

# Perceptions and Barriers to Exclusive Breastfeeding in Manicaland, Zimbabwe

Maxwell Mhlanga Fadzayi Mutseyekwa Matilda Zvinavashe Clara Haruzivishe  
Doreen Mukona Augustine Ndaimani

University of Zimbabwe College of Health Sciences, Zimbabwe) P O box A178, Avondale , Harare, Zimbabwe

## Abstract

The study explored perceptions and barriers to exclusive breastfeeding (EBF) among rural women in Zimbabwe. A descriptive cross sectional design was used with 490 participants (146 men and 344 women). Questionnaires and Focus Group Discussions were held with women 15-49 years who had a child below 2 years and their male partners. The prevalence of exclusive breastfeeding amongst the infants 0 – 6months was 66.8%. Seventy-four and 64.7% of girls and boys respectively were exclusively breastfed. Sixty-three percent of newborns were exclusively breastfed immediately after birth with 32% and 5% of the newborns being initiated within 6 hours and 1 day respectively. Women reported that they were comfortable to exclusively breastfeed for the first 3 months. The top six barriers to EBF were poor support from men (<30%), pressure from in-laws to introduce other foods, scanty knowledge on appropriate infant feeding practices, negative cultural and religious practices and lack of interest in women to exclusively breastfeed. The EBF prevalence was higher amongst young mothers (below 19 years) as compared to older women (20-49 years). EBF practices were lower (58.2%) amongst the more educated women compared to the less educated women (79.2%). The study concluded that community social mobilization should be intensified to increase knowledge and improve perceptions by engaging both men and women and other powerful stakeholders on infant and young child feeding through participatory approaches.

**Keywords:** Exclusive breastfeeding, perceptions, attitudes, knowledge

## 1. Introduction

Exclusive breastfeeding for 6 months remain the gold standard for optimal growth and development of the newborn. However, its practice remains low in Zimbabwe. Exclusive breastfeeding is the provision of only breast milk to a baby for the first 6 months without the introduction of water or other feeds (Abongo, etal 2012). Exclusive breastfeeding prevalence in Manicaland is 41%, (Zimbabwe Multiple Indicator Cluster Survey (MICS), 2014). Its practice should be initiated within an hour after birth and children exclusively breastfed for 6 months. In Manicaland, infant stunting (strongly influenced by breastfeeding practices) stands at 34% (MICS, 2014).

Exclusive breastfeeding is heavily dependent on gender and power dynamics in a household. Research in Cambodia found that cultural beliefs and practices are likely affect a woman's decision to initiate and continue exclusive breastfeeding. "Roasting" (a traditional postnatal activity in which women spend a minimum of 3 days lying beside a fire or hot coals to regain strength and replace any heat that is thought to be lost during childbirth) interferes with breastfeeding, mothers often delay nourishing their babies until the minimum-three-day practice has ended (Wren and Chambers, 2011). Similarly research in Laos showed that women with superstitious beliefs have poor knowledge of antenatal care and proper nutrition (Phoxay, Okumura, Nakamura and Wakai, 2001). A study in Balaka in Malawi revealed that behaviour related to exclusive breastfeeding lag behind the knowledge. Women described advantages of breastfeeding, though there were different perspectives on how long it should be done (Phoxay, Okumura, Nakamura and Wakai, 2001). This study sought to explore the perceptions and barriers to exclusive breastfeeding among rural women in Manicaland.

## 2. Materials and Methods

A descriptive cross sectional design was used in this study. Multi-stage cluster sampling was utilized to select a sample of 490 participants (146 men and 344 women) with a child below 2 years or pregnancy/pregnant spouse. The sample size was statistically calculated using Dobson's formula.

### 2.1 Data Collection

Questionnaires and Focus Group Discussions (FGDs) were utilized to compare men and women's views on MNCH services and practices. Questionnaires took an average of 15 minutes. FGDs were separately held with women 15-19 years, women 20 -49 years and men 18 - 49 years. The *methodological triangulation* approach was followed for the validation of data through cross verification from the wide range of sources. Pretesting of the FGD tool(s) was done in one clinic in Mutasa (Tsonzo) with 10 women of child bearing age. The household questionnaires were pre-tested with 4 people in the same clinic (2 women and 2 men). Data was collected within 40 days (April – May 2014).

## 2.2 Data analysis

Emerging themes from the FGDs were consolidated and content analysis was utilized to analyze qualitative data. Quantitative data was analyzed using Statistical Package for Social Science (SPSS version 16.0) and Microsoft Excel. Data was compared against latest available national data by generating frequencies and cross tabulations. Critical analysis was done through triangulation and statistical treatment.

## 2.3 Ethics

Approval from the Ministry of Health and Child Welfare was sought before the commencement of the study. Ethical clearance for the interview guides was sought through Africa University Research Ethics Committee (AUREC). Permission to conduct the research was also sought from respective local authorities, community leaders, religious leaders and representatives of the apostolic community, government authorities and the respondents themselves. Consent forms highlighted confidentiality and confirmed that the respondent's identity will remain anonymous. Participants were notified that they can terminate the interview at any given moment without questions or any negative consequences. Data storage was done in a manner to assure confidentiality and privacy. Study-related documents were kept under lock and key.

## 3. Results

A total of 490 participants were interviewed (146 (29.8%) men and 344(70.2%) women).

### 3.1 Demographic findings

The mean household size was 5.2 and 87.5% of household heads were men. Child ages for the interviewed participants ranged from below one month to 18 months with more than 50% of the children being 13 -18 months. Table 1 below represents the frequencies for the different child age groups.

*Table 1: Distribution of age of children (N=490)*

District	>1mnh	1-6m	7-12m	13-18m	Total (N=490)
Mutare N=166	4.8% (8)	24.1% (40)	21.1% (35)	50.0% (83)	100% (166)
Mutasa N=164	4.8% (8)	33.5% (55)	24.4% (40)	37.3% (61)	100% (164)
Chipinge N=161	6.8% (11)	31.7% (50)	25.5% (41)	36.0% (58)	100% (160)
<b>Total</b>	<b>5.5% (27)</b>	<b>30.0% (146)</b>	<b>23.7% (116)</b>	<b>41.2% (201)</b>	<b>100% (490)</b>

The majority of the women who participated in the study had either reached primary (45%) or secondary level (52%) of education. Comparing this with the data obtained from men for the same indicator, it was observed that similar trends prevailed amongst men with a mean of 96.6% of men having either attended primary or secondary school education. However, a higher proportion of men (66.5%) had gone up to secondary level. The demographic data also revealed that 21.2% of the participants were from the mainline churches, 22.7% were from Pentecostal churches, 48.5% were from the apostolic churches and 7.6% were from other churches.

Overall, 97.5% of the women in the 3 districts breastfed after birth with 62.7% breastfeeding immediately after birth, 32.3% within 6 hours and 5 % within 1 day. Among all children, 74.4% of girls were exclusively breastfed and 64.7% of boys. The prevalence of exclusive breastfeeding amongst the infants 0 – 6 months was 66.8%. Most mothers hardly breastfeed their children exclusively for more than 3 months. Prevalence of exclusive breastfeeding was 79.2% among women who had reached primary level and 58.2% among those who had reached ordinary level and above.

### 3.2 Reasons for not breastfeeding exclusively

Men and women reported that religious and cultural practices, lack of interest, influence from in-laws, delivering at a TBA's residence where newborns are instantly given supplementary foods and lack of information on the importance of breastfeeding were some of the attributed causes. Women reported that lack of breast milk, lack of food, laziness, lack of correct knowledge on breastfeeding and inability to provide enough milk are some of the reasons they fail to exclusively breastfeed for 6 months. Lack of interest as a barrier was rated third by women in Mutasa. Pressure from in-laws was also highly rated in FGDs with women, rated first in Mutare, second in Chipinge and Mutasa in terms of importance. Negative peer pressure from deviant mothers who practice mixed feeding hence brought heavier babies for routine community growth monitoring exercises was reported as a barrier by young mothers. The satisfaction levels by women on the attitude and support of men on exclusive breastfeeding was below satisfactory levels (<30%). Other perceived barriers to exclusive breastfeeding included

incessant crying of the baby and lack of nutritious food for the mother to exclusively breastfeed. FGDs with women revealed that most mothers exclusively breastfeed for the first 3 months and thereafter they feel the child is breastfeeding too much and hence they are afraid of losing weight.

The average men's score on attitudes of men with regards to support in exclusive breastfeeding across all the sampled communities was 46% while women's perception of male support was even lower at 30%. Adolescent mothers, most of who still stay with in-laws, reported lower satisfaction with their partners' support on exclusive breastfeeding. However, for Mutasa district women's perception and satisfaction on male support was fair standing at 50%. Pressure from in-laws was ranked very high. Discussions with women indicated that in-laws, especially the mother in-law and aunts wield more authority over decisions to do with infant feeding practices. In-laws were reported to be the ones who initiate mixed feeding in the first month of a baby's life and some give herbal porridge. Supplementary water is the first to be added on the baby's diet since they say the child is thirsty and water also prevents dehydration ('*Nhova*'). Men were said to have very little influence on feeding practices, especially breastfeeding, because culturally and traditionally, this has been institutionalized as a female domain controlled by the in-laws and other influential female members.

### 3.3 Perceived roles of different care providers in infant nutrition

Across the 3 districts, the communities mapped the service providers on infant and young child nutrition in their catchment areas and indicated their perceived benefits and reasons for utilizing each of the identified service provider. Below is the list of the service providers identified and their contributions:

**Prophets:** They were believed to have the ability to treat depressed fontanels (*Nhova*) with holy water. Prophets say *Nhova* is caused by coughing and crying. Prophets propagate various religious norms and practices that determine infant feeding practices. Some discourage women who have just delivered from giving their newborns colostrum as they say it's poisonous to the baby.

**Traditional Birth Attendants (TBAs):** Delivering at a TBA's residents was reported to be a deterrent to exclusive breastfeeding. Some TBAs were said to be teaching that even with adequate breastfeeding, children will still get depressed fontanels and need special treatment by TBAs not the clinic. TBAs are paid in cash or kind using commodities like cooking oil, soaps and sugar.

**The role of the husband:** By age group, a higher percentage of women (68.2%) under the age of 19 reported that men always provide some form of support during breastfeeding as compared to older women (64.6%). Women reported that male support included providing food, assisting in domestic chores, encouraging spouses to eat more (83%) and rest more (12.4%), giving them time to breastfeed (15.1%) reminding them to breastfeed (31%), giving expressed breast milk (1.4%) and taking care of the baby (4.6%). Barriers to male support reported by the women by age group were mainly: Too much work to do (20% of young women and 41% person of older women); culturally not acceptable (40% of young women and 31.9% of older mothers) and lack of interest was reported by 19% of young women and 42% of women 20-49 years.

**Village Health workers and Nurses:** Provide information on exclusive breast feeding (six months) and other IYCF practices. They were also reported to be instrumental in monitoring child growth and feeding practices.

### 3.4 Knowledge on the importance of exclusive breastfeeding

Focused group discussions with women on the barriers to exclusive breastfeeding also revealed that lack of correct and consistent information on the importance of exclusive breastfeeding and its practicality was cited as one of the key barriers. In Mutare, the women rated this factor second in importance amongst the 4 major barriers that they identified. In Chipinge, lack of knowledge was rated 4<sup>th</sup> out of the six major barriers to exclusive breastfeeding. Myths and misconceptions nurtured by religion and culture were cited to be the major drivers of behaviour on breastfeeding practices from generation to generation. For example, it was cited that porridge and water is given within the first 24 hours after birth on the assumption that the child is very hungry at birth. Similarly, carbonated drinks are being given to infants (from apostolic groups) on assumption that it neutralizes acids in the baby's stomach. Colostrum (first breast milk) was discarded based on the belief that it is unclean and unsafe for the new-born. Some women thought that depressed fontanels are caused by eating boiled eggs during pregnancy. Fontanels were said to be a mechanism for children to use when breathing and some said depressed fontanels are caused by evils spirits. Men and women generally agreed that most children in these communities are traditionally treated for depressed fontanels.

Of the 146 men interviewed on HIV transmission, 39% of men knew that HIV can be transmitted during breastfeeding and 49.1% and 56.2% of the women interviewed below 19 years and 20- 49 years respectively. The majority of men (98%) knew about the pill as a method of family planning but less than 80% were using the recommended methods of family planning post-delivery.

#### 4. Discussion

Overall, 67% of children between 0 to 6 months of age were exclusively breastfed, ZDHS 2011 reported 31.8% of children being exclusively breastfed, while MICS, 2014 reported 41%, and thus the study results are better compared to both MICS and ZDHS. Seventy four percent of the girls 0- 6 months and 64.7% of boys were exclusively breastfed. In this study, the difference between girls was found to be statistically insignificant with a chi square value of 2.97.

In as much as the results from the questionnaires reflect that there is a significant increase on exclusive breastfeeding practices, discussions that were held in FGDs revealed that exclusive breastfeeding for the recommended 6 months is still a great challenge among both young and adult lactating women. The women said that the majority of them can comfortably exclusively breast feed only for the first 3 months. The reported high prevalence of exclusive breastfeeding could probably be due to the nature of the question that was being asked. The study adopted the standard question recommended by the World Health Organization that is based on a 24 hour recall period with mothers who have children less than 6 months. This question however, can only elicit the general point prevalence of exclusive breastfeeding regardless of the infant's age. This means that there is a high likelihood that EBF prevalence significantly goes down when the study focuses specifically on the prevalence of exclusive breastfeeding for 6 months. In Zimbabwe, exclusive breastfeeding for 6 months is very low because before the infant is 6 months, most families introduce other foods especially porridge and water.

##### 4.1 Influence of knowledge levels on exclusive breastfeeding

The study findings revealed that increased knowledge only does not necessarily translate to behaviour change. For example discussions with women on the recommended feeding practices for children below six months revealed that most women are knowledgeable on exclusive breastfeeding, however, this knowledge did not translate into the same level of practice since less than 40% of the mothers admitted that they did not exclusively breastfeed for the recommended 6 months. In the FGDs conducted with women, they generally agreed that exclusive breastfeeding was feasible for the first 3 months and thereafter it was a difficult task for various reasons cited including the increased demand from the baby.

Knowledge on EBF interventions shapes one's perceptions and practice. At times families fail to exclusively breastfeed due to poor knowledge, such as on danger signs and the consequences of mixed feeding such as malnutrition, diarrhea, poor cognitive development and increased risk of contracting HIV to an exposed newborn. Informed decisions on infant feeding practices are achieved with frequent education. This is similar to what Gabrysh and Campbell in 2009 found in Bangladesh that women's use of health services was associated with higher knowledge.

Adolescent mothers, most of who still stay with in-laws, reported lower satisfaction with their partners' support on exclusive breastfeeding. This can be explained by the fact that their partners are still young men still staying with and under the control of their parents. High levels of male support have been consistently associated with higher levels of male attendance in Antenatal Care (ANC) and this was associated with a higher uptake of exclusive breastfeeding as a recommended practice. However, higher level of academic education for women was associated with low prevalence of exclusive breastfeeding. This could be explained by the mere fact that most of the educated women are professionals hence they have limited time to breastfeed. Similarly, higher education is usually associated with higher levels of income. This also increases the ability of these women to practice mixed feeding as opposed to their less educated and poor counterparts who often have limited alternatives to exclusive breastfeeding.

The study revealed a 9.7% difference in the prevalence of exclusive breastfeeding between boys (64.7%) and girls (74.4%). Triangulating this finding with the discussions held in FGDs with both men and women revealed that there is a cultural disparity in the feeding preferences for a boy and girl child. Boys are believed to be more energetic and more active than girls hence both men and women were in agreement that boys have higher food requirement than girls. It is from such a background that girls are exclusively breastfed for a longer time than boys who are introduced to 'mixed feeding' earlier as the communities feel that breast milk is not enough to meet their energy requirements. This however turns out to be a blessing in disguise for the girls, when one weighs the benefits of exclusive breast-feeding compared to the risk of mixed feeding.

##### 4.2 Limitations

In Zimbabwe, the focus on infant and young child feeding is on ensuring that children are exclusively breastfed for 6 months and continue to breastfeed with age appropriate complementary feeding for at least 2 years. This study and several other studies have only been able to report on the point prevalence of exclusive breastfeeding for infants 0-6 months but have not been able to elicit the prevalence of exclusive breastfeeding for at least 6 months due to the design and scope of the study. Self-reports are known to overestimate results which could be the reason for the surge in the prevalence of EBF. There is great need to elicit this prevalence through further research using observational designs to inform policy makers.

## 5. Conclusion

The study revealed that the main barriers to exclusive breastfeeding are negative cultural and religious practices, negative peer influence, negative influence from in-laws, myths and misconceptions. Negative perceptions and attitudes such as laziness, lack of interest, perceived breast milk inadequacy, perceived inability to produce enough breast milk, dissatisfaction with low male support and perceived disempowerment of women in making critical decisions on infant feeding contributed significantly to the low prevalence of exclusive breastfeeding. Community social mobilization should be intensified to increase knowledge and improve perceptions by engaging both men and women and other powerful stakeholders in any given household. There is great need to discourage women to deliver at TBAs residence since this has a negative multiplier effect on maternal and infant morbidity and mortality.

## Acknowledgements

The authors would like to acknowledge Plan for the permission to use the Satisfaction/Barrier tool.

## References

1. Ahmed, Alan and Sultana (2006). Reaching the unreachable barriers of the poorest to accessing NGO health care services in Bangladesh. *Journal of health, population and nutrition*, 24(4): 456
2. Banerjee B. A Qualitative Analysis of Maternal and Child Health Services of an Urban-Health Centre, By Assessing Client Perception In Terms of Awareness, Satisfaction and Service Utilization. *Indian Journal of Community Medicine*. 2003; 28(4).
3. Choudhury, Ahmed, 2011. Maternal care practices among the ultra-poor households in rural Bangladesh: A qualitative exploratory study. *BMC pregnancy and childbirth*, 11(1): 15
4. Gabrysh, S., & Campbell, O.M.R. (2009). Still too far to walk: Literature review of the determinants of delivery service use. *BMC pregnancy and Childbirth*, 9:34,1-18. doi:10.1186/1471-2393-9-34
5. Khan and Sultana, 2012. An examination of women experiencing obstetric complications requiring emergency care: Perceptions and socio-cultural consequences of caesarean section in Bangladesh. *Journal of health, population and nutrition*, 30(2):159
6. Ministry of Health and Child Welfare, Zimbabwe (2011). Administrative data from Human Resource Board March 2011
7. Mullany, M.C., Hindin, M.J., & Becker, S. (2005). Can women's autonomy impede male involvement in pregnancy health in Katmandu, Nepal? *Social Science & Medicine*, 61:1993 -2006
8. Parkhurst and Rahman, 2006. Overcoming access barriers for facility-based delivery in low-income settings: Insights from Bangladesh and Uganda. *Journal of Health, population and nutrition*, 24(4): 438
9. Paruzzolo, Mehra, Kes and Ashbaugh, 2010. Targeting poverty and gender equality to improve maternal health. Washington D.C. International centre for rescue of women
10. Phoxay, Okumura, Nakamura and Wakai, 2001. "Influence of women's knowledge on maternal health care utilization in Southern Laos." *Asia- Pacific journal of public health* 13(1): 13- 19
11. PRRINN-MNCH (2011). Engaging with communities to increase demand for MNCH services .Summary of results from the end line MNCH KAP survey in Katsina, Yobe and Zamfara States. Accessed online: [http://www.prrinnmnch.org/documents/Results\\_MNCHKAP\\_combine\\_Nov11\\_000.pdf](http://www.prrinnmnch.org/documents/Results_MNCHKAP_combine_Nov11_000.pdf)
12. Shroff, M.R., P.L.Griffiths, C.Suchindran, B.Nagalla, S.Vazir, and M.E.Bentley.2011. "Does maternal autonomy influence feeding practices and infant growth in rural India?" *Social science and medicine*, 73(3):447 -455
13. UNICEF, 2011. State of the world's children 2011. New York: UNICEF
14. Winch, 2005. Local understandings of vulnerability and protection during the neonatal period in Sylhet district, Bangladesh: A qualitative study. *The Lancet*, 366: 478 – 485