
Factors Affecting Exclusive Breastfeeding Practices among Working Class Women Attending Antenatal Clinic in Egbedore Local Government Area, Osun State, Nigeria

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Article

Factors Affecting Exclusive Breastfeeding Practices among Working Class Women Attending Antenatal Clinic in Egbedore Local Government Area, Osun State, Nigeria

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Abstract: Background: Exclusive breastfeeding (EBF) for the first 6 months of life improves the growth, health and survival status of newborns. Breastfeeding has been accepted as the most vital intervention for reducing infant mortality and ensuring optimal growth and development of children. **Objectives:** The general objective was to identify the factors affecting exclusive breastfeeding among working class women in selected wards in Egbedore Local Government in Osun state, Nigeria. **Methodology:** This was descriptive cross-sectional study. Leslie Kish formula was used for sample size calculation and multistage sampling was used in selecting 316 working class women for the study. A structured, self-administered questionnaire was used for data collection. Data was analyzed using SPSS version 21.0 and level of significance was set at 5%. **Results:** 58% of the respondents were between the ages of 25-30. 72% demonstrated good understanding of exclusive breastfeeding based on the 6 months WHO recommendation for exclusive breast feeding, 25.9% had a fair knowledge and awareness of exclusive breastfeeding. 63.3 % of the working class mother has a good practice of exclusive breast feeding, 19.6% of the women moderately practices exclusive breastfeeding while 17.1% poorly practices exclusive breastfeeding. Less than 3-months maternity leave for mothers, lack of crèche closer to place of work and lack of breastfeeding break were identified as barriers to exclusive breastfeeding practices among the working class women. The findings demonstrated a significant relationship between knowledge and practices of exclusively breastfeeding among working class women (P-value .009). **Conclusion:** This study demonstrated that working class women had good knowledge of exclusive breastfeeding and this influenced their breastfeeding practices. A good knowledge was associated with favorable attitudes to the practice of exclusive breast feeding. To derive long-term benefits from early childhood nutrition, interventions should focus on health education and community-based sensitization programs on the needs for mothers to engage in exclusive breast feeding for global development.

Keywords: exclusive breastfeeding; working class; women; knowledge

Introduction

Breastfeeding has been accepted as the most vital intervention for reducing infant mortality and ensuring optimal growth and development of children (Gupta & Arora, 2007). Breastfeeding is the ideal method suited for the physiological and psychological needs of an infant (Subbiah, 2003).

It is estimated that sub-optimal breastfeeding, especially non-exclusive breastfeeding in the first 6 months of life, results in 1.4 million deaths and of the disease burden in children younger than 5 years of age (WHO, 2009). Over the last two decades, there has been a growing attention in the endorsement of exclusive breastfeeding as the recommended feeding practice for newborns, Exclusive breastfeeding (EBF) for the first 6 months of life improves the growth, health and survival

status of newborns (WHO, 2003) and is one of the most natural and best forms of preventive medicine (WHO, 2001). EBF plays a pivotal role in determining the optimal health and development of infants and is associated with a decreased risk for many early life diseases and conditions, including otitis media, respiratory tract infection, diarrhea and early childhood obesity (Ip et al., 2007).

It has been estimated that EBF reduces infant mortality rates by up to 13% in low-income countries (Jones et al., 2003). A large cohort study undertaken in rural Ghana concluded that 22% of neonatal deaths could be prevented if all infants were put to breast within the first hour of birth (Edmund et al., 2006). Reviews of studies from developing countries show that infants who are not breastfed are 6 to 10 times more likely to die in the first months of life than infants who are breastfed (WHO, 2000; Bahl et al. 2005). Some researchers have proposed that lack of suitable facilities outside of the home, inconvenience, conflicts at work, family pressure and ignorance adversely affect the willingness of women to practice EBF (Ogbonna et al., 2000; Forbes et al., 2003). The need to return to work has also been implicated as a factor interfering with EBF (Mahgoub et al., 2002).

The Nigerian government established the Baby-Friendly Hospital Initiative (BFHI) in Benin, Enugu, Maiduguri, Lagos, Jos and Port Harcourt with the aim of providing mothers and their infants a supportive environment for breastfeeding and to promote appropriate breastfeeding practices, thus helping to reduce infant morbidity and mortality rates. Despite these efforts, child and infant mortality continue to be major health issues affecting Nigeria. The infant mortality rate for the most recent five-year period (1999-2003) is about 100 deaths per 1,000 live births. EBF rates in Nigeria continue to fall well below the WHO/UNICEF recommendation of 90% EBF in children less than 6 months (WHO, 2009). A more detailed understanding of the attitude of working mothers to exclusive breastfeeding EBF in Nigeria is needed to develop effective interventions to improve the rates of EBF and thus reduce infant mortality. As such, breastfeeding should be fostered and encouraged by health care professionals and public health campaigns in order to normalize it within our culture.

Numerous studies (Agbo H. A 2013, Agunbiade O.M 2012, Ekanem I.A 2012) have revealed that one of the barriers to exclusive breastfeeding is work status). With enlarged urbanization and industrialization, more and more women have joined the work force (Osibogun et al., 2018). Study has shown that the prevalence of exclusive breastfeeding has been stagnant about a decade ago at 17% (National Demographic Health Survey 2008). It rose to 25% in 2017 according to the Federal Government of Nigeria by Prof Isaac Adewole Federal Ministry of health Abuja (2017). Benefits of exclusive breastfeeding to mother includes: It is a form of contraceptive. Exclusive breastfeeding mothers are less prone to cancer of the breast and ovaries, it is economical. It helps the new mother to lose weight after delivery, it creates bond between mother and child.

Benefits of exclusive breastfeeding to the child includes: It minimizes the dangers of infections and diseases. It decreases infant mortality, it helps promote a healthy gut, it reduces the risk of child obesity, it improves the cognitive function of the child, it helps to make vaccine more effective and also boost immunity.

Methodology

Study Area

Egbedore Local Government Area in Osun state, Nigeria. It's headquarter is located in Awo town 74600N 402400E, it has an area of 270 km² and a population of 74,435 at the 2006 census, it has 26 Primary Health Care out of which 13 Primary Health Care were selected

Study Population

The population for this study consisted of working class women at age 25-45 who were in full-time or part time employment and working in Egbedore local government in Osun state, Nigeria.

Study Design

This was a descriptive cross-sectional study

Sampling Technique

Multistage sampling was used:

Stage 1: Egbedore Local Government has a total of 26 wards, 10 wards were selected using simple random sampling.

Stage 2: from the selected wards, 8 primary health care centres were selected using simple Random sampling, the selected primary health care is the basic PHC at Egbedore local government where our target population (working class women) can be met.

Stage 3: the primary health care centers. Women who met the inclusion criteria were randomly selected.

Method of Data Collection

A structured, self-administered questionnaire adapted from several templates used in previous studies was used in this study, the data collection was carried out over a period of 2 weeks, and questionnaires were collected a few hours after distribution.

Data Analysis

Data analysis was carried out using the Statistical Package for Social Sciences (SPSS), version 17.0. Chi-square was used to determine the association between variables of interest. Results will be presented as frequency tables and charts as appropriate, descriptive and inferential statistics done and level of significance set at 0.05

Ethical Considerations

Ethical approval was obtained from the Research ethics committee of Adeleke University, Ede, Osun State. Informed consent was obtained from the respondents before commencement of the study. Confidentiality was ensured and no incentives were given to any respondents.

Table 1. SOCIO - DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS. (n=316).

VARIABLES	FREQUENCY	PERCENTAGES
1.Age of mothers		
25-30	182	57.6
31-35	94	29.7
36-40	40	12.7
Total	316	100
2.Age of child in months		
3-9	171	54.1
10-16	136	43.0
17-24	9	2.8
Total	316	100
3.Religion of the respondent		
Christianity	174	55.1
Islam	141	44.6
Traditional	1	0.3
Total	316	100
4.Ethnicity of the respondents		
Yoruba	251	79.4
Igbo	47	14.9

Hausa	17	5.4
Others	1	0.3
Total	316	100
5.Marital status of the respondent		
Single	4	1.3
Married	295	93.4
Divorced	17	5.4
Total	316	100
6.Number of children		
1	52	16.5
2	110	34.8
3	105	33.2
4	44	13.9
Others	5	1.6
Total	316	100
7.Educational status		
Primary	0	0
Secondary	16	5.1
Tertiary	300	94.9
Total	316	100
8.Where do you work		
School	122	38.6
Hospital	35	11.1
Bank	47	14.7
Hotel	23	7.3
Bakery	8	2.5
PHC	16	5.1
Radio station	9	2.8
Government office	43	13.6
Company	13	4.1
Total	316	100
9.Spouse level of education		
Primary	8	2.5
Secondary	24	7.6
Tertiary	284	89.9
Total	316	100
10.Employment status		
Full time	277	87.7
Part time	39	12.3
Total	316	100
11.Method of delivery		

Assisted vaginal	203	64.2
Caesarean section	113	35.8
Total	316	100

Table 2. FACTORS/ BARRIERS AFFECTING EXCLUSIVE BREASTFEEDING. (n=316).

VARIABLES	FREQUENCY	PERCENTAGE
1. How long is your maternity leave?		
One month	38	12.0
Two months	66	20.9
Three months	125	39.6
Four months	58	18.4
Five months	21	6.6
Six months	8	2.5
Total	316	100
2. Do you have crèche near your place of work?		
Yes	176	55.7
No	140	44.3
Total	316	100
3. If yes, do you have breastfeeding break at work?		
Yes	184	58.2
No	132	41.8
Total	316	100
4. Do your husband have family support you to exclusively breastfeed?		
Yes	255	80.7
No	61	19.3
Total	316	100
5. Do you have any health condition that could hinder you from exclusive breastfeeding?		
Yes	64	20.3
No	252	79.7
Total	316	100
6. Are you schooling with your work?		
Yes	65	20.6

No	251	79.4
Total	316	100

Table 3. PRACTICE OF EXCLUSIVE BREASTFEEDING. (n=316).

VARIABLES	FREQUENCY	PERCENTAGE (%)
1. When did you initiate breastfeeding?		
After delivery	238	75.3
After some days	57	18.0
After some weeks	20	6.3
After some months	1	0.3
Total	316	100
2. Do you lactate very well?		
Yes	232	73.4
No	84	26.6
Total	316	100
3. Do you extract breast milk for your baby?		
Yes	179	56.6
No	137	43.4
Total	316	100
4. Do you give only breast milk to your child for the first six months?		
Yes	209	66.1
No	107	33.9
Total	316	100
5. If no, for how long do you practice exclusive breastfeeding?		
No reply	203	64.2
One month	12	3.8
Two months	18	5.7
Three months	38	12.0
Four months	35	11.1
Five months	10	3.2
Total	316	100
6. At what month did you introduce complimentary feeding?		
Within the first month	16	5.1

Second month	17	5.4
Third month	33	10.4
Fourth month	29	12.3
Fifth month	10	3.2
Sixth month	201	63.6
Total	316	100
7. Did you breastfeed your baby colostrum?		
Yes	241	76.3
No	75	23.7
Total	316	100
8. How often do you breastfeed in a day?		
Whenever the baby wants it	104	32.9
4-6 times a day	125	39.6
6 times and above	87	27.5
Total	316	100

Table 4. THE ASSOCIATION BETWEEN SOCIO-DEMOGRAPHY CHARACTERISTICS AND PRACTICE OF THE RESPONDENT TOWARDS EXCLUSIVE BREASTFEEDING. (n=316).

		Practice of Exclusive Breastfeeding			X ²	P value	
		Poorly practiced	Moderately practiced	Good practice			Total
Age	25-30	32(10.1%)	38(12.0%)	112(35.4%)	182(57.6%)	3.032a	.553
	31-35	14(4.4%)	20(6.3%)	60(19.0%)	94(29.7%)		
	36-40	8(2.5%)	4(1.3%)	28(8.9%)	40(12.7%)		
Religion	Christianity	39(12.3%)	27(8.5%)	108(34.2%)	174(55.1%)	15.533a	.004
	Islam	14(4.4%)	35(11.1%)	92(29.1%)	141(44.6%)		
	Traditional	1(0.3%)	0(0.0%)	0(0.0%)	1(0.3%)		
Ethnicity	Yoruba	37(11.7%)	51(16.1%)	163(51.6%)	251(79.4%)	8.320a	.216
	Igbo	12(3.8%)	6(1.9%)	29(9.2%)	47(14.9%)		
	Hausa	5(1.6%)	5(1.6%)	7(2.2%)	17(5.4%)		
	Others	0(0.0%)	0(0.0%)	1(0.3%)	1(0.3%)		
Marital status	Single	1(0.3%)	0(0.0%)	3(0.9%)	4(1.3%)	1.521a	.823
	Married	51(16.1%)	59(18.7%)	185(58.5%)	295(93.4%)		
	Divorced	2(0.6%)	3(0.9%)	12(3.8%)	17(5.4%)		
Number of children	1	7(2.2%)	14(4.4%)	31(9.8%)	52(16.5%)	6.408a	.602
	2	21(6.6%)	20(6.3%)	69(21.8%)	110(34.8%)		
	3	15(4.7%)	21(6.6%)	69(21.8%)	105(33.2%)		

	4	11(3.5%)	6(1.9%)	27(8.5%)	44(13.9%)		
	Others	0(0.0%)	1(0.3%)	4(1.3%)	5(1.6%)		
Educational status	Primary	0(0.0%)	1(0.3%)	1(0.3%)	2(0.6%)		
	Secondary	4(1.3%)	2(0.6%)	10(3.2%)	16(5.1)	2.362a	.670
	Tertiary	50(15.8%)	59(18.7%)	189(59.8%)	298(94.3%)		
Place of work	School	19(6.0%)	21(6.6%)	82(25.9%)	122(38.6%)		
	Hospital	5(1.6%)	9(2.8%)	21(6.6%)	35(11.1%)		
	Bank	6(1.9%)	9(2.8%)	32(10.1%)	47(14.9%)		
	Hotel	7(2.2%)	3(0.9%)	13(4.1%)	23(7.3%)		
	Bakery	1(0.3%)	0(0.0%)	7(2.2%)	8(2.5%)	16.110a	.445
	PHC	5(1.6%)	2(0.6%)	9(2.8%)	16(5.1%)		
	Radio station	1(0.3%)	4(1.3%)	4(1.3%)	9(2.8%)		
	Government	7(2.2%)	12(3.8%)	24(7.6%)	43(13.6%)		
	Office	3(0.9%)	2(0.6%)	8(2.5%)	13(4.1%)		
	Company						
Employment status	Full time	49(15.5%)	54(17.1%)	174(55.1%)	(87.7%)		
	Part time	5(1.6%)	8(2.5%)	26(8.2%)	39(12.3%)	.572a	.751
Total		54(17.1%)	62(19.6%)	200(63.3%)	316(12.3%)		

Discussion

Socio - Demographic Characteristics of the Respondents

According to Table 1, participants aged between 25-30 years were 182 (57.6%) followed by Mothers with 171 (54.1%) had the age of their children from 3-9 months, 174 (55.1%) were Christian, 251 (79.4%) were Yoruba, 295 (93.4%) were married, Mothers with 110 (34.8%) has 2 children, Most of our participants has tertiary education with 300 (94.9%), participants work place were school with 122 (38.6%), spouse level of education were Tertiary 284 (89.9%), 277 (87.7%) were on full time jobs. However, most of them had assisted vaginal for their method of delivery with 203(64.2%).

Factors affecting exclusive breastfeeding practices

Barriers to breast-feeding include less than 3-months maternity for mothers, lack of crèche near their place of work and lack of breastfeeding break. Less impactful barriers on non-barriers were spousal and family support for breastfeeding, health conditions and schooling with their work. These are in contrast to finding from Osibogun et al. (2018) who found that regionally, barriers to exclusive breastfeeding have included baby appetite (29%), maternal health challenges (27%), over-dependence on breast milk (26%), breast pains (25%), pressure from mother-in-law (25%)- and work/business resumption (24%) (Agunbiade & Ogunleye, 2012). These findings are however in tandem with Ishola et al. (2019) assertion that lack of crèche near the workplace and lack of electricity to store expressed milk was found to negatively influence the practice of exclusive breastfeeding (EBF). This finding is in tandem with Balogun et al. (2017) who found that urban mother practiced exclusive breastfeeding rural areas. The urban women cited work resumption as reason for non-practice of EBF.

Exclusive Breastfeeding Practices

More than two-third of the women-initiated breastfeeding immediately after safe delivery, and introduced complementary feeding at 6 months of age. The finding is similar to Omoge Adeyemi O. et al. (2021) and Ukegbu et al. (2011) who found that the exclusive breastfeeding (EBF) was 68% and 62.7% at initiation stage. The mothers' pattern of feeding ranged from on-demand 4-6 times or 6 times and above per day. Majority of the mothers lactate very well, breastfed their babies' colostrum-extracted breast milk for their babies and breast fed WHO recommended 6 months for exclusive breastfeeding. This finding in tandem with Balogun et al (2017) who found that urban mother have better knowledge of importance of colostrum feeding on the infant and were well aware of when to initiate exclusive breastfeeding (EBF) compared to women in rural areas. In the same trend, these findings are in agreement with Ukegbu et al. (2011) who demonstrated that breastfeeding education and knowledge was associated with the frequency of breastfeeding behavior and the decision to initiate breastfeeding immediately after delivery.

Association between socio-demographic and Practice of Exclusive breastfeeding

Further results revealed that only religious affiliation was significantly associated with practice of breastfeeding behavior, Maternal age, ethnicity, marital status, number of children, educational status, place of work and employment status were not significantly associated with practice of exclusive behavior. This finding is in contrast with earlier studies demonstrating that socio-demographic factors, for example; maternal age, maternal conjugal status, educational attainment, race, financial status, number of children, size, and support from social networks, all influenced mothers' choices to breastfeed exclusively (Goksen et al., 2002; Li et al., 2002). This contrasts with studies that indicated greater maternal age was associated with a woman's decision to breastfeed exclusively (Goksen et al., 2002; Li et al., 2002; Lawoyin et al., 2001; Omoge Adeyemi O. et al., 2021). This suggests that the different elements of each individual's Health Belief Model (HBM), such as religious affiliation moderate the mother's decision to engage in exclusive breastfeeding, despite knowledge of its benefits and positive attitudes to its outcomes.

Conclusion

This study demonstrated that working class mothers' knowledge was high and this influenced breastfeeding practices. A good knowledge was associated with favorable attitudes to the Practice of exclusive breast feeding. Despite the awareness being created by WHO and other organizations on the benefits of EBF, statistics are still indicative of poor attitude and low Practice among women. Results further demonstrated that working class mothers' knowledge and religious affiliation influenced exclusive breastfeeding practices. The practice of exclusive breastfeeding moderated by the support from religious institutions. Barriers to breastfeeding include less than 3-months maternity leave for mothers, lack of crèche near their place of work and lack of breastfeeding break. These findings have implications for infant health, nutritional status and mothers' health. Working class women need to understand the various factors which influence their breastfeeding choices and the various supports available to promote women's decision to breastfeed exclusively. Counseling and proper education on desirable breastfeeding practices could be adopted to achieve a change in attitudes, perceptions, knowledge and practice of exclusive breastfeeding. The authors strongly believe of the need for continuous education and reiteration of the benefits of EBF by midwives and other health workers at every point of contact with mothers so as to improve on their exclusive breastfeeding practice. Establishment of breastfeeding support groups should be encouraged. Working class women should be allowed to work for half a working day for the period of 1 year after delivery to enable the mother care adequately for the infant.

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