



ORIGINAL ARTICLE

Social and Economic Barriers to Exclusive Breast Feeding In Rural Zimbabwe

Munyaradzi Muchacha, BSW¹✉; Edmos Mtetwa, MSc²

¹ Oasis Zimbabwe, 264 Chiremba Road, Park Meadowlands, Harare, ZIMBABWE

² School of Social Work, University of Zimbabwe, Private Bag 66022 Kopje, ZIMBABWE

✉ Corresponding author email: munyaradzimuchacha@gmail.com

ABSTRACT

Objectives: Exclusive breast feeding (EBF) uptake in Zimbabwe is very low. Given that EBF is a physiological process which transpires in a specific socio-economic milieu, this study investigates the socio-economic factors militating against its uptake.

Methods: The study used a mixed research methodology. The concurrent nested model of mixed methods was utilized using one data collection phase, during which both quantitative and qualitative data were collected simultaneously.

Results: The research noted that factors such as low education, low income, gender inequalities, social influence, and traditional practices were hindering the uptake of exclusive breast feeding.

Conclusions and Global Health Implications: The study envisages that it is pertinent for infant feeding programs to address socio-economic barriers to EBF in order to influence a positive uptake. The potential interventions include increasing men's involvement, raising awareness on EBF, and strengthening the Village Health Worker Program.

Key Words: Exclusive breast feeding • Socioeconomic status • Infant mortality • Zimbabwe
• Mixed-methods research

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Introduction

The infant mortality rate in Zimbabwe which is at 97 deaths per 1,000 is significantly high.^[1, 2] Paradoxically, exclusive breast feeding (EBF), which is one of the major interventions to this social catastrophe which is recommended, free, accessible, sustainable and safe^[3] is not far from the reach of many rural women but is being underutilized.^[4] A large body of evidence demonstrates the benefits of EBF infant feeding practice for child survival, growth, and development.^[4] This is premised on its high immunological, nutritional and hygienic value as compared to other liquids, solids and bottled infant milk formulas.^[5] Lack of EBF is associated with high incidences of diarrhoea, pneumonia, bacterial meningitis, bacteraemia, respiratory tract infection, necrotizing enteric colitis and malnutrition.^[6] These in turn are responsible for high morbidity and mortality in the lifelong associated with poor school performance, impaired intellectual and social development.^[4, 5, 6]

EBF is defined as giving breast milk only to infants from 0-6 months, and not feeding any food or liquid, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicine as only recommended by the health workers^[7] A global health journal series on child survival identified the promotion of EBF of infants during the first 6 months of life and continued breastfeeding to 12 months as the single most-effective preventive public health intervention for reducing mortality among children aged, 5 years and below.^[3] More recently, the series on maternal and child under-nutrition estimated that 1.06 million child deaths (10% of all mortality in children aged 5 years) are attributable to non-exclusive breastfeeding in the first 6 months of life.^[4]

According to the National Nutrition Survey the current national EBF rate in Zimbabwe stands at a staggering rate of 5 percent.^[1] The Multiple Indicator Monitoring Survey provides a higher national rate of 21%, with a higher proportion of 29% in urban areas being exclusively breast fed compared to 26% in rural areas^[2] The Ministry of Health and Child Care in Zimbabwe recommends and promotes EBF as the most appropriate infant feeding practice for children from 0-6 months of age. Despite efforts by

the respective ministries to increase the EBF uptake, its uptake by mothers of infants remain very low.^[1, 2, 4]

Breastfeeding is a complex process governed by psychological and physiological factors, which in turn are conditioned by a wide spectrum of environmental, socioeconomic and cultural circumstances.^[8] In view of the fact that EBF is a physiological process which transpires in a specific socio-economic milieu, the purpose of this paper is to investigate the socio-economic factors that hinders its uptake among rural women in Zimbabwe.

Methodology

Study Design, Target Population and Sampling.

The concurrent nested model of mixed research methodology was employed and was identified by its use of one data collection phase, during which both quantitative and qualitative data are collected simultaneously. The study was carried out in Mataga Ward, Mberengwa District at Mataga Rural Health Center, and Midlands's province in Zimbabwe from April to June 2013.

The target population was mothers who have infants from 0-6 months who were accessing neonatal health services during the data collection month. Convenience sampling method was utilized to select 20 mothers who took part in the study. Purposive sampling was utilized used to select the key informants (Nurses and Village Health Workers). The study was reviewed and approved by the University of Zimbabwe ethics board as well as the general academic board before implementation. In addition, research participants were asked to give their informed consent through the signing of a consent form before any responses were solicited from them.

Data Collection and Analysis. An interview schedule composed of open-ended and closed questionnaires was used to collect data from mothers and an interview guide was used for the key informants. Quantitative data was analysed using the Statistical Package for Social Scientists version 17 while qualitative data was analysed through content coding procedures based on a set of predetermined themes of interest. The main research questions were: 1) what

are the challenges did you/ are you experiencing in practicing EBF. 2) What are the barriers that prevent or affect you/mothers from practicing EBF?

Results

Demographic characteristics - age distribution).

Out of the 20 mothers interviewed in the study, 45% (N=9) were from the 20-25 age range. 15% (N=3) respondents were within 15-19 age range, while age groups 26-30 and 36+ had 3 respondents each. 10% (N=2) of the respondents belonged to the 31-35 age group. The high composition of mothers in the 20-25 age groups confirms the findings of the Zimbabwe Demographic Health Survey which reported a high fertility rate among women from the age of 20-25.^[9]

Respondents' level of education. A large proportion of respondents 13 (65%) managed to reach primary level. A total of 7 (35%) mothers managed to reach secondary level. The primary school attendant rate in this study tallies with the findings of the Multiple Indicator Monitoring Survey which recorded a 99 % primary education net attendance of the girl child in Zimbabwe.^[2] Education levels influence the uptake of EBF.^[2]

Income of the respondents (mothers). Among the 20 (100%) mothers who were interviewed, five (25%) had an income estimate of \$5, four (20%) mothers earned an estimate of \$20, four (20%) mothers earned an estimate of \$50, three (15%) mothers earned \$100, while a paltry two (10%) mothers earned more than \$100. Unemployment thrived in this study. Eighteen (90%) mothers and 13(65) fathers reported that they were not employed. Two (10%) mothers reported that they were self-employed.

Knowledge and understanding of EBF. Many respondents exhibited extensive knowledge and understanding of the meaning and benefits of exclusive breast feeding. Fifteen (70%) mothers indicated that they understand the meaning of EBF and its benefits while five (25%) mothers indicated knowledge of the meaning of EBF but not its benefits. There was no significant correlation between this knowledge of the meaning of EBF and the actual practice. For example, out of the 70% (N=14) of the mothers who reported

knowledge of EBF and its benefits, only 25 % (N=5) of them managed to practice EBF. This state of affairs is a clear pointer to the fact that knowledge of EBF does not translate to the active uptake of the same. These results can be elucidated by the theory of planned behaviour which states that knowledge alone is not sufficient to change behaviour but attitudes, subjective norms and perceived behavioural control regarding behaviour, all influence the intention to perform certain behaviour.^[4]

The discrepancy between knowledge and behaviour could also well be traced back to the influence of culture in rewarding and punishing whatever is deemed acceptable and unacceptable behaviour in the Zimbabwean society. To this end, respondents testified that their culture expects and demands that babies be fed on solids at least within a week of their birth. Failure to comply with such an expectation could be misconstrued for infidelity in a family where tradition holds that feeding on solids is a sign of genetic connection of the baby with its ancestors.

Level of education and EBF practice. Five of the 7 mothers (71%) who had secondary education managed to practice EBF. Eleven (55%) mothers who had no primary education did not practice EBF. Only two mothers (14%) with primary education managed to practice exclusive breast feeding. These results show a higher prevalence of EBF among respondents with secondary education (71%) than with primary education (14%). Such a nexus between level of education and EBF stands as a clear testimony that education, like in other parts of the world, remains a vital weapon to fight against the power of some retrogressive traditional beliefs in Zimbabwean society. The influence of education on the uptake of EBF was also recognized by all the nurses (key informants) who registered a high prevalence among mothers who have secondary education. Implicit in these results is that educating a girl child is likely to promote and sustain positive health behavior in traditional and rural communities.

Traditional practices hindering EBF (Nhova Treatment). Zimbabwe's tradition demands that traditional medicine be administered on babies to try and avert the death caused by the condition that culminates in the subsiding of the fontanel in babies due

mainly to severe dehydration (a condition known as *nhova* in vernacular). This practice is also common in Kenya where infants are given various herbs to treat the condition known in Kenya as *Ndebele*.^[10] Traditionally, this condition is attributed to evil spells. Out of the 70% (N=14) respondents not practicing EBF, 12 of them reported that they had treated *Nhova* on their babies through administering different foods and medicines such as barks, juices, roots, herbs, cooking oil and wild fruits. Once more, such a traditional practice militates against the core tenets of exclusive breast feeding that prohibit the intake of any solids let alone medicine unless prescribed by a qualified medical practitioner. To sustain EBF, sight should not be lost of these traditional practices and safeguards that have tended to supersede modern medicine as guarantees of survival in resource poor communities.

Pressure from in-laws. Significant others such as grandmothers, mothers in-law and husbands influence the infant feeding practices pursued by mothers. Respondents identified mothers-in-law as key authority figures regarding the uptake of EBF. For example, 70% (N=14) of respondents indicated that mothers in law were key decision makers with regard to infant feeding. In an African culture, older persons are regarded as a fountain of knowledge and younger persons tap knowledge from them. Most of the advice that came from the mothers-in-law discourage exclusive breast feeding in favor of mixed infant feeding practice. The mother-in-law is usually powerful and influential in major decisions concerning the behavior and conduct of her daughter-in-law. According to one respondent, the mother in law gave the infant porridge a day after delivery arguing that the family tradition requires that the baby be fed on porridge the day she gets home from the hospital by its grandmother. The respondents confess that their in-laws admonish that their clan is so unique that any of its offspring is born hungry. On the same note, four respondents indicated that on leaving their babies with their grandmothers, they were automatically fed on porridge on account of cultural norms and traditions.

It is worth noting that such a scenario is in no way peculiar to Zimbabwe as it corresponds with findings in Malawi that the influence of the mother-in-

law and husband was one of the greatest barriers to EBF uptake in Malawi.^[11] This state of affairs has its explanation in the theory of planned behavior which envisages that people's behaviors are influenced by normative beliefs, which are beliefs about the normative expectations of others and motivation to comply with those expectations.^[4] Implicit in this scenario is that sometimes one's level of education in a rural environment becomes subservient to the expectations and dictates of culture and tradition. In such a situation, it becomes important for any health promotion strategy to be ingrained within the cultural expectations of the particular locality within which it is conducted.

Gender inequality and EBF. Power dynamics within the family was cited as a key factor exerting its influence with regard to the feeding of the babies.^[4] In an African rural milieu, major decisions are made by the husbands as heads of the family. Eighteen (90%) respondents noted that they had been advised by their husbands on infant feeding. Indications are that fathers of children of 65% (N=13) of the 18 respondents were against EBF as they argued that the child should be given porridge as breast milk was not enough for the baby and that was why the baby is always crying. Another respondent reported that the husband is the one who bought peanut butter and margarine so that she can prepare porridge for the infant. One respondent confirmed having been confronted with what has tended to be the greatest question of the day each time EBF was discussed in a traditional African setup namely: "*where on earth have you seen a baby surviving on breast milk alone*"?

Implicit in such a scenario is that gender roles cut across all the facts of life, undermining even those aspects of human existence ordinarily thought to belong to the wife in a matrimonial relationship. This makes it inevitable for health promotion practitioners to look at husbands as key stakeholders if ever such programs as EBF are to be successful.

Income and EBF. Poverty and unemployment were cited as some of the impediments against EBF by many respondents. Respondents contend that they find it difficult to practice EBF given that inadequate food with low nutritional values exacerbate the low uptake of EBF. This study observed that women in

Zimbabwe have limited income and economic their status is low. Among the 100% (N=20) respondents interviewed 25% (N=5) had an income estimate of \$5, 20% (N=4) respondents earn an estimate of \$20, 20% (N=4) respondents earn an estimate of \$50, 15% (N=3) respondents earn \$100, while a paltry 10% (N=2) respondents earns more than \$100. Many women in rural areas are living far below the poverty line.^[9] Prior study has shown that wealth quintile or income influences the uptake of exclusive breast feeding.^[2]

Low amounts of milk from ill-fed and malnourished mothers have come as an unfortunate deterrent against EBF. The study noted a high prevalence of EBF among mothers whose incomes were above \$100. For example, 66% (N=4) of the 100% (N=6) respondents actively participating in EBF had an income above \$100. 70% (N=14) of respondents not practicing EBF had incomes below 100%. The three nurses and two village health workers in the study reported that most mothers are not adhering to EBF because they were not producing enough milk. The above findings are in sync with those from the Zimbabwe Vulnerability Assessment Committee which found out that 39 - 45 percent of the people in Meringa were food insecure.^[12]

The findings therefore draw the attention of all players in the promotion of EBF program as well as those involved in HIV prevention (especially the prevention of mother to child transmission of HIV) to seriously take poverty, unemployment and malnutrition as obstacles against the achievement of set objectives. Informed by such a reality on the ground, the success of these programs rests on the adoption of a holistic approach to programming. Such programs as supplementary feeding of lactating mothers as well as social cash transfers can go a long way in fostering and sustaining EBF.

Gender of the child. This study could not directly establish the influence of the gender of the child on EBF as the number of the male child was significantly very low to the number of girls. 13 (65%) mothers confirmed that they had a girl child while 35%

(N=7) mothers confirmed that they had a boy child. However, six mothers reported the challenges they faced in practicing EBF, adding that the boy child eats more than the girl child and hence mother's milk is not enough for the male infants. One of the Village Health Workers respondent #2 reported that boys eat very much and that mother's milk might not be enough for the boy child. However, nurse respondent #1 and Village Health Worker respondent #3 denied that boys eat more than girls at this tender age. It was raised that these are some of the beliefs that are held by communities that impede the EBF uptake. All of the Village Health Workers (N=4; 100%) confirmed that this was a wide belief that boys eat very much and it is impossible for them to be satisfied by mother's milk alone. This sends a clear message to public health promoters that they need to know and address the misconceptions and myths held by communities that militate against the uptake of EBF especially for boy-children.

Conclusions and Public Health Implications

This study has revealed many impediments that confront the rural Zimbabwean mothers against adopting EBF. It is therefore pertinent that efforts by the Ministry of Health and Child Care to upscale EBF be holistic so that it reaches all areas that determine the mothers to practice EBF. The respective government ministries should ensure increased male involvement in health programs that target families. Male influence poses a barrier to the practice of EBF, hence it is imperative that they accompany their wives to clinics so that they are educated on the recommended infant feeding practices. Community awareness and behavior change community mobilization on EBF should be scaled up and should not only target mothers but should be extended to members of the extended family such as grandmothers and mothers-in-law.

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Key Messages

- The government needs to avail food to members of the community that are in hunger. Mothers in rural areas are unable to practice EBF because they were producing little milk owing to lack of food and starvation.
- Lack of education is associated with low EBF uptake. Education of women has far greater values not just for EBF practice but for many health outcomes.
- Societal norms, peer pressure, and traditional practices play significant roles in EBF practices among rural women.

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