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Niger Delta Journal Of Medical Sciences

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**EDITORIAL: A New Chapter Begins: Welcoming the Future of NDJMS****Prof. Chika Onyinyechi Duru; MBBS, MPH, MRCPCH(UK), FWACP**

Editor-in-Chief

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It is a great pleasure to introduce myself as the new Editor-in-Chief of the Niger Delta Journal of Medical Sciences (NDJMS), the official journal of the Faculty of Clinical Sciences at Niger Delta University, Wilberforce Island, Amassoma, Bayelsa State. I want to appreciate the former Editor-in-Chief, who is now the Dean of the Faculty of Clinical Sciences at Niger Delta University, Prof. Eugene Maduabuchi Ikeanyi, for the solid foundation he laid in ensuring that the NDJMS maintains an international standard. His efforts in encouraging publications in all aspects of medicine and other medically related fields have been invaluable.

The NDJMS seeks to encourage, promote, guide, and disseminate high-quality and original research work alongside insightful and relevant review papers that not only increase the knowledge base but also improve the skills of the medical community. Every work to be published is subjected to rigorous peer review to ensure that the highest ethical and academic standards are maintained.

This 4th issue of the 3rd volume of the NDJMS features three very interesting manuscripts. We will be reminded of the global efforts to control cancers and Nigeria's contributions to tackling this menace through its advocacy efforts. Another topic of interest is the use of misoprostol in controlling postpartum hemorrhage by midwives. The authors assessed how their knowledge and years of experience contribute to the correct use of misoprostol. This study emphasizes the relevance of training and

retraining primary healthcare workers to reduce maternal morbidity and mortality. Additionally, the role of midwives in supporting breastfeeding is discussed, highlighting the various challenges they face and suggesting ways to mitigate them.

We welcome the new Editorial Board members, a team of committed academics with professionalism and integrity who are passionate about maintaining the high ethical standards of our publications. We deeply appreciate the anonymous reviewers who provide timely and helpful feedback on colleagues' works for their selfless efforts and determination to ensure the success of our journal. We are indeed profoundly indebted to you for your invaluable contributions to the academic world. We look forward to involving more members from the board, faculty, and college at large as and when the need arises. We highly appreciate you in advance.

Special appreciation goes to the University ICT team, notably Mr. Kalsko Dipamo and Mrs. Taiga, who anchored the current web and email addresses and other digital services. Your continued collaboration is highly solicited to ensure the good work is maintained.

This issue is rich in up-to-date medical information, and we encourage you to access it and inform others. Your objective comments are expected and welcome so the journal will keep improving.

Thank you, and God bless.

The use of misoprostol for postpartum haemorrhage among midwives in primary healthcare facilities in Edo state, Nigeria.

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Abstract

Background: Postpartum haemorrhage is a leading global cause of maternal morbidity and mortality. The use of misoprostol in the prevention and treatment of PPH has been shown to be effective particularly in low resource settings where regular supply and maintenance of efficacy of oxytocin and ergometrine cannot be ensured. This study aimed to determine midwives' knowledge and usage of misoprostol in the management of Postpartum haemorrhage in Edo Central Senatorial District.

Methodology: It was a descriptive cross-sectional survey involving 126 midwives. An all-inclusive sampling was adopted for the study. Data was collected by means of a structured questionnaire. Collected data were analysed and presented by means of frequencies and percentages. Pearson's correlation analysis was used to test the hypotheses.

Results: This study showed that 40.5% and 42.9% of respondents knew the correct dose, 77% and 46.8% knew the correct route and 37.3% and 77.8% knew the correct time of administration for prevention and treatment of PPH respectively. In the prevention of PPH, 42.9% of respondents administer misoprostol at the correct time, 46.8% at the correct dose and 66.7% through the correct route whereas, in the treatment of PPH, 62.7% of respondents administered misoprostol at the correct time, 43.7% at the correct dose and 54% through the correct route. Only 38% of respondents had received training on use of misoprostol for PPH. Factors influencing misoprostol use among the

participants were training, adequate knowledge, availability, and effectiveness of misoprostol. There was a significant relationship between midwives' professional qualifications and years of service and correct use of misoprostol.

Conclusion: The knowledge of misoprostol use was still low, and midwives still used misoprostol incorrectly in the management of PPH. It is recommended that relevant authorities should invest in training and retraining of midwives on use of misoprostol for the management of PPH.

KEYWORDS: Post Partum Haemorrhage, misoprostol, prevention, treatment, factors.

Introduction

Postpartum hemorrhage (PPH) is a leading global cause of maternal morbidity and mortality. Approximately 14 million women suffer PPH annually and at least 128,000 of these women bleed to death within four hours of delivery. Majority of these deaths occur in developing countries of the world where there are poor facilities and paucity of trained birth attendants¹. The causes of PPH can be broadly categorized as the 4 Ts- tone, tissue, trauma and thrombin. Of these causes, the most common by a wide margin is uterine atony which is the failure or the inability of the uterus to contract and retract following delivery². Several treatment options for PPH are available including the use of drugs, surgical intervention, and use of aortic compression devices. The drugs include uterotonic agents such as Oxytocin and Ergometrine, haemostatics such as tranexamic acid and misoprostol which is a prostaglandin E1 analogue^{3,4}. Uterine atony can be prevented through active management of third stage of labour (AMTSL) which includes prompt administration of a potent uterotonic drug. The World Health Organisation (WHO) recommends the use of intravenous oxytocin or ergometrine⁴. However, there are limitations to the routine use of oxytocin and ergometrine in low resource settings because they are only available in injection form and require refrigeration. They have short half-lives and can quickly lose

potency if not stored appropriately⁵. The use of misoprostol in the prevention and treatment of PPH has evolved due to its long shelf life and multiple administration routes, especially in settings which have minimal resources and limited skilled providers⁶. It is particularly suitable for use in the prevention and treatment of PPH in low resource settings where regular supply and maintenance of efficacy of oxytocin and ergometrine cannot be ensured⁷.

In general practice for management of PPH, the International Federation of Gynaecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM) jointly recommend misoprostol as a technology to control PPH⁸. The FIGO guidelines recommend the use of Misoprostol in the prevention of PPH using a single dose of 600mcg orally. It also recommends that Misoprostol should be administered immediately after delivery of the new-born after performing an abdominal palpation to confirm that there are no additional babies in-utero. For PPH treatment, one dose of misoprostol 800mcg sublingually or 1000mcg rectally is recommended (irrespective of the prophylactic measures)⁹.

The Federal Ministry of Health in Nigeria also recommends 600 mcg of oral/sublingual misoprostol for prevention and 800mcg-1000mcg

administered rectally for treatment of PPH. For prevention, it recommended that misoprostol 600mcg should be administered immediately after the baby's birth before delivery of the placenta. For treatment, 1000mcg tablets should be inserted rectally after blood loss exceeding 500mls. If bleeding persists, dose should not be repeated but patient should be referred to the nearest hospital¹⁰.

Based on the consensus that misoprostol is a first-line alternative where conventional uterotonic use is not practicable, midwives at the Primary Health facilities need to be aware of the numerous advantages and benefits of misoprostol and thus use it for the benefit of reducing PPH amongst women⁶. Promotion of Misoprostol use for the prevention and treatment of PPH at PHC level is necessary because PHCs are the basic health care units in the country and are located mainly in the rural communities that may not have access to secondary care and blood transfusion services. A large majority of deliveries take place in the rural communities. It is in these rural communities that most cases of maternal mortality occur⁷. Women needing delivery care first present at the Primary Health Care facilities and are only referred to secondary or tertiary care levels when they have complications. Primary PPH is often sudden and unheralded. It is expected that midwives will prevent and treat this complication promptly at the primary health facilities before referring them to secondary levels if necessary⁷. Increased awareness and knowledge of PPH and its effective management using Misoprostol will decrease maternal morbidity and mortality and lead to increased utilization of primary health facilities for maternal care. Post partum haemorrhage being a rapidly developing phenomenon may result in mortality before referral can be

accomplished⁷. Therefore, a practical approach to the prevention of maternal mortality associated with PPH is to ensure that efforts are put in place to prevent and treat PPH effectively when it occurs. Proper use of Misoprostol at the primary health facility level will reduce the need for referral and decrease associated morbidity and mortality.

This study therefore aimed to determine the knowledge and usage of misoprostol by midwives to prevent and treat PPH in primary healthcare facilities across Edo Central Senatorial District, Edo State. The study also seeks to determine the availability of misoprostol in these facilities and identify factors influencing the use of misoprostol by the midwives.

This study will help to identify lapses/gaps in the use of misoprostol among midwives in PHC facilities in Edo Central Senatorial District which can then be addressed for the purpose of improving management of PPH with overall reduction of maternal morbidity and mortality.

Methodology:

This was a descriptive cross-sectional study carried out in Primary Healthcare facilities in across the five local government areas that make up the Edo Central Senatorial District, Edo State between the 1st of July and 31st of August 2022.

The areas are essentially rural, and the people are predominantly farmers and traders. The study population included all the registered midwives employed and currently working in the Primary Health Care facilities within the Edo Central Senatorial District. At the time of this study, there were 128 midwives. All 128 midwives were recruited for the study but 2 declined participation.

Data was collected using a self-administered structured questionnaire. The questionnaire sought information on socio-demographic characteristics, level of knowledge, formal training on misoprostol use, availability of misoprostol, and pattern of misoprostol use (including dose, route and time of administration) by midwives in the prevention and treatment of PPH. A 5-point level Likert scale was used in the assessment of frequency of usage and factors influencing the use of misoprostol by the midwives. The instrument was tested for face and content validity, and reliability. Data collection for the study was completed in eight weeks. Ethical approval was obtained from the ethics and research committee of the Ministry of Health, Edo State.

Data obtained were entered into a spreadsheet, checked for errors and analyzed using Statistical Package for Social Sciences (SPSS) version 24. Data were analysed using frequencies and percentages and presented in tables. Pearson's correlation analysis was done to determine the strength and direction of the relationship between the socio-demographic characteristics (professional qualification and

years of experience) of the midwives and their correct use of misoprostol in prevention and management of PPH.

Results: All the 126 copies of questionnaires administered were retrieved. This gave a response rate of 100%.

Table 1 below shows that of the 126 respondents that participated in this study, 10 (7.9%) were within the ages of 25-29 years, 18 (14.3%) were between 30-34 years, 33 (26.2%) were between 35-39 years while 65 (51.6%) were 40 years old and above. With regards to the Professional Qualification, the table reveals that 34 (27%) were Registered Midwives (RM), 64 (50.8%) were Registered Nurse/midwives (RNM), 25 (19.9%) were Bachelor of Nursing Science (BNSc) holders while 3 (2.4%) were Masters of Science (MSc) Nursing holders. Also, the table reveals that 6 (4.8%) of the respondents had between 1-5 years working experience, 21 (16.7%) had 6-10 years working experience, 40 (31.7%) had 11-15 years working experience, 30 (23.8%) had 16-20 years working experience while 29 (23%) had worked for more than 20 years.

Table 1: Socio-demographic characteristics of the studied population

Socio-Demographic	Factors	Frequency	Percent (%)
Age	? 25 years	-	0
	25 – 29 years	10	7.9
	30 – 34 years	18	14.3
	35 – 39 years	33	26.2
	40 years and above	65	51.6
	Total	126	100.0
Qualification	RM	34	27.0
	RNM	64	50.8
	BNSc	25	19.8
	MSc	3	2.4
	Total	126	100.0
Years of experience	1 – 5 years	6	4.8
	6 – 10 years	21	16.7
	11 – 15 years	40	31.7
	16 – 20 years	30	23.8
	? 20 years	29	23
	Total	126	100.0

Based on data analysis, the major findings of this study are summarized as follows: Misoprostol was available in PHC facilities (n = 113, 89.7%) in Edo Central Senatorial District. In the prevention of PPH using misoprostol, 37.30% of midwives (n = 47) knew the correct time of administration, 40.48% of midwives (n = 51) knew the correct dose and 76.98% of midwives (n = 97) knew the correct route of administration. In the treatment of PPH using misoprostol, 77.78% of midwives (n = 98) knew the correct time of administration, 42.86% of midwives (n = 54) knew the correct dose and 46.83% of midwives (n = 59) knew the correct route of administration. In the prevention of PPH, 63.49% of midwives (n = 80) frequently used misoprostol while 80.95% of midwives (n = 102) frequently used misoprostol for the treatment of PPH. In the prevention of PPH, 42.9% of midwives (n = 54) administered misoprostol at the correct time, 46.80% of midwives (n = 59) administered the correct dose of misoprostol and 66.70% of midwives (n = 84) administered misoprostol through the correct route. In the treatment of PPH, 62.70% of midwives (n = 79) administered

misoprostol at the correct time, 43.70% of midwives (n = 55) administered the correct dose of misoprostol and 54.00% of midwives (n = 68) administered misoprostol through the correct route.

Factors that influenced misoprostol use for the prevention and treatment of PPH were training on misoprostol use (87.30%, n = 110), adequate knowledge on misoprostol use (71.40%, n = 90), availability of misoprostol (67.50%, n = 85), effectiveness of misoprostol (58.00%, n = 73) and concerns about misoprostol safety (51.60%, n = 65).

Only (38.10%) of midwives (n = 48) had been trained on the use of misoprostol for the prevention and treatment of PPH. Majority of midwives (76.98%, n = 97) indicated that they needed to be trained on the use of misoprostol in PPH prevention and treatment.

Table 2 shows there was a strong positive correlation between midwives' qualification and correct use of misoprostol in the prevention (Pearsons' correlation coefficient = 0.974) and treatment (Pearsons' correlation coefficient = 0.963) of PPH.

Table 2: Pearson's correlation table showing p-values and relationship between midwives' professional qualification and correct use of misoprostol in the prevention of PPH.

		Number of midwives per qualification	Number of midwives who use misoprostol correctly for PPT prevention
Number of midwives per qualification	Pearson Correlation	1	.974*
	Sig. (2-tailed)		.026
	N	4	4
Number of midwives who use misoprostol correctly for PPH prevention	Pearson Correlation	.974*	1
	Sig. (2-tailed)	.026	
	N	4	4

*. Correlation is significant at the 0.05 level (2-tailed).

Table 3 shows there was a strong positive correlation between midwives' years of experience and correct use of misoprostol in the prevention (Pearsons' correlation coefficient = 0.945) and treatment (Pearsons' correlation coefficient = 0.916) of PPH.

Table 3: Pearson's correlation table showing p-values and relationship between midwives' years of experience and correct use of misoprostol in the prevention of PPH.

		Frequency per years of experience	Number of midwives correctly using misoprostol for prevention of PPH
Frequency per years of experience	Pearson Correlation	1	.945*
	Sig. (2-tailed)		.015
	N	5	5
Number of midwives correctly using misoprostol for prevention of PPH	Pearson Correlation	.945*	1
	Sig. (2-tailed)	.015	
	N	5	5

*Correlation is significant at the 0.05 level (2 tailed).

There was a statistically significant relationship between midwives' professional qualification and correct use of misoprostol in the prevention and treatment of PPH (p value = 0.026, 0.037 respectively). There was also a statistically significant relationship between midwives' years of experience and correct use of misoprostol in the prevention and treatment of PPH (p value = 0.015, 0.029 respectively).

Discussion:

Results from this study indicated that misoprostol was available in 89.7% (n=113) of the primary health care facilities while 10.3% (n=13) indicated that it was not available. The availability of misoprostol in PHC facilities as observed in this study agrees with findings of a study carried out in Primary Health Care facilities in Lagos State, where 73.7% of the facilities which took part in the study had misoprostol¹¹. However, this was far higher than the low availability (17.1%) of misoprostol by respondents across Primary Health Care facilities from 12 states across the six geopolitical zones between 2013 and 2014¹². This discrepancy in levels of availability of misoprostol in PHC facilities establishes that there still exist levels of non-compliance to the 2011 inclusion of misoprostol in the essential drug list in Nigeria¹⁰. Ensuring that the drug is available at the LGA medical store with regular supply to the facilities will indicate that the LG authority supports the use of misoprostol, is compliant to FMOH inclusion of misoprostol as an essential drug and encourage midwives to use the drug. Making this drug available through regular supply by the LG pharmacy will also save midwives the time and stress of going to pharmacy and chemist shops to source for the drug. Lack of availability or non-provision of misoprostol by the

authority at Primary Health Care level will lead to inadequate use of misoprostol by the midwives. This will result in increased PPH incidence among women since the drug for its prevention is unavailable.

The midwives' knowledge of the correct time for misoprostol administration, dose required and adjunct administration of misoprostol with other uterotonics were low. On the other hand, they were knowledgeable on the route of administration, side effects and management of side effects. The midwives were also knowledgeable on the correct timing for misoprostol administration in PPH treatment. However, the knowledge of midwives on the dose required and route of administration of misoprostol in PPH treatment was below average. This was higher than in an earlier study where respondents when asked the route of administration and the dose of the drug for the prevention of PPH, only 8.2% could mention the correct dose and route of administration⁷. Only 10% of the respondents had a high level of knowledge of misoprostol for the prevention and treatment of PPH. The increase in the level of knowledge may be because some midwives have attended training.

Increased awareness and knowledge of PPH and its effective management using Misoprostol will decrease maternal morbidity and mortality and lead to increased utilization of PHCs for maternal care. This means that knowledge of misoprostol use by midwives for prevention and treatment of PPH still needs to be enhanced by training of midwives. Only 38% of the respondents in this study have been trained formally on misoprostol use for prevention and treatment of PPH. This is still quite low hence the need for more training as well and re-training of midwives to raise the number of formally trained midwives to a minimum of 75%. This knowledge impacts directly on the frequency and the pattern of

use of misoprostol by the midwives.

Findings from this study on the factors influencing the use of misoprostol among midwives in managing PPH showed that adequate knowledge on misoprostol use, training on misoprostol use, availability of misoprostol, and effectiveness of misoprostol were identified as the main factors influencing the use of misoprostol by midwives in the prevention and treatment of PPH. The result of this study is in agreement with the study which identified factors influencing the use of misoprostol to include lack of knowledge of providers and lack of comprehensive training and mentorship to midwives¹³. Training should therefore be on a continuous basis and those who attend such trainings should be encouraged to organize a step down for adequate dissemination. A study had earlier suggested the need for training and on-going education for providers which must include clear dosing information including routes and precautions associated with each type of use. Evidenced-based guidelines for misoprostol use for PPH prevention and treatment need to be put in place and supplemented by training and on-going education of providers¹⁴.

Findings from this study revealed that there is a strong positive correlation between midwives' professional qualification and correct use of misoprostol in the prevention and treatment of PPH. It showed that with higher professional qualification, there is a higher probability for correct use of misoprostol by midwives for the prevention and treatment of PPH. This is in agreement with the study that found out that professional qualification has significant impact on midwives' knowledge and skills in prevention and management of PPH¹⁵. The positive significant relationship between professional qualification and correct use of misoprostol could possibly be as a result

of more exposure to knowledge during learning activities. During academic programmes, hospital based practicals and attachments to tertiary and secondary health facilities organized as part of the curriculum also serve as opportunities for acquisition of more knowledge and skills by the midwife.

There was also a strong positive correlation between midwives' years of experience and correct use of misoprostol in the prevention and treatment of PPH. It showed that with higher years of service, there is a higher probability for correct use of misoprostol by midwives for the prevention and treatment of PPH. This is also in agreement with the study that observed the years of service has significant impact on midwives' knowledge and skills in prevention and management of PPH¹⁵. This is because over the years, more experience is acquired during practice. Usually, Primary Health Care Midwives are posted from one facility to another thus enhancing interaction and knowledge exchange amongst them. Occasional trainings organized by local government, state government and Non-Governmental Organizations also seem to favour the older midwives as attendance is sometimes based on seniority. Therefore, the more the years, a midwife has spent in service, the higher the likelihood of acquiring knowledge and skills in the use of misoprostol.

A limitation encountered in this study was the small number of midwives in the primary health care facilities spread across Edo Central Senatorial District. This necessitated the use of the all-inclusive sampling. This may be a potential source of bias.

Conclusion

The level of knowledge of misoprostol use in the prevention and treatment of PPH among midwives remains low, therefore

majority of the midwives do not correctly use misoprostol in the prevention and treatment of PPH. Major factors affecting misoprostol use by the midwives were adequate knowledge and training of the midwives. There was a significant relationship between professional qualification and years of service and the correct use of misoprostol in the prevention and treatment of PPH.

Recommendations:

Based on the findings, discussions and conclusions of this study, the following are our recommendations are:

- 1). There is need to invest in the training and retraining of midwives on evidence-based technologies including use of misoprostol for the prevention and treatment of PPH. This will improve maternal health and lead to a reduction of maternal morbidity and mortality.
- 2). There is need for adequate procurement and supply of misoprostol by the LG authorities to ensure its availability and use.
- 3). There is need for regular monitoring and supervision of all facilities to ensure that services rendered are correctly done.

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Closing the care gap in cancer care in Nigeria: time to move from commemoration to a coordinated action

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Background

Cancer, a major noncommunicable disease (NCD), is responsible for ill health, disability and death of a significant proportion of the population around the world. About 20 million new cases and 9.7 million deaths were estimated to occur in 2022 and, given the prevailing conditions, it is predicted that there will be more than 35 million new cases in 2050 - a 77% increase in less than three decades.¹ The extant measures and services to cater to the victims of the disease, unfortunately, are grossly inadequate and cannot cope with the rapidly rising burden of the disease.

Controlling the disease demands a holistic approach comprising four principal components: prevention, early detection, diagnosis and treatment, and palliative care.² The World Health Organization (WHO) in collaboration with other international and national organisations have developed several interventions aimed at stemming the rising tide of the disease alongside other NCDs.³ The Sustainable Development Goals (SDGs) initiative also sets a target of achieving a one-third reduction in premature mortality

from NCDs including cancer by 2030.⁴ Cancer control requires the contribution of all segments of the population - individuals, communities, corporate organisations and government at all levels.

One potent weapon for fighting cancer is awareness creation and public education about what needs to be done to address the different components of care for the disease. A global effort to create awareness about cancer is the observance of World Cancer Day (WCD) on the 4th of February annually. Since 2001 when the first WCD was commemorated,⁵ the day has assumed great significance with more countries and organisations joining the annual campaign to reduce the burden of the disease. The Union for International Cancer Control (UICC) has assumed the leadership of the global observance of the day, developing and rolling out a theme/slogan for each year thereby stimulating actions whose impact lasts the whole year, beyond the day itself. Recognising the yawning gap that exists worldwide in the care available and accessible by victims of the disease, "Close the care gap" was developed as a theme to run for three years (2022 - 2024) to ensure

adequate attention was given to address the care element of the disease.⁶

This article describes the focus for each year of the multi-year campaign, summarises the impact of the campaign, highlights Nigeria's involvement and ongoing efforts, and proposes further actions that need to be taken as the world and Nigeria in particular resolve to close the cancer care gap.

WCD 2022: Realising the problem

The first year of the three-year theme focused on increasing knowledge about the disease and addressing the equity gap. Generally, people in low-and middle-income countries (LMICs) and those on the lower side of the social determinants of health (SDoH) gradient in any country are at a disadvantage when it comes to access to healthcare delivery and more so to cancer care.⁷⁻⁹ All too often where people live (the country's human development index (HDI) category, rural or urban), their gender, race, ethnicity, level of education and income category determine the type and quality of healthcare they receive. This negates the principle of universal health coverage (UHC) and SDGs - reaching everyone and leaving no one behind. For instance, cervical cancer is a preventable and curable disease but women in LMICs are disproportionately affected with 85% of cases and 90% of deaths occurring in these countries.¹⁰ The campaign for the year therefore focused on unearthing these disparities among countries and bringing the information to the knowledge of all that need to act to close the gap.

Figure 1 gives a summary of the global reach of the *Close the care gap* campaign as culled from the UICC impact reports and shows a progressive increase in impact over the three years.¹¹⁻¹³

WCD 2023: Uniting our voices and taking action

Knowledge is power and it informs action. With the increased knowledge from the 2023 campaign and the mental walls of

inequities starting to crumble, WCD 2023 sought to harness and unite the different voices all over the world to take action, form stronger alliances and build collaborations at different levels to intensify efforts at controlling the disease. The year's campaign enjoyed increased attention with social media posts, press mentions and activities reaching more people all over the world.¹²

WCD 2024: Together, we challenge those in power

2024 is the last year of the theme "close the care gap" and is a clarion call to governments, policymakers and leaders to increase investment in addressing the inequities and ensure access of all people to cancer care in keeping with the goal of UHC. There were more media and physical activities globally with the year culminating in the launch by UICC of a *World Cancer Day Call to Action* - a set of actionable recommendations to governments for improving equity in health and cancer care. More than 4000 people from 167 countries signed the call which was formally transmitted to all Geneva-based missions of United Nations Member States.¹³

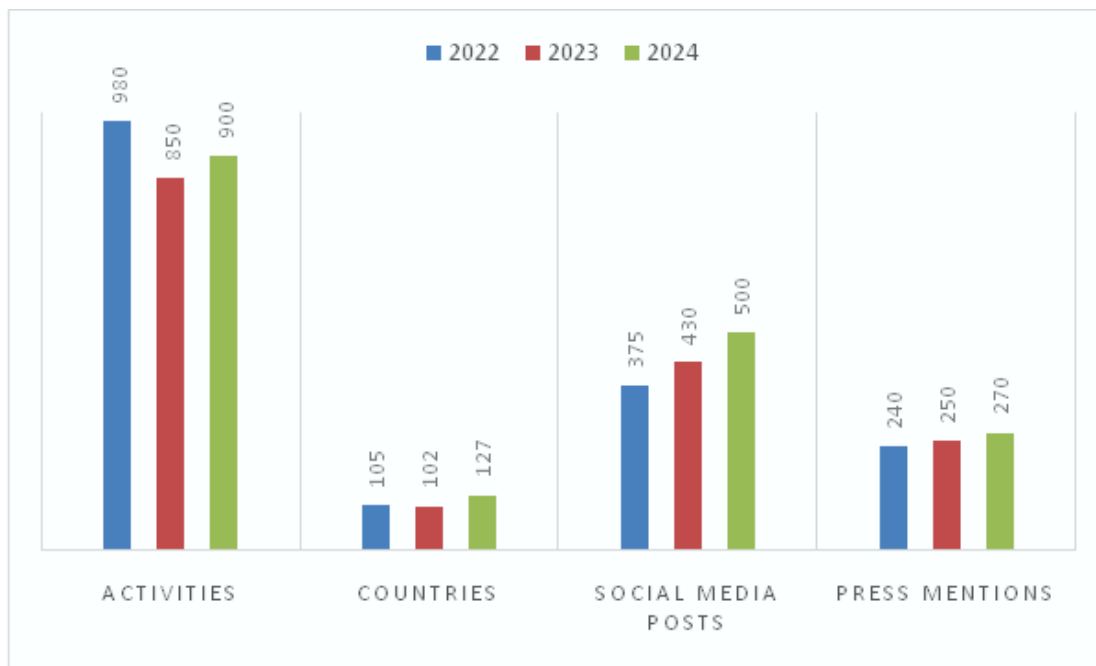


Figure 1: World Cancer Day 2022-2024 global impact in numbers

NB: Social media posts are in thousands (e.g., 375=375,000) while the press mentions are in hundreds (e.g., 240=24,000)

Nigeria's involvement in "Close the care gap"

Nigeria has the second-highest number of cancer cases and deaths in Africa (Egypt is first) and accounts for 127,763 (10.8%) of the 1,184,182 cases and 79,542 (10.4%) of the 763,278 deaths reported for the continent in 2022. 14 Nigeria featured prominently in the commemoration of WCD 2022 to 2024 as shown on UICC's map of activities,^{5,16} though it may be difficult to say with precision the number of activities or events that took place in each year of the multi-year campaign due to a lack of a dedicated national repository/database for such a global observance. There is evidence, however, of nationwide participation in the days by the government and organisations committed to the fight against cancer. Like in other countries, there were social media posts, radio and television news broadcasts and live coverage of events, and newspaper reports.¹⁷⁻²¹ The UICC in its global impact report featured *Pink Blue* for 2022, *11Medicaid* for 2023, 12 and *Pink Africa Foundation* for 2024 13 as major nongovernmental organisations that

participated in the commemoration.

Beyond the days, time for action

Cancer control, like any other disease control, is a marathon – a perennial activity that continues till the disease ceases to be of public health importance, is eliminated or eradicated. Commemorating WCD is not an intervention per se but is meant to stimulate or intensify efforts across established interventions in the cancer control continuum. These interventions are usually coordinated by a cancer control programme at the national and subnational levels. Nigeria has a National Cancer Control Programme that is not operating at full capacity yet and needs to be strengthened to lead and coordinate activities in the 36 states and the Federal Capital Territory (FCT), each of which is expected to have its cancer control programme. Recent activities show some progress but given our weak health system, there is a need for accelerated effort to reduce the burden of the disease and close the care gap in Nigeria.

In the area of cancer prevention, the introduction and inclusion of human papillomavirus (HPV) vaccination as part of the routine vaccination schedule is a significant step towards cervical cancer elimination, tackling the first of the three targets (90-70-90) set by the WHO.²² Getting every eligible girl child vaccinated wherever she lives is a daunting task but it has to be done in the spirit of the SDGs. Liver cancer is another vaccine-preventable disease and there is a need to redouble efforts to improve Hepatitis B virus (HBV) vaccination from the present poor coverage of 67.2% at birth and 56.6% at 23 months to protect the population against the disease.²³ One major reason for the disproportionately high mortality rate from cancer in LMICs compared to high-income countries is late diagnosis often due to late presentation or delay in arriving at a diagnosis because of poor diagnostic resources (human and material).²⁴ There are pockets of interventions promoting screening and early diagnosis for the three most common cancers (breast, cervical, and prostate) but we still do not have a nationwide programme for a high yield.

The Minister of State at the Federal Ministry of Health & Social Welfare in his remarks on WCD 2024 announced the plan of the Federal Government to construct six cancer treatment centres within 3 years – one in each of the six geo-political zones.²⁵ This is a welcome development and will boost the Nigerian Cancer Health Fund (CHF) already being implemented in the six geo-political zones. The Nigerian Cancer Health Fund is a partnership aimed at assisting indigent cancer patients and is targeted at the three most common cancers –breast, cervical and prostate. It is operational in six pilot hospitals: Ahmadu Bello University Teaching Hospital (ABUTH) - North West, National Hospital Abuja (NHA) - North Central, Federal Teaching Hospital Gombe (FTH) - North

East, University of Benin Teaching Hospital, Benin (UBTH) - South South, University of Nigeria Teaching Hospital, Enugu (UNTH) - South East and University College Hospital, Ibadan (UCH) - South West. Accessing the fund involves a process and successful patients can access up to two million naira (\$1,470) to assist with their treatment including drugs and radiotherapy.²⁶ States should take a cue from the Federal Government and seek collaboration that can improve access to cancer care in their respective states. Survivorship (helping cancer survivors live well after treatment) and palliative care (relieving symptoms and reducing the suffering caused by cancer) are not getting adequate attention yet but it is expected that the treatment centres were designed and will be equipped to function as comprehensive cancer centres that will render the full complement of cancer care from prevention to palliative care and offer support to cancer survivors.

Professionals specially trained in the different aspects of oncology care are needed at every stage of the cancer control continuum. Unfortunately, Nigeria suffers from a grossly inadequate workforce for health care, particularly cancer care and the number is dwindling progressively.²⁷ While cancer centres are being established, training of the requisite manpower that will manage the centres should be accorded utmost priority. One of the objectives of the recently established National Institute for Cancer Research and Treatment (NICRAT) is capacity development in cancer prevention and control.²⁸ With a strong political will and commitment of adequate resources to the institute to enable it to fulfil its objectives and implementation of good strategy for workforce retention, the manpower gap can be incrementally closed over the next few years.

Underpinning the aforementioned actions and the ultimate pursuit of optimal cancer care is the inclusion of comprehensive

cancer care in national health-benefit packages (HBPs). Universal Health Coverage (UHC) would be a mirage if the second leading cause of death globally is left out of HBPs. Unfortunately, this is the current reality as reported in the recent WHO global survey that shows that only 39% of the responding countries had cancer services included in their public-sector HBPs. This dwindled to 28% when palliative care was added.²⁹ Nigeria did not respond to the survey but the National Health Insurance Act (NHIA) places some cancer care services on partial exclusion.³⁰ This however falls short of the desired comprehensive care, and until the national and state-operated insurance schemes include cancer care in their benefit package and expand their coverage, closing the care gap will remain a Herculean task as only the rich may be able to afford care.

Conclusion

For three years, the world has come together in a campaign to close the hitherto wide gap in cancer care globally. It is reasonable to believe that these efforts have led to increased awareness of the unacceptable disparities in care between and within countries, the formation of new and strengthening of existing partnerships in cancer control and the reawakening of the conscience of leaders of communities, corporations and countries leading to a renewed commitment to fight cancer with increased investment. As we move towards 2030 - the magic year for the attainment of SDGs - we hope to begin to see evidence of the gains of the three-year campaign. For Nigeria, recent government actions and efforts by non-governmental organisations offer some promise. If the declarations and commitments are followed through, we hope to see a progressive closing of the care gap in the years to come, but this can only become a reality when we shift completely from commemoration to full action mode and establish an active national control programme with fully functioning state counterparts.

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Overcoming challenges in Breast-feeding Support: Insights from midwives in a General Hospital setting

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ABSTRACT

Background: As the primary carers in a general hospital, midwives play a crucial role in breastfeeding support. However, difficulties in providing effective support and confronting cultural beliefs can hinder breastfeeding practices. Understanding midwives' perspective on effective breastfeeding support is crucial for the development of targeted interventions and the improvement of breastfeeding support services.

Aim and Objective: The objective of this study was to analyze the various challenges faced by midwives in providing breastfeeding support within a typical hospital setting.

Method: In-depth interviews with midwives to gather valuable insights and experiences were employed. The data collected were analyzed using thematic analysis as a methodological approach to discern emerging themes and patterns with the help of ATLAS.ti software.

Results: The findings revealed two primary obstacles midwives encounter. First, insufficient personnel and time constraints which impeded their capacity to provide comprehensive support and education to the large number of women seeking assistance. Secondly, cultural beliefs about lactation posed additional obstacles. Misconceptions regarding the sufficiency of breast milk, concerns regarding breast appearance, and the importance of colostrum influenced mothers' ability to exclusively breastfeed. Cultural practices including the premature introduction of complementary foods and the discarding of colostrum impeded the promotion of exclusive

breastfeeding.

Conclusion: *The study showed that staffing and time constraints had a negative effect on provision of breastfeeding support by midwives while cultural norms prevented exclusive breastfeeding. Addressing these challenges by stakeholders' through increased healthcare funding and staffing of health facilities is necessary to ensure effective breastfeeding support, educating the community on the importance of colostrum and breast appearance to eliminate cultural myths, ultimately leading to a successful breastfeeding.*

KEYWORDS: Breastfeeding support, midwives, hospitals, challenges, cultural views, exclusive breastfeeding

INTRODUCTION

Breastfeeding plays a crucial role in facilitating the health and overall welfare of infants, offering a multitude of advantages in both the immediate and distant future. Midwives play a crucial role in delivering breastfeeding support within the general hospital environment, serving as primary carers for both mothers and newborns^{1, 2}. In spite of the acknowledged significance of breastfeeding, there exist several obstacles that can impede the delivery of adequate support, thereby potentially influencing the experiences and outcomes of breastfeeding for both mothers and infants^{3, 4}. Gaining insight into the viewpoints and firsthand encounters of midwives about the provision of breastfeeding support is of paramount importance to recognize and effectively tackle the obstacles associated with this practice⁵. Midwives possess distinct perspectives on the factors that enable or hinder the provision of breastfeeding support, which can provide valuable insights for developing strategies to enhance support systems in general hospital settings. This study intends to investigate the difficulties faced by midwives when assisting mothers with breastfeeding in a general hospital context. Through an exploration of the experiences, perceptions, and strategies utilised by midwives, the objective is to acquire a deeper understanding of the current deficiencies

and ascertain potential remedies for improving breastfeeding support services. In a meticulous gathering and examination of comprehensive qualitative data, the study captures the intricate and nuanced experiences and viewpoints of midwives. This will provide a deeper understanding of the complex array of challenges they face and the various approaches they adopt to surmount these difficulties.

METHODOLOGY

The research was carried out in General Hospital Ekpan (Fig. 1) Uvwie Local Government Area of Delta State, Nigeria. The study population was nurse-midwives from the antenatal, labour, and postnatal units/clinics of General Hospital Ekpan Uvwie in Delta State, Nigeria. The Chief Nursing Officers, and Nursing Officers with varying nursing experience levels were included. A phenomenological research design was employed to investigate the subjective experiences and nuanced interpretations of the provision of breastfeeding support. Comprehensive data was gathered by the research team through key informant interviews with nurse-midwives. To analyze the gathered data, a thematic analysis methodology was utilized, with the assistance of the software ATLAS.ti, to discern and categorize emerging themes and sub-themes.

RESULTS

Demography of the midwives used as key informants in this study, presented in a tabular form.

Midwife	Age	Marital Status	Religion	Qualifications	Role
Midwife 1	53	Widow	Christian	RN, RM, B.Sc. Nursing	Chief Nursing Officer (CNO), Labour Ward
Midwife 2	47	Married	Christian	RN, RM, B.Sc. Nursing	Chief Nursing Officer (CNO), Antenatal Unit
Midwife 3	30	Single	Christian	RN, RM	Nursing Officer (NO), Maternity Ward
Midwife 4	50	Married	Christian	RN, RM, B.Sc., M.Sc. Nursing	Chief Nursing Officer (CNO), Maternity Ward
Midwife 5	32	Single	Christian	RN, RM, B.Sc. Nursing	Nursing Officer (NO), Antenatal Unit
Midwife 6	35	Married	Christian	RN, RM, B.Sc. Nursing	Nursing Officer (NO), Labour Ward

50% of the midwives were married, while the other 50% comprised of singles and widowed, and highly educated. Christians suggested possible convergence in viewpoints shaped by these demographics. In all, the varied socioeconomic and demographic profiles would enable gathering rich, multi-faceted qualitative data to address the research questions from different standpoints.

These dedicated midwives bring their unique expertise to various units, ensuring quality care for expectant mothers and newborns.

All respondents reported that they were facing some challenges as they performed their job with breastfeeding women. About

90% of the midwives said "they didn't have time to eat while at work because of a shortage of personnel and so many clients". They feel that in their current number, they were unable to work effectively to help mothers, nurture them, and educate them about breastfeeding. The midwives stated that aside from system challenges, they blamed cultural and societal influences on mothers' behaviours. Some of the midwives were disappointed with the efforts they put in place, yet mothers disregarded their teachings and accept what society teaches them. Some of those myths are postulated that, breastfeeding a child as a young girl makes the breast sag while other traditional practices promote the act of giving newly born babies liquid such as water immediately after breastfeeding because the breast milk alone will not satisfy the

baby and also the act of expressing the first milk (colostrum) and discarding because it is not pure.

“We don't have enough staff to give breastfeeding support or education to these women. So, we are limited on the number of women are much So, you cannot expect one midwife to be talking to over 100 women and give these women the adequate support. You will not get good results. The number is much but we are not enough. So, it's a major challenge we face with educating and supporting these women. And the facilities to also do these things are not readily available. There's no time to to talk to them in detail. So, time is one major challenge we face with these women. And another thing is that their number is so much, so it's difficult to reach out to them like every one of them, because it's more like an individual thing to an extent. So, you cannot reach out to them individually because of their large number”.

Respondent 2 (antenatal unit)

“okay, cultural practices is a big challenge to the midwife. One, the culture believe that the breast milk is not enough for the child. Another challenge is that they feel that there is no way you will eat and you are not going to be taking water. So, for your food to digest, they want you to take water. When you are not taking water as a mother, they feel that you are a wicked person. So why you are telling your subject to breastfeed exclusively without water? They tend not to take it because of the belief they've gotten. And also, some people believe that when you breastfeed exclusively, your breast will sag as a mother. Which is not true, because whether you breastfeed or not, the breast will still sag. So that is another challenge. Another challenge is that they believe that when you are doing exclusive breastfeeding, you don't leave your child for a very long time. By the time you leave the child, maybe for 2 - 3 hours, by the time you come back, even for a day, they believe that you can no longer continue breastfeeding your baby. I think those are some of the cultural challenges that we face. Then there is another challenge we face too. The issue of the first breast milk that comes out at the onset of lactation. We call it colostrum. And they believe that, that colostrum is not good for the child. And they advise the mother to express it out

and throw it away. But little do they know that this colostrum they are pressing and throwing away helps the child's brain to develop development, so they believe that it's not good for the child. And once they throw that away they are missing a lot for the baby brain development” **Respondent 3 (labour ward).**

The challenges faced by midwives can be categorized as follows:

Time Constraints

- **Shortage of Personnel:** Midwives are overwhelmed due to a high number of clients and a lack of sufficient staff, leading to situations where they don't have time for breaks or meals.
- **Inadequate Time for Education:** The limited number of midwives makes it challenging to provide detailed breastfeeding support and education to each mother.

Cultural/Societal Influences

- **Misconceptions about Breastfeeding:** Cultural beliefs that breast milk alone is not sufficient for the baby and that water or other liquids are necessary.
- **Stigma around Breastfeeding Practices:** Societal pressure and myths, such as the belief that exclusive breastfeeding leads to sagging breasts, which is not necessarily true.

Myths

- **Colostrum Misunderstanding:** The false belief that colostrum, the first breast milk, is impure and should be discarded, not recognizing its crucial role in brain development.
- **Breastfeeding Absence Myth:** The misconception that a mother cannot resume breastfeeding if she leaves her child for a few hours.

These challenges highlight the need for increased staffing, better education to dispel myths, and cultural displacement to support effective breastfeeding practices.

DISCUSSION

The insights provided by the midwives elucidate the difficulties they encounter in delivering assistance for breastfeeding. Respondent 2 (labour ward) identifies the primary obstacle as the insufficiency of personnel to provide adequate support and education to the considerable amounts of women seeking assistance with breastfeeding. Given the constraints of limited resources and time, midwives encounter challenges in delivering personalized support and education to every individual mother. The presence of this constraint has the potential to impede the efficacy of interventions aimed at providing breastfeeding support, thereby influencing the overall outcomes. Respondent 3 (postnatal ward) highlights cultural practices as an additional noteworthy obstacle. The presence of cultural beliefs about breastfeeding can give rise to obstacles and misunderstandings that impact the inclination of mothers to engage in exclusive breastfeeding. Certain cultural beliefs propose that exclusive breastfeeding may not adequately meet the nutritional needs of infants, prompting mothers to introduce supplementary foods or water prematurely.

Moreover, the belief that exclusive breastfeeding leads to breast sagging is a fallacy that discourages mothers from adhering to exclusive breastfeeding protocols. There exist misconceptions surrounding the significance of colostrum, the initial viscous milk secreted by lactating mothers, which are also prevalent within specific cultural ideologies, resulting in the disposal of this vital substance that nourishes the brain by some mothers. The aforementioned cultural obstacles highlight the necessity of implementing focused educational interventions aimed at

rectifying misconceptions and fostering the dissemination of accurate information about breastfeeding. The midwives from postnatal wards/clinics expressed frustration when mothers disregarded their teachings due to societal influences and emphasized the need for community education to address myths and rumours. These research findings validate the study carried out by Vogel *et al.*³, which derived midwives' experiences of providing maternity care in low-resource settings. The research also highlighted challenges encountered by midwives because of limited staffing and client overcrowding, which affected their ability to provide the necessary support and education. Similarly, Hunter *et al.*⁵ identified and reported challenges bedeviling breastfeeding mothers, including physical discomfort, inadequate support, and negative societal attitudes.

Additionally, Sarfraz *et al.*⁶ validated the difficulties midwives face in delivering quality care to breastfeeding mothers in line with the limited resources at their disposal. They further highlighted the impact of overworking pressures and limited resources on the ability of midwives to provide effective lactation support and education to breastfeeding mothers. Similarly, Clark⁷, investigated cultural influences and breastfeeding practices, highlighting how cultural beliefs and misconceptions influence mothers' perspectives on breastfeeding. This is in line with the midwives' (postnatal ward) responses in this research about cultural challenges, including beliefs about breast milk sufficiency and the effects of exclusive breastfeeding on breast appearance. Furthermore, Kakute *et al.*,⁸ carried out research focused on the impact of cultural norms and best practices on breastfeeding. Zhang and Jin⁹ found that the statements

made by midwives (antenatal unit) regarding cultural obstacles and beliefs about breastfeeding exhibit a high level of consistency. Several research findings, among others, corroborate the notion that cultural factors significantly impact breastfeeding practices and pose difficulties for midwives in delivering efficient support and education

CONCLUSION

The study showed that staffing and time constraints had a negative effect on provision of breastfeeding support by midwives while cultural norms prevented exclusive breastfeeding. Addressing these challenges by stakeholders' through increased healthcare funding and staffing of health facilities is necessary to ensure effective breastfeeding support, educating the community on the importance of colostrum and breast appearance to eliminate cultural myths, ultimately leading to a successful breastfeeding. Hospital administrators and legislators must provide enough funding and staff (midwives) to provide high-quality breastfeeding support. A welcoming breastfeeding environment requires a continuous orientation program, proper guidance, and cultural awareness.

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DECLARATION OF INTEREST

The authors declare that they have no known conflicts of interest. The findings are based exclusively on the data collected, analyzed, and professional interpretation of the authors.

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