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Incomplete Exclusive Breastfeeding among Women: A Case Study of Darussalam MCH Center in Baidoa, Southwest State of Somalia

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ABSTRACT

This study explores the prevalence of incomplete exclusive breastfeeding (IEBF) in the district city of Baidoa in Bay Region, SWSS. The aim of the study is to get insights into the practice and prevalence of incomplete exclusive breastfeeding among mothers, especially a group selected from women who visit Darussalam MCH center. A mixed methods design was used to collect and analyze questionnaire data. Purposive sampling was employed to obtain data from 25 mothers who had stopped breastfeeding by the time the study was conducted. The study found that the practice is common among internally displaced women living in the IDP camps and their counterpart mothers from the host community in Baidoa. Each of the mothers in the survey has undergone the experience of IEBF with at least one child while one woman admitted 4 of her babies had experienced termination of breastfeeding before the recommended period of six months. A variety of reasons including illness, divorce, and economic factors were expressed as contributing factors to the occurrences of IEBF among women. A high level of awareness is needed to educate women in particular and society in general about the effect of IEBF on child health in order to avoid the occurrences of preventable diseases caused as a result of the practice.

Keywords: Breastfeeding, Childcare, Exclusive breastfeeding, Healthcare, and Maternal healthcare.

INTRODUCTION:

Breastfeeding from a Global Perspective

As the World Health Organization explains, "'Exclusive breastfeeding" is defined as giving no other food or drink - not even water - except breast milk. It does, however, allow the infant to receive oral rehydration salts (ORS), drops and syrups (vitamins, minerals and medicines)" (WHO, 2015). Breastfeeding is a necessary practice that has tremendous benefits for the newborn. However, many women stop breastfeeding before the baby reaches six months (Jama *et al*., 2020).

While optimal breastfeeding can prevent the death of about one and a half million children every year (Mekuria and Edris, 2015), a growing number of women discontinue breastfeeding the child before they reach six months. Women in Baidoa are not the exception in the practice, in spite of providing several factors as

contributing to the incompletion of child breastfeeding. Many mothers discontinue breastfeeding without medical advice or justifiable health related hazards. In such situations, discontinuation of breastfeeding the child with the nutritious natural milk from the mother can have very serious implications to child health (Stuebe, 2009; Shah *et al*., 2020; Adda *et al*., 2020).

In an article by Leah Selim, (2018), international institutions such as UNICEF and WHO commend exclusively mother's milk for the first six months of life, starting immediately after delivery of the baby. The early start, as well as the practice itself, is extremely beneficial to the newborn because it protects the newborn against infectious and enduring diseases (Selim, 2018). As global statistics reveal, only 20% of women in Sub-Saharan Africa practice exclusive breastfeeding of their last-born baby compared to 41% in North Africa, with Asia scoring higher at 44%, and Latin America 30%, and therefore all performing better than the Sub-Sahara region of the African continent (Reddy & Abuka, 2014; Hazir *et al*., 2013; Jama *et al*., 2020).

Mother's milk is ideally an optimal food for the infant and its growth (Martin *et al.,* 2016). Considered an essential part of the reproductive process, the mother's milk – or lactation – has beneficial health implications to both the infant and the mother a like (Sultana *et al.*, 2013). In neighboring Kenya, a report reveals that 97% of Kenyan mothers breastfeed their infants, and that 86% initiate breastfeeding the baby within the first day after birth, while those who start breastfeeding the newborn within sixty minutes after birth are estimated to be 62% (Kenya National Bureau of Statistics ICF Macro, 2014). This early practice provides the infant with the advantage of intake of colostrum, the first thick and yellowish milk that has contents rich with very essential antibodies the baby needs for prevention from illnesses (Ministry of Health of the Republic of Kenya, 2013).

In order to achieve healthy growth, children 0-6 months of age should be breastfed on demand; that is, they should be given to suckle whenever they want, night and day, 8 - 10 times a day (Federal Ministry of Health, Republic of Sudan 2015). It is, therefore, due to a variety of benefits to the newborn and its mother that exclusive breastfeeding is a recommended practice from childbirth up to six months whenever possible, except in the case of unavoidable medical conditions (Jebena and Tenagashaw, 2022; Kellams *et al.,* 2017).

Breastfeeding in Somalia

In Somalia, a UNICEF report on the website (reliefweb.int) of the UN Office for the Coordination of Humanitarian Affairs discloses that only 3 in every 10 Somali mothers continue exclusively breastfeeding their child up to the recommended six-month period. Astonishingly, the report commends this as a positive trend and "a huge increase from just over 5 per cent in 2009" (Reliefweb, 2017). Ndakwe & Abdi Tari (www.ennonline.net) who, in 2016 and 2018, surveyed 685 households in the three districts of Bullahawa, Luuq, and Dollow in the Gedo region of Somalia, found that although mothers had good "knowledgeable and positive attitudes towards breastfeeding," which returned high results, both were not, however, reflected in the mothers' practice. Influences by elderly women, cultural beliefs, insufficiency of breast milk, competing activities that make mothers busy, and cultural beliefs have been highlighted as some of the reasons leading to the discontinuation of breastfeeding before the exclusive six months. Conducting their study in the district of Burao in northwestern Somalia, Jama *et al.*, (2020) produced lower results which contradicted earlier results by the Somaliland Ministry of Health. Jama and coauthors attributed these low results to various factors, including: mother's lack of formal education; gender of the child - in which case a male child had better chances of completing the exclusive period of breastfeeding than a female child; household income; lack of support from the husband; and lack of awareness or neglect to visit health centers for antenatal care (ANC). In a recently released health survey by the Health Ministry of the Federal Government of Somalia, "60% of children were breastfed within the first hour of their birth," (FRS, 2020, p. 150), which sounds promising, but still demands a more efficient mechanism to maximize the practice by creating awareness among childbearing women.

The Health Situation in Baidoa

Somalia's modern health system can be traced to the arrival of colonialism in the country. Like majority or all of the colonized African countries, the practice of a regulated healthcare system with hospitals, clinics, and

consumption of medical drugs for illnesses are experiences attributed to the arrival of colonialism. In Baidoa, the main referral hospital, Bay Regional Hospital - locally known as *Isbitaal Wiinaaga* (the main hospital) – was built as a result of the colonial project. For instance, corroborating the subject in one of the pioneer scholarly studies on the health system of Baidoa district carried out by the University of Southern Somalia, Abdinor *et al.* (2021, p. 53) explain: "The health facilities that have been built during the colonial administration included the current facility renamed Bay Regional Hospital, which was built in 1933." While it may be claimed that the civil administrations after independence did not add considerable expansion to the health program as inherited from the Italian colonial masters, a few health facilities were established in selected areas where strong members of parliament or figures in the cabinet had kinship interests (Abdinor *et al.*, 2021). However, it was in the period of the military regime of 1969 - 1991, led by General Mohamed Siad Barre, that tangible efforts were made to improve the Somali health system, according to Abdinor *et al.* (ibid). Many healthcare facilities were built, and health and medical personnel were professionally trained and employed to run institutions in different parts of the country (ibid). Remarkably, it was indeed during this era of military dictatorship in the country that the Faculty of Medicine was founded to include the studies offered by the Somali National University, as Eno *et al.* explained elsewhere (Eno *et al*., 2015:14-15). Also established was a specialized Nursing School aimed at boosting the professional capacity of human capital in the health sector. It is noteworthy that despite the military governments' development - focused policy, not much was realized in the health sector in Baidoa district and the entirety of the neighboring areas. Beginning from the early 1990s, however, the situation deteriorated extensively in the wake of the civil war and amid the chaos that brought down all functioning institutions, thereby collapsing the provision of all public services (Yarow *et al*., 2021). As a consequence of the war, Baidoa – like other areas inhabited by the Digil - Mirifle communities - was devastated by marauding, armed militiamen who crisscrossed the entire Digil - Mirifle territory, either in pursuit of their enemies or in retreat to escape from them (Kusow, 1993; Eno, 2008). Many lives were lost, and properties– including livestock and crops - were either looted or deliberately wasted (Abdinor *et al.,* 2021; Yarow *et al*., 2021, p. 28) describe the situation, writing that

> "…during the civil war, Baidoa has experienced a calamitous health situation. For some time, hospitals and other health facilities were either forced out of operation or operated without drugs and medical supplies. In facilities where tiny numbers of trained health personnel were available, services were gradually but inadequately resumed. Even then, a majority of the staff continued working voluntarily without any payment for their services, until international organizations like UNICEF, Médecins Sans Frontières (MSF), SOS Children's Village (Somalia), the International Committee of the Red Cross (ICRC), and others put them in their payroll system."

Although still functioning in a recovery mode similar to that of other districts found elsewhere in the country, Baidoa currently has several established public and private health facilities. While private healthcare institutions charge for their services, public health is provided free due to sponsorships by multiple aid agencies supporting the health sector (Yarow *et al.,* 2021). Not only Baidoa, the capital of the Bay region and provisional seat of the administration of the Southwest State, but other districts and regions that are part of the territory of the Southwest State are similarly benefiting from these services. Among the healthcare facilities is Darussalam Mother and Child Health (MCH) Center, the institution that is the focus of the current case study on incomplete exclusive breastfeeding among mothers.

MATERIALS AND METHODS:

Research Design

This study follows the paradigm of an exploratory case study method (Yin, 2004; Eno & Dammak, 2014; Creswell, 2017) which aims to investigate the prevalence of incomplete exclusive breastfeeding (IEBF) through the perceptions of mothers experiencing the practice. The case study research is suitable for the health sciences because "Individuals' experiences within health systems are influenced heavily by contextual factors, participant experience, and intricate relationships between different organizations and

actors," (Sibbald *et al.,* 2021; Gilson, 2012). It is due to its suitability for health science research that scholars like (Vanw-ynsberghe & Khan, 2007; Yin, 1999; Sibbald *et al.,* 2021) recommend case study research for its ability and flexibility in following up and scrutinizing the inter-relatedness of the subjects under study and their changes over time.

Data Collection Tools

The study was carried out at Darussalam Mother and Child Health (MCH) Center in the district of Baidoa, the capital of the Bay region in the Southwest State of Somalia. A survey questionnaire was designed containing mixed methods questions.

Sampling

A purposive sampling technique was employed whereby only women who had stopped breastfeeding exclusively within six months after childbirth were selected as respondents, while women of all other categories were not considered to participate in the survey. Among the target, a sample size of 25 mothers was selected to collect data, after introduction was facilitated through the staff at Darussalam MCH and consent of the participants had been obtained. Confidentiality was promised and maintained, hence keeping respondents anonymous throughout the study.

Data Analysis

Data analysis was undertaken using SPSS software for the statistical part of the questionnaire. These results are demonstrated in tables in frequencies and percentages. As for the qualitative segment of the responses, coding and categorization methods were approached, considering similarity of opinions, while respondents' quotes were presented to support the data as seen appropriate for inclusion of their voices, perceptions, and viewpoints. The medium of communication was the Maay language, which is dominant in the Bay region and across most regions of southern Somalia, while transcriptions were – in some cases – translated simultaneously into the English language.

Ethical Consideration

The study was endorsed by the Research and Ethics Committee of the University of Southern Somalia, Baidoa, SWSS; Research and Ethics Committee of Hakaba Institute for Research and Training, Baidoa, SWSS; and the Management of Darussalam MCH Center, Baidoa, SWSS.

RESULTS AND DISCUSSION:

This section presents the analysis and discussion of the data using tables and quotes of respondents.

Table 1: Q1. Respondents by age.

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
16-24	9	36	36	36
25-34	12	48	48	84
35-44	4	16	16	100
Above 44	0	0	100	
Total	25	100.0	100	100

The data presented in **Table 1** shows the age distribution of the respondents, with four choices of responses to select from. Age-group 16 - 24 was 36% and second below age cluster 25 - 34, which returned 12 responses equivalent to 48%. Respondents in age-group 35 - 44 consisted of 16%, while none of the respondents were above 44 years of age. Although certain sources maintain early marriage as a cultural reality in Somali society (FRS, 2020; Save the Children [undated]; Sharma *et al.,* 2020), the current study does not show any results to support those findings, despite having no disagreement with available literature. Essentially, the result informs the productivity in the fertile ages between 16 - 44, notwithstanding the variance in the numbers as well as the omission of mothers between 14 and 16, which the facility informed to have had no significant number of such age group in the records among mothers visiting the MCH at the time of the study. Women between 25 and 34 make up 48% of the total number of respondents, thus making this age cluster the more dominant group in the study. That there were no respondents (0%) among the women above 44 years may sound reasonably fair, since women at advanced age may experience menopause, or may not have a problem with breastfeeding, a possible reason why none of that age were captured in the

data of the current study. More significantly, however, the age factor supports the validity and reliability of the study, as the respondents surveyed represent the right age groups who are not only fertile at the conduct of the survey, but purposively also as the right respondents experiencing incomplete exclusive breast-feeding.

Table 2: Q2. Residence.

Valid		Frequency	Percent	Valid Percent	Cumulative Percent
	Baidoa	14	56.0	56.0	56.0
	IDP	11	44.0	44.0	100.0
	Total	25	100.0	100.0	

Table 2 presents the location of the respondents' residence according to the particular area they live in. Because Baidoa hosts a very large community of IDPs from districts surrounding Baidoa and regions adjacent to the Bay region, this particular question was aimed at determining whether majority of women in the survey belonged to the host community or were among the IDPs. In this regard, a 56% majority of the mothers in this survey are residents among the host community while the 44% minority consists of IDPs in the camps on the outskirts of the district. Thus **Table 2** illustrates that incomplete exclusive breastfeeding is a common practice among women who visit Darussalam MCH center, including the host community and same as those in the IDP camps.

Table 3: Q3. Number of children each respondent has.

Valid		Frequency	Percent	Valid Percent	Cumulative Percent
	1-2 children	7	28.0	28.0	28.0
	3-4 children	5	20.0	20.0	48.0
	5-6 children	6	24.0	24.0	72.0
	Over 6 children	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

The data presented in **Table 3** informs the number of children of each of the respondents - with 28% of them having produced 1-2 children, corresponding exactly to the number of mothers with over 6 children. Mothers with 3 - 4 children are the lowest in the ranking, with a score of 20% and lower than women with 5 - 6 children, who consist of 24% of the total respondents. Significantly, women who have mothered more than 2 children dominate the table with a 72% majority, compared to their counterparts in the 1 - 2 children category, which make up only 28% of the 25 participants. In addition to the participants' maturity demonstrated above in **Table 1**, the data in **Table 3** furnishes the reliability of the information given by the surveyed mothers, based on their experience in child-birth and matters related to breastfeeding, the latter of which being the principal aim of this study.

Table 4: Q4 Number of babies a mother experienced IEBF with.

Valid		Frequency	Percent	Valid Percent	Cumulative Percent
	1 child	9	36.0	36.0	36.0
	2 children	9	36.0	36.0	72.0
	3 children	6	24.0	24.0	96.0
	4 children	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

The respondent mothers were asked about the number of children they discontinued breastfeeding with before the exclusive period of six months, yielding results which pose a major concern. The statistics in **Table 4**, confirm the number of children mothers havesubjected to incomplete exclusive breast-feeding is high, with 9

of the respondents (which is 36%) stating to have stopped breastfeeding with a single child. An equal number of 9 respondents (another 36%) admitted to having stopped breastfeeding from 2 children. Furthermore, 6 mothers (24%) has not breastfed 3 children, while 1 mother (4%) mentioned that she did not complete breastfeeding for 4 of her children. The result indicates that majority of the respondents, 18 mothers (72%), have had at least 1 child or 2 children with whom they experienced incomplete exclusive breastfeeding, while the second most respondents (24%) explained that 3 of their children have undergone incomplete exclusive breast-feeding. The last position - which is the third place and with only a single respondent (4%) - shows that 4 of her children have experienced discontinuation from her exclusive breastfeeding. The study provides a clear picture of mothers' neglect toward breast-feeding, or at least the lack of consideration of the multiple benefits and advantages it provides to the infant. The fact that a mother admits to 'denying' or discontinuing provision of breast milk to her newborn, for any reason other than health problems, should raise more serious concerns - not just to her or the health authorities, but to society at large. Whether the reasons leading to the discontinuation of the exclusive breast-feeding practice adequately justify the action or not is the task of the next question, designed in a qualitative format that allowed mothers to present their individual versions of the scenario.

Q5: Reasons for stopping breastfeeding

The reasons why mothers suspended exclusive breastfeeding - or, in some cases, why they have not started it - is the concern of this question. In their own individual responses, several of the respondents said that they "got pregnant before a lactating child reached six months;" so, they "had to stop exclusive breast-feeding for the sake of the currently breast-feeding child's health," although this notion is either not supported by credible scientific evidence (Cetin *et al.*, 2014) or remains controversial, and therefore over-shadowed with inconsistencies (Anitasari *et al.,* 2019).

Unlike these mothers who expressed health concern for the infant, a cohort of mothers stated that their reason was because they "became ill and [were] unable to continue breastfeeding the child." Other respondents were hindered from completing breast-feeding to six months due to "work"-related issues; so, they "could not have time to breastfeed the baby." According to one of them, "it was impossible to leave work for some hours, return home to breastfeed the child, and then go back to work again; it was just impossible." As another mother emphasized, "I have to go and work in order to find food for the other children. We don't have anyone else in the family to provide for us." One of two respondents replied that "the child itself refused to suck breast milk"; while the respondent next to her added: "Yes, she is like me; my baby just wouldn't accept my breast, my milk, for some reason. Her completely refused my milk. I don't know why." Furthermore, six mothers replied that they have stopped exclusive breastfeeding because of economic reasons; they could not get enough food, which left the mother malnourished and thus led to her being unable to produce adequate breast milk for the child. A mother among eight divorced women (shown below in **Table 7**) revealed, "I got divorced and the husband's family took away the baby before the child reached six months." In simple categorization and coding analysis, the responses could be summated as follows:

1) Mother got pregnant before the children reached six months
2) Illness disallowed mother to continue breastfeeding the infant
3) Work/economic factors distracted mother from breastfeeding the newborn baby
4) The child itself refused to feed on breast milk
5) Divorce separated mother from baby; father took the infant before the age of six months

Q6: Child adaptation to the situation

To highlight the response from their point of view, the respondents were asked to discuss infant adaptation to a lack of breast milk. The mothers revealed multiple coping strategies (or reactions) of the infants towards the cessation of breastfeeding. Most of the respondent mothers recalled that "the child felt sick, but later on improved or recovered from the sickness," most after a period of two months or so before adapting to the situation. Seven of the women mentioned how "the child was disturbed by a form of diarrhea," although "it was feeding well on other foods." A section of the mothers described the condition of the child as suffering from "diarrhea" associated with "vomiting." The

mothers experienced "very scary" moments," which one of them described as "a worrying situation for days and nights." In other cases, the child was trying to adapt to the condition with "more crying, more and more crying without stopping." According to one concerned mother, "My child refused to take other foods although slowly, slowly it started eating later." In a more chilling revelation, a respondent mother narrated the child suffering from "prolonged period of sickness," which finally led to the child "succumbing to death as a consequence." Two of the respondent mothers described how the "child didn't change anything," and that "normally [s/he] became accustomed to the situation." In summary, the infants encountered the following situations in the process of adaptation to the discontinuation of breast-feeding –

1) The child felt sick, but adapted to the situation after two months or so
2) The child had diarrhea, but was feeding well on other foods
3) The child had diarrhea, vomiting, more crying and refused to feed on other food for quite some time
4) The child felt very sick and died as a consequence
5) The child didn't change; it became accustomed to the discontinuation of breast milk

Table 5: Q7. Current marital status.

Valid		Frequency	Percent	Valid Percent	Cumulative Percent
	Married	17	68.0	68.0	68.0
	Divorced	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

The data presented in **Table 7** focuses on the marital status of the respondents at the time of stopping breastfeeding, so as to analyze the problem from the perspective of family unity and understand this important segment of the problem. Women, particularly lactating mothers, are exposed to economic problems that can separate them from their child for a long period of time while they are in search of income to maintain and sustain the family. In response, the data shows that 17 of the respondents (68%) are married, while 8 of the respondents (equivalent to 32%) are divorced. Reading the results from majority and minority statistical summation does not portray the urgency of the problem, since the reader may consider the 68% currently married as a good symbol of family unity in existence. In fact, 32% of 25 women caring alone for a family or a child in a difficult situation of unemployment (Ali *et al*., 2022), poor income, inaccessible quality health, in an unpredictable security environment in Baidoa - or Somalia in general - explains why some lactating mothers feel 'forced' to discontinue breastfeeding their infants with the nutritious maternal milk they need and the care they affectionately deserve. Whether divorced or not, the mother must be allowed to be the good caregiver that she can be to her infant. Therefore, for the sake of the infant's growth and wellbeing, parents and other stakeholders in society need to focus on addressing the situation more considerately and honestly, so as to provide the child its right to good health and development; and to the mother, the respect she deserves and her right to a decent wellbeing.

CONCLUSION AND RECOMMENDATIONS:

This study has problematized the prevalence of incomplete exclusive breastfeeding among women in the district of Baidoa in Southwest State of Somalia. The results testify to some of the various factors that contribute to the practice of terminating breastfeeding of a child before it reaches 6 months. Factors including early pregnancy, maternal sickness, work, and economic issues were mentioned as leading to children's inaccessibility to their mothers' milk. In addition, the study highlighted possible strategies of adaptation infant's use as a result of the incompletion of breastfeeding and the dire consequences the practice can have on the child, all of which call for urgent intervention from all stakeholders in the society. The health authorities and institutions including health professionals, women and community organizations as well as development partners need to explore better rewarding and result-oriented strategies that aim to address the situation of IEBF. To that effect, more studies need to be conducted to further corroborate the subject and delve deeper into its conundrums so that the details of

such results are utilized to design sustainable mother-child health policies appropriately focusing on breast-feeding. In order to help the newborn baby benefit from the natural and nutritious minerals in the mother's milk, more focus should be put on how to encourage mothers to continue breastfeeding at least up to the first 6 months after birth, if at all it is not possible to continue it longer.

CONFLICTS OF INTEREST:

The authors have no conflict of interest in either carrying out the study, producing the report or disseminating it in this publication.

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