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Full Length Research Paper

The practice of exclusive breastfeeding by lactating women in Owerri metropolis, Imo State, Nigeria

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The practice of exclusive breastfeeding by lactating women in Owerri metropolis Imo State Nigeria was studied. Structured and validated questionnaires were used to obtain information on the socio-economic characteristics, correct knowledge and practice of exclusive breastfeeding as well as the constraints to the practice. The results of the survey show that about 91% of the lactating women have correct knowledge of exclusive breastfeeding. Also, the survey revealed that not all that have the knowledge are practicing it (66.41%) in the area. However some constraints were identified to be responsible which include, lack of time, lack of knowledge, lack of support from the husband and family members and some do not believe that only breastmilk is enough to sustain their baby of less than 6months as well as many other excuses. Most importantly, there are some of them about 18% that are not ready to practice it on their subsequent child birth due to their believe. This therefore necessitates a more intensified effort in the teaching and implementation of Baby Friendly Initiative (BFI) guidelines for successful breastfeeding in all health institutions and clinics.

Keywords: Exclusive breastfeeding, practice, lactating women, Owerri metropolis.

INTRODUCTION

Early initiation of breastfeeding, by placing the baby immediately post-partum skin-to-skin, allows the first feeding to be led by the baby with maternal support. This often results in a better initial latch, and is empowering in that the mother gains confidence in both herself and her baby (WHO and UNICEF, 2009). Studies have confirmed that this early contact is associated with better thermal regulation, and increased durations of exclusive breastfeeding and breastfeeding in general, and that health workers can readily acquire this knowledge and practices. All other neonatal interventions, such as eye treatments, weighing, vitamin K, etc., can generally wait until after this essential first interaction (WHO and UNICEF, 2009).

Studies show a newborn, left undisturbed with skin-to-skin contact with the mother, will take an average of minutes to begin suckling. So the recommendation now is to initiate breastfeeding within the first hour rather than within the first 30 minutes of birth. This initial contact is also associated with breastfeeding success, improved thermal regulation, improved blood glucose levels, reduced infant crying and summary scores of maternal affectionate love/touch. Other studies have shown that, despite these findings, many practitioners are unaware of the importance of attention to this issue (UNICEF, 2005).

Exclusive Breastfeeding

Optimal infant and young child feeding includes six months' exclusive breastfeeding, starting at delivery, and continued breastfeeding with appropriate complementary foods and feeding for two years and beyond, as well as related maternal nutrition and care. There are benefits in delaying another pregnancy until

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the child is no longer breastfeeding and is able to eat independently, and the mother has recovered her nutrient stores (WHO and UNICEF, 2009).

During this period, one of the major policy changes based on evidence was the shift to a recommendation of six months' exclusive breastfeeding for optimal outcomes. While the Innocenti Declaration referred to six months of exclusive breastfeeding in the preamble, the text of the Declaration itself referred to four to six months. A 2001 expert panel reviewed all the findings for WHO and concluded that there was no evidence of any benefit in giving other foods besides breastmilk prior to 6 months. This shift from a WHO recommendation of four to six months of exclusive breastfeeding is expected to have considerable influence on efforts to sustain exclusive breastfeeding, as it increases by 50 per cent the age at which complementary feeding is considered appropriate (UNICEF, 2005).

The last 20 years have witnessed much success in increasing exclusive breastfeeding. In 1990, only about 34 per cent of mothers of children 0–6 months of age surveyed were seen to be exclusively breastfeeding. Extrapolating from those countries for which trend data are available, UNICEF analyses showed an increase to 39 per cent. The latest data from all countries in *The State of the World's Children 2009* indicate a level of 38 per cent and 17 per cent in Nigeria. While overall increase in exclusive breastfeeding was about 5–6 per cent, some countries doubled, tripled and even quadrupled exclusive breastfeeding rates, especially in the most threatened urban areas, and levels of continued breastfeeding at about 2 years of age increased by about 5 per cent (UNICEF, 2008).

New evidence has become available about exclusive breastfeeding in this 15-year interval. Some of the research advances in recent years have been in the immunological components of breastmilk and in long-term health benefits. Many studies have con-firmed that exclusive breastfeeding saves lives in the neonatal and post-neonatal periods of infancy and beyond (UNICEF, 2005).

There is increasing scientific recognition of the importance of breastfeeding to survival growth and development of all children, with evidence mounting that exclusive breastfeeding may be even more important for LBW infants. Although not as well studied as mother's own milk, research is demonstrating that pasteurized donor breastmilk can provide many of the components and benefits of human milk while reducing the risk of transmission of infectious agents. While heat treatment by pasteurization (62.5°C. for 30 minutes) may have an affect on immunologic factors, it also inactivates or destroys pathogens in the milk. The nutritional components are altered somewhat, resulting in general in slightly slower growth in infants when compared to those infants fed non-pasteurised raw human milk (UNICEF, 2005).

Exclusive breastfeeding is associated with (WHO and UNICEF, 2009)

- **Increased survival:** Studies in developing and industrialized countries confirm the life saving benefits of breastfeeding, particularly in preventing diarrhoea, pneumonia and sudden infant death syndrome (SIDS) deaths.
- **Decreased morbidity:** Infectious and chronic illness is reduced by exclusive breastfeeding, beyond the impact of breastfeeding alone.
- **Improved growth parameters:** Exclusive breastfeeding helps overcome LBW and reduces stunting.
- **Reduced cardiac risk factors:** Early breastfeeding, especially exclusive, is associated with reduced obesity and other factors related to heart disease.
- **Adequacy:** Mean intakes of human milk provide sufficient energy and protein to meet mean requirements during the first six months of infancy. Since infant growth potential drives milk production, the distribution of intakes likely matches the distribution of energy and protein requirements. Some micronutrients are dependent on maternal stores.

Statement of Problem

Although the health benefits of exclusive breastfeeding are widely acknowledged, opinions and recommendations are strongly divided on the optimal duration of exclusive breastfeeding and the practice of exclusive breastfeeding in different cultures and regions. This has led to many lactating women not practicing exclusive breastfeeding. UNICEF (2012) reported that Nearly 8 million children died in 2010 before reaching the age of 5, largely due to pneumonia, diarrhoea and birth complications. In 2010, the infant mortality rate in Nigeria was 88/1000 live births, under 5 mortality rate in Nigeria was 143/1000 live births and neonatal mortality rate was 40/1000 live births, 12% of infants were born with low birthweight, 38% had early initiation of breastfeeding (i.e. ≤1hour), 13% were exclusively breastfed for 6 months, 32% were breastfed at age 2years. The percentages of under-fives (2006–2010*) suffering from: underweight – moderate and severe (23%), severe (9%); stunting – moderate and severe (41%) and wasting – moderate and severe (14%). Vitamin A supplementation coverage rate (6–59 months) 2010 (91%) and percentage of households consuming iodized salt (2006 – 2010) was 97% (United Nations Children's Fund (UNICEF), 2012).

These above statistics are important that the major avoidable causes of maternal and infant/child mortality and malnutrition are eliminated by looking into the exclusive breastfeeding practices of women in Owerri metropolis Imo State.

Research Questions

The major research questions for investigation include the following:

1. Do lactating women in Owerri know the meaning of exclusive breastfeeding?
2. Do lactating women in Owerri practice exclusive breastfeeding?
3. What are the constrains to the practice of exclusive breastfeeding by lactating women in Imo state?

Objective of the Study

The specific objective of the research is as follows:

1. To assess the knowledge of lactating women on the meaning of exclusive breastfeeding in Owerri metropolis.
2. To assess the practice of exclusive breastfeeding by lactating women in Owerri metropolis.
3. To determine the constraints to the practice of exclusive breastfeeding by lactating women in Owerri metropolis.

Significance of the Study

The study embarked upon is significant in that the study will go a long way to determine the implementation of Innocenti Declaration in Owerri Metropolis and Imo state at large. The discovery will aid in various ways which include:

- Helping health workers towards achieving the UNICEF 1990 Innocenti declaration by knowing how and where to channel her education programmes in Owerri Metropolis and Imo state at large.
- Reduce the mortality rate of infants/children due to diarrhoea and other infectious disease, if appropriate intervention strategies are embarked upon.
- Governments implement her policies towards achieving the 2015 Millennium Development Goals (MDGs) 4 and 5 of reducing under-five mortality and maternal mortality in the state.
- Researchers as a guide for further research either for improvement on the work already carried out or otherwise.

MATERIALS AND METHODS

Study Area and Population

The study was carried out in Owerri metropolis. Owerri is the capital of Imo state which is one of the states located in the southern part of Nigeria at the heart of south-east and the indigenes are Igbo language speaking. Lactating women were sampled from different hospitals in the metropolis which include; Federal Medical Center Owerri, Umezurike Hospital Owerri and St. David's Hospital.

Data Collection

Structured and validated questionnaire was used to collect data. The questionnaire was designed to elicit information on personal, socio-economic status, knowledge and practice of exclusive breastfeeding as well as the constraints hindering its practice in the metropolis. The literate lactating women were given the questionnaire to fill while the illiterate lactating ones were interviewed from the questionnaires and the answers recorded.

During the data collection, I collected data from Federal medical centre Owerri, Umezuruike Hospital, and St. David's Hospital on their post-natal days and immunization days. A total of 128 samples were collected.

Data Analysis

The data was analyzed using statistical package for social sciences (SPSS) and the percentages were determined. Also Excel package was used for analyzing the data on charts

RESULT PRESENTATION

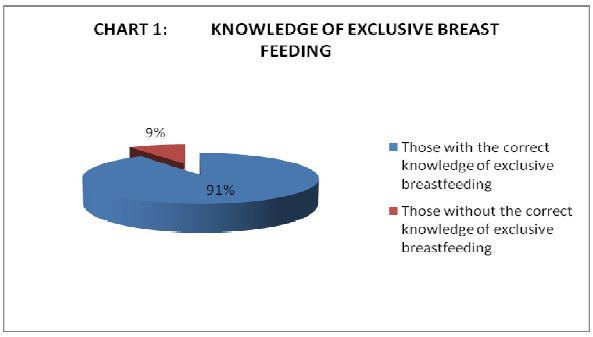
In Table 1 below the statistical data show that there is 5% prevalence of teenage lactating mothers are found in Owerri Metropolis. Most of the lactating women in Owerri are within the age range of 21-30 years. However, exclusive breastfeeding is practiced at the rate of 66.41% by these women sampled. However, about 9.37% of the women do not have correct knowledge of exclusive breastfeeding.

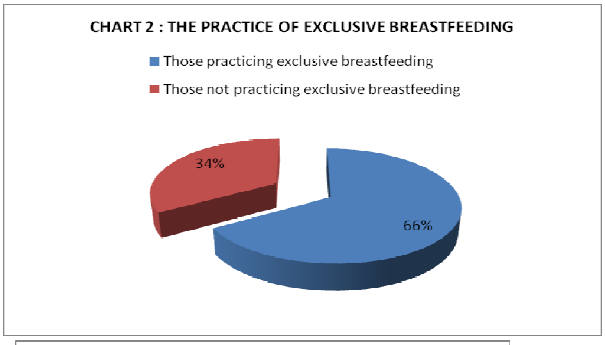
During the survey, the following reasons were identified to be the cause of lack the practice of exclusive breastfeeding in among these women:

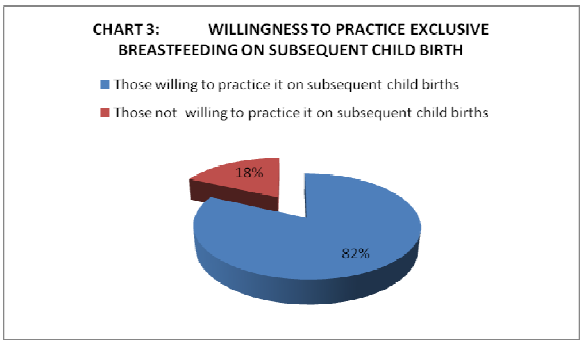
- Poverty (lack of money)
- Lack of husband and family support
- Lack of time
- Lack of knowledge or correct knowledge
- Many do not believe that only breastmilk is enough for their baby
- Many responded that their baby refused to suck early
- Some said that they gave birth to twins
- Some said that their people don't practice it.

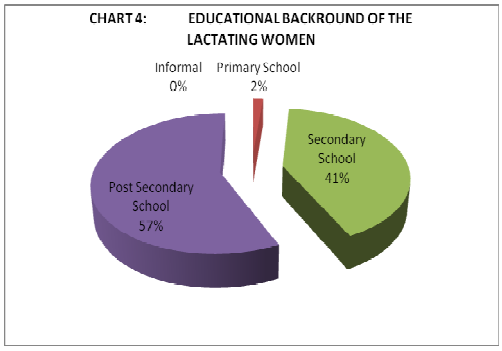
Table 1. Percentage of Personal Characteristics, Knowledge and Practice of Exclusive Breastfeeding by Lactating Women in Owerri Metropolis, Imo State.

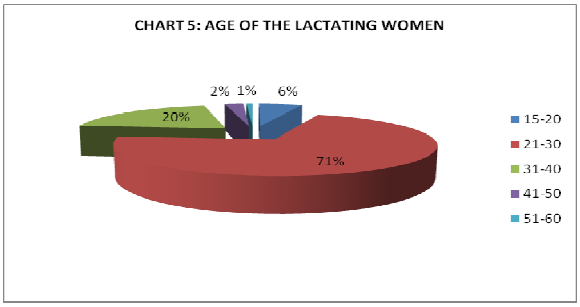
Parameter	Frequency	Percentage
Age		
15-20	7	5.47
21-30	91	71.10
31-40	26	20.31
41-50	3	2.34
51-60	1	0.78
Total	128	**100**
Marital Status		
Married	122	95.31
Single	3	2.34
Widow	2	1.57
Separated/divorced	1	0.78
Total	128	**100**
Educational Background		
Informal	0	0.00
Primary School	2	1.57
Secondary School	53	41.40
Post Secondary School	73	57.03
Total	128	**100**
Occupation		
Farmer	3	2.34
Business/Trading	45	35.16
Civil/Public Servant	27	21.10
Skilled Labour	15	11.72
Unemployed/student	38	29.68
Total	128	**100**
Religion		
Christian	123	96.10
Muslim	0	0.00
Traditional	0	0.00
Others	5	3.90
Total	128	**100**
Age of their baby(months)		
0-1	30	23.44
1-4	77	60.16
4-6	14	10.94
Above 6	7	5.46
Total	128	**100**
Knowledge		
Those with the correct knowledge of exclusive breastfeeding	116	90.63
Those without the correct knowledge of exclusive breastfeeding	12	9.37
Total	128	**100**
Practice		
Those practicing exclusive breastfeeding	85	66.41
Those not practicing exclusive breastfeeding	43	33.59
Total	128	**100**
Those willing to practice it on subsequent child births	105	82.03
Those not willing to practice it on subsequent child births	23	17.97
Total	128	**100**

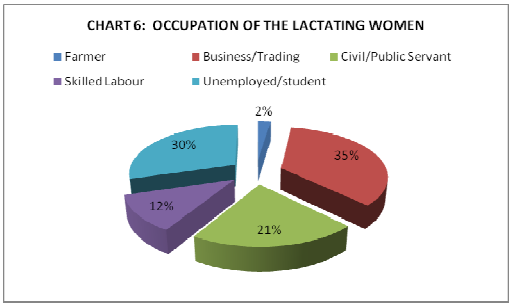












DISCUSSION

In table 2 above, the incidence of teenage mothers in the area calls for a great concern in that breastfeeding infant adds to a teenage girl's nutrition burden, especially if her growth is still incomplete. Simply being young increases the risks of malnutrition and vulnerability to infections independent of important socio-economic factors (Klein, 2005). "Knowledge is power" is a common adage, lack of correct exclusive breastfeeding knowledge and the inability to apply the knowledge in breastfeeding children is a very serious threat to the practice of exclusive and adequate breastfeeding (Okoli, 2009).

The fact that exclusive breastfeeding is practiced by a minority of women may be attributed to a number of factors. Among these are cultural, social, economic and political factors. Cultural factors may be crucial when promoting exclusive breastfeeding everywhere, but are particularly crucial in traditional rural communities. Local perceptions of what constitutes optimal infant feeding practices may differ greatly from international recommendations. Globally, prelacteal feeding is a common practice which includes giving the infant various liquids as well as water, prior to initiation of breastfeeding (Ellie and Sharon, 2008) and continuing throughout the duration of the breastfeeding period.

In a recent study on socio–cultural factors and the promotion of exclusive breastfeeding in rural communities, concluded that exclusive breastfeeding totally lacked credibility among the locals, with even health workers not believing that it was possible or feasible (Davies, 1997). Therefore promotion of optimal breastfeeding practices, including exclusive breastfeeding, cannot be successful if the cultural barrier is not adequately addressed.

Exclusive breastfeeding for up to six months requires the mother and her infant to be in close proximity for this period and to use expressed breastmilk for separation of short duration. However, practicing exclusive breastfeeding may be perceived as being non–compatible with working outside of the home, thus creating an economical barrier. This includes mothers working both in the formal and informal sector (Isaton, 1998).

This notion may be viewed from two angles. Firstly,

from that of the employer, including governments, who may wrongly perceive that the provision of adequate maternity leave, breastfeeding breaks and crèches at the work place would result in losses rather than profits. Secondly, from that of the mother, who may believe that practicing exclusive breastfeeding would limit the time she has for other activities – especially income generating activities.

A sick infant results in a worried mother, which in turn may result in a less productive mother. Absenteeism from work due to a sick infant may have more economical consequences than adequate maternity protection measures for optimal breastfeeding.

The lack of social support systems at the household and community levels is also a barrier to optimal breastfeeding. Mothers require an enabling environment if they are to practice optimal breastfeeding and this can only be possible with full support at both the household and the community levels. The issues to be addressed include the workload of the pregnant and lactating woman, among others (Isaton, 1998).

National policies on breastfeeding are important for the promotion and support of breastfeeding at all levels. The lack of political commitment to breastfeeding promotion and support may probably be due to ignorance of its many benefits for the individual (mother and infant), household, community and the nation. Governments have still to understand the health, social and economic benefits of breastfeeding.

In light of all the barriers outlined above, how can we successfully get mothers to practice optimal

breastfeeding including exclusive breastfeeding? The baby friendly initiative (BFI) is still the answer which outline the following ten steps to successful breastfeeding (WHO and UNICEF, 2009):

- Have a written breastfeeding policy that is routinely communicated to all healthcare staff
- Train all healthcare staff in skills necessary to implement this policy
- Inform all pregnant women about the benefits and management of breastfeeding
- Help mothers initiate breastfeeding within half an hour of birth
- Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants
- Give newborn infants no food or drink other than breastmilk unless medically indicated
- Practice "rooming-in"-allow mother and baby to remain together 24 hours a day
- Encourage breastfeeding on demand
- Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants
- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

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APPENDIX

RESEARCH QUESTIONNAIRE

Instruction- please tick only the correct option and fill in appropriately the blank spaces

SECTION A – PERSONAL DATA

1. Sex: Male ☐ Female☐

2. Age (years): 15-20☐ 21-30☐ 31-40 ☐ 41-50☐ 51-60 ☐

3. Marital status: Married ☐ Single ☐ Widowed ☐ Separated/Divorced ☐

4. Highest Educational Attainment: Informal ☐Primary School ☐ Secondary School☐
post secondary ☐

5. Occupation: Farmer☐ Business ☐ Civil/public servant ☐ Skilled Labour☐
Unemployed/student ☐

6. Religion: Christian ☐ Islam ☐ Traditional ☐ Others……

7. Name of Community/LGA/CITY of residence: ……..

SECTION B –PRACTICE OF EXCLUSIVE BREASTFEEDING

8. How old is your baby? 0-1month ☐1-4months ☐4-6months ☐above6months ☐

10. Do you know what exclusive breastfeeding is? Yes ☐ No ☐

11. If yes what is it? Giving the baby breast milk and water only from birth ☐ Giving the baby breast milk only from birth ☐Giving the baby breast milk and other baby foods from birth ☐
Giving the baby foods, breast milk and water from birth ☐

12. Did you practice exclusive breastfeeding on your baby? Yes ☐ No ☐

13. If yes, how many months did you do it? 0-1month ☐0-2months ☐ 0-3months ☐
0-4month☐ 0-5months☐ 0-6months ☐

14. If no, Why? Due to lack of money ☐Lack of support from my husband☐ Lack of time☐
I think only Breast milk is not enough for my baby☐ my baby refuse to suck ☐
I was not aware of it ☐
My people don't practice It ☐ I don't believe in it ☐Other reasons please specify……

15. Would you like to practice exclusive breastfeeding on your subsequent babies? Yes ☐ No☐