

ICASH-A09

THE EVALUATION OF EARLY INITIATION BREASTFEEDING PRACTICE in Dr. mohammad hoesin hospital palembang

Nuswil Bernolian¹, Amal C. Sjaaf²

¹ Obstetric and Gynecology Department of Dr. Moh. Hoesin hospital Palembang

² Public Health Faculty of Indonesian University

ABSTRACT

Background: Compared to other countries, the rate of EIB in Indonesia remains low (34,5%). During our practice, particularly in delivery room, we often find practices which delayed EIB. The recent finding that early initiation of breastfeeding (EIB) could substantially reduce neonatal mortality should result in more comprehensive efforts to increase the number of infants breast-fed within an hour of birth. Such efforts can only be effective if policies and guidelines are based on a solid knowledge of the barriers and facilitators for EIB.

Aims: To evaluate EIB practice in Dr. Moh. Hoesin hospital.

Methods: This was an analytic observational study, using cross sectional design. Our populations were all of afterbirth mothers (spontaneous or abdominal delivery), doctors, midwives, as well as managerial policy holder. Samples were selected by purposive sampling. Data was obtained from the questionnaire which have been tested for validity and reliability. This study included 29 doctors and 14 midwives as EIB implementers; also 12 managerial staffs.

Results: During the period November to December 2016, there were 19 (51.3%) patients with post spontaneous or abdominal delivery practiced EIB and 18 (48.6%) patients did not practice EIB. Most of patients in "no EIB group" had abdominal delivery ($p = 0,003$). Most of patients complained that no EIB policy in operating room. Most of implementers stated that EIB already done well. The EIB implementers complained that there was lack of support about EIB practice from hospital manager and maternal level of knowledge was low. Our study found the disintegration between the managerial and executive staff, causing ambiguity in the practice of the EIB.

Conclusion: The opportunity of EIB practice was affected by medical condition of mother and fetus, method of delivery, hospital support, EIB policy socialization, and patient's knowledge. There were so many challenges for our hospital to practice EIB, such as no EIB policy in operating room, the mother's condition was not possible to practice EIB, knowledge of the managerial about EIB differ greatly, low socialization about regulations and other elements of the EIB implementation. There is also disintegration between the manager and executive staff causing ambiguity in the practice of EIB and the lack of supervision of EIB practice in the field.

Keywords: early initiation of breastfeeding, opportunity, challenge

INTRODUCTION

Early initiation of breastfeeding (EIB) is defined as the first time for mother to breastfeed the baby after delivery, particularly in the first hour after delivery. The baby's sucking reflex becomes most active during this time [1]. Baby is given the opportunity to obtain colostrum along EIB process. Colostrum is the white blood cells and antibody-containing immunoglobulin A (IgA), that is very important for resistance to infection, intestinal growth, infant survival, as well as create a protective layer for baby's immature intestines [2,3].

Early or timely initiation of breastfeeding is crucial in preventing newborn deaths and influences childhood nutrition. A study in Ghana concluded if the baby is given the opportunity to suck within the first hour with the skin-to-skin contact, then 22% infants aged less than 28 days can be saved. The study also mentioned if the baby starts to suck within twenty to twenty-four hours of its life, only 16% infants aged less than 28 days can be saved [4]. The national rate of EIB is still low, only 34.5% [5]. There are 18 provinces whose rate is below the national average. To increase the value of such coverage, there should be an effort to take advantage of opportunities and overcome the challenges of EIB implementation [6].

In Mohammad Hoesin hospital, EIB programme has become a procedure that must be implemented. Although there is a standard procedure, but its implementation has not gone well. After the mother gave birth spontaneously, EIB done in just a few minutes. The newborn is immediately taken from her mother to measure the body weight and length. EIB also did not run after mother had cesarean section. The baby is considered a high-risk infant and should have neonatal intensive care immediately. This study is aimed to evaluate EIB implementation in Dr. Moh. Hoesin hospital from patient, implementer, and manager's point of view.

METHODS

This was a quantitative study, using cross sectional design. Our populations were all of afterbirth mothers (spontaneous or abdominal delivery), doctors and midwives who worked in delivery room, as well as managerial policy holder. Samples were selected by purposive sampling. Data was obtained from the questionnaire which have to be filled out by the samples. The questionnaire have been tested its validity using Cronbach test. Univariate analysis was performed to calculate the frequency distribution and the proportion of the sample's characteristics. Bivariate analysis consists of a table with Chi square analysis and correlation analysis.

RESULTS

The study was conducted from November to December 2016 and included 37 postpartum mothers, 43 implementer staffs (14 midwives and 29 obgyn residents), as well as 12 managerial staff. The rate of EIB in our hospital is 51.4%. These results are still far below the target of Health People 2010, which about 75% [7]. The patient's characteristic in both of groups were similar. In both of groups, the subject majority aged 21-35 years (age of reproduction), live in the urban city, high educated, and multiparous. This study found significant difference in the mode of delivery, where the cesarean section mostly obtained in the group that did not practice EIB ($p = 0.003$). Figure 1 describes most of patient complained that EIB did not performed in the operating room. This finding may be a consideration for the hospital to create a EIB policy in the operating room for cesarean section patients. Also, most of patients suggest for improving the EIB socialization in our society, not only for in labour mother, but also for pregnant mother. They also suggest to practice EIB in operating room and the information about EIB should be explained clearly to the mother.

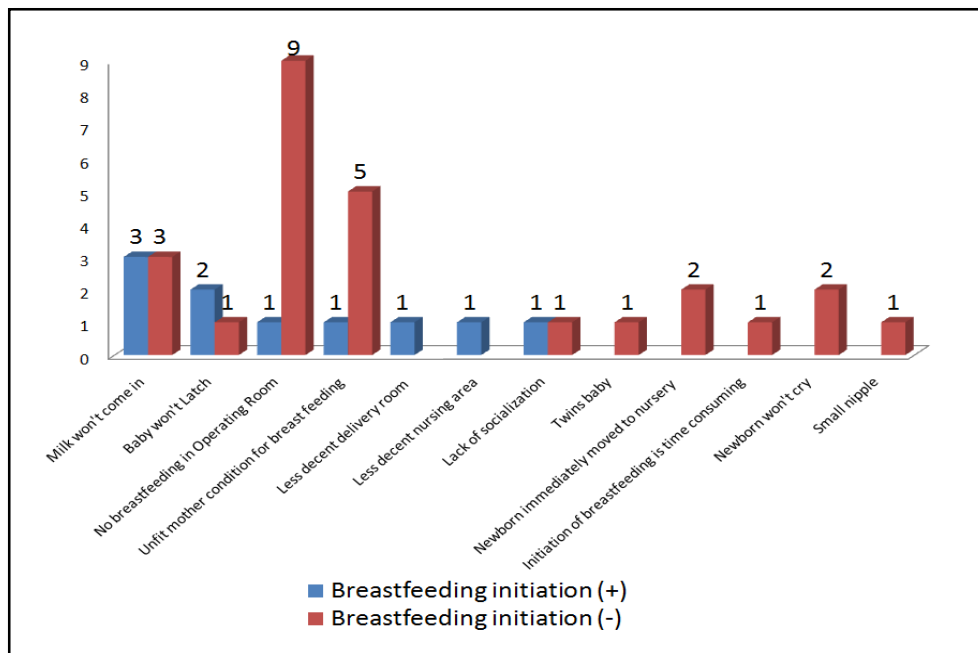


Figure 1. Patient's Complaint about EIB Practice in Moh. Hoesin Hospital*

* Note: a respondent can give more than one complaint

This study also found significant differences in the dimension of EIB implementation in both groups. As many as 50% of respondents from the group "no EIB practice" complained that EIB was unable to do in operating room and delivery room was less feasible. This findings made us outlined that there were four factors inhibiting the EIB in our hospital : no EIB policy in the operating room, delivery room (facilities) were less suitable, socialization about EIB was still low, and education about EIB which was given by doctor or midwife was remain unclear.

From 14 samples of midwife, we found that 12 sampels (85,7%) stated EIB already practice well in our hospital. As well as from 29 sampels of doctor, 19 sampels (65,5%) stated EIB already practice well ($p = 0,279$). Most of them have good knowledge about EIB, whom 9 samples (64,3%) of midwives and 28 samples (96,6%) of doctors ($p = 0,01$). We classified them into 'good' knowledge group if the questionnaire scores ≥ 75 , 'medium' if the scores 55-74, and 'bad' if the scores < 55 . In the doctor group, they complained that maternal knowledge about EIB remain low, lack of support from hospital, and the limited time to practice EIB. While in the midwife group, they stated that not entire of the afterbirth mother able to practice EIB due to her medical reason; also sometimes the newborn condition was unhealthy due to complication from chidbirth. They also complained sometimes the patients do not cooperate because of labor pain and no EIB practice in operating room (figure 2).

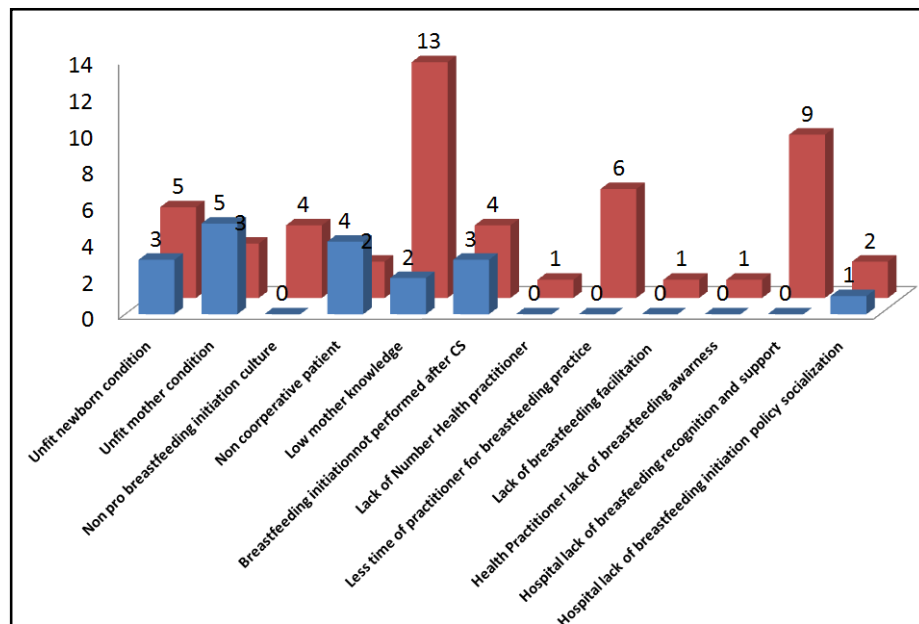


Figure2. Midwife (red) and Doctor (blue) Complaint about EIB Practice*

* Note: a respondent can give more than one complaint

This study found that EIB has generally been implemented properly. Less recognition and support from hospital toward EIB, unavailability of EIB in cesarean section patient, and low maternal knowledge are major complaints of doctors regarding EIB implementation. The patient's condition (uncooperative, medical conditions that do not allow EIB), unavailability of EIB in cesarean section patient, low maternal knowledge, and less of socialization are midwife complaints regarding EIB implementation in our hospital. Respondents suggested to improve hospital support through the socialization of policy; improving patient education but not only given to maternity patients, but also in pregnant patients; and implement EIB in operating room.

In managerial staff group, only 5 (28.6%) among 12 samples who stated that the EIB has been practiced well in our hospital. They worked as managing director, head of the installation, head of the delivery room, and head of the emergency room. There is a possibility of bias, where respondents with structural positions tend to suggest that EIB has been running well, because it is a measurement of their work performance and answered positively (good) will impress their work. Also, we found a contradiction between both groups. In managerial staff group who stated "EIB has been practiced well", they admit availability of evaluation and monitoring system (MONEV) and indicator of EIB success. However, it is contradictory in managerial staff group who stated "EIB practice was bad", because most of them answered no MONEV system in our hospital.

Barriers to practice EIB in our hospital. The "working attitude" is the greatest obstacle in implementing EIB. The managerial group stated that health professional's (midwife and doctor) attitude were inappropriate, such as doctor or midwife do not allow sufficient time for mother to practice EIB or midwife is in a rush to take away the newborn from mother right after the cord was cut. However, when we crosschecked on the barriers, health professional had their own reasons to limit the EIB practice, such as poor maternal condition after birth so she could not do breastfeed, uncooperative mother, no policy to practice EIB in cesarean section patient, and no socialization about policy to practice EIB. This study also found disintegration pattern between the two sides (health

worker/ professional vs managerial staff) leading to the improperly implementation of EIB in our hospital. Unintegrated EIB service raised misunderstanding issue in both providers. It requires an effort to solve the problem by sitting together among providers to formulate an integrative mechanism that benefits all parties about the EIB practice.

DISCUSSION

We found significant differences in the mode of delivery. The group that did not practice EIB had majority cesarean section ($p = 0.003$). This finding gave a hint that one of the obstacles in practicing EIB is no policy to do EIB in cesarean section patient. Mothers who had cesarean section delivery do not get opportunity to practice EIB. Helda wrote in her dissertation that a study held by Doung et al. found the probability risk of postcesarean section mother for not having exclusive breastfeeding is 18,52 [8]. Chandrasekhar in West Nepal stated normal delivery has 7,6 times opportunity to practice EIB than cesarean section patient [9,10].

In managerial group, the knowledge about EIB is varied greatly, so socialization once again seems to be a major obstacle not only at the level of the patient, the doctor and midwife implementers, but also to the managerial level which should dominate all the rules and policies in our hospital. In addition, there is a discrepancy between the managerial groups. In managerial staff group who stated "EIB has been practiced well", they admit availability of evaluation and monitoring system (MONEV) and indicator of EIB success. However, it is contradictory in managerial staff group who stated "EIB practice was bad", because most of them answered no MONEV system in our hospital. This is interesting because actually all of them should have already know and understand about EIB policy. This discrepancy may occur as a result of improper EIB policy- not only in patients but up to managerial level.

The opportunity of EIB practice is affected by medical condition of mother and newborn, method of delivery, hospital support, EIB policy socialization, and patient's knowledge. There are so many challenges for our hospital to implement EIB, such as no EIB policy in operating room, the majority of patients are obstetric referral case with complication so that the mother's condition is often not possible to run EIB, knowledge of the managerial about EIB differ greatly, low socialization about regulations and other elements of the EIB implementation. There is also disintegration between the manager and health worker/ professional causing ambiguity in the implementation of the EIB and the lack of supervision of EIB implementation in the field.

This is the first study in our hospital that evaluate EIB practice and explore its issues at various levels provider. This study used a questionnaire with closed and open questions based on a model of human behavior (Health Believe Model and Malcolm Bridge Model), so it covers the majority of human behavior dimension and makes it possible to analyze each of the behavior. The weakness of this study is its design, using the cross-sectional design, and we did not evaluate the objectivity respondent's answer. We had tried to minimize this weakness by doing cross-checking at all provider levels to reach conclusion. We use a questionnaire that may not necessarily include all issues that may exist in the field, however we tried to minimize this bias by open label question.

CONCLUSION

The rate of EIB in our hospital from November-December 2016 is 51,3%. The opportunity of EIB implementation is affected by medical condition of mother and newborn, method of delivery, hospital support, EIB policy socialization, and patient's knowledge. There are so many challenges for our hospital to implement EIB, such as no EIB policy in operating room, the majority of patients are obstetric referral case with complication so that the mother's condition is often not possible to run EIB, knowledge of the managerial about EIB differ greatly, low socialization about regulations and

other elements of the EIB implementation. There is also disintegration between the manager and health worker causing ambiguity in the implementation of the EIB and the lack of supervision of EIB implementation in the field.

From this study result, we suggest to have socialization of EIB policy by the hospital staff, informative education about EIB to the patients, the new policy of EIB in the operating room, and the EIB integrated service system. Further research needs to be done with a single variable based on the problem issues summarized in this study, so it can focus to evaluate the EIB problems with more valid study design and bias control, also with a larger number of samples.

ACKNOWLEDGMENTS

I would like to express my deep gratitude to Professor Amal C. Sjaaf, my research supervisors, for his patient guidance, enthusiastic encouragement and useful critiques of this research work. My grateful thanks are also extended to Dr. Moh. Syahril as director and Dr. Iskandar Zulqarnain, as the Head of Obgyn Department and all the staff of Dr. Moh. Hoesin hospital for enabling me to do this research in the hospital.

REFERENCES

- [1] Saleha S. Asuhan kebidanan pada masa nifas. Jakarta: Salemba Medika. 2009.
- [2] Edmond KM, Zandoh C, Quigley MA, Etego SA, et al. Delayed breastfeeding initiation increases risk of neonatal mortality. *Pediatrics*. 2006;117(3):3.80-6.
- [3] Bigelow A, Gillis DE, Alex M. Breastfeeding, skin to skin contact and mother infant interactions over infant first three months. *Infant Mental Health J*. 2014;35(1):51-62.
- [4] Aprillia Y. Analisis sosialisasi program insiasi menyusui dini dan ASI eksklusif kepada bidan di Kabupaten Klaten. Semarang: Universitas Diponegoro. 2014.
- [5] Bergstrom A, Okong P, Ransjo A. Immediate maternal thermal response to skin-to-skin care of newborn. *Acta Paediatr*. 2009;5:655-8.
- [6] Bappenas. Peta jalan percepatan pencapaian tujuan pembangunan milenium di Indonesia. Jakarta. 2010.
- [7] Guidelines for Breastfeeding Initiation and Support [Guideline]. Massachusetts Department of Public Health Bureau of Family Health and Nutrition. 2008.
- [8] Helda. Inisiasi Menyusui Dini (IMD) meningkatkan pemberian ASI eksklusif pada bayi yang lahir di RSUD M. Yunus dan Bidan Praktek Swasta (BPS): Analisis kesintasan di Kota Bengkulu pada Juli 2010 – Juni 2011. Program Pascasarjana Ilmu Epidemiologi Fakultas Kesehatan Masyarakat Universitas Indonesia. Depok. 2009.
- [9] Emmanuel A. A Literature review of the factors that influence breastfeeding: an application of the health believe model. *Int J Nursing Health Sci*. 2015;2(2):28-36.
- [10] Chezem J. Breastfeeding attitudes among couples planning exclusive breastfeeding or mixed feeding. *Breastfeeding Med*. 2012;7(3):155-61.