Socio-Demographic Predictors of Exclusive Breastfeeding Practice in Nsukka Urban Area of Enugu State

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Abstract

Exclusive breastfeeding is the most efficient type of infant feeding for the first six months of life. It protects infants from infectious diseases. This study examined socio-demographic predictors of exclusive breastfeeding practice among childbearing mothers in Nsukka urban area of Enugu State. The instrument for data collection was researchers designed and validated questionnaire. Direct approach was used to administer the questionnaire. The researcher with the aid of three research assistants administered and collected data from the respondents. The population for the study consisted of 8,458 of childbearing mothers in Nsukka urban area of Enugu State, out of which 592 were sampled using Cochran formula. All the data collected were analyzed using Statistical Package for Social Sciences (SPSS) while frequency distribution tables and percentages were used to present the results. Chi-square (χ^2) was used to test the hypotheses; and binary logistic regression was used to predict the effect of independent variables on a dependent variable. The result showed that there is statistically significant relationship between marital status (χ^2 =40.151, P=.021) and education (χ^2 =6.360, P=.007)and practice of EBF. Results from regression analysis showed that religion, education and parity were the best predictors of EBF practice. The findings further revealed that majority (60.1%) of the respondents attested that they did not practice EBF due to work pressure, lack of family and social among others. As such, government, organizations, health care providers and social workers should rise to their separate responsibilities in enlightening the mothers and the entire public about the risk of complementary feeding and importance of EBF, and consequently equip them with the better ways of managing the practice. This would definitely help to curtail the diseases and incidence of loss of infants and children as a result of not practicing EBF.

Keywords: Exclusive Breastfeeding, Socio-Demographic, Predictors, Practice, Childbearing Mothers

Introduction

Exclusive breastfeeding is a pattern of feeding an infant with no other food or drink, not even water except breast milk for six months of life. EBF is the best feeding for infants for the first six months which has multiple advantages not just to infants and mothers, but for the larger community and society as well. For instance, EBF is the most preventive intervention to reduce early-childhood mortality and morbidity (Ike, 2013). It saves the infants from life intimidating gastro-intestinal diseases such as necrotizing entercolitis (NEC), lessens the occurrence of otitis media, several bacterial infections such as meningitis, bacteremia, lower respiratory infections and botulism (Oddy, Jianghong, Monique & Andrew, 2011). In other words, EBF reduces common childhood illnesses such as diarrhoea and pneumonia and helps for a quicker recovering during illness (Kramer & Kakuma, 2012). EBF helps in child spacing, reduces the risk of ovarian, breast cancer and type 2 diabetes in mothers, (World Health Organization, WHO, 2012).

To enable mothers to establish, sustain and derive from the benefits exclusive breastfeeding gives for six months, WHO and UNICEF recommend: Initiation of breastfeeding within the first hour of birth; exclusive breastfeeding- that is the infant receives only breast milk without any additional food or drink not even water for six months; mother and baby should sleep together on the same bed; breastfeeding on demand- that is as often as the child wants day and night; no use of bottles, teats or pacifiers for feeding the baby (Danso, 2014 & WHO, 2011). In addition to these, there are new initiative programmes to protect, promote and support EBF which include the International Code of Marketing Breast Milk Substitutes (ICMBMS) (WHO, 2016). This means a set of recommendations to regulate the marketing of breast milk substitutes such as infant formula to ensure that mothers are not discouraged from breastfeeding. The code aims to contribute to provision of safe and adequate

nutrition for infants, by the protection and promotion of breastfeeding and by ensuring the proper use of breast milk substitutes when necessary. Also, Baby Friendly Hospital Initiative (BFHI) was another initiative which has to do with a global effort which aims to improve EBF rates and ensure that evidenced-based best practice standards of care are offered by maternity services (WHO, 2016). Through these programmes, mothers can obtain information about the practice and benefits of EBF when they attend antenatal clinic and following hospital delivery services (UNICEF, 2014).

Despite obvious awareness of EBF, benefits and initiative programmes to improve EBF practice, adoption of EBF has not been fully accepted as evidenced in National Demographic Health Survey (NDHS) (Alade, Titiloye, Oshiname & Arulogun, 2013). In Nigeria, breastfeeding is well achieved and different breastfeeding promotion activities have been put in place. Sanusi, Leshi and Agada (2016) asserted that breastfeeding of infants is widely accepted by mothers and its initiation is on the increase at health facilities after delivery, but the sustained practice of EBF for six months once the mother returns home is distinctly lagging. As it was reported by World Breastfeeding Week Report (2017), only 37% of Nigeria women breastfeed and of these, only 25% do so exclusively. Studies have shown that low EBF rates have been reported in many countries throughout the world. Dudu, Okoro and Otto (2016) reported that the rate of EBF in Nigeria has remained the lowest (17%) following other African countries such as Cameroon (23.5%), Republic of Benin (43.1%) and Ghana (53.4%), which was as a result of several factors and predictors such as traditional beliefs, practices, rites, early introduction of complementary feeding and so on.

The introduction of complementary feed such as cereal pap (*Akamu, Ogi or Kwunu*) made from maize or *zea mays*, guinea corn (sorghum), millet, soya beans among others, based on erroneous assumption are likely to affect EBF initiation and sustainability. For instance, Ike (2013) reported that intense promotion of commercial milk formulae is the reason for decline in EBF practice among mothers. To buttress this point, Ani, Ezekekwu, Njeze and Nnorom (2011) reported that the economic burden on families and community have substantially increased with the use of bottle feeding as a result to high cost of formulae feed in the market. Also, the authors reported that there was lack of awareness of some major recommended practices in the hospitals that will promote and sustain EBF practice among mothers.

According to report from National Demographic Health Survey (NDHS) (2013), indicators of EBF practice include age, residence, zone, mother's education and wealth quintile. This assertion was supported by the observation made by Nwagu (2016) that childbearing mothers of the age 22 and below were the highest participants among which only 20 percent practiced EBF. Other factors such as marital status, job condition, poor knowledge of EBF among health and social workers still hinder the initiation and sustainability of EBF. Consequently, this has led to increase rate of infant mortality and morbidity due to high occurrence of gastroenteritis, common childhood diseases such as pneumonia, diarrhoea and so on. Therefore, the purpose of the study was to examine the socio-demographic predictors of exclusive breastfeeding practice among childbearing mothers in Nsukka urban area.

Research questions.

1. Do childbearing mothers in Nsukka urban practice EBF for the recommended duration?
2. What are childbearing mother's reasons for not adopting EBF in Nsukka urban?
3. What other complementary food were adopted by childbearing mothers in Nsukka urban?

Hypothesis.

1. There is no significant relationship between mother's age, marital status, religion, occupation, education, income, parity, gender and practice of EBF

Method

Cross-sectional survey research design was used for the study. Nsukka urban area of Enugu State was the area of the study. Nsukka urban is made up of the three prominent communities namely; Ihen'Owerre, Nkpunanor and Nru (Aderian, 2014). The population for the study consisted of 8,458 of childbearing mothers in Nsukka urban area of Enugu State within the age range of 15 to 49 years

which is in line with (WHO, 2006) stipulated age for child bearing mothers were selected. 592 childbearing mothers were drawn as sample size using Cochran (1963) formula.

Multi-stage sampling technique was used to select respondents for the study. Stage one involved purposive selection of one community from each of three communities that makes up Nsukka urban. That is Amaukwaegu and Amaeze from Ihen'Owerre; Amaokwe and Amaeze-Ani from Nkpunanor and Amaolu and Umugworie from Nru. Stage two involved the selection of two smaller communities (Amaukwaegu and Amaeze from Ihe n' Owerre; Amaokwe and Amaeze from Nkpunanor; Amaolu and Umugworie from Nru). Stage three was selection of four streets (Ibeziako and Amobi streets from Amaukwaegu; Oloto 1&2 and Odobido streets from Amaeze all in Ihen'Owerre. Amaokwe lane and Onuomozo street from Amaokwe; Emenike Ugwuanyi Street, New Anglican and Tectonics Roads from Amaeze-Ani, all in Echara. Amalu and Umugworie from Umuoyo. Also, 50 respondents were allocated using quota sampling to each of the streets. Systematic sampling was used in selecting compound and dwelling unit.

Researchers designed questionnaire was the major instrument for the quantitative data collection which was divided into 2 sections. Section A focused on the respondent's demographic data, while section B focused on information relevant to the research questions. Direct approach method was used by the researcher with the help of 3 research assistants to administer 600 questionnaires to the respondents. 592 questionnaires were correctly filled and returned. Data was computer processed using version 20 of statistical package for social sciences (SPSS). Percentages and frequency tables were used to present the results, while Chi-square (χ^2) was used to test the hypotheses at .05 level of significance. Binary logistic regression was used to determine the relationship between dependent variables and independent variables.

Results

Table 1 shows that childbearing mothers between the ages of 30-34years constitute the highest population. For religion, the result indicated that 91.2% of the respondents were Christians, 4.6% were ATR, while 4.2% were Islam. As regard to occupation, majority were civil servants (34.6%), followed by traders (24.5%), students (17.1%), artisans (13.2%), private firm workers (9.1%), while house wives and farmers 1.0% and 0.5 respectively. For education, majority were SSCE/GCE holders (24.8%), followed by B.SC (19.9%), HND (19.3%), OND (15.2%), M.Sc (8.8%), FSLC (7.1%), while Ph.D and no formal education/uncompleted primary education were 3.7% and 1.2%. respectively. In terms of monthly income, majority of childbearing mothers (21.5%) earn 26,000-50,000, (18.1%) earn 101,000-125,000, (17.1%) earn 126,000-150,000, (14.9%) earn 10,000-25,000, (12.3%) earn 51,000-75,000, while (9.6%) earn 151,000 and above and (6.6%) earn 76,000-100,000. Based on parity, majority of childbearing mother (35.6%) have four children and above, (23.5%) have two children, (21.5%) have three children, while (11.5%) have one child and (7.9%) have no children. Whereas majority (45.9%) have both male and female children, (30.4%) have only male children, while (15.7%) have only female and (7.9%) have no children.

Table 1
Socio-demographic Characteristics of Respondents

Characteristics	Frequency	Percentage (%)
Age		
15-19	42	7.1
20-24	53	9.0
25-29	103	17.4
30-34	115	19.4
35-39	96	16.2
40-44	95	16.0
45-49	88	14.9
Marital status		
Single	83	14.0
Married	425	71.8
Divorced	40	6.8
Widowed	44	7.4

Religious affiliation		
Christianity	540	91.2
ATR	27	4.6
Islam	25	4.2
Occupation		
Students	101	17.1
Civil servant	205	34.6
Traders	145	24.5
Farmers	3	0.5
Artisans	78	13.2
Private firm workers	54	9.1
House wives	6	1.0
Level of education		
No formal education	7	1.2
FSLC	42	7.1
SSCE/GCE	147	24.8
OND/Diploma	90	15.2
HND	114	19.3
B.Sc	118	19.9
M.Sc	52	8.8
P.hD	22	3.7
Monthly income		
10,000-25,000	88	14.9
26,000-50,000	127	21.5
51,000-75,000	73	12.3
76,000-100,000	39	6.6
101,000-125,000	107	18.1
126,000-150,000	101	17.1
151,000 and above	57	9.6
Place of residence		
Ihen'Owerre	199	33.6
Nkpunanor	196	33.1
Nrue	197	33.3
Parity	68	
1	139	11.5
2	127	23.5
3	211	21.5
4 and above	47	35.6
None		7.9
Gender of children	180	
Male	93	30.4
Female	272	15.7
Both male and female	47	45.9
None		7.9

Table 2 shows that minority of the respondents (39.9%) indicated that they practice EBF, while majority 60.1% did not practice EBF. In terms of number of children exclusively breastfed, majority of the childbearing mothers (32.2%) breastfed two children exclusively, (25.4%) breastfed three children exclusively, while (24.2%) breastfed four children and above exclusively and (18.2%) of the respondents indicated that they exclusively breastfed one child. As regard to the duration of practice, majority of the childbearing mothers (32.1%) exclusively breastfed for 0-6months, (4.6%) exclusively breastfed for 0-4months, 1.7% exclusively breastfed for 0-3months, (0.5%) and (0.5%) exclusively breastfed for 0-2months and 0-5months respectively. Furthermore, (60.1%) did not

breastfeed any of their children exclusively, or they used complementary feeding or mixed breastfeeding or they are not married or have children or married without children.

Table 2
Level of Exclusive Breastfeeding Practice

Level	Frequency	Percentage (%)
Practice of EBF		
Yes	236	39.9
No	356	60.1
Parity of exclusively breastfed children		
1	43	18.2
2	76	32.2
3	60	25.4
4 and above	57	24.2
Duration of practiced EBF		
0-2months	3	0.5
0-3months	10	1.7
0-4months	27	4.6
0-5months	3	0.5
0-6months	190	32.1

Table 3
Other Types of Food Adopted that are not EBF

Other type of food adopted	Responses				Total (%)
	Yes	Per (%)	No	Per (%)	
Breast milk and artificial milk	288	80.9	68	19.1	356 (100.0)
Breast milk and water	267	75	89	25	356 (100.0)
Breast milk, water, artificial milk, pap and soya beans mixed with crayfish	273	76.7	83	23.3	356 (100.0)
Coconut water, breast milk, water and herbs	66	18.5	290	81.5	356 (100.0)
Breast milk, water and beverages	112	31.5	244	68.5	356 (100.0)
Artificial milk, pap, water and beverages	51	14.3	305	85.7	356 (100.0)

Table 3 shows that majority of childbearing mothers who did not adopt EBF (80.9%) fed their babies with breast milk and artificial milk, while (19.1%) did not feed their babies with breast milk and artificial milk, 76.7% fed their baby with breast milk, water, artificial milk, pap and soya beans mixed with crayfish, while 23.3% did not feed their babies with breast milk, water, artificial milk, pap and soya beans mixed with crayfish, 75% fed their babies with breast milk and water, while 25% did not feed their babies with breast milk and water;. Also, 31.5% fed their baby with breast milk, water and beverages, while 68.5% did not feed their babies with breast milk, water and beverages, 18.5% indicated that they fed their babies with coconut water, breast milk, water and herbs, while 81.5% did not feed their babies with coconut water, breast milk, water and herbs; Again, 14.3% fed their baby with artificial milk, pap, water and beverages, while 85.7% did not feed their babies with artificial milk, pap, water and beverages.

Data on Table 4 shows that majority of childbearing mothers (19.9%) indicated that the reason for not adopting EBF for their baby include work pressure, lack of family and social support (17.4%), lack of energy and strength (11.2%), adopted their children (8.1%), not married (8.1%), health issues (7.3%), while (6.2%) and (6.2%) indicated that they do not want to their breast to fall

and EBF is not enough food for the baby. Again (5.3%) reported that they gave birth to twins or more, while (5.3%) indicated that their studies do not allow them. Also, 2.5% and (2.2%) mentioned lack of proper information about EBF recommended practice and duration and late marriage respectively.

Table 4
Reasons for not Practicing EBF

Reasons for not practicing EBF	**Frequ**	**Percentage (%)**
I do not want my breast to fall	22	6.2
lack of family and social support	62	17.4
Health issues	26	7.3
I adopted my child	29	8.1
Lack of proper information about EBF recommended practice and duration	9	2.5
Work pressure	71	19.9
I gave birth to twin or more	19	5.3
My studies do not allow me	19	5.3
Lack of energy and strength	40	11.2
It is not enough food for the baby and cannot quench thirst	22	6.2
Late marriage	8	2.2
Not married	29	8.1
Total	**356**	**100.0**

Table 5 shows the calculated chi-square **(χ^2)** values for the following independent variables and practice of EBF with their corresponding P-values: age (χ^2 =2.178, P=.082), marital status (χ^2 =40.151, P=.021), religion (χ^2 =3.359, P=.067), occupation (χ^2 =.674, P=.231), education (χ^2 =6.360, P=.007), monthly income (χ^2 =.541, P=.257), parity (χ^2 =18.532, P=.331) and gender of children (χ^2 =4.021, P=.744). Since the P-values were less than .05 level of significance at 1, 2 and 3 degrees of freedom respectively, the null hypotheses were accepted. This implies that age, religion, occupation, monthly income, parity and gender of children were not statistically significant with the practice of EBF.

The Table further shows the calculated Chi-square (χ^2)values for marital status (χ^2 =40.151, P=.021) and education (χ^2 =6.360, P=.007) were less than .05 level of significance at 2 and 1 degrees of freedom respectively, the null hypotheses is, therefore rejected. This implies that marital status and level of education were statistically significant with the practice of EBF.

Table 6 shows that age (1.034), marital status (0.756), occupation (1.087), income (1.083) and gender (0.970) were not predictors of the practice of EBF. Other variables like religion (0.022), education (0.050) and parity (0.000) were statistically significant with the practice of EBF. However, it does appear that religion, education and parity were the best predictor of the practice of EBF. In other words, the finding revealed that a unit change in the religion, level of education of respondents (improvement in educational level) and parity (increase in number of children) will result to (1.667), (1.438) and (1.767) unit changes on the practice of EBF respectively.

Table 5
Result of Chi-square (χ^2) Analysis of the Socio-demographic Predictors of EBF Practiced. Practiced EBF (n=236) and did not Practice EBF (n=356)

Socio-demographic predictors				**Total (%)**	**X^2-cal**	**df**	**P-value**	**Critical value**	**Decision**
Age	**Younger mothers**	**Older mothers**							
Practiced EBF	116(49.2%)	120 (50.8%)		236 (100.0%)					
Did not practice EBF	197 (55.3%)	159 (44.7%)		356 (100.0%)	2.178	1	.082	3.841	Reject
Marital Status	**Single**	**Married**	**Divorced/Separated/Widowed**						
Practiced EBF	10(4.2%)	201(85.2%)	25 (10.6%)	236(100.0%)					

Did not practice EBF	73(20%)	224(62.9%)	59 (16.6%)	356 (100.0%)	40.151	2	.021	3.841	Accept
Religion	**Christianity**	**ATR**	**Islam**						
Practiced EBF	221 (93.6%)	9(3.8%)	6(2.5%)	236(100.0%)					
Did not practice EBF	391 (89.6%)	18 (5.1%)	19 (5.3%)	356 (100.0%)	3.359	1	.067	3.841	Reject
Occupation	**Non-working class**	**Working class**							
Practiced EBF	138(58.5%)	98 (41.5%)		236 (100.0%)					
Did not practice EBF	196 (55.1%)	160 (44.9%)		356 (100.0%)	.674	1	.231	3.841	Reject
Education	**Higher education**	**Lower education**							
Practiced EBF	137 (58.1%)	99 (41.9%)		236 (100.0%)					
Did not practice EBF	169 (47.5%)	187 (52.5%)		356 (100.0%)	6.360	1	.007	3.841	Accept
Monthly income	**Higher income**	**Lower income**							
Practiced EBF	110(46.6%)	126(53.4%)		236 (100.0%)					
Did not practice EBF	155(43.5%)	201 (56.5%)		356 (100.0%)	.541	1	.257	3.841	Reject
Parity	**Lower number of children**	**Higher number of children**							
Practiced EBF	118(50.0%)	107(45.3%)		236 (100.0%)					
Did not practice EBF	216 (60.7%)	104(29.2%)		356 (100.0%)	18.532	2	.331	3.841	Reject
Gender of children	**Male**	**Female**	**Both male and female**	**None**					
Practiced EBF	66 (28.0%)	40(16.9%)	116 (49.2%)	14 (5.9%)	236 (100.0%)				
Did not practice EBF	114 (32.0%)	53(14.9%)	156 (43.8%)	33 (9.3%)	356 (100.0%)	4.021	3	.744	3.841	Reject

Table 6: ***Binary logistic regression analysis predicting the influence of some socio-demographic characteristics on the practice of EBF***

	B	SE	Wald	df	Sig	ExpB
Age	.034	.189	.032	1	.858	1.034
Marital status	-.280	.178	2.488	1	.115	.756
Religion	.511	.224	5.219	1	.022	1.667
Occupation	.084	.178	.220	1	.639	1.087
Education	.363	.185	3.831	1	.050	1.438
Income	.080	.176	.204	1	.651	1.083
Parity	.569	.156	13.383	1	.000	1.767
Gender of children	-.030	.088	.115	1	.735	.970
Constant	-.719	.841	.731	1	.393	.487

Discussion

The study shows that majority of childbearing mothers (19.4%) were between 30-34years. In the same vein, the study revealed that majority were married (71.8%), Christians (91.2%), Civil servants (34.6%) and SSCE/GCE holders (19.9%). In addition, it was observed that majority (21.5%) earn 26,000-50,000, while (33.6%) resides at Ihen'Owerre. Also, majority of childbearing mothers used in this study (35.6%) have four children and above, while majority (45.9%) have both male and female children. This is because married women are the ones that give birth and equally adopt the EBF practice. In addition to this, civil servants were higher because childbearing mothers used for this study are working at the University of Nigeria Nsukka, which is suited in one of the communities in the study area.

The study further revealed that majority of childbearing mothers (60.1%) did not practice EBF. The reason could be that they have seen the relevance of EBF on their children's growth and development. Also, the study revealed that majority who breastfed their babies exclusively did it for 0-6months (32.1%). The finding revealed a low level of EBF practice in Nsukka urban, despite the fact that EBF was the best feeding alternative for infants for the first six months, most effective preventive intervention to reduce early-childhood mortality and morbidity and government established programmes in Enugu State to promote EBF. The rate of non-practice of EBF in this study was higher compared to the findings in other studies. For instance, the findings of Ekanem, Ekanem, Asuguo and Eyo (2012) in their study on attitude of working mothers on exclusive breastfeeding in Calabar municipality, Cross River State reveals that 10% of the women never practiced EBF believing that their breast milk was insufficient for babies need. Also, Bayissa, Gelaw, Geletaw, Abdella, Chinasho et al (2015) in their study reported that 66(17.8%) of mothers did not practice EBF.

From the finding, the feeding patterns that mothers mostly adopt were predominant breastfeeding and complementary feeding. For instance, feeding the baby with water and exclusive breastfeeding and other food such as artificial milk, pap mixed with soya beans and so on. This finding is in line with findings of Ekanem et al. (2012), which revealed that (66%) of mothers who practiced mixed feeding believed that their breast milk needs to be supplemented with artificial formulae for fast growth and health of their babies. The finding from this study revealed that mother's reasons for not practicing EBF includes work pressure, lack of family and social support, not enough food for the baby, fear of losing their breast shape among others. Dudu et al. (2016) equally revealed in their study that the rank reasons for the low EBF rate was; the breast milk was not enough food for the baby, breast pain (health issue), feeling dizzy during breastfeeding, lack of husband support and losing firmness of their breast. This finding could be as a result of mothers and their spouse perception and attitude towards EBF practice that made mothers not to practice EBF for their babies.

Findings of this study further revealed that marital status and level of education have statistical significant relationship with the practice of EBF, while religion, education and parity were the best predictors of the practice of EBF among childbearing mothers. This finding could be attributed to the fact that EBF practice are for women who were married with children, coupled with the fact that the study area is an academic environment where mothers easily acquire education.

Conclusion

Breastfeeding mothers in Nsukka urban area are confronted by many prevailing factors as they exert themselves to adopt EBF. It can be seen that there is low rate of EBF in the study area which was as a result of work pressure and lack of family, social support among others. As a result, there is low level of EBF practice in Nsukka urban area.

Recommendation

Government, organizations, health care providers and social workers should rise to their separate responsibilities in enlightening the mothers and the entire public about the risk of complementary feeding and importance of EBF, and consequently equip them with the better ways of managing the practice. This can be done by extending the maternity leave to six months, providing conducive environment at workplaces for breastfeeding mothers and proper diet to be taking to enable

them practice EBF. This will definitely help to curtail the diseases and losses of infants and children experienced as a result of not practicing EBF.

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