Chapter One

Introduction

1.1: Background of the Study

Breastfeeding is widely recognized as the ideal means of providing nutrition to infants for healthy growth and development[1]. It is a fundamental part of the reproductive process that not only benefits the infant but also supports the health and well-being of mothers[2]. The nutritional balance of breast milk from a healthy mother ensures that it is perfectly suited for infants, promoting their sensory and cognitive development[3]. Breastfeeding also offers significant protection against infections and chronic diseases, providing advantages in terms of general health, growth, nutrition, immunological support, psychological benefits, and even economic and environmental sustainability[4]. In addition to these benefits, breastfeeding plays a crucial role in reducing the incidence of morbidity and mortality from conditions such as diarrhea, which remains a significant cause of child mortality in developing countries[5].

However, despite the well-documented benefits of breastfeeding, particularly exclusive breastfeeding (EBF), the global uptake remains low[6]. Exclusive breastfeeding refers to the practice of feeding infants solely with breast milk, without any other liquids, foods, or even water, for the first six months of life, except for prescribed medicines or supplements[7]. In 2018, only 47% of mothers globally were practicing EBF for the recommended six months[8]. Exclusive breastfeeding practice varies significantly across regions, with Africa reporting a rate of 41.7%, Asia at 55.2%, Europe at 43.7%, and the Americas at 43.9%[9]. In Nigeria, eleven studies were analyzed between January 2013 and August 2023, their outcomes suggest significant diversity in the maternal understanding of exclusive breastfeeding because certain mothers exhibit a

commendable comprehension of the significance and advantages of breastfeeding and others require greater awareness or hold misconceptions regarding this practice[10].

Breastfeeding offers significant economic health benefits, including reducing healthcare costs and the incidence of illness in breastfed infants[11]. It also enables parents to dedicate more time to other family responsibilities, reduces parental absenteeism from work, and minimizes income loss due to childhood illnesses[12]. For mothers, breastfeeding helps space pregnancies, lowers the risk of ovarian and breast cancers, and enhances both family and national resources[13]. Given these wide-ranging benefits, the World Health Organization (WHO) strongly recommends EBF for the first six months of life, followed by the introduction of nutritionally adequate complementary foods while continuing breastfeeding for two years or more[14].

The importance of early breastfeeding initiation is also emphasized by the WHO's adoption of the Innocenti Declaration, which encourages mothers to start breastfeeding within the first hour of delivery[15]. Early initiation has been shown to significantly reduce neonatal mortality rates, particularly in resource-limited settings, where access to healthcare may be restricted[15]. Additionally, studies have demonstrated that EBF dramatically reduces infant mortality by lowering the risk of diarrhea and infectious diseases and even reduces HIV transmission from mother to child compared to mixed feeding practices[16].

In Nigeria, while breastfeeding is almost universally practiced, the rate of EBF remains alarmingly low, and trends suggest a decline in recent years[17]. Only 39% of infants in developing countries are exclusively breastfed, with Nigeria falling below this average[18]. Research indicates that suboptimal breastfeeding practices contribute to the high rates of neonatal and infant mortality in Nigeria[19]. For instance, initiating breastfeeding within the first hour of birth could

reduce neonatal mortality and reduction in infant mortality could be achieved if mothers adhered to EBF practices for the first six months[11].

Several barriers to EBF have been identified, including cultural beliefs, poor socioeconomic conditions, and inadequate support from spouses and healthcare providers[20]. Spousal support is particularly crucial, as research shows that mothers who receive emotional and practical support from their partners are more likely to successfully practice EBF[20]. Furthermore, despite national policies and legislative efforts aimed at promoting breastfeeding in Nigeria, gaps remain[21]. Many workplaces, for instance, lack the necessary facilities, such as lactation rooms and crèches, to support breastfeeding mothers in Nigeria[15]. Additionally, public health campaigns often fail to address common breastfeeding challenges, such as sore nipples and perceptions of inadequate milk supply in the country[22].

The decline in EBF rates in Nigeria and other developing countries calls for urgent intervention. Studies have reported that in various regions of Nigeria, the prevalence of EBF is far from satisfactory[23]. For example, in Ibadan and Kano, the prevalence of EBF among women was found to be 36.2% and 31%, respectively[24]. Similar studies in Uyo, southern Nigeria, reported 44.5% prevalence among antenatal attendees[25]. Research conducted in Kano among multigravida women attending antenatal clinics revealed a 47.2% EBF prevalence, while in rural communities in the Savannah region, the rate was even lower[25].

Further studies from Bayelsa, Edo, and Yobe states provide a mixed picture of breastfeeding practices. In Gbaratoru community, Bayelsa, the prevalence of EBF was 44.8%, with a positive correlation between maternal education and adherence to EBF practices[25]. In contrast, in Yobe state, while 78.8% of mothers initiated breastfeeding within the first hour of birth, only 39% of them practiced EBF, with some administering water, animal milk, or other pre-lacteal feeds[25].

Additionally, a study in a military barrack in Nigeria found that while 97.3% of respondents breastfed their infants, only 74.1% practiced EBF, with an average duration of 4.98 months[25]. Bottle feeding was reported by 30.7% of mothers, highlighting a significant deviation from recommended practices[25]. In Oyo State, the prevalence of EBF also remains suboptimal[26]. A study conducted in Ile-Ife revealed that only 61% of mothers adhered to the practice of EBF, while an alarming 99.8% of mothers in Igbo-Ore admitted to giving their infants plain water at birth[25]. These findings underscore the widespread deviation from recommended breastfeeding practices across various regions of Nigeria.

Given the wealth of evidence on the benefits of EBF, as well as the barriers and gaps in practice, it is critical to explore the specific challenges and dynamics surrounding EBF in different communities. In Ibadan North Local Government Area (LGA) of Oyo State, there is a scarcity of published research focused on the knowledge, attitudes, and practices (KAP) of EBF, particularly concerning the role of spousal support. Addressing this gap is essential for understanding how local factors influence breastfeeding practices and for designing targeted interventions to promote EBF in the community. Therefore, this study assessed the knowledge, attitudes, practices, and influence of spousal support on EBF practices among mothers in three selected primary healthcare centers in Ibadan North LGA. Thus, by identifying the specific barriers faced by mothers in this community, this research informed the development of effective public health strategies and interventions to increase the prevalence of EBF and improve maternal and infant health outcomes.

1.2: Problem Statement

The practice of exclusive breastfeeding (EBF) in Nigeria remains significantly below global health recommendations, with only 17% of children under six months being exclusively

breastfed[10]. Inadequate infant feeding practices remain a significant factor contributing to the high rates of malnutrition, infant morbidity, and mortality in developing countries, including Nigeria[27]. Several studies have established that the knowledge and attitude of breastfeeding mothers strongly influence their practice of exclusive breastfeeding[28]. Despite the well-documented benefits, many mothers either do not breastfeed exclusively or stop breastfeeding early, resulting in increased rates of childhood illnesses and complications[29]. In Ibadan, it was estimated that the prevalence of exclusive breastfeeding is 36.2%, a proportion that is lower than the minimum 60% recommended by the World Health Organization and UNICEF[24].

Furthermore, a key factor exacerbating suboptimal exclusive breastfeeding practices is the rapid socio-economic and cultural changes in developing countries, including Nigeria[30]. As urbanization and economic pressures rise, the need for women to engage in income-generating activities has increased, often at the expense of time allocated to breastfeeding[31]. The educational and occupational status of breastfeeding mothers, as well as socio-economic factors such as income level, family support, and maternal health status, plays a critical role in determining their ability to practice exclusive breastfeeding[32]. For instance, the statutory maternity leave in Nigeria is only three months, and many workplaces lack facilities to support breastfeeding, such as breast milk pumping and storage areas[33]. This creates a significant barrier for employed women to continue exclusive breastfeeding beyond this period[33].

Additionally, addressing these challenges requires a supportive environment that empowers mothers to breastfeed exclusively for the recommended six months[34]. This includes creating favorable working conditions, enhancing antenatal and postnatal care, and providing adequate breastfeeding education[34]. Also, improving the quality of services at healthcare centers through the regular training of healthcare workers is essential to improve exclusive breastfeeding rate in

Nigeria[35]. However, considering the low exclusive breastfeeding rates in Nigeria, far below the World Health Organization (WHO) and UNICEF's recommended target of 90%, interventions are critical to improving maternal and child health outcomes[35]. Therefore, this study is essential as it explored the knowledge, attitudes, practices, and the role of spousal support in exclusive breastfeeding among mothers in Ibadan North Local Government Area. Thus, understanding these factors provided valuable insights into the barriers of exclusive breastfeeding, thereby guiding policies and interventions aimed at improving breastfeeding practices and, ultimately, reducing infant malnutrition and mortality.

1.3: Justification of the Study

Traditional beliefs and practices that suggest breast milk alone is insufficient for the first six months pose a significant challenge to exclusive breastfeeding. These misconceptions lead to the early introduction of other feeds, which can have devastating effects on infants, contributing to high infant morbidity and mortality rates. The success of exclusive breastfeeding can be enhanced by addressing several key factors, including maternal knowledge, infant needs, health facility support, and cultural beliefs that influence breastfeeding practices.

This study fills a crucial knowledge gap by identifying the barriers to achieving the WHO/UNICEF standard for exclusive breastfeeding among mothers attending the three selected Primary Healthcare Centers in Ibadan North Local Government. However, by assessing the knowledge, attitudes, practices, and spousal support related to exclusive breastfeeding, the study aims to improve breastfeeding practices among mothers. Additionally, it helps refine health promotional messages delivered during antenatal, delivery, and postnatal care, ultimately increasing the rate of exclusive breastfeeding in the area. Solving these challenges is essential, as failing to do so could result in higher rates of infant malnutrition, morbidity, and mortality, both

in Ibadan North Local Government and across Nigeria. The selected healthcare centers provide accessible, diverse patient populations and offer comprehensive maternal and child health services, making them ideal for this study.

1.4: Significance of the Study

Exclusive breastfeeding rates in Nigeria continue to fall significantly below the WHO/UNICEF recommendation of 90% for infants under six months in developing countries[35]. This study addressed the barriers to achieving this standard by evaluating the knowledge, attitudes, practices, and spousal support related to breastfeeding among mothers attending three selected Primary Healthcare Centres in Ibadan North Local Government. By doing so, it aims to improve the health outcomes of both breastfeeding mothers and their infants.

The findings of this study demonstrated that the nutritional needs of neonates and infants can be fully met by exclusive breastfeeding, without the need for supplementary feeding, until the introduction of complementary foods after six months of age. Exclusive breastfeeding provides substantial benefits compared to artificial feeding for infants under six months, ensuring optimal nutrition and health. Furthermore, this research highlights the broader advantages of exclusive breastfeeding, including economic, psychological, and health benefits for breastfeeding mothers. These include weight loss, uterine contraction, enhanced emotional wellbeing, cost savings, convenience, reduced risk of breast cancer, and natural birth control. This study underscores the importance of exclusive breastfeeding for both maternal and child health, while providing valuable insights for improving breastfeeding practices in the community.

1.5: Aims and Objectives of the Study:

This study aims to assess breastfeeding mothers' knowledge, attitude, practices and the influence of spousal support on exclusive breastfeeding practices among mothers in Ibadan North, Ibadan, Oyo State.

1.6: The specific objectives are:

1. To assess breastfeeding mothers' knowledge level regarding exclusive breastfeeding in Ibadan North, Oyo State.

2. To determine breastfeeding mothers' attitudes towards exclusive breastfeeding in Ibadan North, Oyo State.

3. To determine the exclusive breastfeeding practices commonly adopted by breastfeeding mothers in Ibadan North, Oyo State.

4. To determine the roles of spousal support in promoting exclusive breastfeeding among breastfeeding mothers in Ibadan North, Oyo State.

1.7: Research Questions:

1. What is breastfeeding mothers' knowledge level regarding exclusive breastfeeding in Ibadan North, Oyo State?

2. What are breastfeeding mothers' attitudes towards exclusive breastfeeding in Ibadan North, Oyo State?

3. What are the exclusive breastfeeding practices commonly adopted by breastfeeding mothers in Ibadan North, Oyo State?

4. What are the roles of spousal support in promoting exclusive breastfeeding among breastfeeding mothers in Ibadan North?

1.8: Scope of the Study

This study is focused on breastfeeding mothers of reproductive age, specifically between 15 and 49 years, with infants aged 0 to 6 months. This age bracket was chosen because it represents the period in which mothers are most likely to engage in exclusive breastfeeding, which is defined as providing only breast milk to infants for the first six months of life. The participants were drawn from three selected Primary Healthcare Centres (PHCs) in Ibadan North Local Government Area: Idi Ogungun PHC (Agodi Gate), Sango PHC, and Sabo PHC. These centres were chosen for their accessibility to a diverse population of mothers, providing a representative sample in terms of religion, culture, and socio-economic background. Mothers with infants aged 0 to 6 months were specifically included because this is the critical period where exclusive breastfeeding is most recommended for optimal infant nutrition and health. The study excludes HIV-infected mothers who are not breastfeeding, as these mothers may follow different feeding practices for medical reasons, and their inclusion could skew the analysis of breastfeeding behaviors and support systems. Thus, by limiting the scope in this way, the study aims to provide a clear understanding of the factors influencing exclusive breastfeeding practices within this demographic.

1.9: Operational Definition of Terms

1. Assessment: The process of systematically evaluating and examining the knowledge, attitude, practice, and support of exclusive breastfeeding practices among mothers and infants in three selected Primary Healthcare Centres in Ibadan North Local Government area.

2. Knowledge: The understanding and awareness that mothers have regarding exclusive breastfeeding, encompassing the relevant information about its benefits, duration, and techniques.

3. Attitude: The emotional and psychological disposition of mothers towards exclusive breastfeeding, including their beliefs, perceptions, and feelings related to the practice.

4. Practice: The actual implementation and observance of exclusive breastfeeding by mothers, encompassing the initiation, duration, and adherence to recommended practices for breastfeeding infants.

5. Support: The assistance, encouragement, and facilitation provided to mothers in their efforts to practice exclusive breastfeeding, including emotional, informational, and practical support from healthcare professionals, family, and community.

6. Exclusive Breastfeeding Practices: The act of feeding infants only breast milk, without the introduction of any other liquids or solid foods, for a specified period, usually the first six months of life.

7. Health Status: The overall well-being and health conditions of both mothers and infants, encompassing physical, mental, and social aspects.

8. Mothers: Women who have given birth and are responsible for the care and nurturing of their infants.

9. Infants: Children in the early stages of life, typically from birth to the age of one year.

10. Primary Healthcare Centres: Local healthcare facilities that provide essential and basic health services to the community, often including maternal and child health services.

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CHAPTER TWO

LITERATURE REVIEW

2.0: INTRODUCTION

Exclusive breastfeeding plays an essential role in shaping the health outcomes of both mothers and infants, serving as a cornerstone for early childhood development and maternal well-being. This literature review seeks to provide a comprehensive understanding of exclusive breastfeeding practices by investigating into various dimensions: conceptual review, theoretical review, and empirical review. The main benefit of conducting a comprehensive literature review encompassing conceptual, theoretical, and empirical dimensions is establishing a strong foundation for understanding exclusive breastfeeding practices, allowing for amalgamating existing knowledge and identifying of gaps to inform evidence-based interventions and policies.

2.1 CONCEPTUAL REVIEW

The conceptual review aims to explain the definition and importance of exclusive breastfeeding, shedding light on the challenges in its operationalization and underscoring its profound significance for the health of mothers and infants. Additionally, this concept explores the knowledge landscape surrounding exclusive breastfeeding, considering factors that influence mothers' awareness, such as socioeconomic status, healthcare education, and cultural beliefs. Furthermore, the conceptual review examines the attitudes towards exclusive breastfeeding, uncovering social, cultural, and religious factors that shape perceptions and behaviors. The review also addresses the critical aspect of spousal support on exclusive breastfeeding.

2.1.1: Concept of Exclusive Breastfeeding (Definition and Importance)

Malnutrition contributes to more than half of global under-five childhood deaths and over two-thirds of these deaths which occur in the first year of life are often associated with inappropriate

breastfeeding or feeding practices[1]. In 2018 worldwide, 2.7 million children had died from malnutrition and this accounted for 45% of global deaths in which most of these deaths were in Africa and Asia[2]. Evidently, breastfeeding is regarded as the most cost-effective public health measure that significantly impacts infant morbidity and mortality in developing countries in which Nigeria is not exempted[1]. As regards to sub-Saharan Africa, despite the promotion of exclusive breastfeeding in most countries, many children still do not benefit from this nutritional privilege for up to 6 months and the number of malnourished children continues to increase from 3.7 million in 2017 to 6.3 million in 2018[2]. Thus, inadequate exclusive breastfeeding practice also increases the risk of infant death.

Furthermore, according to UNICEF, an exclusively breastfed infant has a 14-fold lower risk of death than a non-breastfed infant[2]. Exclusive breastfeeding simply means a practice of which infants receive only breast milk and not even water, or liquids, tea, herbal preparations or food during the first six months of life with the exception of vitamins, mineral supplements or medicine[3]. Apparently, in Nigeria many changes in infant feeding practices have occurred over time due to the introduction of alien cultures and the effects of urbanization[4]. This is of serious concern, because of the advantage of exclusive breastfeeding in reducing childhood morbidity and mortality[4].

In addition, breastfeeding advantages for the mother includes: prevention of ovarian and breast cancer, child spacing, optimal mother to child bonding as well as reduced feeding cost and as for the infant, it is considered a rich source of immunoglobulins which are protective against early childhood diseases[4]. Some other advantages for the infants include: reduce incidences of allergies, reducing possibility of enterocolitis and obesity, improved neuro-cognitive development amongst others[4]. However, breastfeeding is very essential for optimal growth and

wellness of a child and should ideally be commenced within 30minutes of birth for vaginal deliveries and 4hours of birth for caesarian deliveries[4]. Therefore, the decision to breastfeed is influenced by both the knowledge and attitude of mothers towards breastfeeding.

2.1.2: Knowledge of Exclusive Breastfeeding

Breastfeeding knowledge plays an essential role in maternal ability to take an informed decision on infant nutrition[5]. Thus, the maternal decision about breastfeeding is affected by several factors, including socio-demographic, labour and child-related[5]. Based on studies from developing and developed countries, pregnant women with better breastfeeding knowledge more often plan to breastfeed, which is crucial for following breastfeeding recommendations later on[5]. However, the knowledge about breastfeeding also influences the duration of nursing among mothers, who have already started breastfeeding [5]. Some factors influencing mothers' knowledge about exclusive breastfeeding practices, including socioeconomic status, healthcare education, and cultural beliefs among others[6].

In addition, the varied knowledge is common in different parts of African countries due to several factors particularly the literacy levels and the accessibility to information desks on health matters[6]. For instance, the study conducted among mothers attending an Infant Welfare Clinic in Osogbo, Osun State, Nigeria, revealed that 64.6% of respondents had knowledge that exclusive breastfeeding should continue until 6 months, which is not in consonance with a study done in Ethiopia where it was reported that 83.4% of mothers were knowledgeable about the recommended duration of exclusive breastfeeding[6]. However, maternal opinions and knowledge, which are easily modifiable by educational programs or peer support, have a key role[5]. A study conducted in Kenya reported that maternal knowledge about breastfeeding, culture of infant young child feeding as well as work and other family responsibilities affected rates of exclusive

breastfeeding but no association was found to exist between maternal knowledge and duration of exclusive breastfeeding[7].

Furthermore, the maternal knowledge on the benefits of breastfeeding is crucial for successful breastfeeding as the mother's knowledge influences choice of infant feeding[7]. Based on the study conducted in Indonesia, breastfeeding knowledge is mother's practical understanding about exclusive breastfeeding[7]. There are several elements concerning breastfeeding knowledge, such as knowledge about breastfeeding benefits to the baby and to the mother, knowledge about benefits of colostrums, knowledge about appropriate feeding, duration of feeding, complementary feeding time and knowledge about problems with breastfeeding[7].

Moreover, out of the 6.9 million deaths of children less than five years in 2017, about 1 million of those children could have been spared of their lives through practices of exclusive breastfeeding[8]. Thus, adequate understanding about practices of exclusive breastfeeding in addition to knowledge is considered to be the solution to solving this problem[8]. This is due to the fact that a study conducted on knowledge of the importance of exclusive breastfeeding for the first 6 months, pointed that the knowledge level of participants was (35.7%), which was seen to be relatively high meanwhile only about half of the participants (17.9%) practiced exclusive breastfeeding[8]. However, this emphasizes the point that knowledge alone is not enough to achieve exclusive breastfeeding[8]. Therefore, knowledge determines the attitude and the attitude of the people in turn dictates their practices[6].

2.1.3: Practice towards Exclusive Breastfeeding

The practice of exclusive breastfeeding, which involves feeding infants only breast milk for the first six months of life, is a well-documented intervention for preventing infant morbidity and mortality[1]. Globally, exclusive breastfeeding has the potential to prevent approximately 1.4

million child deaths every year[9]. However, the global rate of exclusive breastfeeding is relatively low, with only 41% of infants under six months receiving exclusive breastfeeding[9]. The target set for 2030 is to achieve a global exclusive breastfeeding rate of 70%, but this remains an ambitious goal due to various impediments[9]. Several factors influence the continuation of exclusive breastfeeding practice among lactating mothers' worldwide[9]. These include geographical factors such as living area and place of delivery, socioeconomic factors like a mother's education level, employment status, and family income, as well as individual and health-related factors, including the mother's age, mode of delivery, and cultural practices[9]. The support and guidance provided by healthcare professionals are also critical in determining whether a mother adheres to exclusive breastfeeding practices[9].

In high-income countries, the exclusive breastfeeding rates are significantly lower than in low- and middle-income countries[10]. For instance, exclusive breastfeeding rates in the United States, the United Kingdom, and Australia are reported to be 19%, 1%, and 15%, respectively[10]. These figures reflect the shorter breastfeeding durations in high-income countries compared to those in low-income and middle-income countries, where 37% of infants younger than six months are exclusively breastfed[10]. In sub-Saharan Africa, only 53.5% of infants are exclusively breastfed for six months, falling short of the World Health Organization's (WHO) target of 90%[10]. In the Nigerian context, while there is a wealth of knowledge on breastfeeding, various socio-cultural and economic factors limit breastfeeding practices[3]. For instance, many working mothers are unable to maintain exclusive breastfeeding due to the demands of their jobs and the short period of maternity leave granted to them[3]. However, promoting efficient and effective interventions that provide quality support for nursing mothers requires significant efforts from all stakeholders,

including government, non-governmental organizations (NGOs), and healthcare systems, to support breastfeeding practices and improve infant health outcomes[3].

2.1.4: Attitude towards Exclusive Breastfeeding

A mother's decision to breastfeed is largely influenced by knowledge and attitudes towards breastfeeding, which are often shaped during adolescence and early adulthood[1]. Positive attitudes toward exclusive breastfeeding are critical in ensuring adherence to the practice, as recommended by global health organizations[1]. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) advocate for the initiation of breastfeeding within the first hour of birth, exclusive breastfeeding for the first six months of life, and continued breastfeeding for up to two years or beyond, alongside the introduction of adequate complementary foods[10]. Despite these recommendations, attitudes towards exclusive breastfeeding remain undermined in many parts of the world[10]. In Africa, for instance, attitudes toward exclusive breastfeeding are still weak, despite knowledge of its benefits[10]. Similarly, high-income countries also report low levels of breastfeeding practices compared to low- and middle-income countries[10]. This gap between knowledge and practice can be attributed to several factors, including cultural beliefs, the mother's confidence in her ability to breastfeed, and societal norms surrounding breastfeeding, particularly in public spaces[10].

Globally, adherence to exclusive breastfeeding guidelines is inconsistent[10]. For example, only 38% of infants are exclusively breastfed for the first six months of life[10]. The rates in high-income countries, such as the United States, United Kingdom, and Australia, are particularly low, with exclusive breastfeeding rates of 19%, 1%, and 15%, respectively[10]. In contrast, low- and middle-income countries report higher breastfeeding rates, yet these still fall short of the WHO target[10]. For instance, only 53.5% of infants in East African countries are exclusively breastfed

for the first six months, a figure that highlights the need for more targeted interventions to improve attitudes toward exclusive breastfeeding[10].

In Nigeria, despite an understanding of the importance of exclusive breastfeeding, many mothers face challenges within their socio-cultural framework that hinder their ability to practice exclusive breastfeeding[3]. Many mothers, particularly those who work, struggle to balance the demands of breastfeeding with their professional obligations, which often leads to early cessation of breastfeeding[3]. Addressing these challenges requires a concerted effort from various stakeholders to design policies and programs that promote positive attitudes toward exclusive breastfeeding and provide the necessary support to mothers[3].

2.1.5: Spousal Support for Exclusive Breastfeeding

Spousal support plays a crucial role in the success and sustainability of exclusive breastfeeding, which involves feeding infant only breast milk for the first six months of life[11]. This support can significantly influence a mother's ability to maintain breastfeeding, impacting both maternal and infant health outcomes positively[11]. Thus, understanding the multifaceted nature of spousal support is very important in the breastfeeding journey. Emotional support from a spouse is essential in helping a mother navigate the challenges of exclusive breastfeeding[11]. This includes providing encouragement and reassurance, which can help alleviate the stress and anxiety that new mothers often experience[11]. Positive reinforcement from a partner can boost a mother's confidence in her ability to breastfeed, leading to a more enjoyable and successful breastfeeding experience[11]. Also, emotional support also involves being patient and understanding the emotional fluctuations a mother might go through during this period[11].

Additionally, practical support from a spouse is equally important. This can involve taking on additional household responsibilities, such as cooking, cleaning, and caring for older children,

which allows the breastfeeding mother to rest and focus on feeding the baby[12]. Practical support also includes being actively involved in night-time routines, such as changing diapers and soothing the baby back to sleep, which can help reduce the mother's fatigue and stress levels[12]. Thus, by sharing these responsibilities, the partner helps create a supportive environment conducive to exclusive breastfeeding. Informational support is another critical aspect where spouses can make a significant difference. This involves spouse educating themselves about the benefits and challenges of breastfeeding, spouses can provide valuable information and resources to the breastfeeding mother[12]. This can include researching breastfeeding techniques, understanding common issues like latching problems or milk supply concerns, and knowing where to seek professional help if needed[12]. However, an informed spouse can help the mother navigate difficulties and stay committed to exclusive breastfeeding.

Furthermore, the presence of a supportive spouse can help buffer the mother from negative societal pressures and misconceptions about breastfeeding[13]. Cultural and societal attitudes towards breastfeeding can sometimes be discouraging or judgmental[13]. A supportive partner can advocate for the mother, defending the mother's decision to exclusively breastfeed and helping to create a positive environment both at home and in social settings[13]. This advocacy can reinforce the mother's resolve to continue breastfeeding despite external pressures[13]. The health benefits of exclusive breastfeeding are well-documented, including optimal nutrition, enhanced immune protection for the infant, and a lower risk of certain illnesses for both mother and child[13]. Spousal support can enhance these benefits by helping mothers adhere to exclusive breastfeeding recommendations. When mothers feel supported, mothers are more likely to overcome challenges and continue breastfeeding for the recommended duration, ensuring that their infants receive the best possible start in life[13].

In addition to direct support for breastfeeding, spouses can also contribute by promoting a healthy lifestyle that supports lactation[13]. This includes ensuring that the mother has access to nutritious food and adequate hydration, which are crucial for maintaining a good milk supply[13]. Also, encouraging regular rest and stress management can also help maintain lactation and the overall well-being of the mother[13]. Moreover, spousal support during breastfeeding can strengthen the marital relationship[14]. Shared experiences and mutual support in the care of their infant can enhance intimacy and understanding between partners[14]. Thus, when spouses work together towards the common goal of supporting breastfeeding, it can foster a sense of teamwork and mutual respect, contributing to a stronger, more resilient family unit. Despite the clear benefits, some spouses may not naturally know how to provide the necessary support. It is important for healthcare providers to involve both parents in breastfeeding education and support programs[14]. This approach can equip spouses with the knowledge and skills needed to effectively support their breastfeeding partners. However, this proactive approach can help ensure that both parents are prepared to tackle the challenges of exclusive breastfeeding together[14].

2.1.6: Other Means of Support for Exclusive Breastfeeding

Breastfeeding is a recognized means of ensuring optimal nutrition for the infant but without workplace support, exclusive breastfeeding is difficult for working mothers who return to work[15]. It is of no doubt that as a result of rapid changes in the socio-cultural and economic situations worldwide, particularly the rapid urbanization and developing processes going on in developing countries, and the increasingly harsh economic environment, the need for income producing activity of women has increased[15]. Obviously, the educational and occupational status of the mother is an attribute that help determine the time allocation for women and children that in turn influence breastfeeding practices[15]. However, considering the numerous benefits of breastfeeding

it is important that employed women understand its importance and are given the required support at every level[15].

Furthermore, the exclusive breastfeeding habits are an untapped solution which is overlooked by mothers due to social or cultural and even peer beliefs[16]. Thus, some of the major factors that could be responsible for low prevalence of exclusive breastfeeding are mother's lack of formal education, lack of counseling regarding breastfeeding during hospital visit leading to lesser knowledge of exclusive breastfeeding especially in lower socio-economic sectors and other factors such as resuming work early after childbirth, poor family support, negative impact on exclusive breastfeeding by using bottle feeding and pacifiers[16]. Also, breastfeeding is sometimes stopped due to certain difficulties faced such as breast pain, cracks, mastitis, suction problems, which can be subjected under control through hospital and clinical intervention and support[16].

In addition, there is lack of data regarding the number of Nigerian women employed within 6 months following birth[15]. The duration of constitutional maternity leave for working mothers in Nigeria is only 3 months, and support such as facilities for breast milk pumping and storage in the workplace are not widely available in both private and government facilities[15]. Thus, an unfavourable working environment can make it difficult for mothers to implement and continue exclusive breastfeeding[15]. Therefore, in recognition of the problems faced by working mothers in practicing exclusive breastfeeding, the World Breastfeeding Week 2015 adopted the theme, "Breastfeeding and work: let's make it work", to gather support from all sectors in order to enable women worldwide to work and breastfeed successfully but yet there is paucity of data related to support systems for breastfeeding mothers in the workplace in Nigeria[15].

Moreover, the main barriers exclusive breastfeeding practices in Ibadan North Local Government Area in Oyo State include occupation (90.00%), insufficient milk (71.43%),

spouse's influence (66.19%), influence of extended family (62.38%) and inadequate time (54.76%) [17]. Thus, there is a need for women to be empowered through informal education on the benefits of exclusive breastfeeding and regular prenatal counseling should be advocated, both to enhance informed decision-making and to reduce infant mortality[17]. Therefore, despite the numerous benefits of breastfeeding, several studies have shown that women are neither able to meet goals of exclusive breastfeeding, nor adhere to expert recommendations for continued exclusive breastfeeding[17]. This is due to some of the major factors that affect exclusive breastfeeding practices and duration of breastfeeding which include, breast problems, such as sore nipples or the woman's perceptions that she is producing inadequate milk; societal barriers, such as employment and length of maternity leave; inadequate breastfeeding knowledge; lack of familial and societal support; and a lack of guidance and encouragement from health professionals which all serves as impediment towards effective and efficient breastfeeding support[17].

2.2: THEORETICAL REVIEW

In the theoretical review, various infant feeding theories views by others scholars are examined to understand the fundamental theories that influence feeding choices. Theoretical models related to health behavior change, like Theory of Planned Behaviour and Health Belief Model, are explored to provide understandings into promoting behavior change concerning exclusive breastfeeding. Social Cognitive Theory is also critically examined in order to understand how exclusive breastfeeding impacts maternal health outcomes. Considering exclusive breastfeeding programmes within various infant feeding theories is a step in the right direction because theories can sensitize researchers and practitioners to contextually relevant factors and processes appropriate for effective exclusive breastfeeding strategies[18].

2.2.1: Theory of Planned Behavior (TPB)

The Theory of Planned Behavior (TPB) offers a valuable theory for critically analyzing exclusive breastfeeding knowledge, practices, support, and attitudes. This theory indicated that individual behaviour is determined by intentions, which are influenced by three primary constructs: attitudes, subjective norms, and perceived behavioral control[19]. The TPB is an effective theory to predict behavior change and has been also used in predicting breastfeeding behaviour[19]. Additionally, increasing studies have evaluated the associations between knowledge, attitude, subjective norm and practice control and breastfeeding behaviour[19]. Thus, the ability of the theory in predicting continuous behavior such as exclusive breastfeeding has been challenged[20]. However, other variables were added into the theory to improve its predictive ability, including initial breastfeeding experiences, initiation and maintenance of the behavior[20]. This is due to the fact that postpartum support and breastfeeding difficulty experienced after the initiation of exclusive breastfeeding may improve the prediction of its maintenance[20].

In the context of exclusive breastfeeding knowledge, attitudes refer to a breastfeeding mothers overall evaluation of the behavior. Knowledge about the benefits of breastfeeding is significantly associated with breastfeeding attitude, and positive attitude leads to successful breastfeeding initiation and a longer duration[19]. Evidently, mothers with a positive attitude toward breastfeeding are also likely to sustain breastfeeding at 6 months[19]. Positive attitudes towards exclusive breastfeeding, such as recognizing its health benefits, may enhance the likelihood of adopting this practice. Conversely, negative attitudes, perhaps stemming from misconceptions or lack of awareness, could act as barriers. However, assessing exclusive breastfeeding practices, the TPB's emphasis on intentions as the immediate precursor to behavior which highlights the importance of understanding the factors shaping breastfeeding mothers' intentions to exclusively

breastfeed[20]. Therefore, interventions promoting knowledge, debunking myths, and addressing misconceptions can positively impact attitudes, thereby enhancing the likelihood of adopting exclusive breastfeeding practices[20].

Furthermore, Subjective norms play a pivotal role in the social context of exclusive breastfeeding. The perceived social pressure to conform to specific behaviors, shaped by family, friends, and cultural influences, can significantly impact breastfeeding mothers decision to exclusively breastfeed[19]. Support from these social networks is crucial; positive reinforcement and encouragement contribute to the formation of favorable subjective norms[19]. Support is a critical factor in the successful implementation of exclusive breastfeeding. TPB emphasizes the significance of subjective norms, and support from healthcare professionals, family, and community can positively influence caregivers' intentions and practices[21]. Additionally, enhancing support mechanisms, such as lactation counseling and community programs, aligns with the TPB's framework for behavior change[21]. TPB's application to exclusive breastfeeding attitudes emphasizes the need for targeted interventions addressing misconceptions and promoting positive beliefs[19].

Moreover, perceived behavioral control reflects an individual's belief in their ability to perform a behavior. In the case of exclusive breastfeeding, factors like knowledge about lactation, access to support, and workplace policies can influence perceived control[21]. A study indicated that the most common barrier is the perception of inadequate milk supply during an early period[19]. Barriers, such as inadequate information or unsupportive environments, may hinder a breastfeeding mother’s confidence in practicing exclusive breastfeeding which can be amended through education[19] A study conducted in Kelantan community in Malaysia indicates the fact that perceived behavioral control was the strongest predictor of intention, followed by attitude[20]

Educational campaigns can play a vital role in shaping attitudes by providing evidence-based information on the health benefits of exclusive breastfeeding, dispelling myths, and fostering a supportive cultural and social environment[19].

2.2.2: Social Cognitive Theory (SCT)

The environment and human beings are reciprocal predictors of one another[8]. Social Cognitive Theory (SCT), developed by Bandura, is a widely recognized framework in psychology that emphasizes the role of observational learning, imitation, motivation and social influence in shaping human behavior[22]. Evidently, exclusive breastfeeding practice is affected by health promotion program, observational learning, role model, vicarious learning, imitation, attitude, outcome expectation, self-regulation, self-efficacy, and reinforcement[23]. When applied to Exclusive Breastfeeding (EBF) knowledge, attitude, practice, and support, SCT provides valuable understandings into how individuals acquire and maintain behaviors related to breastfeeding. Thus, SCT can be used as basis to improve intervention on early breastfeeding initiation[24].

Furthermore, considering promotion of breastfeeding behaviour, the predictive strength of breastfeeding intention as a social cognitive variable is attributed to socio- demographic and cognitive factors that are viewed as determinants of the intention to breastfeed[25]. Some of these factors include, mother's age and education level, family household income, number of children, mother's knowledge about benefits of breastfeeding, previous breastfeeding experience, and attitude towards breastfeeding among others[25]. This explained the fact that Bandura's theory emphasizes reciprocal determinism, including the dynamic interaction between individual factors, behavior, and the environment. When applied to exclusive breastfeeding, this suggests that

interventions should target not only individuals but also the broader socio-demographic context to create an environment conducive to exclusive breastfeeding[25].

In addition, Social Cognitive Theory describes and explains the mutual interaction between three factors of behavior, people and environment, in which behaviour is influenced by the interaction of human and environmental factors[26]. Some of these human factors include perception, knowledge, belief, confidence, and social norms that can be changed by the intervention program[26]. Also, environmental factors such as social support and norms are influenced by household members, peer groups, government leaders and social organizations[26]. Therefore, Social Cognitive Theory have been applied in designing intervention, a tool for collecting information on role and involvement of mothers and fathers in breastfeeding and nutrition in children[26].

Moreover, social cognitive theory attempts to explain how people regulate their behaviour via reinforcement and control to achieve goal-directed behaviour that can be maintained over time[25]. This theory recognizes how environments shape behaviour, and focuses on people's potential abilities to alter and construct environments to suit purposes the people devise to live. It is of no doubt that breastfeeding is both a health and human behaviour and it is viewed as a product of multiple influences, and one significant source of influence is the web of interactions people have with others within their social circles[25].

Finally, Social Cognitive Theory, goals are defined as plans to acts or intentions to perform a behaviour[25].The outcome expectancy refers to the value attached to the anticipated results or consequences of a person's behaviour and this expected outcome of the behaviour, outcome expectancies are divided into physical, social, and self-evaluative[25]. While, self-efficacy refers to the individual's beliefs in their capabilities to successfully perform behaviour[25]. It is usually

assessed as the degree of confidence that an individual would perform the behaviour in the face of various factors, which are called socio-structural factors[25]. Socio-structural factors in this context refers to as factors that facilitate or inhibit the execution of behaviour[25]. Therefore, in relation to health behaviour, these factors may include living conditions, health systems, political, economic, or environmental systems[25].

2.2.3: Health Belief Model (HBM) Theory

The Health Belief Model denotes the fact that person's perceived threat of an illness together with a person's belief in the effectiveness of the recommended health behavior will predict the likelihood the person will adopt the behavior[27]. The core constructs of the HBM include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to actions and self-efficacy[27]. This model focuses on an individual's perceptions of a health threat and perceived susceptibility is how likely individuals believe to get the condition[27]. Perceived severity reflects how serious individuals view the potential consequences and perceived benefits weigh the advantages of taking action, while perceived barriers consider the downsides[27]. Cues to action are triggers that prompt individuals to act, and self-efficacy is their confidence in successfully following through[27].

Furthermore, multiple studies reported statistically significant improvement in breastfeeding knowledge after educational intervention, supporting the theory that breastfeeding education can improve nurses' knowledge about breastfeeding[28]. This is to support HBM that educational interventions could be cues to action that prompt individual to comply with exclusive breastfeeding principles[27]. Attitude towards breastfeeding can be influenced due to personal breastfeeding knowledge and positive attitudes toward breastfeeding correlated with a higher likelihood to comply[28].

Moreover, healthcare providers' insufficient breastfeeding knowledge and lack of breastfeeding-related skills present a barrier to the support of the breastfeeding and this lack of support contributes to early weaning[28]. Healthcare providers were not confident in their ability to support the breastfeeding and this lack of confidence presented a barrier to effective breastfeeding support[28]. Also, the breastfeeding self-efficacy of nurses positively correlated with their scores on a breastfeeding knowledge assessment[28]. Some other barriers healthcare providers face when providing breastfeeding education to mothers include time constraints, heavy workloads, staffing shortages, unclear breastfeeding policies, inadequate dissemination of policies and procedures, lack of leadership support, and lack of resources[28]. These evidences supported HBM theory as regards to perceived barriers in compliance with exclusive breastfeeding.

In addition, different levels of experience affect and shape exclusive breastfeeding practice in Ghana[29]. Evidently, the decision to practice exclusive breastfeeding, as well as the challenges and strategies employed in managing exclusive breastfeeding, emanates from mothers' personal experiences and interactions with institutional factors[29]. However, there should be counseling on the management of challenges associated with exclusive breastfeeding and provision of accurate information on exclusive breastfeeding to enable mothers practice exclusive breastfeeding[29]. This supported HBM theory in terms of perceived barriers, cues to actions and self-efficacy[29].

2.3.0: Review of Empirical Studies

Exclusive breastfeeding (EBF) refers to the practice of feeding infant only breast milk for the first six months of life, with no additional foods or liquids, not even water, except for oral rehydration solutions or drops/syrups of vitamins, minerals, or medicines[30]. The World Health Organization (WHO) and UNICEF strongly advocate for EBF due to its numerous benefits, which include providing all the necessary nutrients in the proper proportions, protecting against

common childhood illnesses like diarrhea and pneumonia, and promoting sensory and cognitive development[31]. For mothers, EBF can aid in postpartum recovery, reduce the risk of breast and ovarian cancers, and strengthen the maternal-infant bond[31]. Thus, these health benefits underscore the importance of understanding and promoting EBF practices globally, particularly in regions where child and maternal health outcomes need improvement.

In Ibadan North, a bustling urban area within the city of Ibadan, Nigeria, the practice of exclusive breastfeeding is influenced by a myriad of factors including cultural beliefs, socio-economic status, education levels, and healthcare access. Ibadan North is characterized by its diverse population and varying levels of healthcare infrastructure, which can impact mothers' knowledge, attitudes, and practices regarding EBF. The purpose of this empirical review is to assess the current state of EBF among mothers in this region by exploring their knowledge levels, attitudes towards breastfeeding, actual breastfeeding practices, and the influence of spousal support. By gaining a comprehensive understanding of these factors, the review aims to identify gaps and barriers to EBF, ultimately providing insights that can inform policies and interventions to improve breastfeeding rates and child health outcomes in Ibadan North.

2.3.1: Level of Knowledge among Mothers Regarding Exclusive Breastfeeding

Exclusive breastfeeding (EBF) is defined as feeding infant only breast milk for the first six months of life, with no other liquids or solids, except for oral rehydration solutions, drops/syrups of vitamins, minerals, or medicines[30]. This practice is recommended by the World Health Organization (WHO) and UNICEF as the optimal feeding method for infants due to its comprehensive health benefits[3]. Understanding the definition and importance of EBF is crucial for mothers, healthcare providers, and policymakers to ensure clear and consistent communication about breastfeeding practices and their implementation[31]. Adequate knowledge

about EBF directly influences the initiation and continuation of breastfeeding[32]. For infants, EBF provides all necessary nutrients in the correct proportions, helps protect against common childhood illnesses such as diarrhea and pneumonia, reduces the risk of chronic conditions later in life, and supports optimal growth and development[32]. For mothers, EBF aids in postpartum recovery, helps in spacing pregnancies by delaying the return of fertility, and reduces the risk of certain cancers such as breast and ovarian cancer. Awareness of these benefits is essential for encouraging mothers to adopt and sustain EBF practices[32].

Knowledge about EBF also includes understanding practical aspects such as proper latching techniques, the frequency of feeds, and recognizing signs of adequate milk intake in infants[33]. Mothers who are well-informed about these practicalities are more likely to overcome common breastfeeding challenges such as sore nipples, engorgement, and concerns about milk supply. Educating mothers about these aspects can boost their confidence and competence in breastfeeding, thereby enhancing the likelihood of successful EBF[33]. Knowledge about EBF is influenced by various factors including access to healthcare information, cultural beliefs, socio-economic status, and educational background[34]. For instance, mothers with higher levels of education and better access to healthcare services are generally more knowledgeable about EBF and its benefits. Conversely, in regions with limited healthcare infrastructure and lower educational attainment, knowledge gaps are more prevalent. Addressing these disparities through targeted educational interventions and community-based programs is critical for improving EBF rates[34].

Empirical evidence underscores the importance of knowledge about EBF. It was found in a descriptive cross-sectional study of 323 mothers that 72.1% practiced exclusive breastfeeding, with 81.81% having very good knowledge on the topic, and identified factors like mode of

delivery and introduction of prelacteal feeds as significantly related to EBF practices ($p < 0.05$) [35].The study recommended increased support and education from healthcare workers on breastfeeding[35]. A research conducted a cross-sectional study of healthcare workers in Nigeria, finding that overall breastfeeding knowledge was sub sufficient (41.2%), with significant gaps related to breast cancer (13.4%) and hepatitis B (59.4%), and noted that higher education levels were associated with better knowledge, recommending targeted programs to improve support[36]. A study assessed exclusive breastfeeding intentions, knowledge, and attitudes among adolescents in urban Ibadan, finding that only 37.6% intended to exclusively breastfeed, 22.5% had good knowledge, and 50.2% had a positive attitude, with good knowledge and attitude being significant predictors of intention, recommending early EBF education interventions[37]. A study evaluated the Nigeria-UNICEF Country Programme (2018-2022), finding that while the program improved infant feeding practices, it failed to significantly reduce child malnutrition, with wasting rates increasing due to COVID-19's effects on food insecurity and poverty, emphasizing the need for sustained, multisectoral efforts to enhance child nutrition outcomes, improve EBF rates and ultimately enhance child and maternal health [38].

Exclusive breastfeeding, where an infant receives only breast milk without any additional food or drink, offers numerous health benefits for both infants and mothers[39]. This practice, recommended for at least the first six months of life, has profound and far-reaching effects on the health and well-being of both the baby and the mother[39]. Breast milk provides the ideal nutrition for infants, containing the perfect balance of nutrients needed for a baby's growth and development because it is rich in essential fatty acids, lactose, vitamins, and minerals[39]. The composition of breast milk adapts to the changing needs of the growing baby, ensuring that the infant receives optimal nourishment required to their developmental stage[39].

Additionally, breast milk is packed with antibodies, particularly immunoglobulin A (IgA), which plays a crucial role in building the infant's immune system[40]. These antibodies help protect infants from infections and diseases, such as respiratory infections, ear infections, and gastrointestinal issues[40]. Thus, providing this natural immunity boost, breastfeeding significantly lowers the risk of the infant contracting illnesses during their early, vulnerable months. Also, breastfeeding is associated with improved cognitive development and higher IQ scores in children[40]. The presence of long-chain polyunsaturated fatty acids (LC-PUFAs) in breast milk, such as DHA (docosahexaenoic acid), is believed to support brain development[40]. However, the physical and emotional bonding during breastfeeding also contributes to cognitive and emotional development. Breastfeeding fosters a strong emotional bond between the mother and infant. The skin-to-skin contact and the act of nursing provide a sense of security and comfort to the baby[40]. This bonding experience is critical for the infant's emotional and psychological development, helping to establish a secure attachment, which is fundamental for future social and emotional well-being[40].

Moreover, exclusive breastfeeding has been linked to lower risk of developing chronic conditions later in life, such as obesity, type 2 diabetes, and cardiovascular diseases[41]. The early introduction of breast milk influences the metabolic programming of the infant, promoting healthier long-term eating habits and metabolic health. For mothers, exclusive breastfeeding offers several health advantages. It aids in postpartum recovery by helping the uterus contract and reducing postpartum bleeding[41]. Breastfeeding also burns extra calories, which can assist in returning to pre-pregnancy weight[41]. Additionally, it lowers the risk of breast and ovarian cancers, and the risk of osteoporosis later in life[41]. Also, breastfeeding is cost-effective, eliminating the need for expensive formula, bottles, and other feeding supplies[42]. Breastfeeding contributes to

environmental sustainability by reducing waste and the carbon footprint associated with the production, packaging, and transportation of formula[41]. This eco-friendly aspect indicates the broader benefits of breastfeeding for society[41].This are evidence that promoting exclusive breastfeeding can have significant public health implications. Higher rates of breastfeeding can lead to a reduction in healthcare costs by decreasing the incidence of infant illnesses and chronic diseases[42]. However, public health campaigns that encourage breastfeeding can improve health outcomes for the population, contributing to a healthier society overall[42].

2.3.2: Factors Influencing Exclusive Breastfeeding Knowledge Levels

Exclusive breastfeeding (EBF) for the first six months of an infant's life is widely recognized as the optimal feeding practice, providing essential nutrients and antibodies that support growth and immunity[43]. The World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) strongly advocate for EBF, as it is associated with numerous health benefits for both the infant and the mother[43]. Despite its recognized importance, global adherence to EBF remains suboptimal, with various factors influencing mothers' knowledge and practices regarding breastfeeding[43].

Socio-economic status (SES) has a crucial role in determining a mother's knowledge and ability to practice exclusive breastfeeding. Mothers from higher-income families often have better access to resources such as breastfeeding education, lactation consultants, and high-quality healthcare services[44]. Employment status is also significant; mothers who work in formal employment with maternity leave benefits are more likely to practice EBF compared to those in informal jobs where returning to work soon after childbirth may be necessary[44]. The financial stability of a household can influence whether a mother feels compelled to introduce formula or other foods due to perceived or real challenges in maintaining exclusive breastfeeding[44]. Mothers

from higher socio-economic backgrounds are often better informed about the benefits of EBF, owing to their access to a wider range of educational materials and healthcare services[44]. Conversely, mothers in lower socio-economic groups may lack access to such resources, leading to lower knowledge levels about EBF[44]. The disparity in access to education and healthcare resources significantly impacts a mother's ability to make informed decisions about breastfeeding[44].

Furthermore, education is one of the most significant determinants of knowledge regarding exclusive breastfeeding. Mothers with higher levels of formal education are generally more aware of the health benefits of EBF and more likely to seek information from reliable sources[44]. Studies have shown that educated mothers are more likely to understand the importance of exclusive breastfeeding and adhere to recommended practices[44]. Health literacy, defined as the ability to obtain, process, and understand basic health information, is closely linked to educational attainment[43]. Mothers with higher health literacy are better equipped to comprehend breastfeeding guidelines and the long-term benefits of EBF[44]. Mothers in that category are also more likely to critically assess the information they receive, whether from healthcare providers, media, or community sources, and apply it effectively in their breastfeeding practices[44].

Cultural beliefs and practices are powerful influences on breastfeeding knowledge and behavior. In many cultures, traditional beliefs about infant feeding can either support or hinder exclusive breastfeeding[45]. For example, in some cultures, it is believed that giving water to newborns is essential, which contradicts the EBF guidelines that recommend giving only breast milk[45]. These cultural norms and practices can significantly influence a mother's decision-making process regarding EBF[45]. In many communities, elder women and other influential community members play a key role in advising new mothers on infant feeding practices[45]. If these influential figures

hold beliefs that are contrary to EBF, they can impact a mother's knowledge and decisions[45]. Conversely, in communities where EBF is supported by cultural norms, mothers are more likely to practice it[45].

In addition to traditional beliefs, modern influences such as media and social networks also shape breastfeeding knowledge[46]. The portrayal of infant feeding in media, including advertisements for formula milk, can create misconceptions and reduce the prevalence of EBF[46]. Social networks, both offline and online, provide platforms where mothers share experiences and information, which can either support or undermine EBF practices[46]. Healthcare providers play a critical role in disseminating information about exclusive breastfeeding[43]. Regular antenatal visits provide an opportunity for healthcare professionals to educate expectant mothers about the benefits of EBF and address any concerns or misconceptions[43]. However, the quality and consistency of information provided can vary greatly. Healthcare providers who are well-trained in breastfeeding support are more likely to effectively communicate the importance of EBF, whereas those who lack training may provide incomplete or even contradictory advice[46].

2.3.3: Attitude of Mothers towards Exclusive Breastfeeding

The decision to breastfeed is presumably made during adolescence, it is important to understand the perspectives of adolescents in order to develop timely interventions[37]. Breastfeeding and other complementary feeding techniques are important for a child's growth and development and require moms to go through a difficult adaptation process while raising a child[43]. Less than 40% of infants aged 0 to 6 months are exclusively breastfed worldwide, which is significantly less than the 70% global target set for 2030.1 Research has shown that non-exclusive breastfeeding contributes to 11.6% of child mortality in children under the age of five[37]. WHO statistics show that 95% of births in low- to middle-income countries occur to mothers under the age of 20, with

sub-Saharan Africa having the highest rates of this population[37]. Nonetheless, optimum breastfeeding has the potential to save around 820,000 children under the age of 5 years each year[37]. Nigeria appears to have a low EBF of 17%, while World Bank data indicated that 22.9% of Nigerian women are young moms[37]. The low EBF rate and rise in adolescent pregnancies indicate that adolescents' intentions to engage in EBF should be recorded. Research has shown that having the correct knowledge enhances understanding and cultivates a positive attitude, both of which are critical factors in the decision to breastfeed[37].

Furthermore, being 35 years of age or older and having an unplanned pregnancy were found to reduce the likelihood of having a strong intention to exclusively breastfeed an infant[37]. Other factors associated with the practice of EBF include age of mothers, inadequate support from significant others, and inaccurate information about the practice[37]. These suggestions are based on the well-established benefits it offers to both the mother and the infant[37]. Also a semi-structured questionnaire, administered by interviewers, was used in this community-based cross-sectional study to measure the intention, knowledge, and attitude of 271 Nigerian teenagers, aged 15-19, living in urban neighbourhoods in Ibadan, Nigeria, regarding breastfeeding exclusively[43]. Using proportions from a prior study with teenage schoolgirls, the Leslie Kish method was used to estimate the sample size for this investigation. Being between the ages of 15 and 19 and never having given birth or been breastfed previously were the inclusion criteria 2 INQUIRY for this research. Respondents from the communities were chosen using a multi-stage (4-stage) sampling technique[43].

Verbal informed consent was gained from respondents who were minors, while written informed consent was collected from respondents who were 18 years of age and the parents/guardians of those who were underage[43]. The questionnaire had already been pre-tested, standardized, and the

field assistants had received training. The data were analyzed using logistic regression at the 5% level of significance, the chi-square test, and descriptive statistics. The research was conducted from May 2019 to January 2020[43]. The majority of teenagers showed little desire to breastfeed. The efficacy of treatments aimed at addressing this practice should take into account the EBF intention, which was shaped by several factors[43]. Thus, in order to reap the many benefits of exclusive breastfeeding, there is an urgent need for integrated breastfeeding education programs that start in youth and advance the practice by adulthood[43].

2.3.4: Impact of Attitude on Breastfeeding

The goal of breastfeeding support policies is to provide moms with informational, practical, and other types of assistance so they can initiate and maintain nursing[47]. The World Health Organization (WHO) and United Nations Children Fund (UNICEF) have supported the Baby-Friendly Hospital Initiative (BFHI), which comprises ten steps to implement breastfeeding practices, including rooming-in and on-demand feeding[47]. Since breast milk conveys a balanced diet that is essential to a child's entire growth and development, this directly affects the health of newborns[47]. A lot of hospitals have qualified lactation consultants who work one-on-one with many new moms to make sure that babies benefit from the immunoglobulin and immunological elements in breast milk that protect them from illnesses and infections[47].

Furthermore, support groups led by the community, such as La Leche League International (LLLI), organize regular support meetings and provide one-on-one mentoring[47]. By encouraging and supporting breastfeeding, many of these organizations help to lower the occurrence of chronic disorders in children, such as obesity, type 2 diabetes, asthma, and certain malignancies[47]. Health professionals provide nutritional guidance to mothers participating in home visitation

programs to ensure that their infants are exclusively breastfed, which improves cognitive development and raises the infant's IQ[47]. Laws requiring compliance with the necessary accommodations for working m others such as providing private spaces, educating the public and mothers about the benefits of breastfeeding, and granting breaks for nursing or milk expression help to maintain breastfeeding practices[47]. Breastfeeding is supported and promotes the long-term health of the babies when laws and regulations are created upholding the rights of women who wish to breastfeed and ensuring that information about breastfeeding is incorporated into legislation[47].

Additionally, despite breastfeeding being a natural event, certain societies view it as scandalous, and women who engage in this practice are generally viewed as being vulgar[47]. Because of this, some moms find it uncomfortable or even embarrassing to nurse in public[47]. For example, certain distinct cultural myths and beliefs may dissuade women from maintaining the advised practice of exclusive nursing for those, the significance has been explained[47]. Furthermore, there's the restriction of not being able to receive assistance when looking for work. Some companies offer either little or no paid parental leave, or they don't provide enough space in the workplace for breastfeeding mothers[47]. It is particularly difficult for younger moms since they are compelled to work and cannot afford to take maternity leave due to their low financial means[47].

When it comes to supporting breastfeeding mothers, healthcare systems can fall short. These shortfalls include the underprepared healthcare workforce for supporting breastfeeding mothers, the lack of information provided to expectant mothers during antenatal care clinic visits regarding breastfeeding, or the lack of lactation consultants[47]. Additionally, one type of barrier that mothers are likely to face if they choose to exclusively breastfeed is financial because

mothers may believe that formula milk is a reasonable option, particularly for those who must return to work soon after giving birth[43].

2.3.5: Breastfeeding Practices Commonly Adopted by Mothers

Prominent international health agencies advise not introducing any other meal to a newborn for the first six months of life after they are breastfed exclusively[48]. A study showed that exclusive breastfeeding is essential in supporting an infant's physical, mental, social development, and disease protection[49]. This is because some of the nutrients found in breastmilk assist strengthen and increase an infant's immune system and lower their risk of death and morbidity[50].

Additionally, findings showed that a disproportionately small percentage of infants worldwide especially in small- and middle-income nations like Nigeria are fed exclusively breast milk during the first six months of their lives[49]. Although numerous tactics have been employed to improve the knowledge and application of exclusive breastfeeding, there is still a dearth of research on the possible effects of radio advocacy programs in urban areas, notably in Enugu, Nigeria[49]. Due to its multicultural makeup and fast population growth, Enugu presents both special potential and problems for the promotion of newborn health[51]. This emphasizes the necessity of doing methodical and ongoing scientific research to support child health advocacy through the use of media apparatuses to reach the important parties involved in decisions about breastfeeding infants[52].

In this sense, radio is an excellent medium for reaching nursing moms, especially in urban areas, as it is a widely available and regularly used medium for communicating health-related information in Nigeria[53]. This is due to its widespread use, capacity to overcome barriers and

illiteracy, as well as geographical constraints, and ability to reach sizable and diverse segments of the population[54].

Research on exclusive breastfeeding practices in Nigeria and Ghana found that misinformation is the main barrier to adherence, with the studies using descriptive survey designs to effectively gather data from large participant groups, providing a comprehensive overview of the issue[49]. Exploring, describing, and elucidating a particular issue can also be done with simplicity using descriptive survey research design[55]. A survey of 380 participants, primarily aged 26–33 and mostly married, found that despite significant exposure to radio advocacy on exclusive breastfeeding, the majority of working-class nursing women in Enugu urban do not practice it, with educational levels ranging from FSLC to master's degrees[49]. This may be explained by the complex interactions between the influences of important stakeholders on breastfeeding decisions made by infants and other socio-cultural barriers like modernization, peer pressure, preconceived notions, and the desire to maintain breast beauty[56].

Comprehensive community-based policies and well-coordinated intervention programs would be needed to address these issues[49]. Regular (re)orientation of nursing mothers as well as other important parties involved in the decision to breastfeed an infant, such as mothers, grandmothers, husbands, caregivers, traditional birth attendants (TBAs), mother-in-laws, and religious leaders, would also be necessary[49]. Furthermore, more nuanced approaches should be used in future interventions and advocacy campaigns, combining messages that are sensitive to cultural differences and dispelling preconceived notions on exclusive breastfeeding as well as modernization effects[57]. Identifying and resolving these factors would enable more focused and ultimately effective campaigns to encourage exclusive breastfeeding among working-class nursing moms[49]. Finally, the efficacy and reach of lobbying can be increased by enlisting the

help of local authorities and medical specialists[49]. Educational programs that are specifically designed to meet the unique obstacles experienced by working-class nursing women may also be more effective in encouraging the adherence to exclusive breastfeeding practices[58].

2.3.6: Factors Shaping Maternal Attitude on Exclusive Breastfeeding

Maternal health literacy (MHL) is a critical determinant of how well women navigate the complexities of pregnancy and childbirth. Defined as the ability to acquire, comprehend, and apply health-related knowledge specific to obstetrics and gynecology, MHL encompasses the cognitive and social skills essential for managing both personal and child health[59]. The significance of MHL in shaping positive health outcomes has been well-documented, with research highlighting its role in promoting effective feto-maternal health through informed decision-making and health management[59].

One area where MHL profoundly impacts maternal attitudes is breastfeeding. Effective breastfeeding practices are crucial for the health and development of both mother and child[60]. Maternal health literacy influences a woman's understanding of the benefits of breastfeeding, proper breastfeeding techniques, and the ability to address common challenges associated with it[61]. Women with higher MHL are better equipped to make informed choices about breastfeeding, which is known to improve infant health outcomes and foster stronger mother-infant bonding[62]. Despite the established advantages of comprehensive MHL, many women in Nigeria face substantial barriers to accessing and understanding health information, including guidance on breastfeeding[59]. Low levels of literacy and numeracy, coupled with difficulties in interpreting medical guidelines, limit the ability of many pregnant women to engage effectively with healthcare resources[63]. This challenge is compounded by significant disparities in maternal

health literacy, with estimates indicating that between 10% and 45.5% of pregnant women in Nigeria struggle with inadequate MHL[59].

The consequences of inadequate MHL extend beyond pregnancy and childbirth, affecting postpartum care, breastfeeding practices, and overall maternal and child health behaviors[64]. For example, women with lower MHL may be less likely to initiate and maintain breastfeeding, which can lead to suboptimal health outcomes for both mother and infant[59].

Addressing this issue requires targeted strategies to enhance maternal health literacy and support effective breastfeeding practices. Researchers emphasize the need for improved educational interventions and resources to bridge the literacy gap and promote better health outcomes[59]. One promising approach is the establishment of a Maternal Health Literacy Institute dedicated to providing midwives with specialized training and resources. This institute would enable midwives to assess maternal health literacy levels and offer tailored support to women, including education on breastfeeding[65]. Additionally, leveraging various media platforms such as radio, television, and billboards can facilitate widespread dissemination of breastfeeding information and support MHL among expectant mothers. Health organizations should also advocate for policies that integrate maternal health literacy into national healthcare strategies, emphasizing the role of midwives in promoting breastfeeding education[66]. Thus, by implementing these recommendations, Nigeria can enhance maternal health literacy, improve breastfeeding practices, and ultimately achieve better maternal and child health outcomes[67]. Investing in maternal health literacy and education will be crucial for addressing health inequities and ensuring the well-being of mothers and infants across the country[59].

2.3.7: Challenges and Barriers of Exclusive Breastfeeding

Exclusive breastfeeding (EBF) is widely recognized for its crucial role in infant health, providing optimal nutrition and fostering a strong bond between mother and child. Despite its benefits, EBF faces significant challenges globally, including in developing regions like Nigeria. This write-up explores the barriers to achieving EBF, particularly focusing on adolescent perspectives, cultural factors, and educational gaps. Globally, less than 40% of infants aged 0 to 6 months are exclusively breastfed, falling short of the 70% target set for 2030[37]. In Nigeria, the EBF rate is alarmingly low at 17%, exacerbated by a high prevalence of adolescent pregnancies, with 22.9% of Nigerian women being young mothers[37]. The disparity between recommended practices and actual breastfeeding rates highlights significant challenges. Adolescents' intentions regarding EBF are influenced by their knowledge and attitudes towards breastfeeding. Research indicates that accurate information is crucial for developing positive breastfeeding attitudes[37]. However, many adolescents lack sufficient knowledge about the benefits and practices of EBF, which impedes their ability to make informed decisions. Adolescents face unique challenges such as limited access to healthcare resources, inadequate support from family or significant others, and societal pressures[37]. These factors contribute to their difficulties in committing to EBF[37]. The socioeconomic background of young mothers, including lower educational attainment and financial constraints, further complicates their ability to practice EBF effectively[37].

Cultural and societal beliefs play a significant role in shaping breastfeeding practices. In some communities, there are misconceptions about breastfeeding, such as beliefs that it is degrading or that infants should be given water before six months. These cultural norms can discourage exclusive breastfeeding and contribute to lower breastfeeding rates[43]. A study conducted in Ibadan, Nigeria, with 271 adolescents aged 15-19, found that only 22.5% had a high level of

breastfeeding knowledge. Although 50.2% of participants had a positive attitude towards breastfeeding, only 37.6% intended to exclusively breastfeed[43]. The study highlighted that many adolescents are not adequately informed about the importance of EBF, and their intentions are often influenced by their age, educational background, and cultural beliefs. Insufficient breastfeeding education materials and programs contribute to poor breastfeeding practices. Many adolescents receive inadequate or incorrect information, leading to misunderstandings about the benefits and methods of EBF[43].

The lack of support from family, peers, and healthcare providers affects adolescents' ability to practice EBF. Support systems play a critical role in encouraging and sustaining breastfeeding practices, and their absence can lead to reduced breastfeeding rates[37]. Limited access to healthcare services and breastfeeding support further exacerbates the challenge. In many regions, especially in developing countries, healthcare infrastructure may not provide adequate support for breastfeeding education and assistance[37]. To address these challenges, it is essential to improve breastfeeding education, particularly targeting adolescents. Educational programs should be comprehensive, culturally sensitive, and designed to address common misconceptions about breastfeeding[43].

Strengthening support systems for young mothers, including family, community, and healthcare providers, is crucial. This includes training healthcare providers to offer effective support and creating community-based programs that provide guidance and encouragement[37]. Programs should also focus on changing cultural beliefs and practices that hinder exclusive breastfeeding. Public health campaigns can help shift societal attitudes and provide accurate information about the benefits of EBF[43]. Exclusive breastfeeding is vital for infant health, but achieving it faces numerous challenges, particularly among adolescents. Addressing these barriers through targeted

education, improved support systems, and cultural change is essential for increasing EBF rates and improving maternal and child health outcomes. Thus, by focusing on these areas, we can work towards achieving better breastfeeding practices and ensuring healthier futures for infants.

2.3.8: Roles of Spousal Support in Promoting Exclusive Breastfeeding

Breastfeeding is universally acknowledged as a cornerstone of infant health and development. Exclusive breastfeeding, where an infant receives only breast milk for the first six months of life, is recommended by major health organizations, including the World Health Organization (WHO) and the American Academy of Pediatrics (AAP) [45]. However poor breastfeeding practices have severe consequences for infants aged 0–6 months, contributing to malnutrition, responsible for 60% of the world's 10.9 million under-five fatalities[45]. It provides essential nutrients, antibodies, and bonding opportunities that significantly contribute to an infant's growth and development[45]. However, achieving and maintaining exclusive breastfeeding can be challenging for many mothers. While healthcare providers, family members, and societal support play critical roles, the support of a spouse can be particularly influential. Additionally, workplace facilities for nursing mothers play a critical role in supporting optimal breastfeeding practices[45]. Emotional support from a spouse can help alleviate some of these stresses however in Nigeria, inappropriate feeding practices account for over 40% of infant deaths[45]. Failure to breastfeed exclusively increases the risk of neonatal diseases such as diarrhea and respiratory infections, and starting breastfeeding more than 24 h after birth significantly increases infant mortality risk[45].

However, male awareness and involvement in breastfeeding is poor in Nigeria and this constitutes a major threat to satisfactory breastfeeding practices thus increasing the likelihood of ill-health and death among infants but a partner who listens actively and empathetically can

boost the mother's confidence and morale[68]. Offering reassurance, celebrating small victories, and providing comfort during challenging times can make a significant difference[68]. This emotional backing helps mothers to persevere through difficulties such as nipple pain, latch issues, and feelings of inadequacy. Furthermore, a positive and supportive partner can reinforce the mother's commitment to breastfeeding, helping her to stay motivated and focused on her goals[68]. Breastfeeding demands considerable time and energy, particularly in the early days when feeding is frequent and the mother's body is adjusting. Practical support from a spouse can significantly ease this burden. Thus, by sharing household responsibilities such as cooking, cleaning, and caring for other children, a partner allows the mother to concentrate on breastfeeding and recuperating[68].

Practical assistance also includes handling tasks such as preparing snacks and drinks for the breastfeeding mother, ensuring she remains hydrated and nourished[68]. In cases where the mother experiences difficulties such as sore nipples or engorgement, a supportive partner can assist with tasks like applying ointments or managing the use of breast pumps[68]. This practical support helps to create a more balanced and less stressful environment, facilitating a smoother breastfeeding experience. Education plays a critical role in successful breastfeeding[68]. A partner who educates themselves about the benefits and challenges of breastfeeding can provide invaluable support. This education can include understanding the nutritional needs of a breastfeeding mother, the importance of exclusive breastfeeding, and common breastfeeding issues[68].

Moreover, women are by default targeted for information on breastfeeding while the men are often sidelined meanwhile an informed spouse can also advocate for breastfeeding within their social circles[45]. This advocacy can involve addressing misconceptions, countering negative opinions, and promoting breastfeeding-friendly environments[45]. By actively supporting

breastfeeding in conversations with family and friends, partners help to create a more supportive and accepting atmosphere, reducing external pressures that might otherwise discourage breastfeeding[45]. Returning to work can be a major challenge for breastfeeding mothers[45]. The need for work flexibility and suitable facilities for breastfeeding or expressing milk can be a significant barrier. A supportive spouse can play a key role in navigating these challenges by advocating for breastfeeding-friendly policies in the workplace[68].

Additionally, the economic hardships in Nigeria make men to work extra hours away from home and hence have little or no time to contribute towards the health of their family including breastfeeding but this advocacy might include negotiating with employers for flexible work hours or designated breastfeeding breaks[69]. It can also involve ensuring that there is a private and hygienic space for pumping milk[69]. When spouses are proactive in addressing these needs, they help to reduce the risk of early cessation of breastfeeding due to work-related issues[69]. This support is crucial in enabling mothers to continue breastfeeding upon their return to the workplace[69]. Breastfeeding is not always a straightforward process. Common issues include difficulties with latching, concerns about milk supply, and the physical discomfort of breastfeeding. A supportive partner can assist in managing these challenges by participating in problem-solving efforts and seeking out resources[68]. For example, attending lactation consultations together can provide both partners with valuable information and strategies for overcoming breastfeeding difficulties[69]. Spouses can also help by researching solutions, such as adjusting breastfeeding positions or managing feeding schedules. When challenges arise, a collaborative approach can help to find effective solutions and maintain the mother's motivation to continue breastfeeding[69]. Beyond immediate support, spouses can help build a broader network of support for breastfeeding[69]. This network may include breastfeeding support groups,

online communities, and healthcare professionals. By connecting with these resources, both partners can access additional advice, support, and encouragement[68].

Participating in breastfeeding support groups allows both partners to share experiences with other families and gain insights from those who have faced similar challenges. Online communities can offer 24/7 support and access to a wealth of information[69]. Building a strong support network helps to reinforce the mother's commitment to exclusive breastfeeding and provides a safety net of resources and advice[69]. Spousal support plays a multifaceted and vital role in promoting and sustaining exclusive breastfeeding. From offering emotional encouragement and practical assistance to educating oneself, advocating for breastfeeding-friendly environments, and addressing challenges together, the involvement of a spouse can significantly enhance the breastfeeding experience[69]. Thus, by providing a supportive and understanding environment, spouses help to overcome barriers, reduce stress, and create a nurturing space for breastfeeding[68]. The journey of exclusive breastfeeding is often demanding, but with the active participation of a supportive partner, it becomes more manageable and rewarding[69]. This collaborative effort not only benefits the health of the infant but also strengthens the family bond, contributing to a more harmonious and resilient family dynamic[69]. As both partners work together to support exclusive breastfeeding, they lay the foundation for a healthier start in life for their child and a more connected and supportive family unit[68].

2.3.9: Forms of Spousal Support in Breastfeeding

Breastfeeding is a crucial aspect of infant care, providing essential nutrients and fostering a strong bond between mother and baby. Despite its benefits, breastfeeding can be challenging and demanding, especially in the initial stages. Support from a spouse can significantly influence a

mother's ability to successfully breastfeed and navigate these challenges[70]. The early days of breastfeeding can be emotionally taxing for new mothers[69]. Emotional support of breastfeeding from a spouse includes offering reassurance, celebrating small victories, and providing a listening ear[69]. Positive affirmations and encouragement can boost a mother's confidence, helping her to overcome self-doubt and persevere through the challenges of breastfeeding[69].

A supportive partner helps alleviate stress by creating a calm and understanding environment[69]. Managing stress effectively can positively impact milk production and overall breastfeeding success. A spouse who actively works to reduce stress whether through helping with household chores, offering relaxation time, or simply being present plays a vital role in this aspect[69]. Breastfeeding requires significant time and energy, particularly in the initial weeks. Practical support from a spouse regarding breastfeeding includes taking over household responsibilities such as cooking, cleaning, and managing other children[71]. Thus, by handling these tasks, a partner allows the mother to focus on breastfeeding and recovery[71].

Additionally, Partners can assist with feeding logistics, including preparing snacks and drinks for the breastfeeding mother or managing milk storage and cleaning pump equipment[71]. This practical help ensures that the mother remains well-nourished and that the breastfeeding process runs smoothly[71]. Educating spouse about breastfeeding benefits, techniques, and potential challenges can significantly impact the success of breastfeeding[72]. A supportive spouse takes the initiative to learn about breastfeeding, attending prenatal classes, reading literature, and understanding common issues[72].

Moreover, an informed spouse can advocate for breastfeeding within their social and family circles. This advocacy includes addressing misconceptions, countering negative opinions, and

promoting breastfeeding-friendly environments[72]. By actively supporting breastfeeding, a partner helps to create a positive and informed atmosphere around this important practice[72]. For many mothers, returning to work while maintaining breastfeeding can be a major challenge. A supportive spouse can help by negotiating with employers for flexible work hours, breastfeeding breaks, or suitable facilities for expressing milk[73]. This advocacy ensures that the mother can continue breastfeeding while managing her work responsibilities[73].

Partners can assist in setting up a comfortable and private space for breastfeeding or pumping, both at home and, if applicable, at the workplace[73]. This environment is crucial for maintaining the frequency and effectiveness of breastfeeding[73]. Breastfeeding can present various challenges, including latch issues, sore nipples, or concerns about milk supply. A supportive spouse participates in problem-solving efforts in regards to breastfeeding, such as attending lactation consultations together, researching solutions, and offering practical help with feeding techniques[69]. Assistance with physical comfort can include tasks like applying creams for sore nipples, helping the mother adjust breastfeeding positions, or managing any discomfort that arises[69]. This hands-on support can make a significant difference in overcoming physical barriers to breastfeeding[69].

A supportive spouse can help build a network of resources for breastfeeding support[69]. This network may include lactation consultants, breastfeeding support groups, and online communities. Engaging with these resources provides additional advice, encouragement, and support[69].

Attending breastfeeding support groups together can offer both partners valuable insights and a sense of community[72]. Sharing experiences with other families and learning from their journeys

can strengthen the couple's resolve and provide practical tips for overcoming common breastfeeding challenges[72]. Breastfeeding can be physically exhausting, especially for new mothers. A supportive spouse can encourage and facilitate self-care by ensuring the mother gets adequate rest and recovery[73]. This might involve taking over nighttime feedings, arranging for additional help, or simply encouraging breaks and relaxation[73].

The transition to motherhood can also bring mental health challenges such as postpartum depression or anxiety[69]. A partner who is attentive to the mother's mental well-being during breastfeeding and encourages seeking professional help when needed plays a crucial role in maintaining overall health[74]. This support not only benefits the mother but also contributes to a more positive breastfeeding experience[74]. Sometimes, extended family members may have their own opinions or advice regarding breastfeeding[69]. A supportive spouse can help manage these dynamics by communicating clearly with family members and ensuring that their support aligns with the couple's breastfeeding goals[75]. This involves setting boundaries and advocating for the mother's needs and preferences in a respectful manner.

Partners can also take on the role of educating extended family about the benefits of breastfeeding and the importance of respecting the mother's choices[75]. Thus, by fostering understanding and support within the extended family, the couple creates a more supportive environment for breastfeeding[75]. Feeding difficulties such as cluster feeding or issues with milk supply can be stressful. A supportive spouse can assist in addressing these problems by providing emotional comfort, helping with troubleshooting, and exploring solutions together[69]. Whether it involves consulting a lactation specialist or experimenting with different breastfeeding positions, joint efforts can help overcome these challenges[69]. Keeping track of the baby's feeding patterns, weight gain, and overall health can be a collaborative effort. A partner

who is attentive and involved in monitoring the baby's well-being helps ensure that breastfeeding is going smoothly and that any concerns are promptly addressed[76].

A supportive spouse can model positive attitudes towards breastfeeding, which can influence both the mother's experience and the broader social environment[77]. Demonstrating confidence and pride in the breastfeeding journey helps reinforce the mother's commitment and counters any negative perceptions or pressures[77]. Spousal support is not limited to the initial stages of breastfeeding but extends to long-term goals as well. Partners can discuss and plan for extended breastfeeding, setting realistic and mutually agreed-upon goals[69]. This might involve planning for continued breastfeeding as the baby begins to eat solid foods or preparing for weaning when the time comes[69].

Life circumstances can change, and maintaining flexibility is essential. A supportive spouse helps adapt to changing needs and schedules, whether it's adjusting breastfeeding routines to fit with new responsibilities or finding solutions when facing unforeseen challenges[69]. One of the challenges of breastfeeding can be breastfeeding in public. A supportive spouse can help by standing by the mother in public settings, providing reassurance and assistance if needed. This support is crucial in helping the mother feel comfortable and confident when breastfeeding outside the home[69]. The various forms of spousal support in breastfeeding encompass a wide range of emotional, practical, educational, and advocacy roles[78]. Each type of support contributes to creating a positive and successful breastfeeding experience[78]. From offering emotional reassurance and practical assistance to advocating for breastfeeding rights and managing transitions, a supportive partner plays a critical role in the breastfeeding journey[78].

Therefore, by actively participating and providing support, spouses help to address the challenges of breastfeeding, enhance the overall experience, and contribute to the health and well-being of both mother and baby[78]. This collaborative effort not only supports the immediate goal of successful breastfeeding but also fosters a strong and supportive family dynamic[78]. Understanding and embracing these various forms of spousal support can lead to a more rewarding breastfeeding experience and a healthier, more connected family[78].

2.3.10: Impact of Spousal Support on Breastfeeding Outcomes

Breastfeeding is widely recognized as the optimal method of feeding for infants, providing essential nutrients, antibodies, and fostering a unique bond between mother and child. However, the success of breastfeeding is not solely dependent on the mother's willingness or ability. Emerging research has highlighted the crucial role that spousal support plays in breastfeeding outcomes[79]. This article delves into how the involvement and encouragement from a spouse can significantly impact breastfeeding success and duration[79]. Spousal support can manifest in various forms, including emotional encouragement, practical assistance, and social support[78]. Emotional support involves the spouse offering reassurance, empathy, and motivation to the breastfeeding mother[78]. Practical support may include helping with household chores, caring for other children, or assisting in managing breastfeeding routines[78]. Social support involves advocating for the mother's choice to breastfeed in public or within the family, thereby reducing societal pressures or stigmas[78]. Research has shown that when spouses are actively involved and supportive, mothers are more likely to initiate and continue breastfeeding for longer periods[79]. This support helps alleviate the physical and emotional challenges that often accompany breastfeeding, such as fatigue, stress, and concerns about milk supply[79].

Additionally, one of the most significant impacts of spousal support is on the mother's confidence and resilience. Breastfeeding can be a challenging experience, especially for first-time mothers who may encounter difficulties such as latching problems, pain, or concerns about whether their baby is getting enough milk[77]. A supportive spouse who encourages and reassures the mother can help her overcome these hurdles, thereby increasing the likelihood of successful breastfeeding[77]. Studies have shown that mothers who receive emotional support from their partners are less likely to experience postpartum depression, a condition that can negatively affect breastfeeding[45]. By fostering a positive and supportive environment, spouses can help mothers maintain the emotional stability needed to continue breastfeeding[45].

The physical demands of breastfeeding can be exhausting, especially during the early weeks when feeding sessions are frequent and unpredictable. A spouse who shares household responsibilities or takes on more care giving tasks can significantly reduce the mother's workload, allowing her to focus on breastfeeding and recovery[68]. Practical support also extends to the breastfeeding process itself. For instance, a spouse who is knowledgeable about breastfeeding can assist with positioning the baby, helping the mother get comfortable, or even encouraging her to seek help from lactation consultants when needed[71]. This kind of hands-on support can make a substantial difference in the mother's ability to breastfeed effectively and comfortably[71].

The social aspect of spousal support is equally important. In some cultures or families, breastfeeding may not be widely accepted or supported, leading to added stress for the mother. A spouse who actively advocates for breastfeeding can help mitigate these pressures by standing up for the mother's decision and helping create a supportive environment[45]. This advocacy can extend beyond the home. For example, a spouse who supports breastfeeding in public or within

social circles helps normalize the practice, which can empower the mother and reduce feelings of embarrassment or shame[68]. This type of social support is crucial for ensuring that mothers feel confident and supported in their breastfeeding journey[68].

The impact of spousal support on breastfeeding outcomes cannot be overstated[68]. A supportive spouse plays a vital role in helping mothers initiate and sustain breastfeeding, ultimately benefiting both mother and child[68]. By providing emotional, practical, and social support, spouses can create a nurturing environment that promotes successful breastfeeding[68]. As more awareness is raised about the importance of spousal involvement, it is essential for healthcare providers to include spouses in breastfeeding education and support programs[68]. By fostering a strong partnership, couples can work together to overcome challenges and ensure the best possible outcomes for their children[68]. Promoting spousal involvement in breastfeeding is crucial for improving outcomes[68]. Healthcare providers, including obstetricians, pediatricians, and lactation consultants, have key role in encouraging this involvement[68]. During prenatal visits, healthcare providers can educate both parents about the benefits of breastfeeding and the significant role that spousal support plays in its success[68]. This education should emphasize that breastfeeding is a shared responsibility, not just a task for the mother[68]. Workshops, support groups, and educational materials designed for both parents can also be valuable. These resources can provide practical tips for spouses on how to support breastfeeding effectively, from understanding the basics of breastfeeding to learning how to help manage challenges like low milk supply or sore nipples[68]. However, by making breastfeeding a shared goal, both partners can contribute to the process, enhancing the mother's experience and increasing the likelihood of sustained breastfeeding[68].

Despite the recognized benefits of spousal support, there are challenges that can hinder a spouse's ability to provide this support[68]. One common barrier is a lack of knowledge or understanding about breastfeeding[68]. Many spouses may not fully comprehend the complexities of breastfeeding, leading to feelings of helplessness or frustration when challenges arise[68]. Providing education and resources can help bridge this gap and empower spouses to take a more active role[68]. Another challenge is the societal and cultural norms that often place the burden of child-rearing solely on the mother. In some cultures, there may be an expectation that the mother is responsible for all aspects of infant care, including breastfeeding, while the father's role is more peripheral[45]. Challenging these norms and encouraging a more egalitarian approach to parenting can help shift attitudes and foster greater spousal involvement[45].

Workplace demands and time constraints can also limit a spouse's ability to provide support. In many cases, spouses may struggle to balance work responsibilities with the desire to be present and supportive at home[73]. Employers can play a role in addressing this by offering parental leave policies that allow both parents to take time off to support each other during the early stages of a child's life[73]. The benefits of spousal support extend beyond the immediate breastfeeding period. When spouses are actively involved in the early stages of parenting, it sets the foundation for a more balanced and supportive partnership in raising children[71]. This shared responsibility can lead to stronger family bonds, better communication, and a more equitable distribution of parenting tasks[71].

Additionally, For the mother, continued spousal support can reduce the risk of postpartum depression and anxiety, contributing to better mental health and overall well-being[77]. For the child, prolonged and successful breastfeeding, facilitated by spousal support, is associated with numerous health benefits, including stronger immunity, reduced risk of chronic diseases, and

improved cognitive development[77]. Moreover, the positive impact of spousal support on breastfeeding can also influence future family planning and parenting decisions[71]. Couples who successfully navigate breastfeeding together may be more likely to approach other parenting challenges as a team, fostering a cooperative and nurturing environment for their children[71].

The impact of spousal support on breastfeeding outcomes is profound, underscoring the importance of viewing breastfeeding as a partnership rather than a solitary endeavor[80]. Also, by involving spouses in breastfeeding education, encouraging active participation, and challenging societal norms that limit their role, we can create a more supportive environment for breastfeeding mothers[80]. Healthcare providers, policymakers, and employers all have a role to play in promoting spousal support[81]. By recognizing and addressing the barriers that can impede spousal involvement, we can help ensure that more mothers have the support they need to breastfeed successfully[81]. This, in turn, will lead to better health outcomes for both mothers and their children, fostering stronger families and healthier communities[81].

2.4.0: Theoretical Framework

In examining the "Knowledge, Attitude, and Practice of Exclusive Breastfeeding and Spousal Support as a Determinant among Mothers in Ibadan North," the Theory of Planned Behavior (TPB) and Social Cognitive Theory (SCT) are the most fitting frameworks to comprehensively understand both the personal and social influences on exclusive breastfeeding practices. Unlike the Health Belief Model (HBM), that emphasizes individual health beliefs and perceived susceptibility to health risks, TPB and SCT account for broader social, psychological, and environmental factors that determine health behaviors. TPB is essential for analyzing how mothers' attitudes toward exclusive breastfeeding, societal norms, and perceptions of control shape their intentions to practice breastfeeding. Meanwhile, SCT's focus on self-efficacy,

observational learning, and reciprocal determinism addresses how mothers learn from and are supported by their social environment, especially spouses, to establish and maintain exclusive breastfeeding. Both theories emphasize the role of self-confidence, social modeling, and family support in health practices, which are crucial elements in an African context where community and family can significantly impact health behaviors.

This framework, therefore, provides a dual lens on the individual (mothers) and the social (spousal support), capturing the intricate relationship between internal motivations, external influences, and how these interact to support exclusive breastfeeding. Together, TPB and SCT reveal how mothers' intentions and self-efficacy are influenced and reinforced by the surrounding support structures, particularly the involvement of their spouses, ensuring a holistic approach to understanding exclusive breastfeeding in Ibadan North.

2.4.1: Application of the Framework to the Thesis

Theory of Planned Behavior (TPB)

TPB's key constructs of attitudes toward behavior, subjective norms, and perceived behavioral control are highly relevant for understanding exclusive breastfeeding and spousal support in Ibadan North.

Attitudes toward Behavior: In TPB, attitudes are defined as the positive or negative evaluations that mothers hold regarding exclusive breastfeeding. This variable encompasses beliefs about breastfeeding benefits, such as improved infant health, bonding, and maternal satisfaction which can be influenced by mother's knowledge on exclusive breastfeeding. In the context of this study, a positive attitude toward exclusive breastfeeding is likely to increase a mother's intention to practice it. This framework determined if mothers with supportive spouses develop stronger positive attitudes toward exclusive breastfeeding, compared to those with minimal or no support.

Subjective Norms: Subjective norms reflect the perceived social pressure from significant others, such as family members, friends, and especially spouses, to perform or not perform a particular behavior. For mothers in Ibadan North, subjective norms are particularly influenced by spousal support, where a spouse's approval and encouragement can lead to a stronger intention to practice exclusive breastfeeding. This study determined how breastfeeding mothers perceive their spouses' attitudes toward breastfeeding and whether breastfeeding mothers feel encouraged or pressured to engage in it, capturing the social influence of close family support on breastfeeding practices.

Perceived Behavioral Control (PBC): PBC represents the perceived ease or difficulty of performing exclusive breastfeeding, influenced by both internal (knowledge, confidence) and external factors (spousal and family support, accessibility to resources). For this study, PBC is critical because mothers with high levels of perceived control, potentially strengthened by emotional, financial, and logistical support from their spouses, are more likely to initiate and sustain exclusive breastfeeding. This study determined how spousal support in household chores, baby care, and healthcare visits enhances perceived behavioral control among breastfeeding mothers, thus positively influencing their breastfeeding intentions and practices.

TPB, therefore, explains how these three constructs (attitudes, subjective norms, and perceived control) directly shape the intention to practice exclusive breastfeeding, which subsequently translates to actual breastfeeding behavior.

Social Cognitive Theory (SCT)

SCT brings in additional key concepts: self-efficacy, observational learning, and reciprocal determinism which are essential for understanding the behavioral and environmental dynamics in exclusive breastfeeding practices and the influence of spousal support.

Self-Efficacy: SCT emphasizes self-efficacy, or a breastfeeding mother's belief capacity to exclusively breastfeed. This variable is crucial because mothers who feel confident in their ability to breastfeed are more likely to engage in and continue the practice. Self-efficacy is often strengthened by positive reinforcement from spouses and other family members. In this study, self-efficacy was examined in relation to spousal support, exploring whether mothers who receive encouragement and help from their spouses report higher confidence in their ability to breastfeed exclusively.

Observational Learning: Observational learning in SCT focuses on the idea that individuals can learn and adopt behaviors by observing others. In the context of exclusive breastfeeding, mothers may observe other women in their communities or family settings, and with spousal support, breastfeeding mothers might feel more empowered to emulate these behaviors. This study looked into how mothers learn breastfeeding practices by observing peers or family members and whether spousal encouragement to adopt these behaviors determined their decisions. Additionally, if spouses themselves are supportive by being informed and engaged in the breastfeeding process, mothers might find it easier to sustain exclusive breastfeeding.

Reciprocal Determinism: SCT's concept of reciprocal determinism highlights the dynamic interplay between the mother's personal characteristics, her behavior (breastfeeding), and her environment (spousal and social support). This variable is highly relevant, as it addresses how mothers' attitudes toward breastfeeding and their actual practices are influenced by external support systems, particularly from their spouses. In this study, reciprocal determinism explained how spousal support not only influences mothers' breastfeeding behaviours but is also reinforced by the breastfeeding process itself, potentially leading to increased spousal engagement over time.

2.4.2: Overall Framework Summary

Together, TPB and SCT provide a robust framework for exploring exclusive breastfeeding practices among mothers in Ibadan North. TPB's constructs of attitudes, subjective norms, and perceived behavioral control offer a psychological lens for understanding mothers' intentions toward exclusive breastfeeding, particularly how supportive spousal attitudes influence breastfeeding practices. SCT complements this by emphasizing self-efficacy, observational learning, and reciprocal determinism, providing insight into how confidence, social learning, and environmental reinforcement shape breastfeeding behavior. This combined framework thus enables a comprehensive exploration of both individual motivations and social influences, particularly the role of spousal support, in promoting and sustaining exclusive breastfeeding among mothers in Ibadan North.

2.5.0: Conceptual Framework

To construct a conceptual framework for the study on "Knowledge, Attitude, and Practice of Exclusive Breastfeeding and Spousal Support as a Determinant among Mothers in Ibadan North," All the variables based on Theory of Planned Behavior (TPB) and Social Cognitive Theory (SCT) and their relationships were map out.

Breakdown of the variables and relationships for the conceptual framework:

Theory of Planned Behavior (TPB) Variables:

Attitudes toward Exclusive Breastfeeding: Mothers' beliefs and perceptions about the benefits and importance of breastfeeding which is influenced by the breastfeeding mother knowledge.

Subjective Norms: Social expectations from spouses, family, and peers regarding exclusive breastfeeding.

Perceived Behavioral Control (PBC): Mothers' perceived ability to practice exclusive breastfeeding, influenced by confidence, resources, and spousal support.

Social Cognitive Theory (SCT) Variables:

Self-Efficacy: Mothers' confidence in their ability to breastfeed exclusively.

Observational Learning: Learning breastfeeding behaviors by observing others, reinforced by positive examples and spousal support.

Reciprocal Determinism: The dynamic interaction between mothers' attitudes, behaviors, and supportive social environment, especially spousal support.

Spousal Support (Central Influence in Both TPB and SCT):

Emotional Support: Spouses' encouragement and motivation for breastfeeding.

Practical Support: Help with baby care, household chores, and healthcare visits to reduce mothers' burdens and boost breastfeeding efficacy.

Financial Support: Assistance with healthcare and nutrition-related expenses.

Outcome Variables:

Intention to Practice Exclusive Breastfeeding: Driven by TPB constructs and SCT self-efficacy, indicating the motivation to begin or sustain breastfeeding.

Exclusive Breastfeeding Practice: The actual engagement in breastfeeding exclusively, influenced by intention, self-efficacy, spousal support, and learning from others.

2.5.1: Conceptual Framework Diagram:

The conceptual framework for this study integrates elements from the Theory of Planned Behavior (TPB) and Social Cognitive Theory (SCT) to examine factors influencing exclusive breastfeeding practices. This framework delineates three sections: individual factors, moderating influences, and outcome variables.

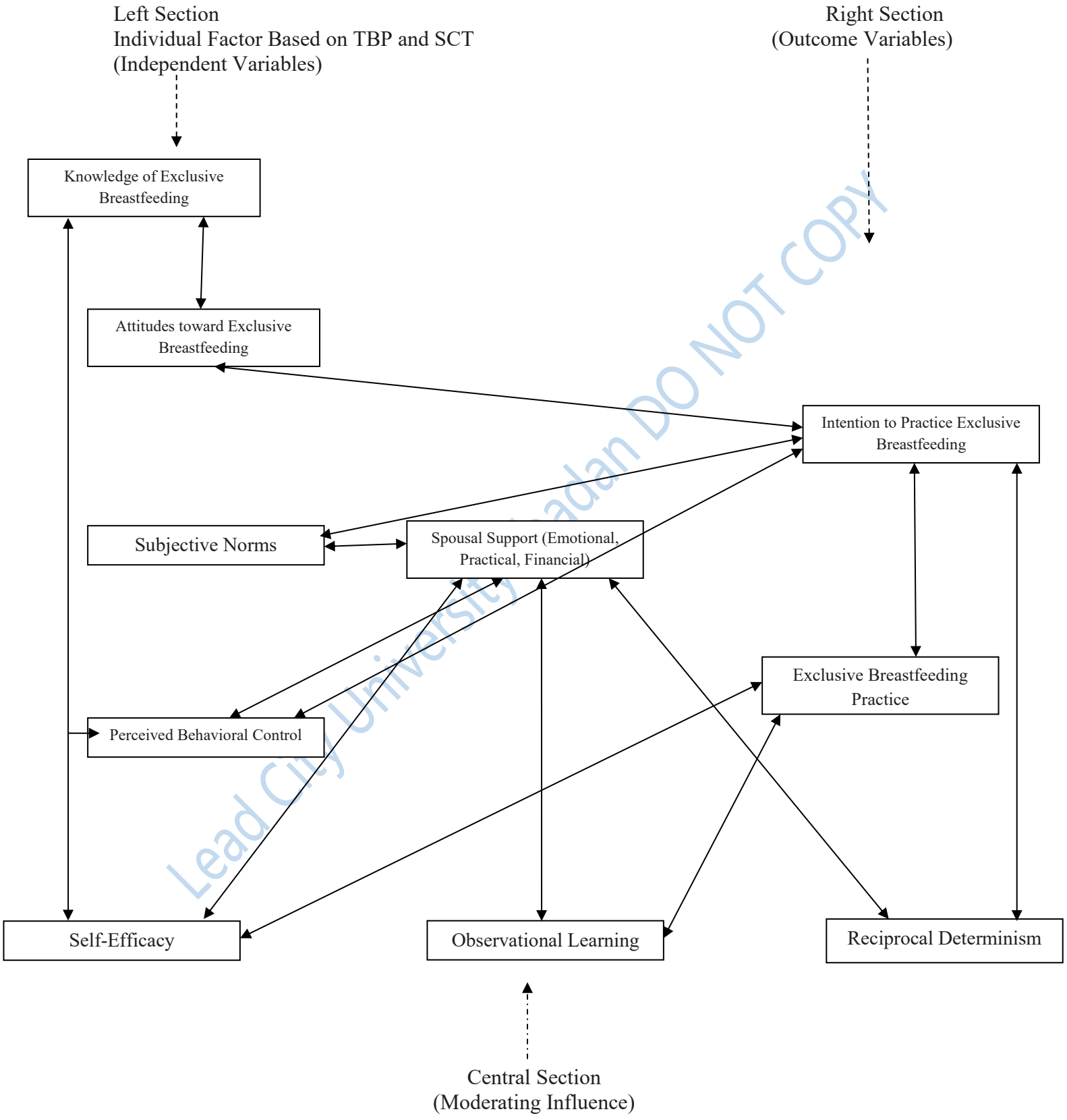
In the left section (Individual Factors based on TPB and SCT), specific variables rooted in TPB and SCT guide the formation of exclusive breastfeeding intentions and behaviors. Knowledge of Exclusive Breastfeeding informs both Attitudes toward Exclusive Breastfeeding and individual Perceived Behavioral Control, as well as Self-Efficacy. These factors subsequently drive intentions and behaviors. According to TPB, Attitudes toward Exclusive Breastfeeding influence the Intention to Practice Exclusive Breastfeeding. Subjective Norms which is the perceived social pressure to engage in breastfeeding also contribute to this intention, as does Perceived Behavioral Control over the ability to breastfeed exclusively. Self-Efficacy, a concept from SCT, directly impacts Exclusive Breastfeeding Practice by strengthening confidence in executing this behavior.

The central section represents the Moderating Influence of Spousal Support, which provides emotional, practical, and financial backing that positively affects Perceived Behavioral Control, Self-Efficacy, and Subjective Norms, along with Observational Learning which is a process through which individuals learn from observing the behaviors and outcomes of others. Spousal support is critical, as it reinforces a mother's confidence and perceived control, while aligning subjective norms with her intention to exclusively breastfeed.

In the right section (Outcome Variables), the Intention to Practice Exclusive Breastfeeding is expected to translate into Exclusive Breastfeeding Practice. Additionally, Observational Learning aids in the continuation of exclusive breastfeeding by modeling behaviors and promoting adherence. Finally, Reciprocal Determinism a concept from SCT operates as a feedback loop within this framework, where continuous engagement in exclusive breastfeeding strengthens spousal support, which in turn sustains the breastfeeding practice. This feedback mechanism suggests that practice and spousal support dynamically reinforce one another over time, enhancing the stability and success of exclusive breastfeeding.

Therefore, this conceptual framework thus provides a comprehensive model for understanding how individual factors, moderated by spousal support, shape the intention and actual practice of exclusive breastfeeding, incorporating feedback for sustained support and behavioral adherence.

CONCEPTUAL FRAMEWORK DIAGRAM



2.6: Summary of Gaps in Literature

2.6.1: Introduction

Exclusive breastfeeding (EBF) for the first six months of an infant's life is critical for ensuring optimal growth and development, as recommended by the World Health Organization (WHO) [43]. Despite the global emphasis on its importance, the literature reveals significant gaps in understanding, promoting, and implementing EBF practices. This section provides a summary of the gaps in the literature related to EBF, particularly focusing on knowledge gaps, challenges, common misconceptions, and barriers to acquiring accurate information.

2.6.2: Knowledge Gaps and Challenges of Exclusive Breastfeeding

Evidently, one of the significant gaps in the literature is the limited research on how socio-cultural contexts influence exclusive breastfeeding practices[45]. Most studies have predominantly focused on Western contexts, leaving a gap in understanding how cultural beliefs, norms, and practices in non-Western societies impact EBF[46]. For instance, traditional beliefs that encourage the early introduction of solid foods or water to infants are not well documented in the literature, leading to a lack of culturally sensitive interventions[46].

Another critical gap is the underrepresentation of the role of fathers in the literature on exclusive breastfeeding. The existing research has largely centered on mothers, overlooking how paternal support, or the lack thereof, influences a mother's decision to practice EBF. Fathers can play a crucial role in supporting breastfeeding, yet their knowledge, attitudes, and influence remain understudied[13]. Furthermore, there is a notable lack of longitudinal studies that track breastfeeding practices over time[45]. Most research on EBF is cross-sectional, capturing data at a single point in time[45]. This approach does not account for changes in breastfeeding practices or the challenges that mothers may face as they attempt to maintain EBF over several months.

Longitudinal studies could provide valuable insights into the factors that sustain or disrupt EBF over time.

Additionally, while healthcare providers are critical sources of breastfeeding information, there is a gap in the literature regarding their knowledge and attitudes toward EBF[82]. In many cases, healthcare providers may lack up-to-date information or may hold biases that affect the quality of the advice they give to mothers[83]. Studies exploring the training and knowledge of healthcare providers, especially in low-resource settings, are scarce[83].

Moreover, in low-resource settings, challenges such as inadequate healthcare infrastructure, lack of access to clean water, and poor maternal nutrition can significantly hinder EBF practices[43]. However, the literature often glosses over these context-specific challenges, leading to interventions that may not be feasible or effective in these environments. More research is needed to develop strategies that address the unique barriers faced by mothers in low-resource settings.

The primary area of knowledge gap between those works and this one is that, while the majority of them concentrated on illiteracy as the primary cause of nursing mothers' noncompliance with exclusive breastfeeding and, therefore, concentrated their studies on illiterate members in remote communities, the potential impact of a complex interplay of socio-cultural inhibitors, such as peer pressure and pre-existing misconceptions, as well as the effects of urbanization and modernization, coupled with the growing desire of modern city women to maintain physical body shapes, has not attracted enough scholarly attention and scientific investigation as a potential contributing cause to the practice of exclusive breastfeeding not being followed in metropolitan regions[49]. Important decision-makers for breastfeeding babies, like grandmothers, mothers-in-law, and traditional birth attendants (TBAs), are also understudied[49]. Therefore, this

study adds to the body of knowledge already available on maternal and child health in Nigeria and offers insightful advice to policymakers, medical professionals, and communication specialists looking to maximize radio advocacy programs for encouraging exclusive breastfeeding in Enugu and other similar urban settings in Nigeria and abroad.

2.6.3: Common Misconceptions and Knowledge Deficits

A common misconception among mothers is that breast milk alone is insufficient to meet their infant's nutritional needs, especially in the first six months[82]. This belief often leads to the early introduction of formula or solid foods. The literature indicates that this misconception is widespread, yet there is insufficient focus on how to effectively counter this belief through education and support.

Also, another prevalent misconception about exclusive breastfeeding is that infant formula is just as good as breast milk[82]. This belief is often reinforced by aggressive marketing strategies by formula companies, which can mislead mothers into thinking that formula is a convenient and equally nutritious alternative to breast milk[82]. The literature highlights the need for more robust regulations on formula marketing, but there is a gap in understanding how to combat these misconceptions effectively at the community level.

Furthermore, some mothers believe that breastfeeding can negatively impact their health, leading to fatigue, nutrient depletion, or body changes that are difficult to reverse[84]. While breastfeeding does require energy and resources from the mother, the literature shows that it also offers significant health benefits, including a reduced risk of certain cancers and postpartum depression. However, this aspect is not well communicated, leading to knowledge deficits that discourage EBF.

Additionally, proper breastfeeding techniques, such as ensuring a good latch and comfortable positioning, are crucial for successful EBF[85]. However, many mothers lack knowledge about these techniques, leading to difficulties such as nipple pain, low milk supply, and ultimately, the early cessation of breastfeeding[85]. The literature points to a gap in education on breastfeeding techniques, both during antenatal care and postpartum support, particularly in low-resource settings.

Moreover, there is a widespread belief that infants need water or other fluids in addition to breast milk, particularly in hot climates[86]. This misconception persists despite evidence showing that breast milk provides all the necessary hydration an infant needs[86]. The literature lacks sufficient exploration of how to address this misconception effectively, particularly in communities where there is limited resources and deeply rooted.

2.6.4: Barriers to Acquiring Accurate Information

It is of no doubt that one of the primary barriers to acquiring accurate information about exclusive breastfeeding is the healthcare system itself[14]. In many regions, particularly in low-resource settings, healthcare providers may not have adequate training on EBF or may be too overburdened to provide the necessary support to mothers[14]. This lack of support can lead to gaps in knowledge and incorrect practices among mothers.

Furthermore, access to education and resources is another significant barrier to exclusive breastfeeding[87]. In many low-income communities, mothers may not have access to antenatal classes, lactation consultants, or even basic information about the benefits of exclusive breastfeeding[87]. The literature suggests that while breastfeeding promotion programs exist, they are often not accessible to the most vulnerable populations, leaving significant knowledge gaps.

Additionally, cultural barriers can also prevent mothers from acquiring accurate information about EBF. In many cultures, traditional practices and beliefs about infant feeding are passed down through generations, often taking precedence over modern medical advice[88]. These cultural norms can create significant barriers to the dissemination of accurate breastfeeding information, particularly when healthcare messages conflict with long-standing traditions.

Moreover, the influence of marketing, particularly from infant formula companies, is a well-documented barrier to acquiring accurate information about exclusive breastfeeding[89]. Aggressive marketing campaigns often portray formula as an equivalent or superior alternative to breast milk, leading to confusion and misinformation among mothers[89]. The literature highlights the need for stricter regulations on formula advertising, but there remains a gap in understanding how to counteract these messages effectively in communities.

Also, language and literacy barriers also have a significant role in preventing mothers from accessing accurate information on exclusive breastfeeding[87]. In regions with high levels of illiteracy, written materials about breastfeeding may be ineffective, and mothers may rely on word-of-mouth information, which can be inaccurate. Additionally, in multilingual communities, the lack of breastfeeding materials in local languages can further hinder the dissemination of accurate information[87].

2.6.5: Conclusion on Summary of Gaps in Literature

Conclusively, the literature on exclusive breastfeeding reveals significant gaps and challenges that need to be addressed to improve EBF rates globally. Knowledge gaps and misconceptions about EBF are widespread, and there are numerous barriers to acquiring accurate information, ranging from healthcare system limitations to cultural practices and aggressive marketing by formula companies. To address these gaps, more research is needed, particularly in non-Western

contexts, to develop culturally sensitive interventions that can effectively promote exclusive breastfeeding. Additionally, there is a need for better training of healthcare providers, more accessible education and resources for mothers, and stricter regulations on formula marketing to ensure that all mothers have the knowledge and support they need to practice EBF successfully.

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CHAPTER THREE

METHODOLOGY

3.1: Research Design

The study adopted cross-sectional descriptive study to assess the knowledge, attitude, and practice of exclusive breastfeeding and spousal support as a determinant of exclusive breastfeeding in three selected Primary Healthcare Centres in Ibadan North Local Government Area. A cross-sectional descriptive study assesses the associations between conditions and other variables of interest as it exist in a population[1]. Some of the advantages of this study design in this kind of research include the fact that it is fast and efficient, less labor-intensive data collection methods to answer the research question and several variables can be studied at one-time[1]. Descriptive research describes a situation, problem, phenomenon, or service systematically, provides information about the living conditions of a community, or describes attitudes towards an issue[2].

3.2: Study Period

The study period was within the space of 3 months interval, covering the months of July, August, and September 2024. This schedule includes key activities, each essential to the successful completion of this thesis.

3.3: Study Setting

The study was carried out in three selected Primary Healthcare Centres (Idi Ogungun Primary Healthcare Center (PHC) Agodi Gate Ibadan, Sango Patako PHC, and Sabo PHC) in Ibadan North Local Government irrespective of religion, age, culture, and socio-economic background. Ibadan North Local Government is an urban area which is one of the 33 Local Government Areas in the state with a population of 306 795 as at the 2006 census, which comprised 153 039

males and 153 756 females[3]. The growth rate of Ibadan North Local Government Area is 3.46% per year, the projected population for 2011 was 365 200[3]. Ibadan is considered as the largest city in West Africa which is situated at latitude 07°23'North of the Equator and longitude 03°58'East of Greenwich Meridian, located in the transition zone between the forest and grass lands in the southwestern area of Nigeria, in Oyo State[4].

Ibadan North Local Government is a unique educational area that comprises of various primary, secondary and higher institutions such as the University of Ibadan, Ibadan Polytechnic, and other private and public institutions[4]. The local government also has modern health facilities such as the University College Hospital which is a federal hospital and Adeoyo Maternity Hopspital which is a state hospital[4]. The three selected PHCs consisted of multi-ethnic groups, predominantly Yoruba, Ibo, Edo, Hausa and other minority tribes.

3.4: Study Population

Population refers to a group of all the units on which the research findings are to be applied[5]. This simply means study population consists of all the units which possess variable characteristic under study and for which findings of research can be generalized[5]. The study population comprised all the breastfeeding mothers between the ages of 15-49 years with infants between the ages of 0-6 months attending post-natal clinic in the three selected Primary Healthcare Centres in Ibadan North Local Government.

3.5: Data Source

The data source comprised of both primary data source and secondary data source.

3.5.1: Primary Data Source

The primary data is the original data that was collected firsthand based on the research objectives. This data was gathered directly from the source by the researcher through structure questionnaire.

3.5.2: Secondary Data Source

The secondary data source is the information that has already been collected, processed, and published by someone else. Thus, the secondary data source of this research was obtained from books, articles, reports and online databases.

3.6: Eligibility Criteria

The eligibility criteria for this research focused on the inclusion criteria and exclusion criteria.

3.6.1: Inclusion Criteria

All the breastfeeding mothers in the earlier mentioned selected Primary Healthcare Centres with infants 0-6 months old were employed to participate in the study. The health centers included for this research include Idi Ogungun Primary Healthcare Center (PHC) Agodi Gate Ibadan, Sango PHC and Sabo PHC irrespective of religion, age, culture, and socio-economic background.

3.6.2: Exclusion Criteria

Breastfeeding mothers whose infants are more than 0-6 months were excluded from this research. Also, HIV positive mothers with infants aged 0-6 months who were not breastfeeding their infants are excluded from this research.

3.7: Sampling Technique

A sample in research simply means a group of people, objects, or items that are taken from a large population for measurement[6]. Sampling is a procedure to select a sample from individual or from a large group of population for certain kind of research purpose[6]. A subset of population that represents it completely is known as sample[5]. This implies that sample in research means the units, selected from the population, which represent all kind of characteristics of different types of units of population[5]. Thus, due to various reasons, data are collected from units of sample instead of all units of population in majority of researches and their findings are generalized in

the context of entire population[5]. The respondents for this research were selected using simple random sampling technique. The respondents were clustered into three groups based on their days of post-natal visit. Simple random sampling offers equal opportunities for any member of the population to be selected[1]. This type of sampling offers the members of the sample to be selected randomly and purely by chance[6]. Thus, the sample quality is not affected as every member has an equal chance of being selected in the sample[6].

3.8: Sample Size Calculation

The sample size was calculated using the formula for the estimation of a single proportion according to Naing, $n = \frac{Z^2 P(1-P)}{d^2}$. [1]

3.9: Sample Size Determination

A suitable sample size of 406 breastfeeding mothers with infants 0-6 months were applicable using the formula mentioned earlier to estimate a single proportion.

Where n = Sample size

Z = Z statistic for a level of confidence (1.96)

P = Expected prevalence or proportion (0.362)

d = Level of Precision (in proportion of one; if 5%, d = 0.05).

In Ibadan, it was estimated that the prevalence of Exclusive Breastfeeding was 36.2%, a proportion lower than the minimum 60% recommended by the World Health Organization and UNICEF[7]. Thus, Ibadan reports sub-optimal practice of exclusive breastfeeding among breastfeeding mothers. However, the expected prevalence or proportion was based on the estimated 36.2% (0.362).

$$n = \frac{1.96^2 0.362(1-0.362)}{0.05^2}$$

n= 369

Therefore, the required sample size is approximately 369 breastfeeding mothers between the age of 15-49 years with new born babies 0-6 months old. To account for potential non-response and incomplete data, the sample size was increased by 10%, resulting in a final sample size of approximately 406 breastfeeding mothers. Thus, n = 406

To allocate proportionally: Idi Ogungun PHC with 304 expected breastfeeding mothers for post-natal clinic: $\frac{304}{669} \times 406 = 184$. Sabo PHC with expected 207 breastfeeding mothers: $\frac{207}{669} \times 406 = 126$. Sango PHC:

$\frac{158}{669} \times 406 = 96$.

(Where 669 are the total expected breastfeeding mothers and 406 is the total sample size).

3.10: Data Collection Tool

The primary data collection tool for this study was a structured questionnaire, designed to capture both closed-ended (multiple choice) and open-ended responses. Structured data collection methods are typically aligned with quantitative research, where each aspect of the research process objectives, design, sample, and questionnaire content is predetermined[2]. This approach allows for quantifying the variations within a problem or issue, such as determining the proportion of people facing a particular problem or holding a specific attitude[2]. For this study, the questionnaire was specifically structured based on the research objectives rather than being adopted from any source, thus aligning closely with the unique aspects of the research focus. The primary data collection tool was repeatedly tested to ensure both its validity and reliability, providing assurance that it would accurately capture the targeted information. The questionnaire is structured to assess multiple dimensions of exclusive breastfeeding among mothers in Ibadan North, specifically focusing on their demographic information, knowledge, attitudes, practices,

and the influence of spousal support. Below is a breakdown of each section of the data collection tool:

3.10.1: Section A: Demographic Information

This section gathers baseline demographic details about the respondents, such as age, marital status, education level, employment status, and income level. These factors helped to contextualize the data, allowing for analysis of how different demographic characteristics might influence attitudes and practices around exclusive breastfeeding. It also provided an understanding of the socio-economic and cultural background of the participants, which may affect breastfeeding choices and access to healthcare information.

Questions 1-10: These questions focus on age, marital and employment status, family structure, and household income, providing a foundation for analyzing the influence of these factors on breastfeeding practices.

3.10.2: Section B: Level of Knowledge among Mothers regarding Exclusive Breastfeeding

This section assesses mothers' knowledge of exclusive breastfeeding, which is crucial for understanding their ability to make informed decisions. Knowledge questions cover basic definitions, recommended practices, benefits for both the child and mother, as well as potential health benefits and techniques.

Questions 11-20: These questions determine whether mothers have heard of exclusive breastfeeding, where they received information, the correct duration, the benefits, and any relevant dietary precautions. This section identifies gaps in knowledge and potential sources for educating mothers.

3.10.3: Section C: Attitudes of Mothers towards Exclusive Breastfeeding

The questions in this section examined mothers' attitudes toward exclusive breastfeeding, including their personal beliefs, comfort levels, confidence, and perceived importance. Attitudes significantly influence whether mothers choose to initiate and continue exclusive breastfeeding, especially in the presence of cultural or social challenges.

Questions 21-30: This section includes statements on perceived benefits, confidence in breastfeeding abilities, comfort in public breastfeeding, and the influence of cultural beliefs. It also asks mothers to evaluate their openness to support from healthcare providers and their likelihood of recommending breastfeeding to others, as well as factors shaping their attitudes.

3.10.4: Section D: Breastfeeding Practices commonly adopted by Mothers in Ibadan North

This section examined the actual breastfeeding practices of mothers, specifically whether breastfeeding mothers practice exclusive breastfeeding, the frequency and duration of breastfeeding, and any challenges faced. It aims to connect knowledge and attitudes to actual behavior, noting any deviations from recommended practices.

Questions 31-40: These questions capture specific behaviors, such as whether mothers supplement with other foods, breastfeeding frequency, and use of breastfeeding aids. The section also asks about common challenges like pain, latching issues, and low milk supply, as well as strategies for managing these difficulties, to understand practical barriers.

3.10.5: Section E: Roles of Spousal Support in Promoting Exclusive Breastfeeding among Mothers in Ibadan North

This section determined the influence of spousal support on breastfeeding practices, assessing both the level and types of support provided. Spousal support can play a significant role in a mother's decision and ability to maintain exclusive breastfeeding, so this section helped to understand the relational dynamics at play.

Questions 41-50: These questions ask if and how spouses support breastfeeding efforts, whether they participate in household responsibilities, provide emotional or financial support, or encourage breastfeeding education. This section also seeks to understand the impact of spousal involvement or absence on the mother's breastfeeding experience and explore areas where mothers may need more support.

3.11: Procedures of Data Collection

Data collection procedures for this research involved grouping respondents into three clusters according to their post-natal visit days. Selection within each group was conducted using simple random sampling to provide each group member an equal chance of selection. This method helped to gather a representative sample of breastfeeding mothers aged 15-49 years with infants aged 0-6 months attending post-natal clinics at the three selected healthcare centers. The questionnaire was administered to selected breastfeeding mothers, and where necessary, questions were explained for clarity. Additionally, Community Health students from Oyo State College of Health Science and Technology were trained as research assistants during the study period to support data collection.

3.12: Data Quality Assurance

Data quality assurance was prioritized in this study, with specific attention to the validity and reliability of the research instrument.

3.12.1: Validity of the Research Instrument

Validity refers to the extent to which the research instrument accurately measures the intended variables. In this study, the questionnaire was developed to comprehensively assess knowledge, attitudes, practices, and spousal support related to exclusive breastfeeding and its influence among mothers in Ibadan North Local Government. To ensure content validity, the questionnaire

was based on key research objectives rather than adopted from any pre-existing source, and it was rigorously tested with a small group in a pilot study to confirm clarity, coverage, and suitability of questions. Results from the pilot test were compared with results from another validated instrument to confirm the accuracy of the new questionnaire in measuring exclusive breastfeeding measures, reinforcing that it reflects the realities of the target population.

3.12.2: Reliability of the Research Instrument

Reliability, which assesses the consistency of the instrument, was tested through repeated administration. The questionnaire was given to a small group twice, with a set time interval of two weeks between each administration, and responses were analyzed for consistency. This repeated testing confirmed that the questionnaire reliably yielded similar results over time, strengthening confidence in its consistency as a research tool.

3.13: Data Analysis

Data Analysis involves the process of scrutinizing raw data with the purpose of drawing conclusion about that information with the aim of converting the available cluttered data into a format which is easy to understand, more legible and conclusive in order to supports the mechanism of decision-making[8]. The whole process of data analysis begins with the question (what is to be measured?) and the answers to these questions gives a researcher a clear idea about the main motive that the analysis should address[8]. Thus, the potential of data analysis is in its ability to solve researchable problems and provide new opportunities[8]. Evidently, the most critical aspect of an analysis is its quality or validity and an analysis is considered valid if it measures what it was created to measure[8].

The research utilized a questionnaire featuring both closed- and open-ended questions, providing a comprehensive approach to data collection. Quantitative data analysis techniques, specifically

descriptive and inferential statistics, were employed using SPSS version 21. Descriptive analysis summarized the demographic characteristics and assessed knowledge, attitudes, practices, and spousal support regarding exclusive breastfeeding (EBF) among mothers at three Primary Healthcare Centers in the Ibadan North Local Government Area. Frequencies and percentages were used to describe these variables, highlighting key aspects of the respondents' backgrounds and their engagement with EBF. To further explore the data, a series of advanced analyses were conducted. Bivariate analysis examined relationships between demographic variables and mothers' levels of knowledge, attitudes, practices, and spousal support for EBF, offering insights into factors that may correlate with or influence EBF behaviors using Chi-Square Test. Additionally, logistic regression analysis was performed to identify specific factors associated with EBF practices, determining the likelihood of mothers practicing EBF based on selected predictor variables. A multivariate analysis was also conducted to assess the combined effects of knowledge, attitudes, practices, spousal support, and other relevant factors on EBF practices, providing a comprehensive understanding of the determinants influencing EBF among the study population. This holistic approach enabled an in-depth examination of the key influences shaping EBF practices within this context.

3.14: Ethical Approval

Ethical approval for this study was granted by multiple authoritative bodies to ensure adherence to ethical standards. Initial approval was obtained from Oyo State Primary Healthcare Board, with the reference number AD, 072/Vol. 1/303 through the Medical Officer of Health (MOH) Ibadan North Local Government Primary Healthcare Authority. Additionally, approval was secured from the Oyo State Ministry of Health, assigned the NREC reference number NHREC/OYOSHRIEC/10/11/12. Verbal consent was also obtained from all participating

breastfeeding mothers after informing them of the potential benefits of the study, ensuring their awareness and voluntary participation. Furthermore, ethical approval was granted by Lead City University, the home institution overseeing the research. These approvals reflect the study's commitment to upholding ethical considerations across all research activities.

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Chapter Four

Results and Discussion of Findings

4.1: Socio-Demographic Characteristics of Respondents

This study explored the socio-demographic characteristics of participants, shedding light on factors that may influence exclusive breastfeeding practices. Variables such as age, marital status,

education level, employment status, household income, family structure, and number of children were analyzed. The age distribution of participants revealed that the majority 44.6% (181/406), were aged between 25-34 years, a prime age for childbearing and family responsibilities, potentially impacting exclusive breastfeeding practices. Following this group were participants aged 15-24 years, comprising 35.2% (143/406), who may face different social and healthcare challenges due to their relatively younger age. A smaller percentage of participants, 20.2% (82/406), were aged above 34, which could also affect exclusive breastfeeding practices based on different life experiences and healthcare needs in older age groups.

In terms of marital status, most participants were married, accounting for 90.9% (369/406). Marriage could provide a support system that influences exclusive breastfeeding practices positively, though the presence of 3.0% (12/406) who were single, 3.7% (15/406) who were divorced, and 2.5% (10/406) who were widowed highlights the need to consider how different marital situations might create additional challenges in exclusive breastfeeding practices. Education levels also varied, with 49.0% (199/406) having attained tertiary education and 36.2% (147/406) holding a secondary education. The high education level among participants suggests that many may have access to better health information, which could facilitate positive attitude and practice of exclusive breastfeeding. However, 11.3% (46/406) had only primary education, and 3.4% (14/406) had no formal education, potentially representing a group at higher risk of negative attitude and practice of exclusive breastfeeding due to limited health literacy.

Employment status provided further insights, with the majority 56.4% (229/406) being self-employed. Self-employment may offer flexibility in attending healthcare appointments but could also present economic instability, affecting access to consistent exclusive breastfeeding practice. Meanwhile, 27.6% (112/406) were employed in more structured jobs, possibly ensuring better

health insurance and access to healthcare, while 16.0% (65/406) were unemployed, a group potentially facing economic barriers to accessing right information on exclusive breastfeeding and its practices. When examining household income, a significant portion of participants 58.9%, (239/406) fell into the medium-income category. Income stability at this level could ease the financial burden of maintaining adequate exclusive breastfeeding practices. However, 26.1% (106/406) were in the low-income bracket, representing a group that might struggle with healthcare costs, while only 15.0% (61/406) had high incomes, suggesting that financial challenges remain a key factor in practicing exclusive breastfeeding for many participants.

In terms of family structure, the majority 73.4% (298/406) lived in nuclear families, which may offer a close-knit support system, potentially aiding exclusive breastfeeding practice. On the other hand, 26.6% (108/406) lived in extended families, which might offer broader familial support but could also introduce complexities related to decision-making in healthcare. Finally, the number of children varied among participants, with most 29.1% (118/406) having two children, and 27.6% (112/406) having three children. These family sizes reflect the reproductive burden and caregiving responsibilities that may complicate exclusive breastfeeding practices and compliance. Smaller percentages of participants had four 16.7% (68/406), five 3.4% (14/406), or six 1.2% (5/406) children, indicating varying family dynamics that could influence healthcare access incase of any exclusive breastfeeding challenge.

Table 4.1a: Socio-Demographic Characteristics of Respondents

Variables	Frequency	Percentage
Age		

15-24	143	35.2
25-34	181	44.6
Above 34	82	20.2
Marital Status		
Single	12	3.0
Married	369	90.9
Divorced	15	3.7
Widowed	10	2.5
Level of Education		
No formal education	14	3.4
Primary education	46	11.3
Secondary education	147	36.2
Tertiary education	199	49.0
Employment Status		
Unemployed	65	16.0
Self-employed	229	56.4
Employed	112	27.6

Source: Fieldwork, 2024

Table 4.1b: Socio-Demographic Characteristics of Respondents

Variables	**Frequency**	**Percentage**

Household Income Level		
Low	106	26.1
Medium	239	58.9
High	61	15.0
Types of Family Structure		
Nuclear	298	73.4
Extended	108	26.6
Number of Children		
1	89	21.9
2	118	29.1
3	112	27.6
4	68	16.7
5	14	3.4
6	5	1.2

Source: Fieldwork, 2024

4.2: Knowledge about Exclusive Breastfeeding: Summary of Findings

The data revealed a high level of awareness about exclusive breastfeeding among participants, with 93.8% (381/406) reporting that they had heard about the practice, while a small proportion 6.2% (25/406) had not. This indicates a generally good level of exposure to the concept of exclusive breastfeeding within the population studied. Among those who had heard about exclusive breastfeeding, healthcare providers were the most common source of information, with

66.7% (271/406) receiving this knowledge directly from healthcare professionals. This highlights the critical role of healthcare workers in promoting breastfeeding education and supporting maternal health practices.

In contrast, media outlets, such as television, radio, and the internet, were a less frequent source of information, with only 24.6% (100/406) reporting media as their source. The majority 75.4%, (306/406) had not been exposed to exclusive breastfeeding information through these channels. This suggests that while media can reach a broad audience, it may be underutilized in spreading knowledge about breastfeeding. Similarly, friends and family were also a relatively less common source of information, with 24.6% (100/406) reporting they had learned about exclusive breastfeeding through their social circles, while 75.4% (306/406) had not. This indicates that while community and family networks play a role, they are not the primary means of disseminating breastfeeding knowledge.

Community programs were cited by 12.6% (51/406) as a source of information, with 87.4% (355/406) not having been reached by these programs. This suggests that community-based initiatives, though important, may not have extensive reach in certain populations. A negligible number of participants 0.2% (1/406) cited other sources, showing that alternative platforms or less common channels for breastfeeding information are rarely used. The overwhelming majority 99.8%(405/406) did not report learning about exclusive breastfeeding through these less traditional methods. These findings emphasize the need to strengthen media and community programs in disseminating information about exclusive breastfeeding to complement the efforts of healthcare providers. Additionally, engaging friends, family, and social networks could enhance the reach and effectiveness of breastfeeding education.

Table 4.2: Knowledge about Exclusive Breastfeeding

Variables	Yes n (%)	No n (%)
Have you heard about exclusive breastfeeding?	381 (93.8)	25 (6.2)
Where did you hear about it? Healthcare provider	271 (66.7)	135 (33.3)
Where did you hear about it? Media (TV, Radio, Internet)	100 (24.6)	306 (75.4)
Where did you hear about it? Friends/Family	100 (24.6)	306 (75.4)
Where did you hear about it? Community programs	51 (12.6)	355 (87.4)
Where did you hear about it? Others	1 (0.2)	405 (99.8)

Source: Fieldwork, 2024

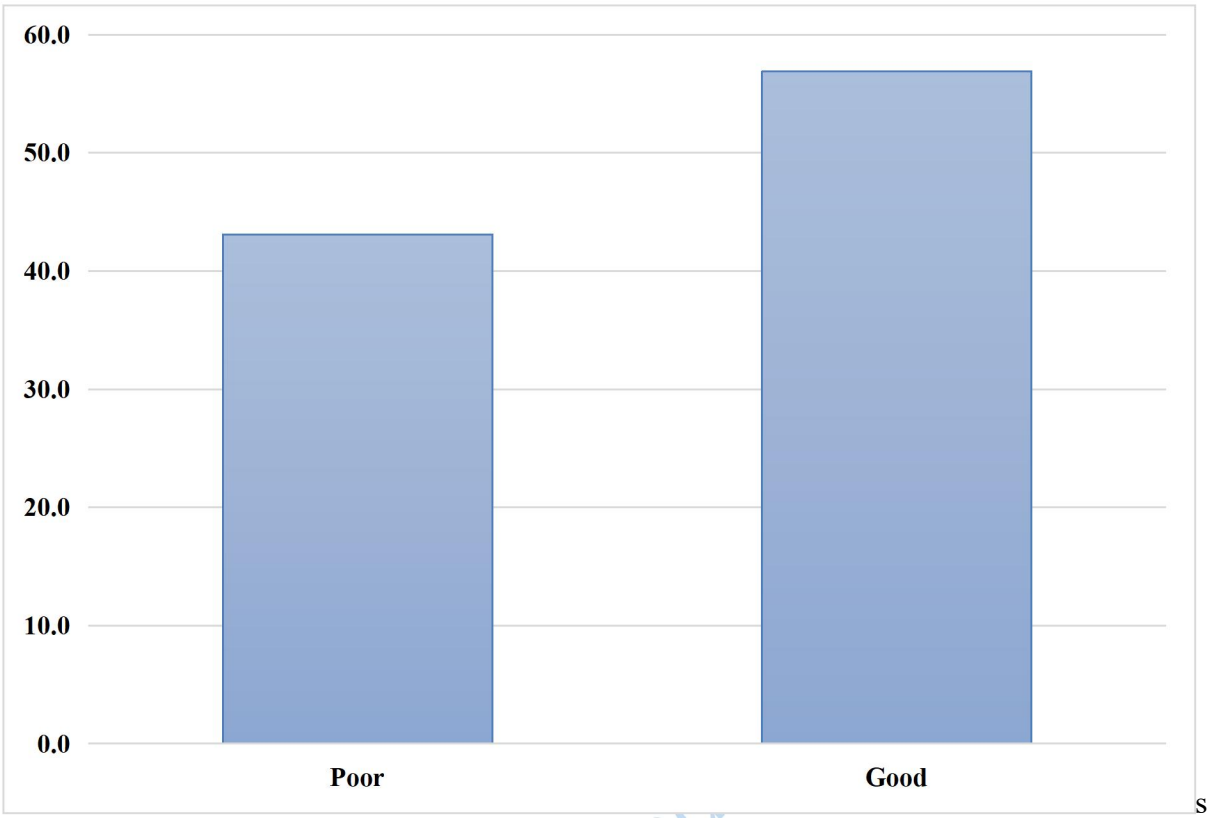

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Figure 1: Level of knowledge of Exclusive Breastfeeding

4.3: Attitudes towards Exclusive Breastfeeding

Most participants agreed that exclusive breastfeeding is beneficial for the baby, with 34.0% (138/406) agreeing and 39.2% (159/406) strongly agreeing. However, 15.5% (63 individuals) remained neutral, while a smaller percentage 11.3% (46/406) disagreed, indicating that while the majority understand the benefits, there remains a portion of individuals who are less certain or informed about its advantages. When asked about their confidence in exclusively breastfeeding their baby, 75.6% (307/406) responded positively, expressing confidence, while 24.4% (99/406) indicated a lack of confidence. This highlights the need for targeted support to boost confidence among those who may feel unsure about their breastfeeding abilities.

Regarding comfort with breastfeeding in public, responses were varied. A significant portion, 33.3% (135/406), reported feeling comfortable, while 25.6% (104/406) were very comfortable. However, 22.9% (93/406) were uncomfortable, and 0.7% (3/406) were very uncomfortable. These findings suggest that public breastfeeding remains a challenge for some, potentially influenced by societal norms or personal reservations. Participants were also asked whether they believed breastfeeding was a natural process or one that required learning. Almost half 49.5% (201/406) felt that breastfeeding was a natural process, while 33.5% (136/406) believed it required a lot of learning. Another 17.0% (69/406) felt that it was both natural and a learned skill, pointing to diverse perspectives on the ease or difficulty of breastfeeding.

Regarding the significance of exclusive breastfeeding for a newborn's health, the majority saw it as critical, with 41.1% (167/406) rating it as very important and 27.8% (113/406) seeing it as important. Nevertheless, 25.1% (102/406) were neutral, and 5.9% (24/406) felt it was not important, suggesting the need for further education on the health benefits of exclusive breastfeeding. Feelings towards breastfeeding support from healthcare providers were generally positive. 40.1% (163/406) viewed the support as positive, and 28.8% (117/406) saw it as very positive. Some, however, expressed neutrality 18.7% (76/406), and a small percentage 12.3% (50/406) had negative feelings. This emphasizes the importance of reinforcing the role of healthcare providers in offering encouragement and support for breastfeeding mothers.

With 42.9% (174/406) answering "likely" and 27.6% (112/406) replying "very likely," the majority of participants were inclined to advise exclusive breastfeeding to other mothers. Only a few 0.5% (2/406) were very unlikely to recommend it, and 9.9% (40/406) were unlikely, while 19.2% (78/406) remained neutral. A significant portion of participants believed that cultural beliefs affect attitudes toward exclusive breastfeeding, with 41.1% (167/406) agreeing and

29.1% (118/406) strongly agreeing. Only 13.5% (55/406) disagreed, while 16.3% (66/406) were neutral, underscoring the importance of considering cultural factors in breastfeeding promotion.

Furthermore, on whether exclusive breastfeeding is more beneficial than formula feeding, 37.9% (154/406) agreed and 34.2% (139/406) strongly agreed, while 12.6% (51/406) disagreed and 15.3% (62/406) remained neutral. This indicates that while most participants recognize the benefits of breastfeeding over formula feeding, there are still some who may need additional information or clarification on the topic.

Table 4.3a: Attitudes towards Exclusive Breastfeeding

Variables	Response	Frequency	Percent
Do you believe that exclusive breastfeeding is beneficial for the baby?	Disagree	46	11.3
	Neutral	63	15.5
	Agree	138	34.0
	Strongly agree	159	39.2
Do you feel confident in your ability to exclusively breastfeed your baby?	Yes	307	75.6
	No	99	24.4
How comfortable are you with breastfeeding in public?	Uncomfortable	93	22.9
	Very Uncomfortable	3	0.7
	Neutral	71	17.5
	Comfortable	135	33.3
	Very comfortable	104	25.6
Do you think breastfeeding is a natural process or one that requires a lot of learning?	Natural process	201	49.5
	Requires a lot of learning	136	33.5
	Both	69	17.0

Source: Fieldwork, 2024

Table 4.3b Attitudes towards Exclusive Breastfeeding

Variable	Response	Frequency	Percent
How important do you think exclusive breastfeeding is for a baby's health?	Important	113	27.8
	Very important	167	41.1
	Not important	24	5.9
	Neutral	102	25.1
What are your feelings towards breastfeeding support from healthcare providers?	Negative	50	12.3
	Neutral	76	18.7
	Positive	163	40.1
	Very Positive	117	28.8
How likely are you to recommend exclusive breastfeeding to other mothers?	Very unlikely	2	0.5
	Unlikely	40	9.9
	Neutral	78	19.2
	Likely	174	42.9
	Very likely	112	27.6
Do you believe that cultural beliefs affect attitudes toward exclusive breastfeeding?	Disagree	55	13.5
	Neutral	66	16.3
	Agree	167	41.1
	Strongly agree	118	29.1
Do you believe that exclusive breastfeeding is more beneficial than formula feeding?	Disagree	51	12.6
	Neutral	62	15.3
	Agree	154	37.9
	Strongly agree	139	34.2

Source: Fieldwork, 2024

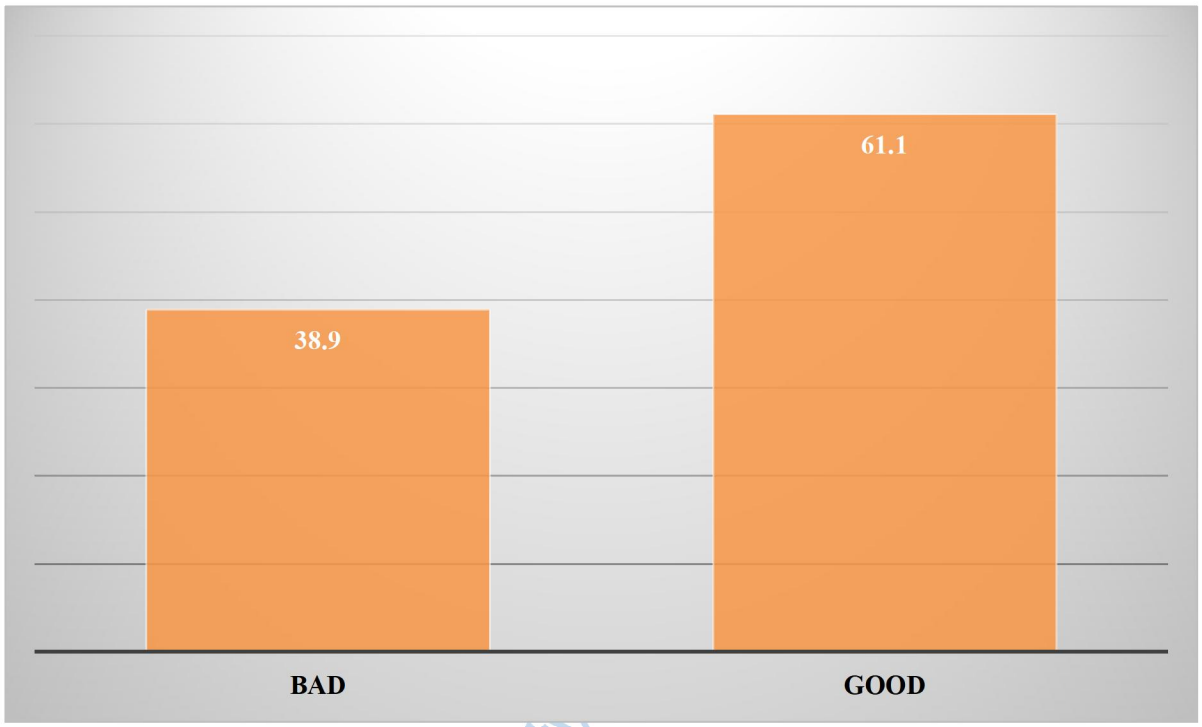

Figure 2: Attitude Level towards Exclusive Breastfeeding

4.4: Factors Influencing Participants' Attitudes Toward Exclusive Breastfeeding

The study explored various factors influencing participants' attitudes toward exclusive breastfeeding. The most impactful factor appeared to be healthcare advice, with 37.2% (151/406) indicating that guidance from healthcare professionals shaped their attitudes toward exclusive breastfeeding. However, 62.8% (255/406) reported that healthcare advice did not play a significant role, highlighting the need for enhanced communication and education from healthcare providers to improve perceptions and adherence. Personal experience was another key factor, influencing 34.0% (138/406). This shows that many individuals rely on their own past breastfeeding experiences or observations, while a majority, 66.0% (268/406), indicated that personal experience was not a primary factor. This suggests that other influences may play a larger role in shaping the breastfeeding attitudes of some participants. Family influence also contributed to attitudes, with 28.1% (114/406) reporting that family opinions shaped their breastfeeding decisions. However, for the majority 71.9% (292/406), family influence was not significant, suggesting that while familial input can be important, it is not universally decisive.

Cultural beliefs played a moderate role in shaping attitudes, as 25.4% (103/406) stated that cultural factors influenced their attitudes toward exclusive breastfeeding. Interestingly, the same percentage 25.4% (103/406) reported that cultural beliefs did not play a role, reflecting the diverse cultural landscape in which some individuals might prioritize traditional norms, while others may rely more on external information sources. In contrast, media had an almost negligible effect on attitudes. Only 1.0% (4/406) considered media (including TV, radio, or the internet) to be a major influence on their breastfeeding attitudes, while an overwhelming 99.0% (402/406) indicated that media did not shape their views. This finding suggests that media

campaigns on exclusive breastfeeding may not be reaching their intended audience or may lack the persuasive power to influence attitudes. Also, when asked about other factors, none of the participants 0.0% (0/406) reported additional influences beyond those listed, suggesting that the key factors driving attitudes toward exclusive breastfeeding were adequately captured by the study. Overall, healthcare advice and personal experience were the most significant factors influencing breastfeeding attitudes, while media and other external influences played minimal roles. This underscores the importance of strengthening healthcare provider communication and support, as well as recognizing personal experiences in shaping positive breastfeeding practices.

Table 4.4: Factors influencing the Attitudes toward Exclusive Breastfeeding

Variables	Yes n (%)	No n (%)
What factors influence your attitude towards exclusive breastfeeding the most? Personal experience	138 (34.0)	268 (66.0)
What factors influence your attitude towards exclusive breastfeeding the most? Family influence	114 (28.1)	292 (71.9)
What factors influence your attitude towards exclusive breastfeeding the most? Healthcare advice	151 (37.2)	255 (62.8)
What factors influence your attitude towards exclusive breastfeeding the most? Cultural beliefs	103 (25.4)	103 (25.4)
What factors influence your attitude towards exclusive breastfeeding the most? Media	4 (1.0)	402 (99.0)
What factors influence your attitude towards exclusive breastfeeding the most? Other	-	406 (100.0)

Source: Fieldwork, 2024

4.5: Breastfeeding Practices Among Mothers

The data from the study provides insights into the exclusive breastfeeding practices among mothers. A notable majority, 64.3% (261/406), reported that they practiced exclusive breastfeeding for their youngest child, while 35.7% (145/406) did not adhere to exclusive breastfeeding practices.

When looking into the supplementary foods or drinks provided to infants during the breastfeeding period, 25.9% (105/406) indicated that they gave their baby water, while a larger portion, 74.1% (301/406), did not provide water to their infants. Formula milk was a more common supplement, with 38.2% (155/406) reporting its use, whereas 61.8% (251/406)

refrained from giving formula milk to their babies. Juice and solid foods were rarely introduced during the exclusive breastfeeding period, as only 5.9% (24/406) gave juice to their infants, and 94.1% (382/406) did not. Similarly, 7.1% (29/406) introduced solid foods to their babies, while a vast majority, 92.9% (377/406), adhered to exclusive breastfeeding without solid food supplementation. Other forms of food or drink were minimal, with just 0.7% (3/406) providing alternatives, and 99.3% (403/406) not offering any additional forms of sustenance outside of breast milk.

The findings show that while many mothers practice exclusive breastfeeding, a considerable proportion still introduce supplementary liquids and foods, potentially impacting the health benefits associated with exclusive breastfeeding for the first six months of life.

Table 4.5: Breastfeeding Practices Among Mothers

Variables	Yes n (%)	No n (%)
Did you practice exclusive breastfeeding for your youngest child?	261 (64.3)	145 (35.7)
What other food or drink did you give to your baby? Water	105 (25.9)	301 (74.1)
What other food or drink did you give to your baby? Formula milk	155 (38.2)	251 (61.8)
What other food or drink did you give to your baby? Juices	24 (5.9)	382 (94.1)
What other food or drink did you give to your baby? Solid foods	29 (7.1)	377 (92.9)
What other food or drink did you give to your baby? Others	3 (0.7)	403 (99.3)

Source: Fieldwork, 2024

4.6: Breastfeeding Management Practices Among Mothers

The study explored the difficulties and management of breastfeeding as well as when to introduce other foods and how frequently to breastfeed. The data shows that mothers introduced other foods or drinks to their babies at varying ages, with the earliest age being 1 month and the latest being 24 months. The mean age for introducing additional foods was 5.6±2.95. This indicates that, on average, most mothers introduced complementary feeding within the recommended window of 4-6 months, though there was a significant variation in timing among the participants. Regarding the frequency of breastfeeding per day, responses ranged from as few as 1 feeding per day to as many as 30 feedings. The mean frequency was 6.71 feedings per day, with a standard deviation of 3.83, indicating that most mothers breastfed their babies multiple times throughout the day, which aligns with exclusive breastfeeding recommendations, which encourage frequent feeding to ensure adequate milk supply and infant nutrition.

Among the respondents, 39.9% (162/406) of mothers reported using breastfeeding aids such as breast pumps and nursing pillows. Despite the availability of these tools, the majority, 60.1% (244/406), chose not to use any aids, suggesting that many mothers prefer more traditional breastfeeding practices without additional equipment. Breastfeeding challenges were prevalent among the participants, with 72.7% (295/406) of mothers reporting some form of difficulty, while 27.3% (111/406) did not experience significant challenges. The most commonly cited issue was pain or discomfort, affecting 48.0% (195/406) of the mothers. This high percentage highlights the physical strain that breastfeeding can impose, which may influence a mother's willingness or ability to continue breastfeeding.

Additionally, 27.6% (112/406) of mothers reported insufficient milk supply as a key issue, which can be discouraging for those who aim to practice exclusive breastfeeding. Interestingly, fewer

mothers, 14.5% (59/406), indicated latching problems, while 19.2% (78/406) faced a baby's refusal to breastfeed, showing that issues related to the baby's behavior were less common but still significant. In terms of managing these challenges, the majority of mothers, 60.6% (246/406), sought healthcare advice to help them overcome breastfeeding difficulties. This indicates that healthcare providers play a crucial role in supporting mothers. A smaller percentage 24.1% (98/406), managed their issues by changing feeding positions, while 18.7% (76/406) used breastfeeding aids to alleviate discomfort or improve the breastfeeding process. Notably, only 13.8% (56/406) received support from families to manage their breastfeeding challenges, emphasizing the need for broader familial involvement in supporting breastfeeding mothers. When it came to feeding schedules, 63.5% (258/406) of mothers practiced on-demand breastfeeding, responding to their baby's hunger cues, while 36.5% (148/406) adhered to a scheduled breastfeeding routine.

Table 4.6a: Breastfeeding Practices Among Mothers

Variable	Yes n (%)	No n (%)
Do you use any breastfeeding aids (e.g., breast pump, nursing pillow)?	162 (39.9)	244 (60.1)
Have you faced any difficulties while breastfeeding?	295 (72.7)	111 (27.3)
What difficulties have you faced? Pain or discomfort	195 (48.0)	211 (52.0)
What difficulties have you faced? Insufficient milk supply	112 (27.6)	294 (72.4)
What difficulties have you faced? Latching problems	59 (14.5)	347 (85.5)
What difficulties have you faced? Baby's refusal to breastfeed	78 (19.2)	328 (80.8)
How do you manage these difficulties? Seeking healthcare advice	246 (60.6)	160 (39.4)
How do you manage these difficulties? Using breastfeeding aids	76 (18.7)	330 (81.3)
How do you manage these difficulties? Changing feeding positions	98 (24.1)	308 (75.9)
How do you manage these difficulties? Support from family	56 (13.8)	350 (86.2)

Source: Fieldwork, 2024

Table 4.6b: Breastfeeding Practices Among Mothers

Variable	Response	Frequency	Percent
Do you practice on-demand breastfeeding or scheduled breastfeeding?	On-demand	258	63.5
	Scheduled	148	36.5

Source: Fieldwork, 2024

4.7: Spousal Support in Promoting Exclusive Breastfeeding

The findings from the study highlight the crucial role of spousal support in the breastfeeding experiences of mothers. Overall, a significant portion of participants reported limited support from their spouses regarding their breastfeeding efforts, with 59.9% (243/406) stating that their spouse does not support their breastfeeding efforts, while only 40.1% (163/406) indicated they do receive support. When asked about specific types of support, the data revealed that emotional support is crucial yet underutilized, as 28.6% (116/406) reported receiving emotional backing from their spouses. In contrast, a significant 71.4% (290/406) did not feel that emotional support was provided. Similarly, while 29.1% (118/406) reported that their spouse helps with household chores, a large majority 70.9% (288/406) did not experience this kind of assistance.

Financial support emerged as the most recognized form of spousal support, with 52.2% (212/406) acknowledging that their spouse provides financial help related to breastfeeding, while 47.8% (194/406) felt this support was lacking. However, more passive forms of support, such as accompanying healthcare visits and assisting in baby care to allow mothers time to rest, were reported less frequently. Only 12.1% (49/406) mentioned that their spouse accompanies them to healthcare visits, and just 33.3% (135/406) stated that their spouse helps take care of the baby to give them a chance to rest. Furthermore, 22.7% (92/406) reported that their spouse participates in

feeding expressed breast milk, while a mere 18.0% (73/406) indicated that their spouse attends breastfeeding education sessions with them.

The perception of spousal support's importance was notably high, with 67.0% (272/406) viewing it as "very important" for successful exclusive breastfeeding. Conversely, only a small percentage, 5.4% (22/406), deemed spousal support as "not important." Despite this recognition of its significance, many participants noted that the lack of spousal support negatively impacted their breastfeeding experience, with 55.4% (225/406) indicating adverse effects. In comparison, only 20.2% (82/406) felt positively affected by the presence of spousal support, while 24.4% (99/406) reported no effect. Regarding additional support needed, 82.5% (335/406) expressed a desire for more emotional support from their spouses, emphasizing its critical role in their breastfeeding journey. This was followed by 16.7% (68/406) who sought financial support, while only a small fraction, 0.7% (3/406), mentioned the need for social support.

Overall, these findings show the necessity for increased engagement and support from spouses to enhance the breastfeeding experience for mothers, indicating that while some forms of support are acknowledged, there is substantial room for improvement, particularly in emotional and practical assistance.

Table 4.7a: Spousal Support in Promoting Exclusive Breastfeeding

Variables	Yes n (%)	No n (%)
Does your spouse support your breastfeeding efforts?	163 (40.1)	243 (59.9)
In what ways does your spouse support your breastfeeding? Emotional	116 (28.6)	290 (71.4)

In what ways does your spouse support your breastfeeding? Helping with household chores	118 (29.1)	288 (70.9)
In what ways does your spouse support your breastfeeding? Providing financial support	212 (52.2)	194 (47.8)
In what ways does your spouse support your breastfeeding? Accompanying healthcare visits	49 (12.1)	357 (87.9)
In what ways does your spouse support your breastfeeding? Others	-	406 (100.0)
Does your spouse encourage you to continue exclusive breastfeeding?	161 (39.7)	245 (60.3)
Does your spouse assist in taking care of the baby to give you time to rest?	135 (33.3)	271 (66.7)
Does your spouse participate in feeding the baby expressed breast milk?	92 (22.7)	314 (77.3)
Does your spouse attend breastfeeding education sessions with you?	73 (18.0)	333 (82.0)

Source: Fieldwork, 2024

Table 4.7b: Spousal Support in Promoting Exclusive Breastfeeding

Variables	Response	Frequency	Percent
How important do you think spousal support is for successful exclusive breastfeeding?	Important	63	15.5
	Very important	272	67.0
	Neutral	42	10.3
	Not important	22	5.4
	Not at all important	7	1.7
How often does your spouse discuss breastfeeding with you?	Never	75	18.5

	Rarely	190	46.8
	Occasionally	75	18.5
	Frequently	66	16.3
How does the presence or absence of spousal support affect your breastfeeding experience?	Negatively	225	55.4
	No effect	99	24.4
	Positively	82	20.2
What additional support would you like from your spouse regarding breastfeeding?	Financial support	68	16.7
	Emotional support	335	82.5
	Social support	3	0.7

Source: Fieldwork, 2024

4.8: Association between Socio-demographic variables and Attitudes

Chi-square analysis found significant associations between attitudes and several socio-demographic variables: age ($X^2 = 13.224$, $p = 0.001$), marital status ($X^2 = 18.118$, $p = 0.000$), education level ($X^2 = 13.627$, $p = 0.003$), employment status ($X^2 = 12.472$, $p = 0.002$), household income ($X^2 = 14.326$, $p = 0.001$), and family structure ($X^2 = 6.456$, $p = 0.011$). Positive attitudes were more common among younger participants, those with tertiary education, employed individuals, higher-income groups, and those in nuclear family settings.

Table 4.8a Association between Socio-demographic variables and Attitudes

Variables	Attitude Category		df	X_2	P - value
	Bad n (%)	Good n (%)			

Age					
15-24	72 (55.7)	71 (87.3)	13.224	2	0.001
25-34	63 (70.4)	118 (110.6)			
Above 34	23 (31.9)	59 (50.1)			
Marital Status					
Single	10 (4.7)	2 (7.3)	18.118	3	0.000
Married	134 (143.6)	235 (225.4)			
Divorced	6 (5.8)	9 (9.2)			
Widowed	8 (3.9)	2 (6.1)			
Level of Education					
No formal education	8 (5.4)	6 (8.6)	13.627	3	0.003
Primary education	28 (17.9)	18 (28.1)			
Secondary education	49 (57.2)	98 (89.8)			
Tertiary education	73 (77.4)	126 (121.6)			
Employment Status					
Unemployed	36 (25.3)	29 (39.7)	12.472	2	0.002
Self-employed	90 (89.1)	139 (139.9)			
Employed	32 (43.6)	80 (68.4)			

Table 4.8b Association between Socio-demographic variables and Attitudes

Variables	**Attitude Category**		**df**	**X_2**	**P - value**
	Bad n (%)	**Good n (%)**			
Household Income Level					

Low	55 (41.3)	51 (64.7)	14.326	2	0.001
Medium	89 (93.0)	150 (146.0)			
High	14 (23.7)	47 (37.3)			
Type of family structure					
Nuclear	127 (116.0)	171 (182.0)	6.456	1	0.011
Extended	31(42.0)	77 (66.0)			

4.9: Association between Socio-demographic Variables and Knowledge

Chi-square analysis found statistical significance between knowledge levels and several socio-demographic variables: age ($X^2 = 19.783$, $p = 0.000$), marital status ($X^2 = 18.334$, $p = 0.000$), employment status ($X^2 = 24.072$, $p = 0.000$), and household income ($X^2 = 22.445$, $p = 0.000$). Younger age, employment, and higher income were associated with better knowledge. In contrast, family structure did not significantly affect knowledge ($X^2 = 0.649$, $p = 0.421$).

Table 4.9a Association between Socio-demographic Variables and Knowledge

Variables	**Knowledge Category**		**df**	**X_2**	**P - value**
	Bad n (%)	**Good n (%)**			
Age					
15-24	49 (61.6)	94 (81.4)	19.783	2	0.000
25-34	100 (78.0)	81(103.0)			

Above 34	26 (35.3)	56 (46.7)			
Marital Status					
Single	1 (5.2)	11 (6.8)	18.334	3	0.000
Married	171 (159.1)	198 (209.9)			
Divorced	3 (6.5)	12 (8.5)			
Widowed	0 (4.3)	10 (5.7)			
Level of Education					
No formal education	8 (6.0)	6 (8.0)	11.464	3	0.009
Primary education	11 (19.8)	35 (26.2)			
Secondary education	74 (63.4)	73 (83.6)			
Tertiary education	82 (85.8)	117 (113.2)			
Employment Status					
Unemployed	26 (28.0)	39 (37.0)	24.072	2	0.000
Self-employed	121 (98.7)	108 (130.3)			
Employed	28 (48.3)	84 (63.7)			

Table 4.9b Association between Socio-demographic Variables and Knowledge

Variables	**Knowledge Category**		**df**	**X_2**	**P - value**
	Bad n (%)	**Good n (%)**			
Household Income Level					
Low	56 (45.7)	50 (60.3)	22.445	2	0.000

Medium	109 (103.0)	130 (136.0)			
High	10 (26.3)	51 (34.7)			
Type of family structure					
Nuclear	132 (128.4)	166 (169.6)	0.649	1	0.421
Extended	43 (46.6)	65 (61.4)			

4.10: Association between Socio-demographic Variables and Practice

Chi-square analysis indicates no statistically significant associations between socio-demographic variables and practice levels. Age ($X^2 = 2.968$, $p = 0.227$), marital status ($X^2 = 6.835$, $p = 0.077$), education level ($X^2 = 7.357$, $p = 0.061$), employment status ($X^2 = 3.012$, $p = 0.222$), household income ($X^2 = 0.841$, $p = 0.657$), and family structure ($X^2 = 1.116$, $p = 0.291$) all show p-values above 0.05, indicates that these variables are not significantly associated with practice.

Table 4.10a Association between Socio-demographic Variables and Practice

	Practice Category				
Variables	**Poor n (%)**	**Good n (%)**	**df**	**X_2**	**P – value**
Age					
15-24	73 (78.5)	70 (64.5)	2.968	2	0.227
25-34	108 (99.4)	73 (81.6)			
Above 34	42 (45.0)	40 (37.0)			
Marital Status					

Single	10 (6.6)	2 (5.4)	6.835	3	0.077
Married	203 (202.7)	166 (166.3)			
Divorced	7 (8.2)	8 (6.8)			
Widowed	3 (5.5)	7 (4.5)			
Level of Education					
No formal education	6 (7.7)	8 (6.3)	7.357	3	0.061
Primary education	21 (25.3)	25 (20.7)			
Secondary education	93 (80.7)	54 (66.3)			
Tertiary education	103 (109.3)	96 (89.7)			
Employment Status					
Unemployed	31 (35.7)	34 (29.3)	3.012	2	0.222
Self-employed	134 (125.8)	95 (103.2)			
Employed	58 (61.5)	54 (50.5)			

Table 4.10b Association between Socio-demographic Variables and Practice

Variables	**Practice Category**		**Df**	**X_2**	**P - value**
	Poor n (%)	**Good n (%)**			
Household Income Level					
Low	60 (58.2)	46 (47.8)	0.841	2	0.657
Medium	127 (131.3)	112 (107.7)			

High	36 (33.5)	25 (27.5)			
Type of family structure					
Nuclear	159 (163.7)	139 (134.3)	1.116	1	0.291
Extended	64 (59.3)	44 (48.7)			

4.11: Logistic Regression on factors influencing Exclusive breastfeeding

Logistic regression indicates that household income and family structure significantly influence exclusive breastfeeding. Medium income level is associated with lower odds of exclusive breastfeeding (OR = 0.203, p = 0.000), while nuclear family structure increases the likelihood (OR = 0.565, p = 0.036). Other factors, including marital status, education, employment, and age, show no significant impact (p > 0.05).

Table 4.11: Logistic Regression on factors influencing Exclusive breastfeeding

Variables	**OR**	**95% Confidence Levels**		**P - value**
		Lower Bound	**Upper Bound**	
Marital Status				
Single				
Married	0.580	0.131	2.576	0.474
Divorced	0.218	0.034	1.397	0.108
Widowed	373185124.460	.000		0.999
Level of Education				

No formal education				
Primary education	1.519	0.304	7.591	0.611
Secondary education	0.430	0.102	1.816	0.251
Tertiary education	1.420	0.337	5.976	0.633
Employment Status				
Unemployed				
Self-employed	0.592	0.266	1.318	0.199
Employed	0.733	0.293	1.833	0.506
Age				
15-24				0.289
25-34	1.429	0.834	2.455	0.196
Above 34	1.689	0.813	3.506	0.160

Variables	**OR**	**95% Confidence Levels**		**P – value**
		Lower Bound	**Upper Bound**	
Household Income Level				
Low				
Medium	0.203	0.105	0.396	.000
High	0.744	0.288	1.923	.541
Type of family structure				

Nuclear				
Extended	0.565	0.331	0.965	0.036

4.12: Logistic Regression on Attitude, Knowledge and Practice on Exclusive Breastfeeding

The logistic regression analysis shows that attitude and knowledge significantly influence the outcome, while practice does not. A positive attitude was associated with higher odds (OR = 2.237, p = 0.000), and greater knowledge further increases the odds (OR = 3.338, p = 0.000). However, practice shows no significant effect (OR = 1.153, p = 0.537).

Table 4.12: Multivariate Logistic Regression on Attitude, Knowledge and Practice on Exclusive Breastfeeding

Variables	OR	95% Confidence Levels		P – value
		Lower Bound	Upper Bound	
Practice	1.153	0.734	1.811	0.537
Attitude	2.237	1.426	3.510	0.000
Knowledge	3.338	2.126	5.241	0.000

Table 4.13: Multiple regressions of factors influencing Exclusive breastfeeding

4.13: Multiple regressions of factors influencing Exclusive breastfeeding

The multiple regression analysis reveals that attitude and spousal support are significant

Variables	Unstandardized Coefficients		Standardized Coefficients	T	P – value
	B	Std. Error	Beta		
Constant	13.887	10.872		1.277	0.202
Knowledge	0.520	0.351	0.076	1.480	0.140
Attitude	0.529	0.200	0.139	2.651	0.008
Spousal	.591	0.300	0.107	1.968	0.050

predictors, while knowledge is not. Attitude has a positive and significant effect on the outcome (B = 0.529, p = 0.008), indicating that more positive attitudes are associated with higher scores. Spousal support also shows a marginally significant effect (B = 0.591, p = 0.050), suggesting its potential influence. Knowledge, however, does not significantly impact the outcome (B = 0.520, p = 0.140).

4.14: Discussion of Findings

The results revealed that a large majority of participants 93.8% had heard about exclusive breastfeeding, primarily from healthcare providers 66.7%. This demonstrates that healthcare professionals are key sources of information, underscoring their role in promoting breastfeeding

knowledge. However, the media and social networks were less commonly cited as sources, suggesting potential areas for improvement in public health messaging. Strengthening media and community outreach programs could expand the reach of breastfeeding education, especially considering the small percentage 12.6% who gained knowledge from community programs. Despite the widespread awareness of exclusive breastfeeding, the study highlights the need for more comprehensive strategies that integrate both traditional and modern communication channels to ensure that all mothers receive accurate and consistent information. This findings support the evidence that using a holistic or multi-pronged health communication approach that is context-specific and participatory could attract more uptakes of health messages[1].

Most participants exhibited positive attitudes toward exclusive breastfeeding, with 73.2% agreeing or strongly agreeing that it is beneficial for the baby. Additionally, 75.6% expressed confidence in their ability to exclusively breastfeed, highlighting an overall understanding of the importance of the practice. However, a notable portion 24.4% lacked confidence, suggesting a need for targeted interventions to address concerns and build mothers' self-efficacy in breastfeeding. Public breastfeeding remains a sensitive issue, as 33.6% of mothers reported feeling uncomfortable breastfeeding in public, which may reflect societal and cultural pressures. A majority of participants 49.5% viewed breastfeeding as a natural process, but a significant number 33.5% saw it as a skill that requires learning, pointing to a diverse range of beliefs about breastfeeding. This emphasizes the importance of education and practical support for new mothers, particularly those who may struggle with breastfeeding initially. The study also found that cultural beliefs significantly influenced attitudes, with 70.2% agreeing that cultural factors affect breastfeeding practices. This highlights the need to tailor breastfeeding promotion programs to respect and incorporate cultural contexts, ensuring they resonate with different

groups. These findings supported that addressing sociocultural barriers through community-based interventions could significantly influence mothers attitudes and practices on exclusive breastfeeding[2].

Additionally, the most significant factor shaping participants' attitudes was healthcare advice, with 37.2% acknowledging its influence. This finding underscores the pivotal role that healthcare professionals play in forming positive breastfeeding attitudes, although many mothers 62.8% reported that healthcare advice did not substantially influence their views. Personal experience also played a crucial role, affecting 34.0% of participants. This suggests that while education and information are important, personal and lived experiences significantly shape mothers' perceptions of breastfeeding. Family and cultural beliefs also had moderate influence, impacting 28.1% and 25.4% of participants, respectively. Surprisingly, media had an almost negligible effect on breastfeeding attitudes, with only 1.0% of mothers considering it an influential factor. This finding calls for more effective media campaigns that are tailored to mothers' needs and are designed to engage their attention in a meaningful way.

The findings show that 64.3% of mothers practiced exclusive breastfeeding for their youngest child, indicating a solid adherence to recommended practices. However, a substantial portion 35.7% did not adhere to exclusive breastfeeding, with many introducing supplementary liquids such as water 25.9% and formula milk 38.2%. This suggests that despite awareness, certain barriers may lead mothers to deviate from exclusive breastfeeding guidelines. Introducing water, formula, or other foods could undermine the health benefits exclusive breastfeeding offers during the first six months. This calls for more in-depth education on the reasons behind exclusive breastfeeding and its long-term benefits for both mother and child. The findings on breastfeeding management revealed a wide range of practices regarding the introduction of supplementary

foods and the frequency of breastfeeding. While the average age for introducing complementary foods was within the recommended 4-6 months window, there was significant variation, with some mothers introducing foods as early as 1 month. This variability points to the need for clearer guidance and support on optimal feeding timelines. The frequency of breastfeeding, averaging 6.71 feedings per day, aligns with recommendations for frequent breastfeeding to ensure milk supply and infant nutrition. However, challenges such as pain or discomfort 48.0%, insufficient milk supply 27.6% , and latching problems 14.5% were common, and a majority of mothers 72.7% reported experiencing some form of difficulty. The reliance on healthcare advice for managing these challenges 60.6% highlights the crucial role of healthcare providers in supporting breastfeeding mothers, but the low level of family support 13.8% suggests that more could be done to involve families in helping mothers overcome breastfeeding obstacles. These evidences supported that family's involvement and service delivery challenges must be considered for successful scale-up on exclusive breastfeeding[3].

The findings of this study emphasize the significant yet often underutilized role of spousal support in facilitating exclusive breastfeeding practices among mothers in Ibadan North. The data reveals a striking disparity between the perceived importance of spousal support and its actual presence in mothers' breastfeeding experiences. Although 67% of participants acknowledged the critical nature of spousal support for successful exclusive breastfeeding, a substantial 59.9% reported not receiving any support from their spouses. This inconsistency suggests that, while mothers recognize the importance of having their partners involved in the breastfeeding process, many do not experience that support in practice. Emotional support emerged as a particularly crucial area, with only 28.6% of mothers reporting that they received emotional backing from their spouses. In contrast, a significant 71.4% felt that this vital form of

support was lacking. The emotional landscape of breastfeeding is complex, and mothers often face challenges that require encouragement and understanding from their partners. The need for increased emotional support is further highlighted by the fact that 82.5% of participants expressed a desire for more of this type of backing. This highlights an opportunity for interventions aimed at educating partners on how to support breastfeeding mothers emotionally, thus improving the overall breastfeeding experience. The findings also reveal a gap in practical support, such as assistance with household chores and baby care. Only 29.1% of mothers reported receiving help with chores, while 33.3% noted that their spouses assisted in baby care. This lack of practical support can place an additional burden on mothers, especially in the demanding early months of parenting. Furthermore, passive forms of support, such as accompanying healthcare visits, were reported by only 12.1% of participants. These statistics indicate that many mothers may feel overwhelmed, particularly when they are not receiving the necessary assistance from their partners. Interestingly, financial support was the most commonly recognized form of spousal support, with 52.2% of participants acknowledging this form. While financial assistance is undeniably important, it is evident that emotional and practical support could substantially enhance the breastfeeding journey. The fact that 55.4% of mothers indicated that a lack of spousal support negatively affected their breastfeeding experience further emphasizes the need for a comprehensive understanding of support types required by breastfeeding mothers. However, the study's findings highlight the necessity for increased engagement and multifaceted support from spouses to enhance the breastfeeding experience for mothers. While there is an understanding of the importance of spousal support, actual practices often fall short. Improving communication about the roles spouses can play, particularly in emotional and practical capacities, may lead to better breastfeeding outcomes and overall

maternal well-being. These findings supported the evidence that spousal role is essential in promoting effective exclusive breastfeeding practices[4].

Additionally, the findings from this study offer insights into the complex relationships among knowledge, attitudes, practices, socio-demographic factors, and the role of spousal support in exclusive breastfeeding among mothers in Ibadan North. The analysis reveals a nuanced pattern of factors influencing exclusive breastfeeding practices, with significant associations found between attitudes, knowledge, and socio-demographic variables, while practices were not directly influenced by these factors. The role of spousal support, though marginal, appears to be a potential determinant in exclusive breastfeeding success.

The study's chi-square analysis highlights how several socio-demographic factors significantly influence attitudes and knowledge toward exclusive breastfeeding, whereas socio-demographic factors do not significantly impact practices. Age, marital status, education level, employment status, household income, and family structure all significantly associate with attitudes towards breastfeeding. Specifically, positive attitudes are more common among younger mothers, those with tertiary education, employed individuals, those with higher household income, and those from nuclear families. These findings align with prior research suggesting that younger, educated, and financially stable mothers are more likely to perceive breastfeeding positively due to greater exposure to breastfeeding education and increased access to resources that facilitate breastfeeding[5].

Knowledge of exclusive breastfeeding also shows significant associations with age, marital status, employment status, and household income, though family structure does not have a significant effect. Higher knowledge levels among younger, employed, and higher-income mothers may reflect their access to more extensive healthcare information and support networks,

a trend observed in studies of urban breastfeeding patterns[6]. This indicates that health education and employment status could play a critical role in increasing breastfeeding knowledge, enabling mothers to make informed decisions about exclusive breastfeeding.

Contrary to expectations, socio-demographic variables such as age, marital status, education, employment, household income, and family structure did not show statistically significant associations with breastfeeding practice levels. The non-significance of these factors may reflect broader structural challenges in promoting breastfeeding practice, where knowledge and attitudes do not necessarily translate into sustained practice. This finding is consistent with literature indicating that while positive attitudes and knowledge are essential, practical implementation can be influenced by factors beyond socio-demographics, such as workplace policies, societal norms, and immediate family support[7].

Furthermore, the logistic regression analysis shows that household income and family structure significantly influence exclusive breastfeeding. A medium income level is associated with lower odds of exclusive breastfeeding, while nuclear family structure increases the likelihood. This aligns with previous studies showing that financial stability and a supportive family environment are crucial facilitators of exclusive breastfeeding practices, as mothers with financial means and a close family support system can better manage the demands of exclusive breastfeeding[8]. The finding on family structure suggests that nuclear families might offer a more supportive environment than extended families, which may reflect differences in caregiving expectations and the distribution of household responsibilities.

In the logistic regression analysis, both attitude and knowledge significantly influenced exclusive breastfeeding outcomes. A positive attitude towards breastfeeding was associated with a more

than two-fold increase in the odds of exclusive breastfeeding, while higher knowledge levels increased the odds even further. This supports established evidence that mothers with positive attitudes and adequate knowledge about the benefits and techniques of exclusive breastfeeding are more likely to adhere to recommended practices. The findings align with health behavior theories, which emphasize that both knowledge and positive attitudes are essential in motivating and sustaining health-promoting behaviors such as exclusive breastfeeding[9].

Moreover, the multiple regression analysis indicates that while knowledge does not significantly predict exclusive breastfeeding, attitude and spousal support do. The positive influence of spousal support, though only marginally significant, suggests that having a supportive partner may empower mothers to continue exclusive breastfeeding despite potential challenges. This finding aligns with literature underscoring the role of family and partner support in maternal health behaviors, particularly in cultural contexts where breastfeeding requires both emotional and logistical backing[5]. Partner involvement in breastfeeding education and encouragement has been shown to foster a positive breastfeeding environment, ultimately benefiting both the mother and the infant.

Therefore, the findings emphasize the need for targeted health interventions to support exclusive breastfeeding among mothers, particularly focusing on improving attitudes, enhancing knowledge, and fostering spousal involvement. Programs should prioritize educating both mothers and their partners about breastfeeding benefits and practices, as this could strengthen attitudes and ensure continued support. Additionally, policies that address structural barriers to breastfeeding, such as workplace support for nursing mothers, are essential to translate positive attitudes and knowledge into consistent breastfeeding practice. Given the influence of socio-

demographic factors on attitudes and knowledge, future interventions may also benefit from being tailored to specific demographic groups to address their unique challenges.

Conclusively, this study highlights that while attitudes and knowledge significantly impact exclusive breastfeeding; socio-demographic factors and practical support from family and partners also play critical roles. The lack of association between socio-demographic factors and breastfeeding practices suggests that while informational and attitudinal support is crucial, practical implementation of exclusive breastfeeding requires comprehensive support systems. Efforts to improve breastfeeding practices should address not only individual knowledge and attitudes but also seek to foster supportive environments that enable mothers to engage in exclusive breastfeeding effectively.

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Chapter Five

Conclusion

5.1: Summary of Findings

This study investigated the knowledge, attitudes, practices, and influence of spousal support on exclusive breastfeeding among mothers in Ibadan North, Nigeria. The findings reveal a nuanced interaction of socio-demographic factors, cultural beliefs, and practical challenges impacting

breastfeeding practices. The study found high levels of awareness regarding exclusive breastfeeding, with 93.8% of mothers attributing their knowledge primarily to healthcare providers (66.7%). Despite this, the limited role of media and social networks in disseminating breastfeeding information reflects an unaddressed communication gap. Younger participants, those employed and higher-income groups demonstrated better knowledge, while family structure showed no significant association with knowledge levels. Positive attitudes towards exclusive breastfeeding were observed in 73.2% of participants, with younger, better-educated, employed, higher-income individuals, and those in nuclear family settings more likely to exhibit favorable attitudes. However, 24.4% expressed doubts about exclusive breastfeeding due to social stigma and cultural beliefs, with 33.6% feeling uncomfortable breastfeeding in public. Cultural influences were a barrier for 70.2% of mothers.

Additionally, only 64.3% of mothers adhered to exclusive breastfeeding for the recommended duration, while 35.7% introduced supplementary foods or liquids earlier. Despite generally high awareness and positive attitudes, practices did not align with recommendations, reflecting barriers such as physical discomfort, insufficient milk supply, and latching issues (reported by 72.7% of participants). Importantly, socio-demographic variables such as age, marital status, education Alevel, employment status, household income, and family structure showed no significant associations with breastfeeding practices, as indicated by chi-square analysis.

Furthermore, a key finding of this study is the critical yet underutilized role of spousal support. While 67% of mothers recognized its importance, 59.9% reported receiving no spousal support. Emotional support was particularly lacking, with 71.4% of mothers not receiving it, and practical support with household tasks (29.1%) and baby care (33.3%) was minimal. Financial support was more common (52.2%) but insufficient to bridge the gaps in emotional and practical

assistance. Logistic regression revealed that a nuclear family structure positively influenced exclusive breastfeeding odds (OR = 0.565, p = 0.036), while medium household income negatively impacted it (OR = 0.203, p = 0.000).

Moreover, statistical analyses underscored that positive attitudes (OR = 2.237, p = 0.000) and greater knowledge (OR = 3.338, p = 0.000) were significant predictors of exclusive breastfeeding. However, actual breastfeeding practices did not significantly influence outcomes (OR = 1.153, p = 0.537). Multiple regression analysis further highlighted that attitudes (B = 0.529, p = 0.008) and spousal support (B = 0.591, p = 0.050) were significant predictors of better breastfeeding outcomes, whereas knowledge alone did not significantly contribute (B = 0.520, p = 0.140).

5.2: Conclusion

The findings highlight both the successes and challenges in promoting exclusive breastfeeding among mothers in Ibadan North. Healthcare providers play a vital role in educating mothers, but an expanded outreach strategy through media and social networks could bridge the informational gaps and normalize breastfeeding practices. While positive attitudes and high awareness levels are encouraging, cultural norms and physical challenges continue to prevent many mothers from adhering to exclusive breastfeeding. Additionally, this study underscores the critical yet often absent role of spousal support in both emotional and practical forms. Thus, addressing exclusive breastfeeding requires a multi-dimensional approach: improving healthcare education, promoting positive cultural attitudes, strengthening community networks, and involving spouses more actively in the breastfeeding journey. By fostering an inclusive, supportive environment that

encompasses healthcare, community, and family, exclusive breastfeeding practices can be sustainably improved.

5.3: Recommendations

To enhance exclusive breastfeeding practices and provide comprehensive support for breastfeeding mothers, the following recommendations are proposed:

1. Expand Public Health Messaging Using Diverse Media Channels

Public health campaigns should leverage digital and traditional media to disseminate culturally sensitive and engaging information about exclusive breastfeeding. By utilizing social media, radio, and television, accurate information can reach broader audiences, including mothers who may not frequently visit healthcare facilities. Collaboration with local influencers and community leaders can also amplify these messages, helping normalize breastfeeding practices within the community.

2. Promote Comprehensive Spousal Involvement in Breastfeeding Support

Spousal support is critical in empowering mothers to exclusively breastfeed, yet it remains limited. Healthcare facilities should integrate fathers into prenatal and postnatal sessions, educating them on the emotional, financial, and practical ways to support their partners. Targeted workshops and counseling sessions for men can demystify breastfeeding and emphasize its importance to family health, fostering a supportive environment at home.

3. Enhance Breastfeeding Support Services in Healthcare Settings

Continuous, structured support for breastfeeding mothers in healthcare facilities can address common breastfeeding issues such as latching problems, pain, and concerns about milk supply.

Dedicated lactation consultants and peer support groups can help mothers navigate these challenges, promoting an environment of shared learning and encouragement. Additionally, peer support networks within hospitals can offer a space for mothers to connect and gain confidence from one another.

4. Implement Community-Based Support Programs Tailored to Cultural Contexts

Community-based interventions, developed with an understanding of local cultural norms, can encourage family and community involvement in breastfeeding. Partnering with community leaders, religious institutions, and women's groups can create supportive networks that address societal stigma around breastfeeding, especially in public settings. These networks can help mothers feel empowered and reduce cultural barriers to exclusive breastfeeding.

5. Increase Practical Education and Skills Training for New Mothers

Providing mothers with hands-on breastfeeding techniques and peer mentoring programs can build confidence and enhance their breastfeeding skills. Practical education sessions integrated into prenatal classes and peer-to-peer mentoring systems can offer continuous guidance and support. Peer mentors can share valuable personal experiences, providing emotional and practical support to mothers who may face similar challenges.

6. Implement Workplace Policies Supporting Breastfeeding Mothers

Employment-related challenges often discourage exclusive breastfeeding. Employers should be encouraged to adopt breastfeeding-friendly policies, including flexible working hours, lactation rooms, and paid breastfeeding breaks. Such policies enable employed mothers to continue

exclusive breastfeeding without feeling pressured to supplement with formula due to work constraints.

7. Develop Male-Centric Breastfeeding Awareness Campaigns

Male-centric campaigns can be valuable in raising awareness of breastfeeding's benefits and encouraging spousal involvement. Targeted campaigns for fathers can highlight the health benefits of exclusive breastfeeding and the practical ways they can support their partners. Public health authorities could organize workshops and community events specifically designed for men, helping them understand the significance of their role in supporting breastfeeding mothers.

5.4: Contribution to Knowledge

This study adds valuable insights to the existing literature on exclusive breastfeeding by emphasizing the often-overlooked role of spousal support, particularly emotional and practical aspects, in sustaining breastfeeding practices. Additionally, the study highlights how cultural beliefs and socio-demographic factors shape breastfeeding attitudes and practices, underscoring the need for culturally sensitive interventions. The findings also support the importance of a holistic communication approach that integrates healthcare information with media outreach, providing a model that can be adapted to other regions and cultural contexts. These contributions enhance understanding of the complex factors influencing exclusive breastfeeding and provide a basis for more targeted interventions.

5.5: Suggested Areas for Further Research

To deepen understanding of exclusive breastfeeding practices and provide more modified support to mothers, the following areas are recommended for future research:

1. Explore the Effectiveness of Different Types of Spousal Support

Future studies should investigate which specific types of spousal support: emotional, financial, or practical are most effective in sustaining exclusive breastfeeding practices. This knowledge can guide the design of spousal intervention programs that focus on the most impactful support types.

2. Examine the Long-Term Impact of Enhanced Spousal Support on Maternal and Child Health

Research on the long-term effects of comprehensive spousal support on maternal and child health outcomes related to breastfeeding could offer insights into the extended benefits of family-centered approaches to breastfeeding. Such findings could support policies that promote spousal involvement in maternal and child healthcare.

3. Conduct Comparative Studies across Cultural and Socio-Economic Groups

Comparative studies examining breastfeeding practices across various socio-economic and cultural backgrounds could provide deeper insights into how cultural beliefs and socio-economic status influence breastfeeding decisions. This could help tailor breastfeeding interventions to meet the unique needs of diverse populations.

4. Investigate the Impact of Digital Media on Breastfeeding Practices

Research into the influence of digital media, including social media, virtual support groups, and health-focused mobile applications, on breastfeeding awareness and practices would offer insights into optimizing health communication strategies. Understanding the role of modern communication tools could improve outreach efforts, especially among younger mothers.

5. Assess the Effectiveness of Peer-to-Peer Support Networks for Breastfeeding

Evaluating the impact of peer-to-peer support programs on exclusive breastfeeding could provide evidence for expanding community-based networks for breastfeeding mothers. Researching these networks' effectiveness can inform initiatives to establish supportive, mother-centered communities that offer practical and emotional backing.

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Appendix

LEAD CITY UNIVERSITY

PUBLIC HEALTH DEPARTMENT

MINISTRY OF HEALTH NREC ASSIGNED NUMBER: NHREC/OYOSHRIEC/10/11/22

OYO STATE PRIMARY HEALTH CARE BOARD REFERENCE NUMBER: AD, 072/Vol. 1/303

Dear respondents, I am a postgraduate student of Lead City University in the Department of Public Health. I am to carry out a research in Ibadan North Local Government. The aim of this research is to assess the knowledge, attitudes, practices, and influence of spousal support on exclusive breastfeeding among mothers in Ibadan North. Your honest responses will provide valuable insights for this study and will be kept confidential. Also, your response will be used solely for academic purposes and contribute significantly to the success of this research. Thank you for participating in this survey.

Section A: Demographic Information

1. Age: _____

2. Marital Status:

- Single
- Married
- Divorced
- Widowed

3. Educational Level:

- No formal education
- Primary education
- Secondary education
- Tertiary education

4. Employment Status:

- Unemployed
- Self-employed
- Employed

5. Number of Children: _____

6. Age of Youngest Child: _____

7. Household Income Level:

- Low
- Medium
- High

8. Religion:

- Christianity
- Islam
- Traditional
- Others (Please specify): _____

9. Duration of Residence in Ibadan North: _____

10. Type of Family Structure:

- Nuclear
- Extended

Section B: Level of Knowledge among Mothers regarding Exclusive Breastfeeding in Ibadan North

11. Have you heard about exclusive breastfeeding?

- Yes
- No

12. If yes, where did you hear about it? (Select all that apply)

- Healthcare provider
- Media (TV, Radio, Internet)
- Friends/Family
- Community programs
- Others (Please specify): _____

13. How long should exclusive breastfeeding be practiced according to health recommendations?

- 3 months
- 6 months

- 9 months
- 12 months

14. Exclusive breastfeeding means:
    - Feeding the baby only breast milk without any additional food or drink, not even water
    - Feeding the baby breast milk and water
    - Feeding the baby breast milk and other liquids (juices, teas)
    - Don't know
15. What are the benefits of exclusive breastfeeding for the baby? (Select all that apply)
    - Provides essential nutrients
    - Boosts immunity
    - Promotes healthy growth
    - Reduces risk of infections
    - Don't know
16. What are the benefits of exclusive breastfeeding for the mother? (Select all that apply)
    - Helps in postpartum recovery
    - Reduces risk of certain cancers
    - Aids in weight loss
    - Enhances mother-baby bond
    - Don't know
17. Can breastfeeding prevent certain illnesses in babies?
    - Yes
    - No
    - Don't know
18. Do you know the correct breastfeeding techniques?
    - Yes
    - No
19. Are there any foods or drinks that should be avoided while breastfeeding?

- Yes
- No
- Don't know

20. Are you aware of any breastfeeding support groups or resources in your area?
- Yes
- No

Section C: Attitudes of Mothers towards Exclusive Breastfeeding in Ibadan North

21. Do you believe that exclusive breastfeeding is beneficial for the baby?
- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

22. Do you feel confident in your ability to exclusively breastfeed your baby?
- Yes
- No

23. How comfortable are you with breastfeeding in public?
- Very comfortable
- Comfortable
- Neutral
- Uncomfortable
- Very uncomfortable

24. Do you believe that exclusive breastfeeding is more beneficial than formula feeding?
- Strongly agree
- Agree
- Neutral
- Disagree

- Strongly disagree

25. How important do you think exclusive breastfeeding is for a baby's health?

- Very important
- Important
- Neutral
- Not important
- Not at all important

26. Do you think breastfeeding is a natural process or one that requires a lot of learning?

- Natural process
- Requires a lot of learning
- Both

27. What are your feelings towards breastfeeding support from healthcare providers?

- Very positive
- Positive
- Neutral
- Negative
- Very negative

28. How likely are you to recommend exclusive breastfeeding to other mothers?

- Very likely
- Likely
- Neutral
- Unlikely
- Very unlikely

29. Do you believe that cultural beliefs affect attitudes towards exclusive breastfeeding?

- Strongly agree
- Agree
- Neutral

- Disagree

- Strongly disagree

30. What factors influence your attitude towards exclusive breastfeeding the most? (Select all that apply)

- Personal experience

- Family influence

- Healthcare advice

- Cultural beliefs

- Media

- Others (Please specify): _____

Section D: Breastfeeding Practices commonly adopted by Mothers in Ibadan North

31. Did you practice exclusive breastfeeding for your youngest child?

- Yes

- No

32. If no, what other food or drink did you give to your baby? (Select all that apply)

- Water

- Formula milk

- Juices

- Solid foods

- Others (Please specify): _____

33. At what age did you introduce other foods or drinks to your baby? _____

34. How frequently do you breastfeed your baby per day? _____

35. Do you practice on-demand breastfeeding or scheduled breastfeeding?

- On-demand

- Scheduled

36. How long do you typically breastfeed during each session? _____

37. Do you use any breastfeeding aids (e.g., breast pump, nursing pillow)?

- Yes

- No

38. Have you faced any difficulties while breastfeeding?

- Yes

- No

39. If yes, what difficulties have you faced? (Select all that apply)

- Pain or discomfort

- Insufficient milk supply

- Latching problems

- Baby's refusal to breastfeed

- Others (Please specify): _____

40. How do you manage these difficulties? (Select all that apply)

- Seeking healthcare advice

- Using breastfeeding aids

- Changing feeding positions

- Support from family

- Others (Please specify): _____

Section E: Roles of Spousal Support in Promoting Exclusive Breastfeeding among Mothers in Ibadan North

41. Does your spouse support your breastfeeding efforts?

- Yes

- No

42. In what ways does your spouse support your breastfeeding? (Select all that apply)

- Emotional support

- Helping with household chores

- Providing financial support

- Accompanying to healthcare visits

- Others (Please specify): _____

43. How important do you think spousal support is for successful exclusive breastfeeding?

- Very important
- Important
- Neutral
- Not important
- Not at all important

44. Does your spouse encourage you to continue exclusive breastfeeding?
- Yes
- No

45. Does your spouse assist in taking care of the baby to give you time to rest?
- Yes
- No

46. Does your spouse participate in feeding the baby expressed breast milk?
- Yes
- No

47. How often does your spouse discuss breastfeeding with you?
- Frequently
- Occasionally
- Rarely
- Never

48. Does your spouse attend breastfeeding education sessions with you?
- Yes
- No

49. How does the presence or absence of spousal support affect your breastfeeding experience?
- Positively
- Negatively
- No effect

50. What additional support would you like from your spouse regarding breastfeeding?

Informed Consent Form

Title of the Study:

Knowledge, Attitude, and Practice of Exclusive Breastfeeding and Spousal Support as a Determinant among Mothers in Ibadan North

Introduction:

You are invited to participate in a research study conducted by Ayegbayo Oluwasegun Isaac from Lead City University, Public Health Department. The purpose of this study is to assess the knowledge, attitudes, and practices of exclusive breastfeeding among mothers, as well as the role of spousal support in promoting exclusive breastfeeding within the Ibadan North Local Government Area.

Procedures:

If you agree to participate in this study, you will be asked to complete a questionnaire that will take approximately 20-30 minutes. The questionnaire will include questions about your knowledge, attitudes, and practices regarding exclusive breastfeeding, as well as the support you receive from your spouse.

Risks and Discomforts:

There are no known risks associated with participating in this study. However, some questions may make you feel uncomfortable. You may skip any questions that you do not wish to answer.

Benefits:

While there may be no direct benefit to you, your participation will help us understand the factors influencing exclusive breastfeeding practices. This information could contribute to the development of better support and educational programs for breastfeeding mothers.

Confidentiality:

All information collected in this study will be kept confidential. Your responses will be anonymized, and no personal identifying information will be linked to your responses. The data will be stored securely and only accessed by the research team.

Voluntary Participation:

Your participation in this study is entirely voluntary. You have the right to withdraw from the study at any time without any consequences. If you choose not to participate or decide to withdraw, it will not affect your access to healthcare or any services you receive.

Contact Information:

If you have any questions about the study, please contact:

Ayegbayo Oluwasegun Isaac

[08146243102]

[ayegbayooluwasegun@gmail.com]

For questions about your rights as a research participant or any concerns, please contact:

Lead City University Research Ethics Committee

Lead City University

[lcu.hrec@lcu.edu.ng]

Ibadan

Consent Statement:

I have read the information provided above and have had all my questions answered to my satisfaction. I voluntarily agree to participate in this study.

Participant's Name: _____

Signature: _____

Date: _____
Researcher's Name: Ayegbayo Oluwasegun Isaac
Signature:

Timeline

July 2024

Week 1-2 (July 21 – July 28): Proposal Writing and Ethical Approval Application

-Drafted and submitted research proposal to Lead City University, Ibadan.

-Submitted application for ethical approval from Lead City University, Ibadan.

-Submitted required documents and applications for approvals to the Oyo State Primary Healthcare Board and the Oyo State Ministry of Health for research in Idi Ogungun, Sabo, and Sango Primary Healthcare Centres.

Week 3-4 (July 29 - August 9): Begin Chapter One - Introduction

-Develop the Introduction (Chapter One), detailing the research background, problem statement, objectives, research questions, scope of the study and significance of the study.

-Follow up on ethical approval processes with Lead City University and the Oyo State authorities.

August 2024

Week 1 (August 10 - August 17): Chapter Two - Literature Review

-Complete Literature Review (Chapter Two), focusing on studies related to exclusive breastfeeding, spousal support, and determinants of breastfeeding practices.

-Integrate insights on previous findings and identify gaps addressed by this research.

Week 2 (August 17 - August 24): Ethical Approvals Confirmation and Preparation for Data Collection

-Confirm ethical approvals from Lead City University and the Oyo State authorities.

-Finalize data collection instruments (e.g., surveys, questionnaires).

-Coordinate with the three selected primary healthcare centres (Idi Ogungun, Sabo, and Sango) to arrange data collection schedules.

Week 3-4 (August 25 - September 3): Data Collection in Selected Primary Healthcare Centres

-Begin data collection, starting with Idi Ogungun Primary Healthcare Centre.

-Continue data collection at Sabo Primary Healthcare Centre.

-Conclude data collection at Sango Primary Healthcare Centre.

-Conduct interviews and focus groups, if applicable, with mothers and gather spousal support perspectives as part of data collection.

September 2024

Week 1 (September 4 – September 11): Chapter Three - Methodology

-Complete the Methodology (Chapter Three), detailing research design, sampling techniques, data collection methods, and analysis plans.

-Begin data cleaning and initial organization for analysis.

Week 2-3 (September 12 - September 19): Chapter Four - Analysis and Discussion of Findings

-Conduct data analysis, including statistical tests, qualitative analysis, and interpretation of findings.

-Draft the Analysis and Discussion of Findings (Chapter Four), discussing results in relation to research objectives and comparing them with existing literature.

Week 4 (September 20 - September 27): Chapter Five - Conclusion and Final Compilation

-Write the Conclusion (Chapter Five), summarizing key findings, implications for policy, and recommendations.

-Revise and proofread the entire document.

-Finalize the thesis for submission to Lead City University, Ibadan.

Summary Table of Activities and Timeline

Month	Activity	Timeline
July 2024	Proposal Writing and Ethical Approval Applications	July 21 - July 28
	Begin Chapter One – Introduction	July 29 - August 9
August 2024	Chapter Two - Literature Review	August 10 – August 17
	Confirm Ethical Approvals & Prepare for Data Collection	August 17 - August 24
	Data Collection (Idi Ogungun, Sabo, and Sango Primary Healthcare Centres)	August 25 - September 3
September 2024	Chapter Three – Methodology	September 4 - September 11
	Chapter Four - Analysis and Discussion of Findings	September 12 - September 19
	Chapter Five - Conclusion and Final Compilation	September 20 - September 27

This timeline ensures a structured, efficient approach to completing this thesis within the three-month timeframe.