, 18.4% said it was too stressful, while 13.2% (mostly orderlies/cleaners) had no knowledge of the benefits of EBF for 6 months (Table 2). Another 3.9% did not practise EBF because they lacked family support as their families spoke against it (one doctor, one nurse and one laboratory scientist).

Eight per cent of the respondents had breastfed at least one of their babies for up to 2 years, while only 1% had done so for all their babies. Those who could not give reasons such as: the babies stopped on their own (32.6%), they were expecting another baby (30.4%), the baby was too old to suckle after 1 year (8.7%) or they were ashamed of breastfeeding up until 2 years (10.9%) (Table 3). The mean age of the children when stopping breastfeeding entirely was 14 months.

Doctors stopped breastfeeding earlier (mean child age 10 months) than other HCWs (mean 14 months; $p \leq 0.05$), and older mothers breastfed longer than younger ones ($p \leq 0.05$) as shown in Tables 4 and 5. There was no significant relationship between profession, age of the HCW and having practised EBF for 6 months ($p > 0.05$).

Discussion

This study represents breastfeeding practices of non-nulliparous female HCWs who were mostly within childbearing age. The prevalence (25%) of EBF reported in the current study is within the range of 20 - 43%^[12,13] reported for developing countries, and is comparable with the 27% prevalence reported as Nigeria's average.^[14] However, it is higher than the 11.1% prevalence found in a previous study among resident doctors in Benin, Nigeria, probably because the current study included other HCWs and not just doctors as was the case in the study by Sadoh *et al.*^[15] Furthermore, the prevalence is markedly below the 90% level recommended by the WHO^[16,17] as a level that must be reached for this cost-effective intervention to save infant's lives. This emphasises the need to intensify awareness and hospital-based interventions that promote EBF among HCWs. In addition, only 3% of these HCWs breastfed all their babies, the majority practising EBF for their first babies only, probably because as only children, first babies enjoyed more maternal attention than subsequent siblings.

Table 1. Sociodemographic characteristics of respondents (N=100)

Variable	n /%
Age (years)	
21 - 25	1
26 - 30	11
31 - 35	38
36 - 40	45
>40	5
Religion	
Christianity	100
Ethnicity	
Igbo	86
Hausa	2
Yoruba	2
Other	10
Profession	
Nurse	40
Doctor	27
Laboratory scientist	14
Orderly/cleaner	9
Pharmacist	6
Community HCW	4
Marital status	
Married	63
Separated	12
Divorced	10
Single	15
Widowed	0

HCW = healthcare worker.

Table 2. Reasons for not practising EBF for 6 months (N=97)

Reason	n (%)
Had to resume work/had a busy work schedule	47 (61.8)
Family/relations spoke against it	3 (3.9)
No knowledge of benefits of EBF	10 (13.2)
Too stressful	14 (18.4)
Other	2 (2.6)

EBF = exclusive breastfeeding.

Table 3. Reason for not continuing breastfeeding until 2 years (N=92)

Reason	n (%)
Child stopped on his/her own	30 (32.6)
Was already pregnant	28 (30.4)
Ashamed of doing it for that long	10 (10.9)
By choice	9 (9.8)
Felt that the child was too old to breastfeed after 1 year	8 (8.7)
Relations stopped the mother	6 (6.5)
Did not know that breastfeeding was practised up until 2 years	1 (1.1)

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Table 4. Profession or mother and average age of children at cessation of breastfeeding (N=100)*

Profession (N)	Average age (months) of children when breastfeeding was stopped, n (%)					
	<6	6 - 9	10 - 12	13 - 15	16 - 18	19 - 24
Community HCW (4)	0 (0)	0 (0)	0 (0)	0 (0)	2 (50.0)	2 (50.0)
Doctor (27)	1 (3.7)	7 (25.9)	16 (59.3)	1 (3.7)	2 (7.4)	0 (0)
Laboratory scientist (14)	0 (0)	2 (14.3)	3 (21.4)	5 (35.7)	3 (21.4)	1 (7.1)
Nurse (40)	0 (0)	0 (0)	1 (2.5)	21 (52.5)	16 (40.0)	2 (5.0)
Orderly (9)	0 (0)	0 (0)	0 (0)	0 (0)	3 (33.3)	6 (66.7)
Pharmacist (6)	0 (0)	0 (0)	3 (50.0)	3 (50.0)	0 (0)	0 (0)

HCW = healthcare worker.

* Fisher's exact $p < 0.05$.

Table 5. Age of the mother and average age of child at cessation of breastfeeding (N=100)*

Age (years), range (N)	Average age (months) of children when breastfeeding was stopped, n (%)					
	<6	6 - 9	10 - 12	13 - 15	16 - 18	19 - 24
21 - 25 (1)	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)	0 (0)
26 - 30 (11)	0 (0)	3 (27.3)	6 (54.5)	1 (9.1)	0 (0)	1 (9.1)
31 - 35 (38)	1 (2.6)	3 (7.9)	10 (26.3)	15 (39.5)	8 (21.1)	1 (2.6)
36 - 40 (45)	0 (0)	3 (6.7)	6 (13.3)	14 (31.1)	14 (31.1)	8 (17.8)
>40 (5)	0 (0)	0 (0)	0 (0)	0 (0)	4 (80.0)	1 (20.0)

* Fisher's exact $p < 0.05$.

In this study, the reasons for having not practised EBF were busy work schedule (61.8%) and that EBF was too stressful (18.4%), which were similar to reports of deterrents of EBF previously reported in SA^[6] and Nigeria.^[7] A notable finding was that ignorance of the benefits of EBF was a reason for having not practised EBF among 13.2% of the respondents, reported exclusively among the lower cadre of HCWs (community health extension workers (CHEWs) and orderlies), showing that training on the benefits, support and protection of breastfeeding may have eluded this group and instead been concentrated on the senior HCWs (doctors and nurses). It may erroneously be assumed that the junior HCWs are not the primary HCWs that educate patients. However, mothers who consider HCWs as role models may not be able to differentiate orderlies and CHEWs from nurses and hence may seek and subsequently obtain wrong information concerning breastfeeding from those who have poor knowledge of the benefits of EBF. This may give rise to low rates of EBF in the community.

Although only 3.9% attributed not breastfeeding exclusively to a lack of family support, this finding agrees with previous reports^[7,8] that a lack of family support affects a mother's ability to breastfeed exclusively since women struggle to withstand family pressures. This indicates that substantial interventions have to be put in place to empower HCWs to practise EBF, for their own children's sake, and to encourage the imparting of the correct message to their community.

The current study shows that only 8% of HCWs breastfeed at least one child for up to 2 years with only 1% doing so for all their children; primary reasons being that the babies stopped on their own (32.6%) and that the mothers were expecting another baby (30.4%). Other reasons were that the baby was too old to suckle after 1 year (8.7%) and 10.9% were ashamed of breastfeeding to 2 years. These reasons reflect these mothers' knowledge of breastfeeding practices and show that many may still be ignorant of correct practices and the benefits of breastfeeding. A remarkable number were ashamed of breastfeeding for 2 years, showing low self-esteem when it comes to

breastfeeding their infants. If HCWs cannot proudly breastfeed their babies, who then would support and promote the WHO guidelines of continuing breastfeeding until 2 years?

The mean duration of breastfeeding entirely was 14 months, with the shortest duration of breastfeeding (mean 10 months) recorded among doctors and younger mothers. There was no significant influence of religion and tribe on breastfeeding practice, probably because the participants were predominantly Christians and of the Igbo tribe, and very few were of other other religions and tribes.

The major limitation of this study might have been recall bias: the HCWs were aged 21 - 42 years, and they were asked about the feeding practices of their infants when they were <2 years of age, without considering the age of their last child; a long recall period was involved and some mothers may have forgotten their exact practice and have given wrong accounts, altering the actual prevalence of EBF. HIV status may be an important factor affecting the practice of breastfeeding of mothers; however, the researchers did not access the HIV status of the HCWs. In addition, measuring EBF prevalence with a cross-sectional study using recall since birth is difficult. A better design that would have given a reliable estimate would have been a longitudinal study, where a cohort of infants is followed from birth with frequent recordings of breastfeeding. However, a longitudinal study is expensive, takes a long time to conduct and is associated with attrition of the mother-child pairs with time.

Conclusion

There are obvious shortcomings in breastfeeding practices among HCWs attributable to work schedule, poor family support and lack of knowledge. HCWs need to be empowered and supported to practise breastfeeding and in turn promote and support breastfeeding among their patients in particular, and society in general. Training and retraining should be conducted periodically to improve their breastfeeding practices and knowledge of correct breastfeeding.

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