

Knowledge, Attitude and Practice of Exclusive Breastfeeding by Women of Reproductive Age in Nigeria.

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Abstract: *The objective of this study was to assess the knowledge, attitude and practice of exclusive breastfeeding (EBF) by women of reproductive age in Nigeria. The methodology involved the use of quantitative and qualitative instruments to elicit the required information from 8 communities comprising two semi-urban locations and 6 rural areas from 479 respondents. The result from the study indicated that the knowledge of the women was poor on EBF thereby leading to poor attitude and practice of exclusive breastfeeding. Thus, the paper concluded by recommending the promotion of EBF among women of reproductive age in Nigeria.*

1. Introduction

The call for policies that would cultivate an exclusive breastfeeding culture was at the Innocenti Declaration in 1990 by WHO/UNICEF [1, 2,]. In 2012, the World Health Assembly Resolution 65.6 endorsed a comprehensive implementation plan on maternal, infant and young child nutrition [3], which specified six global nutrition targets for 2025 with a target to increase the rate of exclusive breastfeeding in the first six months to at least 50% [4]. According to Black et al. [5] and WHO [6], only 38% of infants of 0 to 6 months old are exclusively breastfed globally. Recent analyses indicate that suboptimal breastfeeding practice, including non-exclusive breastfeeding, contribute to 11.6% of mortality in children under 5 of age. This was equivalent to about 804,000 child deaths in 2011[5]. Based on the WHO Global data on Infant and Young Child Feeding in Nigeria, 22.3% of children were exclusively breastfed for less than 4 months, while 17.2% were exclusively breastfed for less than 6 months, in the year 2003 [7]. The figure of

17.2% dropped slightly to 17% according to the 2013 Nigeria Demographic Health Survey (8). What is exclusive breastfeeding (EBF)? How important is EBF? Exclusive breastfeeding is the giving of breast milk only and no other liquids, except drops or syrups with vitamins, mineral supplements or medicines [9, 10]. From the perspective of WHO [11], exclusive breastfeeding is the practice of only giving an infant breast-milk for the first six months of life (no other food or water).

The importance and advantages of EBF has been well documented [12, 13, 14, 15-18]. Exclusive breastfeeding helps with the growth, health and survival of newborn [11] and acts as a form of natural preventive medicine to the newborn [13, 14] which in turn aid in decreasing early life diseases of infants [15]. A notable outcome of this trend is that, it could reduce infant mortality rate by 13% in low –income countries [19, 20, 21]. WHO [11] noted that increasing rates of exclusive breastfeeding can help drive progress against other global nutrition targets such as: stunting, anaemia in women of reproductive age, low birth weight, childhood overweight and wasting and is one of the most powerful tools policy-makers have at their disposal to improve the health of their people and their economies– underscoring the place of EBF in reducing infant mortality rate. Hence, WHO [11] advocated the provision of: hospital- and health facilities-based capacity to support exclusive breastfeeding, community-based strategies to support exclusive breastfeeding, including the implementation of communication campaigns tailored to the local context; limit the aggressive and inappropriate marketing of breast-milk substitutes by strengthening the monitoring, enforcement and legislation related to the international code of marketing of breast-milk

substitutes and subsequent relevant World Health Assembly resolutions; empower women to exclusively breastfeed by enacting six-months mandatory paid maternity leave as well as policies that encourage women to breastfeed in the workplace and in public and to invest in training and capacity-building in exclusive breastfeeding protection, promotion and support.

Despite the benefits of EBF as documented from various studies and bodies, the rate of exclusive breast feeding in Nigeria has remained the lowest in Nigeria (17%) with Nigeria lagging behind fellow African Countries such as Ghana (53.4%), Republic of Benin (43.1%) and Cameroon (23.5%) [22]. Several factors are responsible for the low rate of exclusive breast feeding in Nigeria. Davies-Adetugbo [22] and WHO [10] identified traditional beliefs, practices and rites as responsible for the low rate of EBF. According to Davies-Adetugbo [23] in Yoruba and Bini communities, EBF is considered dangerous to the health of the infant who is thought to require water to quench thirst or stop hiccoughs - a phenomenon WHO [10] described as: mixed feeding - believing an infant needs additional liquids or solids before 6 months because breast milk alone is not adequate. Other reasons adduced for low EBF in the literature are: delivery of women outside health facility [24] and knowledge/attitude of mothers on EBF [25, 26]. Other factors according to WHO [11] are: hospital and health-care practices and policies that are not supportive of breastfeeding; lack of adequate skilled support (in health facilities and in the community); aggressive promotion of infant formula, milk powder and other breast-milk substitutes; inadequate maternity and paternity leave legislation and other workplace policies that support a woman's ability to breastfeed when she returns to work and lack of knowledge on the dangers of not exclusively breastfeeding and of proper breastfeeding techniques among women, their partners, families, health-care providers and policy-makers.

Exclusive breastfeeding is necessary for successful curbing of infant malnutrition and the reduction of child mortality rate across Nigeria [27]. Two aspects of EBF practice are crucial – initiation and duration which are affected by factors such as level of education, nature of job, place of delivery, culture, family pressure [28,29-33]. The rate of breastfeeding initiation has been on the increase compared to the duration in Nigeria [31]. A detailed study of the knowledge, attitude and practice of EBF is therefore imperative for the understanding of the practice of EBF among women of reproductive age in Nigeria as a way of promoting greater infant health and reducing infant mortality.

2. Methods:

2.1 Study Area and Research Design

The study was conducted in Ughievwen Clan in Ughelli South Local Government Area of Delta State, Nigeria. Ughievwen is made up of four sub-clans such as: Orhoghwe, Owahwa, Ukpedi and Ophurie which are referred to as Emeneghievwen (Four sons of Ughievwen). These sub-clans are made up of 32 communities with the Headquarters in Otughievwen where the traditional ruler –the Okobaro-of-Ughievwen resides and presides over the affairs of the clan. More recently, there have been attempts at secession of the sub-clans to become autonomous Units. Ughievwen covers a land area of about 275 square kilometres and is bounded on the south by the Forcados River, on the east by Olomu clan, on the west by Udu clan and on the north by Agbarho and Ughelli clans. The people are Ughievwen dialect of Urhobo; hence they are also called Ughievwen. The study was conducted in Otughievwen, Otokutu (Semi -Urban Communities) Otor-Owahwa, Egbe-Ide, Oginibo, Ughevughe, Igwrekan and Edjophe.

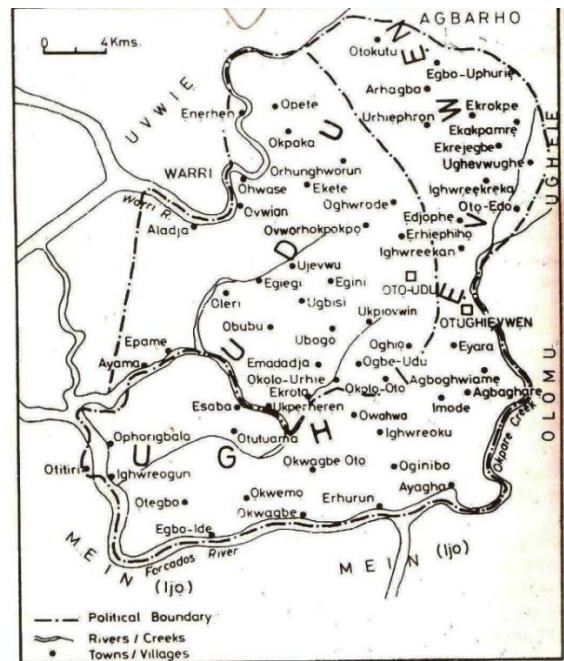


Figure 1: A map showing communities in Ughievwen and other surrounding towns

This research employed complementary mixed method involving the use of structured questionnaire, in-depth interview, and focus group discussion to study women of child bearing age who were currently

breastfeeding at the time of the study or who had stopped breastfeeding not later than a year before. These women were from Ughievwen speaking dialect of Urhobo ethnic nation of Delta State (inclusion criteria) while mothers who never breastfed or were temporary visitors (who are not from Ughievwen) to the studied communities were excluded from the study (exclusion criteria). Hence, some respondents were visitors in the locations where they took part in the study but once they meet the inclusion criteria are allowed to take part in the study. The qualitative method was used to complement the quantitative method. In the quantitative phase of this study, the structured questionnaire was the dominant method; while face-to-face in-depth interviews and focus group discussion were adopted in the qualitative phase to enhance, as well as clarify, the quantitative results generated in the survey [34]. This decision was influenced by the position that mixed methods provide researchers the opportunity to understand social reality from different research paradigms [35]. The study took place between November 2014 and February 2015 in the sampled communities.

2.2 Research Instruments/ Sampling Procedure

Three research instruments consisting of questionnaires, in-depth interview and focus group discussion guide were used in this research. The study questions were in two parts. The first comprised questions that elicit respondents' demographic information i.e., age, level of education, place of child birth, occupation, marital status, sex of the baby. The second section comprised questions on Exclusive breastfeeding knowledge, attitude, and practice of EBF such as those who have heard about EBF, how soon a mother should breastfeed after birth, time of breastfeeding initiation, duration of exclusive breastfeeding, age child stop breastfeeding, how early are complementary feeding introduced to a child, factors encouraging or discouraging mothers from the practice of exclusive breastfeeding. Questions were also asked on attitude of mother to breastfeeding such as: whether pacifiers should be use for babies; breastfeeding and working mothers, and mothers' attitude to colostrums. The sampled communities were purposively selected by convenient sampling technique by dividing Ughievwen Kingdom into four Units comprising of the sub-clans of Oroghwe from where Igwrekan and Edjophe communities were selected; Owahwa from where Otor-Owahwa and Egbo-Ide were selected; Ukpédi from where Otughievwen and Oginibo communities were selected and Uphurie from

where Ughevughe and Otokutu communities were selected – comprising two communities from each sub-clan in Ughievwen. The eight communities were further grouped into semi-urban and rural communities with Otughievwen and Otokutu falling within the first group while the other six communities of Otor-Owahwa, Egbe-Ide, Edjophe, Igwrekan, Ughevughe and Oginibo fell within the later group to make for an effective comparative study of exclusive breastfeeding in semi-urban locations and rural setting.

The quantitative aspect of the study involved the administration of 500 questionnaires in the 8 studied communities comprising 200 questionnaires administered in the two semi-urban communities and 300 in the rural setting. Each of the semi-urban communities was administered 100 questionnaires with 50 each administered in each rural communities by 4 research assistants who were trained for the purpose for a week. Out of these questionnaires 9 and 12 were invalidated in the semi-urban communities and rural locations respectively, leaving the valid questionnaires at 479 that were used for the analyses in this study. The research assistants were ladies and graduates of social sciences who worked with the first author who served as the coordinator of the project. The third author acted as field coordinator while the second author worked with other authors to design the research instruments and monitor the quality of the research throughout the duration of the project. The administration of the questionnaires in the selected communities entailed the used of systematic sampling techniques. In every selected community, the administration of questionnaires involved two research assistants going to the centre of the community and one facing the north and the other south and the administration of the questionnaire beginning from the first house in the first street as movement commence from the centre of the community involved by the right of any of the research assistant, to seek for any woman who meet the inclusive criteria. After this, a count of the every third house is included in the street until that direction is completed and the research assistant take to another street till the questionnaires were all exhausted.

In the qualitative phase, additional insights into some of the responses elicited from the survey were sought through face-to-face structured interviews and focus group discussion sessions. Generally, qualitative methods provide in-depth information such as participants' perceptions and experiences of EBF. Despite the emphasis on depth, qualitative studies are often limited in scope [36]. In all, two focus group discussions were heard comprising one each in semi-urban communities and one in rural setting. Each of these two focus group discussions were conducted by two female research assistants with one facilitating

while the other record and take notes as well. The FGDs were conducted in Urhobo Language. Apart from the FGDs, 8 in-depth interviews were held to explore some aspects of the answers from quantitative data.

2.3 Data Analysis

Quantitative data were analysed using SPSS Version 21 using descriptive statistics such as percentage and tables to present demographic attributes of the respondents. Descriptive statistics was also used to describe knowledge, attitude and practice. The authors devised scoring and grading system for knowledge which was used with each correct answer attracting a mark. A score >50% was graded as adequate knowledge of EBF. As for qualitative data, the tape-recorded information were transcribed, coded and analyzed using N6 software for qualitative data analysis according to themes

2.4 Ethical considerations

Ethical approval was given by Centre for Population and Environmental Development (CPED), Benin City, ethical committee and a letter of introduction and approval from the Executive Director to participating stakeholders. Verbal informed consent was obtained from study subjects in their own language (Ughievwen-Urhobo) explaining the purpose of the study and the right to withdraw from it. The respondents were also assured of confidentiality.

3. Results

3.1 Profile of Respondents

Table 1 indicated that the mothers in the survey were mostly in the age bracket of 26 to 30 years with 25.8%. This was closely followed by 31 to 35 years with 22.1%. Also significant is the proportion in the age bracket of 21 to 25 years with 18.2%. Educationally, most of the respondents attended secondary and primary schools with 35.7% and 30.5% respectively. The data in Table 1 also showed that most of the women give birth in the home of traditional birth attendants (53.3%) and public hospitals (35.2%) with most of them being farmers (40.9%) and

traders/business owners (36.5%) as revealed by their responses to their type of occupations. A vast proportion of the women (89.3%) was married and had

more baby girls (53%) than boys. Their children were mainly between the age of 3 -6 months (36.7%).

Table 1: Selected characteristics of the survey respondents (N=479)

Variables	N	%
Age		
15 – 20 years	45	9.5
21 – 25 Years	87	18.2
26 – 30 Years	124	25.8
31 – 35 Year	106	22.1
36 – 40 Years	68	14.2
41 – 45 Years	49	10.2
Education		
No Education	83	17.3
Primary	146	30.5
Secondary	171	35.7
Post Secondary	79	16.5
Place of Birth		
Traditional Birth	255	53.3
Attendant Home	169	35.2
Public Hospital	55	11.5
Private Hospital		
Occupation		
House Wife (Full Time)	10	2.1
Civil Servant	73	15.3
Farming	196	40.9
Trading/Business	175	36.5
Employed in Private Sector	25	5.2
Marital Status		
Married	428	89.3
Devoiced	12	2.5
Separated	16	3.3
Widow	5	1.1
Single	18	3.8
Sex of Baby		
Male	225	47.0
Female	254	53.0
Age of Child(months)		
Less than 3	137	28.6
3-6	176	36.7
7-10	131	27.3
11-14	35	7.4

3.2 Profile of Interviewee and Focus Group Discussants

The focus group discussants and interviewee have an average age of 32.2 Years and 34.7 Years respectively. All the participants at the focus group discussions [16] and interviews [8] were married, except two interviewees who were separated from their marriages. The focus group discussants have average of 3.4 children while it was 3.6 for the interviewee. At least 75% of them were aware of exclusive

breastfeeding for focus group discussants and Over 80% for interviewees.

3.3 Knowledge of Exclusive Breastfeeding

In Table 2, the knowledge of exclusive breastfeeding was analysed. The analyses revealed that a high proportion (63%) of the respondents have heard about exclusive breastfeeding. However, the responses to other issues bothering on their knowledge of exclusive breastfeeding showed a low understanding of exclusive breastfeeding. For example, only 46.6% of the respondents are knowledgeable that mother should breastfeed their babies 30 minutes immediately after delivery. Similarly, only 23.7% of the respondents understand that exclusive breastfeeding is a form of child spacing. Lastly, the lack of knowledge of EBF in the study location was further demonstrated by the agreement by 67.1% of respondents that babies should be given food supplements before they are six months and the assertion by 66.8% of the respondents that the baby can take water before he/she is seven months. Insights from the focus group discussions and interviews equally support some of the data above as presented below:

“What are we saying? No! my child cannot go on with only breast milk that will not be ok with him. He will be hungry if other things are not given to him”--- excerpt from FGD

“We can give baby breast milk at any time after birth but we equally have to feed them with water. My children normally cry a lot when you give them only breast milk. I equally give infant formula like glucose at the beginning and change to Cerelac or pap depending on their growth. All these talk of exclusive breastfeeding is foreign” “Wis kine baby friendly them dey talk for here. For a long time our mama dem don de giv water to their child even the first day wen dem born am. Watin come be say make we no giv water to our children. Dem wan say make our children come de die?”

(What kind of baby friendly are they talking about? For a long time, our mothers have been giving water to their children even the first day they are given birth to. What is this one that they are telling us not to give water to our children? Are they saying that our children should die)

Table 2: Knowledge of Exclusive Breastfeeding (N=479)

Variables	N	%
Heard about Exclusive Breastfeeding		
Yes	302	63.0
No	177	37.0
Mothers should breastfeed 30 minutes immediately after delivery		
Yes	223	46.6
No	256	53.4
Exclusive breastfeeding is a form of child spacing		
Yes	114	23.7
No	365	76.3
Give baby food supplements before they are six month		
Yes	321	67.1
No	158	32.9
Exclusively breastfed child cannot take water until 7 month or more		
Yes	159	33.2
No	320	66.8

3.4 Attitude to Exclusive Breastfeeding

Apart from the knowledge of respondents about exclusive breastfeeding, the study was interested in the attitude of the respondents to breastfeeding as a way of looking at the impact of their understanding on their behaviour. Table 3 present findings on this. In the analyses of the likert scale questions on the agreement or disapproval of certain statements, strongly agreed and agreed were combined to be agreed while disagreed and strongly disagreed were equally combined as disagreed. The reflection on the level of understanding of the respondents’ understanding of exclusive breastfeeding was explicitly evident in their attitude to EBF. From Table 3, 60.8% of the respondents agreed that pacifiers should be use for babies. Also, 62% of respondents were of the opinion that Supplementary food should be given to babies very early in their birth to make them not to be hungry while 68.1% of the respondents equally agreed that working mothers should not exclusively breastfeed their babies. Regarding whether nursing babies should be fed on demand, while 52.4% of the respondents agreed it should be so, as high as 47.7% however disagreed with this. On whether babies who are exclusively breastfed fare better health wise than those not exclusively breastfed, 57.6% agreed that EBF babies are better while a good proportion of 42.4% thought otherwise. The last issue bothering on attitude of respondents to EBF was on what nursing mothers think about Colostrum by asking if the coloured milk

is too dirty to be given to babies immediately after their birth. While 51.2% of the studied respondents disagreed with this, 48.8% agreed with the fact that colostrums was too dirty to be given to the newborn. A host of statements from the interviews and FGDs equally demonstrated the kind of attitude the studied population have toward exclusive breastfeeding as presented from a few extracts below:

“How can a working mother exclusively breastfed a baby while her job is waiting. This was possible in the past – for our mothers who were full time housewives. Certainly, this thing is not for the women of today”

-----extract from an FGD

“Feed baby on demand? No! That is not just possible. I need to also attend to my other baby –my business. While we try to breastfeed as much as time allows us, baby food will equally help while we attend to our careers”

-----excerpt from an interview

“What is the different between the exclusively breastfed baby and the one not exclusively breastfed? I do not see an advantage of exclusive breastfeeding over those who are not doing it. Both children are healthy after all”

-----a portion of FGD

Table 3: Attitude to exclusive breastfeeding

Variables	Strongly Agreed		Agreed		Disagreed		Strongly Disagreed		Total	
	N	%	N	%	N	%	N	%	N	%
Pacifiers should be use for nursing babies	131	27.3	160	33.5	92	19.2	96	20.0	479	100
Supplementary food should be given to babies very early in their birth to make them not to be hungry	154	32.1	143	29.9	86	18.0	96	20.0	479	100
Working mothers should not exclusively breastfeed their babies	143	29.8	183	38.3	74	15.4	79	16.5	479	100
Nursing babies should be fed on demand	119	24.9	132	27.5	136	28.3	92	19.3	479	100
The health of babies who are breastfed exclusively is better than those who are not	137	28.6	139	29.0	106	22.1	97	20.3	479	100
Colostrum is too dirty to be given to babies immediately after their birth.	130	27.1	104	21.7	133	27.8	112	23.4	479	100

3.5 Practice of exclusive breastfeeding

The practice of exclusive breastfeeding was explored in this study apart from the knowledge and attitude of the people of the studied area in Table 4. On the commencement of the feeding of a baby after birth, a good number of the mothers (39.2%) were of the opinion that it was done immediately after birth while 34.2% commence feeding their babies within the first two hours while others do also feed after the above intervals. However, revelations from the FGDs showed that a lot of factors are responsible for this and this varies from mother to mother as the statements below indicate:

“Ordinarily it is good to feed one child as soon as birth. However, there are mothers who cannot be stable after birth to do this. Also, there are instances where for health reasons, the mother cannot feed the

child until well some time after birth. Occasions equally arise when the child may be sick immediately after birth and breastfeeding will be impossible”

“It is an individual thing. Some of us are lazy while some of us are strong women. Birth to most women is

a big task that required extensive resting including not feeding the child until such women can cope to avoid issues after birth”

The interrogation of respondents on the number of times a baby receive breastfeeding showed that most women do not actually take this into account as 57.4% did not count this. Only 20.9% of the women in the study agreed that they exclusively breastfeed their children (This is the figure of the women who breastfed their children for 6 months or more). However, the figure of exclusive breastfeeding within

the first 3 months or less stood at 45% while EBF for 4 months recorded 34.1%. However, those who comply with the true understanding of EBF were 20.9% from 19.7% women who breastfed exclusively for 6 months and 1.2% of women who extended exclusive breastfeeding for over 6 months. The data in Table 4 further attest to the fact that most of the respondents in this study do not practice exclusive breastfeeding as some of them rarely (15%),

sometimes (20%) often (24.2%) or most times (20.2%) give baby supplement other than milk during the first 6 months, thus indicating that, just a little above 20% of the respondents practice exclusive breastfeeding. Though most of the respondents could not remember the length of the breastfeeding of their children, those who could remember take 30 minutes to 1 hour (28.4%) to feed their babies.

Table 4: Practice of exclusive breastfeeding (N=479)

<i>Variables</i>	<i>N</i>	<i>%</i>
When did you start feeding your baby after birth		
Immediately after birth	188	39.2
Within the first two hour after birth	164	34.2
After two hour after birth	82	17.1
On the second day after birth	16	3.3
Cannot remember	29	6.2
How often do you breastfeed your baby daily		
Did not count	58	57.4
6 -8 times	158	13.0
More than 8 times	179	12.1
As much as my baby desire	84	17.5
Is your baby exclusively breastfed		
Yes	94	19.7
No	385	80.3
How long do you feed your baby exclusively with breast milk		
Less than 3 months	216	45.0
4 months	163	34.1
6 Months	94	19.7
More than 6 Months	6	1.2
Give baby supplement other than milk during the first 6 months		
Rarely	72	15.0
Sometimes	96	20.0
Often	116	24.2
Most of the time	101	20.2
No supplement	94	20.6
Length of each breastfeeding		
Less than 30 minutes	64	13.4
30 minutes to 1 hour	136	28.4
More than 1 hour	62	12.9
Not Recorded	217	45.3

3.6 Factors discouraging exclusive breastfeeding

Table 4 indicated that only just above 20% respondents practice exclusive breastfeeding. Hence, it is imperative to find out what is responsible for the low incidence of EBF. Table 5 revealed a host of factors as ranked by the respondents in the study which accounted for low exclusive breastfeeding. To be able to do this, the respondents who were not practicing exclusive breastfeeding as at the time of the survey were asked to tick as many reasons they

think is responsible for their action. The one mostly ticked was selected as the greatest reason for not practicing exclusive breastfeeding in descending order. From Table 5, reasons given for not practicing exclusive breastfeeding in descending order of ranking were: the breast milk was not enough for baby (46.5%); I wanted to go back to work (44.2%); my

baby was not gaining enough weight (44.1%); fear of infant depending solely on breast milk after growth (37.5%); due to pain in my breast (30.3%); I was not feeding well (30.2%); due to another pregnancy

(30%); I was feeling dizzy during breastfeeding (30%); baby refuse breast milk (25.9%); I was tired of breastfeeding the baby (22.2%) I was pressurised into weaning the baby (22%); I was not making enough breast milk (19.7%); Lack of husband support (17.7%); It will reduce the firmness of my breast (15.3%) I was ashamed of breastfeeding my baby (12.6%). Therefore, the reasons which prevent one

woman from exclusive breastfeeding vary according to different women though some may have common reasons as evident from the group of women holding onto the same reasons for not practicing exclusive breastfeeding. The insights from the qualitative data combined different reasons as outlined from the quantitative analyses.

Table 5: Ranking of factors discouraging exclusive breastfeeding (N=379)*

Variables	N	%
The breast milk was not enough for baby	176	46.5
I wanted to go back to work	168	44.2
My baby was not gaining enough weight	167	44.1
Fear of infant depending solely on breast milk after grow	142	37.5
Due to pain in my breast	115	30.3
I was not feeding well	114	30.2
Due to another pregnancy	113	30.0
I was feeling dizzy during breastfeeding	113	30.0
Baby refuse breast milk	98	25.9
I was tired of breastfeeding the baby	84	22.2
I was pressurized into weaning the baby	83	22.0
I was not making enough breast milk	75	19.7
Lack of husband support	67	17.7
It will reduce the firmness of my breast	58	15.3
I was ashamed of breastfeeding my baby	48	12.6

* Respondents could pick more than one factor

3.7 Exclusive breastfeeding and some demographic characteristics of respondents

The focus of this analysis is to examine if there exist a relationship between some demographic variables such as education, place of birth and occupation of the respondents and their practice of exclusive breastfeeding. From Table 6, it obvious that EBF was highest with respondents with no education (32.3%), followed by primary and secondary schools

leavers with 26% and 25.4% respectively and lastly by those having post secondary education. Regarding place of birth, more respondents who give birth in the home of traditional birth attendants (47.9%) and public hospital practice exclusive breastfeeding compared to 17% who give birth in private hospital. In term of the occupation of respondents and exclusive breastfeeding, farmers (34%) and traders/business owners (31.9%) are more involved in EBF than person employed in civil service and private sectors and house wives.

Table 6: Relationship between some variables and exclusive breastfeeding (N=479)

Variables	Yes		No	
	N	%	N	%
Education				
No Education	30	32.3	53	13.8
Primary	24	26.0	122	31.7
Secondary	25	25.4	146	37.9
Post Secondary	15	16.3	64	16.6
Place of Birth				
Traditional Birth Attendant Home	45	47.9	210	54.5
Public Hospital	33	35.1	136	35.3
Private Hospital	16	17.0	39	10.2
Occupation				

Continuation of Table 6: Relationship between some variables and exclusive breastfeeding (N=479)

House Wife (Full Time)	8	8.5	2	0.5
Civil Servant	12	12.8	61	15.8
Farming	32	34.0	164	42.6
Trading/Business	30	31.9	145	37.7
Employed in Private Sector	12	12.8	13	3.4

Exclusive Breastfeeding and Residents of respondents

From Table 7, it was obvious that more of rural residents practice exclusive breastfeeding (59.6%) compared to semi-urban residents (40.4%).

Table 7: Exclusive Breastfeeding and Residence of Respondents

	Yes	%	No	%
Semi Urban Communities	38	40.4	196	50.9
Rural Communities	56	59.6	189	49.1

4. Discussion

The place of exclusive breastfeeding as a necessary ingredient for successful curbing of infant malnutrition and the reduction of child mortality rate across Nigeria has been documented [11,19, 20, 21, 27]. However, the rate of breastfeeding initiation has been on the increase compared to the duration in Nigeria [31]. This study dealt with knowledge, attitude and practice of EBF among women of reproductive age in Nigeria.

Evidence from the study indicate that a high proportion of the mothers (63%) have heard about exclusive breastfeeding but had poor knowledge of exclusive breastfeeding. For instance, their knowledge of breastfeeding within 30 minutes of birth was relatively low since only 46.6% of the women had this knowledge among the sampled population. Also, the knowledge of the exclusive breastfeeding as a child spacing alternative was poor as only 23.7% of the respondents understand that exclusive breastfeeding is a form of child spacing. The result from the study also revealed that most of the women (67.1%) believed that baby can take water before he/she is seven months. Tegegn and Gelaw [37] and Guttmacher Institute [38] indicated that persons with knowledge of health services and indeed health issues were three times more likely to ever use such services than persons with no such knowledge.

From this study and data analysed, it is clear that the knowledge of the women on exclusive

breastfeeding is relatively poor and hence their ability to practice exclusive breastfeeding could be hampered by the limited knowledge as Tegegn and Gelaw [37] and the Guttmacher Institute [38] observed separately. Hence, to a major extent, poor knowledge of exclusive breastfeeding connotes poor practice. It has

been documented that a part of exclusive breastfeeding should be given breast milk within 30 minutes of birth [16] for the healthy growth of the child. In this study the awareness was low hence the babies of these groups of women might be starved or given other supplements which might not be healthy for their children. It was not surprising that most of the discussion from qualitative data support most of these quantitative position and lack of knowledge, questioning the rationale behind not given water to babies before they are six months.

The nexus between knowledge and attitude was evident in the study result. From the results, most of the women (60.8%) believed that pacifiers should be use for babies; 62% of them advocated that Supplementary food should be given to babies very early in their birth to make them not to be hungry while 68.1% of the respondents equally agreed that working mothers should not exclusively breastfeed their babies. Though 52.4% of the women were of the opinion that nursing babies should be fed on demand, as high as 47.7% however disagreed to this. The women do not also see the health of exclusively breastfed babies to be better than those not so breastfeed as 42.4% of them did not agreed that there is a difference. Lastly on attitude of the women in the study, 48.8% see colostrums as dirty to be given to babies immediately after their birth. The qualitative data also supported most of the position from quantitative data. From the above, it is indicative that the fact that the women of the study have limited knowledge their attitude to some exclusive breastfeeding is bad. The use of pacifier most time is to prevent women from breastfeeding their babies even when those babies are hungry. Pacifiers enable the child to keep quiet while sucking on a rubberlike object that takes the place of breast. While the children suck on the pacifier for breast, the hunger remained unchecked leading to malnutrition in such children. It is also clear from this study that most

women do not desire to breastfeed their babies while working as this is perceived as obstacle to their jobs and careers. In Nigeria, though the benefits of exclusive breastfeeding and breastfeeding general are known, attitude such as these inhibits the practice of EBF [30]. For example in this study, as high as 48.8% of the women believed that colostrums is too dirty to be given to a newly born baby - thus denying the newly born child of an essential form of nutrient and early vaccination which colostrums provide. This finding is in consonance with Davies-Adetugbo's study on awareness and relevance of colostrum among nursing mothers in a rural Yoruba community in Nigeria. In that study colostrum was perceived as milk that had stayed in the breast during the 9 months of pregnancy and thus become stale [7]. The other dimension to the perception of colostrums as bad is that most mothers delay initiation of breastfeeding for the child in search of "pure milk" since colostrums is perceived as dirty and not fit for baby consumption. During this time, the child starves for the period of not giving colostrum, the child is also denied the benefits of the immunological constituents of colostrum and subsequently delays the proper establishment of lactation later[39] While awaiting the establishment of the "clean milk", the mothers gave prelacteals in form of boiled water, honey and animal milk [40, 41, 42, 43].

This study indicates that exclusive breastfeeding practice by women in the studied area was only 20.9%. Tough this figure is slightly higher than the national figure of 17% reported by the 2013 Nigeria Demographic Health Survey [8], it was lower than exclusive breastfeeding outcome by Oche, Umar and Ahmed [43] but slightly higher than the one reported by Agunbiade and Ogunleye [7]. Though 39.2% of women commence feeding of a baby after birth, a good number of the mothers (39.2%) were of the opinion that it was done immediately after birth while 34.2% commence feeding their babies within the first two hours, others do feed their children after the above interval. The delay observed by some of the women may be due to different reasons. Oche, Umar and Ahmed [43] attributed it to some women perceiving their breast milk as dirty due to its colour and for fear not given what is "not healthy or contaminated" to the new baby. According to Oche, Umar and Ahmed [43] while waiting for the "clean milk" the child may be given water and other infant formula to take in the place of breast milk.

To account for the low rate of EBF recorded in this study, the women were asked to rank reasons of this. Most ranks reason were: the breast milk was not enough for baby (46.5%); I wanted to go back to work (44.2%); my baby was not gaining enough

weight (44.1%); fear of infant depending solely on breast milk after growth (37.5%); due to pain in my breast (30.3%); I was not feeding well (30.2%); due to another pregnancy (30%); I was feeling dizzy during breastfeeding (30%); baby refuse breast milk (25.9%); I was tired of breastfeeding the baby (22.2%) I was pressurised into weaning the baby (22%); I was not making enough breast milk (19.7%); Lack of husband support (17.7%); It will reduce the firmness of my (15.3%) I was ashamed of breastfeeding my baby (12.6%). Therefore, the reasons which prevent one woman from exclusive breastfeeding vary according to different women

those some may have common reasons as evident from the group of women holding onto the same reasons for not practicing exclusive breastfeeding. The insights from the qualitative data combined different reasons as outlined from the quantitative analyses. Some of these reasons were equally given by other studies such as Agunbiade and Ogunleye [7], Otoo, Lartey and Pérez-Escamilla [33] Oweis, Tayem and Froelicher [44]

The examination of relationship between some demographic variables such as education, place of birth and occupation of the respondents and their practice of exclusive breastfeeding showed that from Table 6, it obvious that EBF was highest with respondents with no education (32.3%), followed by primary and secondary schools leaves with 26% and 25.4% respectively and lastly by those having post secondary education. The incident of high EBF among non educated women may be due to their involvement in personal farming and trading other than paid private jobs and civil services, thus finding time to breastfeed their babies according to their conscience. For the same reason likely, it is the less educated that patronize traditional birth attendance hence a high proportion of them (47.9%) were involved in exclusive breastfeeding than those who visit public hospital and private hospital. Regarding occupations and EBF, it was curious that it was housewives that recorded the lowest incident of 8.5% with farmers and traders/business owners 34% and 31.9% than person employed in civil service and private sectors and house wives. The low incidents of EBF recorded by house wives may not be unconnected to the small figure used in the analysis. This runs contrary to the findings from Oche and Umar [41] of 79% of house wives who were engaged in EBF. More women (59.6%) in rural communities practice EBF compared to 40.4% in Semi-urban areas.

5. Conclusion

The promotion of exclusive breastfeeding in Nigeria is being hampered by inadequate knowledge by women of reproductive age who are the centre of EBF. This lack of knowledge further give rise to attitudes and practices which do not promote exclusive breastfeeding, there is need to build the capacity of women of reproductive age on EBF by giving incentive to practitioners. If we require healthy children who will develop into healthy adults then, EBF policies must be enacted. However, it is

imperative to also look into factors which distract women full participation in exclusive breastfeeding as dealing with such issues will reinforce new commitments from women of reproductive age both in rural and urban communities.

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