



Knowledge and Practice of Exclusive Breastfeeding amongst Mothers Attending Infant Welfare Clinic, Ekiti State University Teaching Hospital, Ado-Ekiti

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Authors' contributions

This work was carried out in collaboration between all authors. Author OAA designed the concept of the study, interpretation of data, wrote the first draft of the article. Author EFO managed literature searches and wrote the protocol. Author CNE designed the study, managed data acquisition and analysis. All authors read and approved the final manuscript.

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ABSTRACT

This study examined the knowledge and practice of exclusive breastfeeding amongst breastfeeding mothers attending Infant Welfare Clinic, Ekiti State University Teaching Hospital, Ado-Ekiti Nigeria. The Self-efficacy theory was used as the theoretical foundation for the study. The research design was non-experimental descriptive research design. The sample size was calculated using the Yaro Yamane formula created in 1967 and the sample size was 120. Data was collected using a self-administered structured questionnaire. Sampling technique was purposive and convenience. Data from the study was analyzed using descriptive statistics with frequency distributions, Tables and percentages. The findings revealed that almost half (48.8%) of the participants' decision to breastfeed was influence by Doctors/Midwives. Also, more than two-third (86.2%) of the participant indicated that they had access to information on breastfeeding. The

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majority (63%) of the participants in the study were well knowledgeable as they were able to define exclusive breastfeeding and 66.3% are aware of the benefits of exclusive breastfeeding. Also, almost half (46.3%) of the participants breastfed their babies so as to ensure their wellbeing and 75.0% initiated breastfeeding immediately and within few hours after birth although the majority (58.8%) of the participants weaned their babies between 1-4 months. The socio-economic status of mothers was found to influence their decision to exclusively breastfeed their babies as almost all (87.3%) the participants that are practising exclusive breastfeeding had tertiary education and more than two third (74.6%) are employed with higher family income. The study recommended that Nurses and midwives should create more awareness on the benefits of exclusive breastfeeding to mothers and the community at large.

Keywords: Knowledge; practice; exclusive breastfeeding; mothers.

1. INTRODUCTION

Over the last two decades, there has been a growing attention in the endorsement of exclusive breastfeeding as the recommended feeding practice for new-borns. This to a great extent has been heartened by increasing scientific proof on the importance of exclusive breastfeeding in reducing infant morbidity and mortality. Exclusive breastfeeding is the most efficient type of infant feeding for the first six months of life. According to the United States Breastfeeding Committee (USBC) and the American Academy of Paediatrics (AAP), breastfeeding is the physiologically normal form of infant and child feeding [1,2]. Exclusive Breastfeeding is a post-natal activity that is of paramount importance to different groups of professional in paediatrics, nursing, endocrinology, psychology, as well as sociology and anthropology [3].

Breastfeeding is a natural method of infant feeding and it involve two main practises, exclusive and partial breastfeeding with the latter being the common methods among mothers. It ensures a good mental, emotional and physical collaboration between the mother and her newborn for desired outcome [4]. Exclusive breastfeeding (EBF) is the provision of only breast milk to a baby for the first six months of life without introducing water or other feeds [5]. As stated by WHO [6], exclusive breastfeeding should be initiated within an hour of birth and children will be exclusively breastfed for six months. Furthermore, the WHO [6], also indicated that exclusive breastfeeding is a cornerstone of care for childhood development. The practice of exclusive breastfeeding in the first six months of life builds the child immunity, protects the child from diarrhoea, respiratory diseases and improves the child response to vaccination [7].

Similarly, Leon-Cava et al. [8] observed that improved breastfeeding practices are crucial for child growth and development. Evidence from population studies in developing countries has shown that the greatest risk of nutritional deficiency and growth retardation occurs in children between 3 and 15 months of age, a period noted for suboptimal breastfeeding and inadequate complementary feeding practices [9]. The principal advantages of breast milk are for the mother as breastfeeding encourages uterine involutions and thus helps the mother to regain her pre-gravid body weight and shape. Breast feeding also promotes an affectionate bond between mother and child, it is economical and convenient [10].

Researchers from different continents have studied exclusive breastfeeding and it has been concluded that there are several factors responsible for the non-compliance of mothers towards exclusive breastfeeding. These include education, social class, culture, location, nature of work, and health status of both the nursing mothers and their infants [11,12]. Prominent among these values and behaviors are western education and formal employment. Studies have shown that breast-feeding rates have significantly reduced among educated and employed women.

The process of child nurturing is as old as mankind, and it has been a fundamental duty that every woman owes her child. The promotions, protection as well as the acceptance of breast-feeding help to safeguard the Rights of children and contribute to women empowerment, although women are expected to make their own choices regarding the feeding and nurturing of their babies [12]. The motivation for the study was the low rate of EBF in Nigeria. According to UNICEF [13], only 15.1% of babies below 6 months of age were exclusively breastfed in

Nigeria between 2008 and 2012. It was also shown by [12] that the EBF rate in Nigeria is low and falls below the expected levels required to achieve a significant reduction in child mortality. Hence, the study aim was to assess the knowledge and breastfeeding practices amongst women thereby creating an agenda towards reducing infant morbidity and mortality that are related to breastfeeding practices of mothers.

Self-efficacy theory was used as the foundation for the study, it was originated by Bandura in 1997. The concept of self-efficacy is based on the social cognitive theory that an individual believes that they are capable of making things happen [14]. Self-efficacy was defined as "people's beliefs about their capabilities to produce effects". It was further expanded this concept by exploring how thoughts, feelings, and actions affect behaviour and are vital factors in achieving goals. In addition to motivation, incentive and perseverance, perception, consciousness, cognition, learning, memory and emotion all play significant parts in self-efficacy. There are four main sources of self-efficacy: enactive mastery experiences, vicarious experience, social and verbal persuasion, perception of emotional and physical (somatic) reactions [14].

Enactive mastery experiences are those learnt through personal experience and interplay of several factors can affects enactive mastery experiences. For example, pre-existing knowledge and task difficulty is two of these factors. Other factors include the ability of an individual to assess their own performance before, during and after a task. Thus, self-monitoring occurs and reconstruction of enactive mastery experiences by thoughtful reflection allows the individual to assess their goal attainment [14]. When a mother is breastfeeding, the amount of efforts utilized on breastfeeding depends on her previous breastfeeding experience, her level of commitment and her knowledge of breastfeeding. She also evaluates

the difficulty of the task. She cognitively monitors and judges her performance both during and after breastfeeding. She then evaluates whether the outcome is as expected which is a healthy infant.

Vicarious experience is gained through observation of others undertaking a task, this is also known as modelling. The knowledge and credibility of the model is a vital factor in the degree of influence of vicarious experience and modelling is further supported by verbal persuasion. This involves the mother envisioning others who have had similar characteristics i.e. breastfeeding. In observing them, she gains knowledge about exclusive breastfeeding, thus she is more likely to engage in breastfeeding leading to positive outcome.

Verbal and social persuasion is the third source of self-efficacy. Social persuasion generally manifests as direct encouragement or discouragement from another person. The supportive verbal persuasion of the partner, parents, friends and verbal support of health professionals can influence breastfeeding practices. Breastfeeding knowledge and practice can be improved by verbal and social persuasion. And lastly, Somatic experience is the fourth source of self-efficacy and is physiological. Situations which are interpreted by the individual as demanding or stressful can undermine performance and produce the feared outcome. This is because the perception of stress activates fear, anger, sorrow or a mixture of these feelings. In breastfeeding, an individual with a history of breastfeeding challenges such as nipple pain, cracked nipple may develop fear subsequently which may hinder effective breastfeeding. As shown in Fig. 1, the Social Learning Theory, as known as the Social Cognitive Theory, assumes that learning is a cognitive process that takes place in social context and can occur through observation or direct instruction even in the absence of direct instruction.

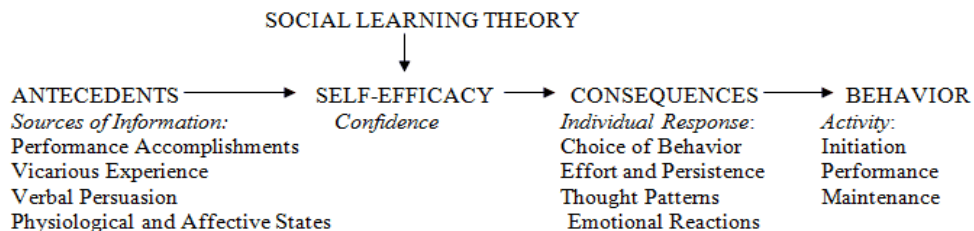


Fig. 1. Illustration of the social learning theory [14]

2. MATERIALS AND METHODS

The study location was the Ekiti State University Teaching Hospital, Ado-Ekiti, Ekiti State in Nigeria. The design adopted was non-experimental descriptive research design. The target population were breastfeeding mothers attending the hospital. The techniques used was purposive and convenience. The inclusion criteria for the study were women of childbearing age, who are currently breastfeeding or have breastfed not more than two years ago, using the Teaching Hospital, and willingness to participate. The sample size was calculated using the Yaro Yamane formula created in 1967:

$$n = \frac{N}{1 + N(e)^2}$$

Where

n = sampling size,
N = Population size,
e = Margin error which is a constant = 0.05.

Using the formula above, the sampling size can be calculated thus:

n =? (Unknown)
N = 150
e = 0.05

$$n = \frac{150}{1 + 150(0.05)^2}$$

$$n = \frac{150}{1 + 150(0.0025)}$$

$$n = \frac{150}{1 + 0.375}$$

$$n = \frac{150}{1.375}$$

n = 109

Therefore the number of respondents to be used in this research is 109.

Total calculated sample size was 109 and ten percent of the desired sample size was added to the calculated sample size (109) because of high attrition and non-response, thus N was 120. The data was collected using self-administered structured questionnaire which contain both closed and open-ended questions. The questionnaire was into two sections; Section A investigates the demographic characteristics of

the participants. Section B was on questions that sought to investigate the participants' knowledge and practice of exclusive breastfeeding. The validity of the instruments was established through face and content validity criteria. The questionnaire was given to colleagues, expert in the field for an evaluation of its contents, relevance and clarity of thought and corrections were made. Hence, the tool was adjudged valid. The reliability of the questionnaire was done using the test-retest method, the same questionnaire was given twice to women who met the inclusion criteria and the results were compared over time to assess if the respondents understood the questionnaire and if the results would be similar, their responses were analysed and using the Cronbach Alpha Model the outcome was 0.8 as the correlation coefficient which was significant. Thus the tool was adjudged to be reliable. Before the commencement of the study, approvals were obtained from The Research Ethics Committee of Afe Babalola University and The Research Ethics Committee of Ekiti State University Teaching Hospital. Written and verbal informed consent was sought and obtained from participants before administration of the questionnaire. Participation was made voluntary without coercion, manipulation or undue inducement. The participants were told that they could freely withdraw at any point during the study process. The researcher administered the questionnaire to the participants. All eligible women found in the hospital were involved. There were 120 women recruited for the study out of which 98 responded adequately to the questionnaire. The questionnaires were retrieved from the participants immediately after completion. Data gathering was from August to October 2015. Data from the study was analyzed using descriptive statistics with frequency distributions, Tables and percentages.

3. RESULTS

As shown in Table 1, almost one-third (31.6%) of the participants were within the age of 19-25 years while 16.3% were 40 years and above. The highest proportions (67.3%) of participants were married and 54.1% were Christians. The majority (69.4%) of the participants had tertiary education. Regarding participants' occupation, 39.8% were employed/civil servants. With regards to participants' number of children, 43.6% had only one child while 3.2% had more than five children. With respect to participants'

family income, almost half 46.9% earn above N100000 monthly.

With respect to mothers' decision on baby feeding, as shown in Table 2, about half (49.5%) of the participants made their decision before pregnancy. On who influenced participants' decision to breastfeed, 48.8% them indicated mentioned their doctors or midwives while 32.6% of them indicated they were influenced by their mother-in-law.

Table 1. Demographic profile of participants (N=98)

Socio demographic characteristics	Frequency (N=95)	%
Age		
19 – 24	31	31.6
25 – 32	29	29.6
33 – 39	22	22.4
40 and above	16	16.3
Marital status		
Single	8	8.2
Engaged	16	16.3
Married	66	67.3
Divorced	5	5.1
Widow	3	3.1
Educational level		
Not educated	10	10.2
Secondary	20	20.4
Tertiary	68	69.4
Occupation		
Student	11	11.3
Full time housewife	17	17.5
Employed/civil servant	39	40.2
Self employed	30	30.9
Religion		
Christianity	53	54.1
Islam	22	22.4
Traditional	9	9.2
Others	14	14.3
Monthly income		
Below \$200	10	10.4
\$200- \$300	13	13.5
\$300- \$400	28	29.2
Above \$400	45	46.9
Number of children		
One	41	43.6
2-3	35	37.2
4-5	15	16.0
Above 5	3	3.2

When the participants were asked if they had access to breastfeeding information during pregnancy, more than two-thirds (86.2%) of the participants indicated that they had access to information on breastfeeding. Almost half

(46.3%) of the participants breastfed their babies so as to ensure the child's wellbeing and 36.8% also signify bonding/closeness to baby has their reason. Only 10.5% and 6.3% of the participants mentioned money and family/cultural beliefs respectively as their main reasons for breastfeeding.

Table 2. Decision to breastfeed as indicated by the participants

Options	Number	%
First decision to breastfeed		
Before pregnancy	48	49.5
During pregnancy	33	34.0
After delivery	16	16.5
Total	97	100
Who influenced breastfeeding decision?		
Mother/mother in-law	28	132.6
Friends	4	4.7
Partner	12	14.0
Doctor/Midwife/ Nurse	42	48.8
Total	86	100
Access to breastfeeding information		
Yes	81	86.2
No	13	13.8
Total	94	100
Major reason for breastfeeding		
Baby's wellbeing	44	46.3
Bonding/closeness to baby	35	36.8
To save money	10	10.5
Family traditions/cultural beliefs	6	6.3
Total	95	100
Intended duration to breastfeed		
1-3 months	6	6.8
4-6 months	30	34.1
7-9 months	33	37.5
Above 10 months	19	21.6
Total	88	100

In exploring the participants' adherence to exclusive breastfeeding, as revealed in Table 3, when the participants' place of delivery was investigated, the majority (81.9%) of them indicated they delivered in hospitals or maternity homes. With regards to mode of delivery, 64.9% of the participants had vaginal deliveries.

Participants were asked about when breastfeeding was initiated, 38.0% of the participants indicated that they initiated breastfeeding immediately after birth, 37.0% commenced breastfeeding some hours after birth while 6.5% never breastfeed their babies. Participants were also asked the kind of food their babies were eating, 43.8% of babies were on breastfeeding only and the

majority (76.1%) of the mothers had tertiary education. While 29.2% were taking breast milk with other foods. When asked on the number of times baby was breastfed, 44.4% of them indicated they fed their babies between 7 to 9 times daily.

When investigating the possible factors hindering the participants from adherence to exclusive breastfeeding, as shown in Table 4, the majority (56.4%) had not received any suggestion to stop breastfeeding. More than half (55.1%) of the participants who had been advised to stop breastfeeding mentioned their spouses while 18.4% mentioned their mother/mother-in-law. Some of the reasons why the mothers were advised to stop breastfeeding include because of work demands (33.9%), family/cultural belief (43.5%) and 14.5% indicated not enough breast milk.

Table 3. Participants' adherence to exclusive breastfeeding

Options	Number	%
Mode of delivery		
Vaginal delivery	61	64.9
Caesarean delivery	33	35.1
Total	94	100
Place of delivery (hospital/maternity home)		
Yes	77	81.9
No	17	18.1
Total	94	100
Time of breastfeeding initiation		
Immediately after delivery	35	38.0
Some hours after delivery	34	37.0
Some days after delivery	17	18.5
Never breastfed baby	6	6.5
Total	92	100
Age of baby		
1-4 months	37	38.9
5-8 months	24	25.3
9-12 months	13	13.7
Above 12 months	21	22.1
Total	95	100
Infant feeding		
Breast milk only	42	43.8
Infant formula	10	10.4
Pap, custard and other meals	16	116.7
Breast milk with other foods	28	29.2
Total	96	100
Number of times baby is breastfed daily		
1-3 times	11	13.6
4-6 times	22	27.2
7-9 times	36	44.4
10-12 times	12	14.8
Total	81	100

When the participants were asked if they personally made the decision to stop breastfeeding, 16.4% of the participants made the decision themselves while the remaining 83.6% indicated that their babies were not sucking well (68.9%), baby is old enough for weaning (18.6%) and 7.0% discontinued breastfeeding because of work/school. With regards to the age of baby at weaning, the majority (58.8%) of the participants mentioned 1-4 months (55.0% were age 24 years and below and the majority 65.0% had tertiary education). Almost one third (29.4%) of the mothers indicated 5 to 8 months while the remaining (11.7%) stopped breastfeeding their babies after 8 months.

Table 4. Factors hindering the participants from adherence to exclusive breastfeeding

Options	Number	%
Suggestion to stop breastfeeding		
Yes	34	43.6
No	44	56.8
Total	78	100
Who suggested breastfeeding cessation		
Father of the baby	27	55.1
Mother/Mother in-law	9	18.4
Friends	8	16.3
Co-workers	5	10.2
Total	49	100
Reasons for suggestion to stop breastfeeding		
Work demands	21	33.9
Family traditions/cultural beliefs	27	43.5
Not enough breast milk	9	14.5
Sore nipples/teething/biting	5	8.1
Total	62	100
Personal decision to stop breastfeeding		
Yes	9	16.4
No	46	83.6
Total	55	100
Reason for stopping breastfeeding		
Baby not sucking well at breast	60	69.8
Baby old enough	16	18.6
Resumption of work or school	6	7.0
Family tradition	4	4.7
Total	86	100
Age of baby when breastfeeding was stopped		
1-4 months	20	58.8
5-8 months	10	29.4
9-12 months	1	2.9
Above 12 months	3	8.8
Total	34	100

Table 5, shows the knowledge and practice of exclusive breast feeding by the respondents. With regards to the meaning of exclusive breast feeding, the majority (80.5) of the mothers responded in affirmative. When the participants were also asked to define exclusive breastfeeding in their own words and it was discovered that the majority (63%) of the participants were well knowledgeable as they were able to defined exclusive breastfeeding as when the infant receives only breast milk and no other liquids or solids are given, not even water but with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines for the first 6 months of life.

When asked if they practice exclusive breastfeeding, more than two thirds of the participants (88.9%) indicated yes, and the majority (61.1%) of the participants are below the age of 32 years. On the benefits of exclusive breastfeeding, the majority (66.3%) of the participants are aware of the benefits and all the respondents were able to state one or two benefits of exclusive breastfeeding. Their responses includes exclusive breastfeeding practice protects against common and widespread childhood diseases, makes baby healthy, for development of baby bones and teeth, reduces infant mortality and may also have longer-term benefits such as lowering mean blood pressure and cholesterol, and reducing the prevalence of obesity and type-2 diabetes. Again, others stated that exclusive breastfeeding contributes to the health and well-being of mothers owing to the fact it supports child spacing, decreases the risk of ovarian cancer and breast cancer, and maintains family's income.

With regards to the participants' knowledge on the disadvantages of not breastfeeding, all of them were able to identified one or two disadvantages of not breastfeeding which includes poor growth of the infant, poor development of teeth and bones of the infant, decreased intelligence of the infant, low weight of the infant, high spending in buying infant formula, drugs and taking the infant to hospital if in case the infant falls sick.

When the participants were also asked if they feel uncomfortable to breastfeed in a public places and the majority (51.6%) of the mothers indicated no. On reasons while they feel uncomfortable when breastfeeding their babies in public places, 37.3% of the them indicated they

were self-conscious/embarrassed, 21.6% were uncomfortable due to the inappropriateness of the breastfeeding location while 33.3% were uncomfortable due to the fact that there was no privacy/too many people and only 7.8% of the participants mentioned partners dislike. More than two thirds (73.3%) of the participants gave the indication that they were very satisfied with breastfeeding.

Table 5. Knowledge and practice of exclusive breast feeding

Options	Number	%
Do you know the meaning of exclusive breastfeeding?		
Yes	66	80.5
No	16	19.5
Total	82	100
Practice of exclusive breastfeeding		
Yes	72	88.9
No	9	11.1
Total	81	100
Benefits of exclusive breastfeeding		
Yes	66	66.7
No	33	33.3
Total	100	100
Disadvantages of not breastfeeding		
Yes	60	75.9
No	19	24.1
Total	79	100
Do you feel uncomfortable to breastfeeding publicly?		
Yes	44	48.4
No	47	51.6
Total	91	100
Reasons for being uncomfortable breastfeeding publicly		
Self-conscious/embarrassed	19	37.3
Inappropriate breastfeeding location	11	21.6
No privacy/ too many people	17	33.3
Partner dislike	4	7.8
Total	51	100
Was breastfeeding experience satisfactory?		
Very satisfied	66	73.3
Satisfied	17	18.9
Dissatisfied	6	6.7
Very dissatisfied	1	1.1
Total	90	100

4. DISCUSSION

As found in the study, almost half (48.8%) of the participants decision to breastfeed was influence

by Doctors/Midwives. Also, more than two-third (86.2%) of the participant had access to information on breastfeeding. According to Agho et al. [12], mothers who accessed antenatal care services during pregnancy were more likely to practice exclusive breastfeeding because they have learnt appropriate key messages during antenatal care services. Lactation counselling is another service that influences exclusive breastfeeding positively. Existing evidence in Nigeria revealed that lactation counselling has significantly been associated with increased rates of exclusive breastfeeding [5]. It was also indicated that if pregnant women are counselled properly on the benefits of exclusive breastfeeding they are more likely to practice exclusive breast feeding than their peers who were not counselled.

In this study, 81.9% of the participants delivered in hospitals/maternity homes. The place or location in which a pregnant woman delivers is indicated to have influence on the decision of a mother to exclusively breastfeed. Qureshi et al. [5] observed that women, who delivered at a health facility for example in a hospital, were more likely to practice exclusive breastfeeding than mothers who delivered at home. It was further explained that mothers who deliver at health facilities are more likely to be counselled on exclusive breastfeeding and therefore tend to practice exclusive breastfeeding than mothers who delivered at home.

The majority (63%) of the participants were well knowledgeable as they were able to defined exclusive breastfeeding. Also, as found in the study, the majority (66.3%) of the participants are aware of the benefits of exclusive breast feeding and all the respondents were able to state one or two benefits of exclusive breastfeeding. Also, almost half (46.3%) of the participants breastfed their babies so as to ensure the child's wellbeing and 36.8% also signify bonding/closeness to baby has their reason.

Despite the enormous benefits of exclusive breastfeeding, many breastfeeding mothers practice exclusive breastfeeding for various reasons. It was established that some mothers in Southwest Nigeria, practice exclusive breastfeeding because they are aware that it will helps new-borns to grow properly [15]. These findings were consistent with study by Black et al. [16] who revealed in their study that exclusive breastfeeding builds infants' immunity

and also reduce the risk of infections, thus reduce the rate of infant and child morbidity and mortality. Exclusive breastfeeding has also been found to be beneficial to the breastfeeding mother [10]. Paschal [17], mentioned that breastfeeding continues to serve as an appropriate method through which new-borns are offered essential nutrients necessary for optimal growth and intellectual development. Breast milk is regarded as perfect, natural and protective food for new-borns, it prolong lives (by reducing mortality) and preventing disease (by reducing morbidity) which are some of the goals of public health [18]. Breast milk is readily available and sterile than formula feeds and this makes breast milk more beneficial as it is also less expensive and healthier than formula feeds [19].

In this study, 75.0% of participants initiated breastfeeding immediately and within few hours after birth while only 6.5% never breastfeed their babies. Although exclusive breastfeeding is overwhelmed with numerous benefits which are enough motivation for mothers to practice it but many mothers were reluctant or refuse to exclusively breastfeed their children for different reasons. In Nigeria, [20] observed that although the initiation of exclusive breastfeeding is on the increase, the duration of the practice for six months continues to decline.

The socio-economic status of mothers has also been found to influence the decision of mothers' to exclusively breastfeed. Agho et al. [12] also found that mothers from socio-economically privileged groups were more likely to exclusively breastfeed than their counterparts in the lower socioeconomic status. Also [12] argue that mothers with higher socioeconomic status tend to have high education and are more likely to be better informed about the practice of exclusive breastfeeding than mothers with lower socioeconomic status who are more likely to have lower education. These findings are in consistent with this study as almost all (87.3%) the participants that are practising exclusive breastfeeding had tertiary education and more than two third (74.6%) are employed with higher family income. Majority (73.9%) of the participants that commenced breastfeeding immediately and few hours after birth had tertiary education. Likewise more than two third of the mothers (88.9%) indicated that they are practising exclusive breastfeeding and the majority (61.1%) of the participants are below the age of 32 years.

As found in the study, almost half (48.4%) of the participants were uncomfortable breastfeeding in public places and some of the reasons mentioned were been self-conscious/embarrassed, inappropriateness of the breastfeeding location, and partners dislike. Some of the reasons why participants were advised stop breastfeeding their babies include because of work demands (33.9%), family/cultural belief (43.5%) and 14.5% indicated not enough breast milk. Other factors that have been known to influence exclusive breastfeeding rates and contribute to the low level of practice in Nigeria and other developing countries include unhealthy hospital practices, unemployment, lack of support for breastfeeding mothers, perceived lactational insufficiency, illiteracy and ignorance of the benefits of exclusive breastfeeding [12,21,22]. Others are adverse cultural practices, resistance to change, fear of maternal depletion syndrome, urbanization, working mothers, poor attitude of health workers, beliefs relating to the use of colostrum and sexual practices during breast feeding as well as aggressive advertising and marketing of breast milk substitutes. Other studies have observed that some mothers do not practice exclusive breastfeeding because they have cracked nipples or engorged breast that causes them pain during breastfeeding.

Self-efficacy theory was pertinent to the study because mother's knowledge of the benefits of breastfeeding along with her prior breastfeeding experiences will determine the extent of her efforts utilized on breastfeeding as well as her commitment to EBF. Also, very importantly the supportive verbal persuasion of the partner, parents, friends and verbal support of health professionals can influence breastfeeding practices. Breastfeeding knowledge and practice can be improved by verbal and social persuasion.

5. CONCLUSION, RECOMMENDATION AND LIMITATION

The results from the study revealed that the majority of the participants had access to information on breastfeeding and many of the mothers initiated breastfeeding within few hours of birth although more than half weaned their babies between one to four months of breastfeeding. Thus, it is imperative for professional Nurses and midwives to create more awareness on the benefits of exclusive

breastfeeding to mothers and the community at large.

Based on the findings of this study, it is recommended that nurses and midwives should educate mothers on the use of supplementary feeding so as to discourage it unless the mother is unable to breastfeed. Mothers and women of child bearing age should also be encouraged to practice exclusive breastfeeding. Breastfeeding mother should be encouraged to attend antenatal clinic in order to have access to adequate information on breastfeeding.

The limitation for the study is the purposive and convenient sample of mothers using Infant Welfare Clinic, Ekiti State University Teaching Hospital, Ado-Ekiti, hence the results may not be generalizable to a larger context.

ETHICAL APPROVAL

All authors have obtained all necessary ethical approval from The Research Ethics Committee of Afe Babalola University and The Research Ethics Committee of Ekiti State University Teaching Hospital.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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