

## CONSTRAINTS TO EXCLUSIVE BREASTFEEDING PRACTICES AMONG RURAL WOMEN IN RIVERS STATE, NIGERIA

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### ABSTRACT

*The study examined constraints to exclusive breastfeeding among rural women of Rivers State, Nigeria. A multi-stage sampling procedure was used to select 306 respondents. Questionnaire and interview schedule were used to elicit data from the respondents. Descriptive statistical tools such as frequency distribution, percentage, mean, and inferential statistics such as regression was used. Result of the descriptive statistics showed that the mean age of the respondents was 35 years, 32.6% women were housewives and 42.5% were civil servants; 61.9% of women were married, 35.7% of the women had secondary education. The mean household size of the women was 6 persons and a mean monthly income of ₦38,792. Result on knowledge of rural women on exclusive breastfeeding showed that majority (80.1%) of women knew the right definition of exclusive breastfeeding. The benefits of exclusive breastfeeding included; building of infants immunity ( $\bar{x}=3.31$ ), saves money ( $\bar{x}=3.47$ ) and leads to healthy mothers and children ( $\bar{x}=3.46$ ). The factors militating against exclusive breastfeeding among rural women were; use of medications harmful to the baby by the mother ( $\bar{x}=3.44$ ), health related problems ( $\bar{x}=3.35$ ), refusal of breast milk by some children (3.32) and not enough breast milk production (3.27). The socio-economic characteristics influencing exclusive breastfeeding were occupation, marital status, education and household size. The study showed that there was no significant relationship between knowledge and practice of exclusive breastfeeding in the study area. Based on the findings, it was recommended that there is an urgent need for everybody to encourage exclusive breastfeeding because the benefits are enormous.*

**Keywords:** Constraints, Exclusive Breastfeeding, Practices, Rural Women

### Introduction

Exclusive breastfeeding means that an infant receives only breast milk no other liquids or solids are given – not even water – with the exception of oral rehydration solution or drops/syrups of medicines (WHO, 2009). According to certain definitions, the newborn must get breast milk directly from the mother's breast for six months (Maduforo and Onuoha, 2011). Others argue that intimate contact with the mother's breast may not be necessary at all during the 6-month period. While some claim that the practice implies that breast milk must be given for at least 6 months, but that other infant formula and meals can be supplemented (Onah et al, 2014).

Breastfeeding exclusively has been identified as an essential public health intervention for the primary prevention of morbidity and mortality in children. As a result, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) suggest exclusive breastfeeding for the first six months after delivery, followed by the introduction of supplementary foods and continuous breastfeeding for at least 24 months (WHO, 2009). Breast milk has two functions: one is to supply nutrients, and the other is to promote immunity and development (Kramer et al.,

2008). Breast milk varies its composition from colostrum to mature milk to satisfy the nutritional demands of infants to older infants (Picciano, 2001). It offers the minerals needed by children in easily digestible and accessible forms. Antibodies, enzymes, and hormones are just a few of the biological components found in breast milk (Hamosh, 2001). Disparities in exclusive breastfeeding rates have been found in rural areas; for example, in a study involving rural women in South-West Nigeria, eighty-one percent of respondents believed that exclusive breastfeeding causes breast ptosis (Alade et al., 2013). Among the indigenous Mam-Mayan women in Guatemala, there is a belief of transmission of emotions e.g. fright ('susto') through breast milk and this was found to be a major deterrent in exclusively feeding their infants less than 6 weeks old (Wren et al., 2015). Most women do not practice exclusive breastfeeding because of the belief by mothers that baby needs herbs for strength and vitality, baby needed water to quench thirst and that breast milk alone does not satisfy (Alade et al., 2013). Most people have these perceptions such as breast milk alone is not enough, exclusive breastfeeding not being convenient, mother will return to work, baby

needed water, and advise against exclusive breastfeeding influence the practice of exclusive breastfeeding despite the launching of new initiatives on the promotion of exclusive breastfeeding in many States in Nigeria, (Okari et al, 2020)

Despite the numerous advantages of exclusive breastfeeding and all the efforts made to promote exclusive breastfeeding, its benefits have not been fully accepted and practice in Nigeria is still low as reflected in Nigeria's Ministry of Health's 2018 breastfeeding objective, which aims to attain 50 percent exclusive breastfeeding (Federal Ministry of Health (FMH), 2017). The study therefore aimed at investigating challenges to exclusive breastfeeding among women in rural communities of Rivers State.

**Objective of the Study**

The broad objective of the study was to examine challenges to exclusive breastfeeding among women in rural communities of Rivers State.

. Specifically, the study was designed to:

- i. describe the socio-economic characteristics of respondents in the study area;
- ii. ascertain the knowledge of respondents on exclusive breastfeeding;
- iii determine respondents perception on benefit of exclusive breastfeeding practices; and
- iv identify factors that militated against exclusive breastfeeding practices in the study area.

**Statement of Hypothesis**

**H0<sub>1</sub>:** Mothers' practice of exclusive breastfeeding is not significantly influenced by their socio-economic characteristics.

**Methodology**

The research was carried out in Rivers State, one of the 36 States in Nigeria. Rivers state is located in southern Nigeria's Niger Delta region. Rivers State is a state under the Niger Delta region of south-South Geopolitical zone, Nigeria. The State was created on 27th May in the year 1967, during the administration or government of General Yakubu Gowon. The State had once been referred to as Oil Rivers Protectorate, a name derived from its central role in the oil trades of the last two centuries. The state is the heart of the hydro-carbon industry responsible for a huge chunk of the nation's foreign exchange earnings (Rivers State Dairy, 2014). Rivers State borders Imo and Abia Anambra States to the North, Akwa Ibom State to the East, and Bayelsa and Delta states to the West. The State is located between latitudes 4°15'N and 5°45'N and longitudes 6°22'E and 7°35'E and covers an area of 11,077 km<sup>2</sup> (4,277 sq mi) making it Nigeria's 26th largest state (Google Earth). Port Harcourt, the state capital, is a bustling metropolis that serves as the commercial hub for Nigeria's oil industry (Rivers State Government Website, 2010). The National Population Commission (NPC), estimate the population of Rivers State at 5,198,716 comprising of 2,673,026 males and 2,525,690 females (National Population Commission, NPC, 2006). The state has thirty three (33) general

hospitals, three hundred eighty (380) Primary Health Centers and two (2) teaching hospitals. The State is divided into three senatorial zones. They include: Rivers-South East – made up of seven LGAs, namely Eleme, Khana, Gokana, Andoni, Opobo/Nkoro, Oyigbo and Tai.

The study adopted a multi-stage sampling technique. Firstly, two local government areas were randomly selected from each of the three senatorial zones of the state, making a total of six local government areas in the sample. The chosen local government areas were Okirika, Etche, Eleme, Andoni, Ogba/ Egbema / Ndoni and Degema. In the second stage, two communities were chosen using purposive sampling procedure based on the presence of health centers from each of the selected local government areas and giving a total of twelve communities. In the third stage, proportionate stratified random sampling procedure was employed in selecting lactating mothers who were chosen from primary health centers. A total of three hundred and six (306) lactating mothers were surveyed. Data for this study were generated from primary sources using questionnaire and personal observation. Collected data were analyzed using both descriptive and inferential statistics such as frequency distribution, percentage mean, were used to describe the data and they were presented in tables. For the inferential statistics, the statistical tool used was Logistic Regression. The model that will be employed in the analysis is specified as follows:

$$\ln Y = \ln \left( \frac{P_i}{1-P_i} \right) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + \beta_6 X_6 + e \dots\dots\dots 3.4$$

Where;  
 Y = Practice of exclusive breastfeeding (Yes = 1, No =0)  
 P<sub>i</sub> = probability of practicing exclusive breastfeeding  
 1-P<sub>i</sub> = probability of not practicing exclusive breastfeeding  
 Ln = natural logarithm function  
 X<sub>i</sub> = independent variables (where i goes from 1 – 7)  
 Where: X<sub>1</sub> = Sex (Dummy, Male=1, Female=2); X<sub>2</sub> = Age (years); X<sub>3</sub> = Level of Education (No formal education=1, Primary education=2, Secondary education=3, Tertiary education=4); X<sub>4</sub> = Marital status (Married=1, Single=2, Sepearted=3, Divorced=4, Widow/ widower=5); X<sub>5</sub> = Occupation (Self employed=1, farmer=2, civil/public servant=3; Others=4) X<sub>6</sub> = Household size (Persons); X<sub>7</sub> = Income level (₦); β<sub>0</sub> = Constant  
 β = Regression coefficient; e = Stochastic error term.

**Results and Discussion**  
**Socio-Economic Characteristics of the Respondents**

The result in Table 1 revealed that more (39.5%) of the women were within 31-40 years. The mean age for the respondents was 35 years indicating that the women were still in their reproductive and active ages and are

most likely faced with the delima either to or not to practice exclusive breastfeeding. The finding of this study confirm that of Ishikaku *et al* (2022) on attitude of rural men towards exclusive breastfeeding who found that most of the respondents were still in their reproductive ages. More (32.6%) of the women were full time housewives. Since most of the women in the study area were full time housewives, this indicates that they will practice exclusive breastfeeding. This finding further corroborates with that of Abdulmaleek and Musa (2016) who found that 50.8% of women attending antenatal clinic in Aminu Kano teaching hospital were full time housewife. A small proportion (6.5%) of the women had no formal education, 35.7% of the women had secondary education (SSCE/GCE), 26.5% of the women had Ordinary National Diploma or Higher National Diploma (OND/HND), 16.7% had primary education (FSLC) while 13.7% women had First degrees (B.Sc/Bed), and 2.1% of the women had second degrees (M.Sc/MBA). Cummulatively, 93.5% of the women had formal education implying that they were all capable of accessing nutrition and health information regarding exclusive breastfeeding from the common sources available. This finding is in line

with the study of Johnson, Felicia and Iroroturi (2016) in which more (35.7%) of the women (mothers) had secondary education.

The study revealed that most 61.9% of the women were married, this means they are responsible nursing mothers who have an insight of what exclusive breast feeding means having attended maternity clinics (Elenwa et al, 2019; Nnodim, et al, 2012). The result on household size showed that more (52.2%) of the women had household sizes ranging between 6 to 10 persons. The mean household size was 6 persons. This implies a fairly large household size, higher than the country approved household size of four (4) (Elenwa and Ishikaku, 2018).

Finally the result on income revealed that the women (39.9%) earned a monthly income of ₦49000 - ₦5800 and 17.9% of the women earned between ₦39000 – ₦48000. The mean monthly income was ₦38,792 000 indicating that the monthly income of the respondents could be said to be medium-high especially as their median monthly income of ₦38,792 was a little higher than the Nigerian government minimum wage of ₦30,000 monthly (Albert et al, 2013).

**Table 1: Socio-Economic Characteristics of the Respondents**

Variables	Women		Mean
	Freq. n=291	%	
<b>Age</b>			
21-30	94	32.3	35 years
31-40	115	39.5	
41-50	82	28.2	
51-60	-	-	
<b>Occupation</b>			
Full time Housewife	95	32.6	
Farming	59	20.3	
Civil servant/ company worker	49	16.8	
Trading	77	26.5	
Artisan	1	0.3	
Fishing	10	3.4	
<b>Education Certificate</b>			
None	19	6.5	
FSLC	45	12.1	
SSCE/GCE	104	35.7	
OND/HND	77	26.5	
B.Sc/Bed	40	13.7	
M.Sc/MBA	6	2.1	
<b>Marital status</b>			
Single	17	5.8	
Married	180	61.9	
Seperated	54	18.6	
Widowed	35	12.0	
Divorced	5	1.7	
<b>Household size</b>			
1-5	132	45.4	6 persons
6-10	152	52.2	
11-15	7	2.4	

Total	291	100.0	
<b>Income (₦)</b>			
9000 – 18000	51	17.5	
19000 – 28000	37	12.7	
29000 – 38000	32	11.0	₦38,792
39000 – 48000	52	17.9	
49000 - 58000	116	39.9	
59,000 – 68,000	3	1.0	

Source: Field Survey, 2021

### Knowledge of Respondents on Exclusive Breastfeeding

The result in Table 2 revealed that majority (93.8%) of the nursing mothers indicated that they had heard of exclusive breastfeeding, while 5.2% indicated no, meaning that they had not heard about exclusive breastfeeding and only 1.0% indicated that they did not know. This implies that almost all the respondents (women) had heard about exclusive breastfeeding. The respondents were further asked what they understood about exclusive breastfeeding and majority (80.1%) of the women indicated breast milk without water or any other food followed by 4.1% of the women who mentioned feeding the baby with breast milk and water for the first six months, while 15.8% of the women were of the opinion that it is feeding the baby with breast milk and vitamins. The finding revealed that a good percentage (80.1%) of the women were knowledgeable about exclusive breastfeeding and were able to define exclusive breastfeeding according to the World Health Organization definition. This high level of knowledge agrees with 90.6% rate reported by Maduforo *et al.* (2013) in Owerri. Their findings revealed high level of awareness and adequate knowledge of exclusive breastfeeding practice. In order to further support the

high level of knowledge of exclusive breastfeeding in this present study, 86.9% of the women knew that breast milk is better than infant formula. Reasons given for this ranged from breast milk was it is safer as 59.5% of the women affirmed to the exclusive breast feeding had more nutrients, 52.9% women said it was more convenient. On commencement of breastfeeding, 54.0% of women indicated that breast feeding should commence anytime on the day of delivery. Exclusive breastfeeding is a pattern of feeding which comprises feeding an infant with breast milk alone without adding any other complementary feed or water for the first six months, but allows the infant to receive oral rehydration solution (ORS), vitamin syrups and medicine and continued breastfeeding with appropriate complementary foods for the period of two years. A man said, exclusive breastfeeding means feeding a new born baby with only breast milk without adding any other type of food, water or drink, except vitamin syrups, drops and medication for the first six months. This study further corroborates that of Bolanle (2013) who reported that majority of mothers initiated breastfeeding within one hour of delivery, and most of the women and men knew that colostrum was good for the baby.

**Table 2: Rural Women Knowledge of Exclusive Breastfeeding**

Items	Freq.	%
Have you heard of exclusive breastfeeding		
Yes	273	93.8
No	15	5.2
Don't know	3	1.0
What do you understand by exclusive breastfeeding		
Breast milk with water	12	4.1
Breast milk with vitamins	46	15.8
Breast milk with any liquid		
Breast milk without water or any other food	233	80.1
Right time to initiate breastfeeding		
Within the first one hour	124	42.6
Anytime on the day of delivery	157	54.0
When the baby has passed stool	4	1.4
After 24hours	6	2.1
Is breast milk better than infant formula		
Yes	253	86.9
No	8	2.7
Don't know	30	10.3
Reasons why breast milk is better than infant formula		
It is safer	173	59.5
It is more convenient	88	30.2

It contains more nutrients	154	52.9
It is cheaper	149	51.2
Is colostrum good for the baby		
Yes	148	50.9
No	41	14.1
Don't know	102	35.1

*Source: Field Survey, 2021*

### **Rural Women Perception of the Benefit of Exclusive Breastfeeding Practices**

The women were asked to mention the benefits of exclusive breastfeeding to children, mother and community. Result in Table 2 showed several benefits of exclusive breastfeeding as indicated by the respondents (women). The study showed that exclusive breastfeeding helps to build infants immunity ( $\bar{x}=3.31$ ) and was the highest benefit the child derives while the mothers' highest benefit was that it saves money ( $\bar{x}=3.47$ ) and the highest benefit for the community was that it leads to healthy mothers and children ( $\bar{x}=3.46$ ). Other benefits children derive from exclusive breastfeeding were; reduces symptoms of upper respiratory tract infection and collection of injection ( $\bar{x}=3.13$ ), this is in line with the findings of Aryeetey and Goh (2013) who reported that breast milk contains valuable antibodies from the mother that strengthens the immune system of the child against various forms of infections.

Exclusive breastfeeding also helps children to develop high intelligent quotient ( $\bar{x}=2.96$ ), it makes infants healthy and look plump ( $\bar{x}=2.95$ ), protects infants from sudden infant death syndrome (SIDS) ( $\bar{x}=2.65$ ) and it reduces the risk of asthma, obesity, heart diseases and diabetes later in life ( $\bar{x}=2.64$ ). The benefits of exclusive breastfeeding for the mother are as follows; it helps mothers in spacing their children ( $\bar{x}=2.90$ ), it helps to reduce the risk of pre-menopausal breast and ovarian cancer ( $\bar{x}=2.86$ ), exclusive breastfeeding helps to contract the uterus to its normal size ( $\bar{x}=2.60$ ), it helps burn the fats accumulated during pregnancy ( $\bar{x}=2.57$ ) and it helps to prevent and reduce bleeding ( $\bar{x}=2.55$ ). Another benefit for the community is that it lowers neonatal and infant mortality rates ( $\bar{x}=2.81$ ), mother to child bonding ( $\bar{x}=2.64$ ), this agrees with Chidozie *et al.* (2013) who opines that maternal psychosocial bonding between a mother and her child (infant) can be strengthened through exclusive breastfeeding. In the same vein, the women diasrees that exclusive breastfeeding helps mothers to return to their normal shape after delivery ( $\bar{x}= 2.37$ ).

A grand mean of 2.87 was recorded for women responses showed that the perception of women towards the benefits of exclusive breastfeeding were positive. The children who were exclusively breastfed were more smart and clever than others. In the vein of exclusive breastfeeding helps in spacing children. The finding of this study further agrees with that of Ojong and Chukwudozie (2019) who revealed that exclusive breastfeeding builds up the immune system of a child,

and also that exclusive breastfeeding is less expensive and healthier than formula feeds thus making the family save more money. The finding also corroborates the findings of Aborigo *et al.* (2012) who found that exclusive breastfeeding reduce the risk of respiratory tract infections such as pneumonia in children.

**Table 3: Mean Distribution of Rural Women Perception of Benefits of Exclusive Breastfeeding Practices**

Perceived benefits	Sum	Mean	Std. Deviation
<b>Benefits to children</b>			
Exclusive breastfeeding helps to build infants immunity	962	2.31	0.79
It reduces the risk of asthma, obesity, heart diseases and diabetes	731	2.44	0.80
It helps children to develop high intelligent quotient	864	2.96	0.79
It makes infants healthy and look plump	857	2.95	0.69
Protects infants from sudden infant death syndrome (SIDS)	712	2.65	0.83
Reduces symptoms of upper respiratory tract infection and complications	911	3.06	0.70
<b>Benefits to Mothers</b>			
Exclusive breastfeeding helps to contract the uterus to its normal size	758	2.60	0.97
It helps to prevent and reduce bleeding	742	2.55	0.86
It helps to reduce the risk of pre-menopausal breast and ovarian cancer	832	2.86	0.79
It helps mothers to return to their normal shape after delivery	689	2.37	0.83
It helps mothers in spacing their children	843	2.90	0.76
It helps burn the fats accumulated during pregnancy	749	2.57	0.74
Mother to child bonding	769	2.64	0.82
Saves money	1009	3.47	0.70
<b>Benefits to Community</b>			
Healthy mothers and children	1008	3.46	0.61
Lower neonatal and infant mortality rates	818	2.81	0.77
<b>Grand mean</b>		<b>2.87</b>	

Source: Field Survey, 2021  $\geq 2.5 = \text{Very Great Benefit}$ ;  $< 2.5 = \text{Not a Benefit}$

the breast milk was not enough for baby, mothers wanted to go back to work, my baby was not gaining enough weight, fear of infant depending solely on breast milk after growth, due to pain in my breast, mothers not feeding well, babies refusing breast milk, not producing enough breast milk, lack of husband's support, reduced milkiness of my breast and mothers ashamed of breastfeeding their babies. This findings further support the report by the Federal Ministry of Health (2012) and Karacam (2008) that some mothers believe they do not produce enough milk to satisfy the baby, others believe that producing baby is an indication that the breast milk is not enough and has to be supplemented with family food or water and further corroborates that the report of Ella (2016) that lack of proper information was a constraint to exclusive breastfeeding.

**Factors Militating Against Exclusive Breastfeeding Practices by Rural Women**

The result in Table 4 revealed several factors militating against exclusive breastfeeding practices in Rivers State. The study revealed that women agreed to the following militating factors; use of medications harmful to the baby by the mother ( $\bar{x}=3.44$ ) was found to be the highest constraint militating women from exclusively breastfeeding. Health related problems ( $\bar{x}=3.35$ ), refusal of breast milk by some children ( $\bar{x} =3.32$ ), not enough breast milk production ( $\bar{x}=3.27$ ), adoption of children ( $\bar{x}=3.21$ ), resumption to work ( $\bar{x}= 3.02$ ) and concern that certain food mothers eat will make the baby sick ( $\bar{x}=3.07$ ). Other constraints as identified by women include; mother not feeding well ( $\bar{x}=2.97$ ), giving birth through caesarian operation ( $\bar{x}= 3.15$ ) giving birth to twin or more ( $\bar{x}= 2.88$ ), returned to school ( $\bar{x}= 2.90$ ), lack of husband's support ( $\bar{x}=2.90$ ), lack of proper information about exclusive breastfeeding recommended duration ( $\bar{x}=2.89$ ), type of mother's job or trade ( $\bar{x}=2.81$ ), sore or painful nipples  $\bar{x}=2.61$  and mother losing weight ( $\bar{x}=2.50$ ). However, the respondents (women) disagreed to the following factors; concern that breastfed babies are smaller compared to formula-fed babies ( $\bar{x}=2.30$ ), pressure from family and peers to introduce fluids and food ( $\bar{x}=2.48$ ), lack of energy and strength due to farm work ( $\bar{x}=2.45$ ). The finding of this study is in agreement with that of Johnson, Felicia and Ireroturi (2016) who found that factors militating against exclusive breastfeeding were;

**Table 4: Mean Distribution of Factors Militating Against Exclusive Breastfeeding Practices**

Factors	Sum	Women	
		Mean	Std. Deviation
Resumption to work	880	3.02	1.05
Lack of husband's support	845	2.90	0.92
Not enough breast milk production.	952	3.27	0.85
Concern that certain food mothers eat will make the baby sick	892	3.07	0.85
Concern that breastfed babies are smaller compared to formula-fed babies	670	2.30	0.80
Returned to school	843	2.90	1.08
Sore or painful nipples	754	2.59	1.05
Use of medications harmful to the baby by the mother	1002	3.44	0.72
Pressure from family and peers to introduce fluids and food.	721	2.48	1.01
Health related problems	974	3.35	0.85
Refusal of breast milk by some children	967	3.32	0.70
Type of mother's job or trade	817	2.81	0.92
Mother not feeding well	864	2.97	0.95
Giving birth through caesarian operation	918	3.15	1.00
Mother losing weight	742	2.55	0.94
Lack of proper information about Exclusive Breastfeeding recommended duration	840	2.89	0.96
Giving birth to twin or more	839	2.88	1.04
Adoption of children	935	3.21	0.96
Lack of energy and strength due to farm work	713	2.45	0.89
<b>Grand mean</b>		<b>2.92</b>	

Source: Field Survey, 2021

$\geq 2.5 = \text{Very Great Factor (VGF)}$ ,  $< 2.5 = \text{Not a Factor (NF)}$

#### **Influence of Socio-economic Characteristics on Exclusive Breastfeeding**

**H0<sub>1</sub>:** Mothers' practice of exclusive breastfeeding is not significantly influenced by their socioeconomic characteristics.

Table 5 showed that the practice of exclusive breastfeeding was significantly influenced by occupation, marital status, education and household size at 0.05 and 0.10 levels of significance.

The coefficient for occupation (0.490) was positively signed and significantly influenced exclusive breastfeeding practice. This might be due to the fact that working as an employee and exclusively breastfeeding an infant were difficult tasks for nursing-mothers. Furthermore, existing workplace policies were not sensitive to breastfeeding status of nursing-mothers, coupled with the cultural practice that frowns at women exposing their breasts in the public. The period of maternity leave in Nigeria was shorter than the period the mother was expected to breastfeed exclusively. Furthermore, there were no facilities such as the crèche provided for baby care while mother was at work, which would have encouraged mothers to take their infants to their work place. The findings of this study corroborated with the findings of Ella (2016) in Cross River State who found a significant relationship between occupation and practice of exclusive breastfeeding. The coefficient of

marital status (0.609) was positive and statistically significant at 5% level. This is an indication that the presence of a husband can have positive influence on exclusive breastfeeding practice. This is in line with the findings of Essien and Samson-Akpan (2013) in their study on factors influencing the practice of exclusive breastfeeding among mothers in Ikot Omin, Calabar, which revealed a significant relationship between marital status and practice of exclusive breastfeeding. This was an indication of husband's influential role as breadwinners and decision makers in family matters. Husbands probably give the much needed financial support to promote and sustain exclusive breastfeeding till 6 months. The coefficient of education (0.250) was positively signed and significantly influence the practice of exclusive breastfeeding at 10% level. This implies that mothers with higher level of educational qualification practiced exclusive breastfeeding compared to those with lower level of education. This assertion was in line with the finding of Ibe et al. (2016) in which educational attainment had significant relationship with exclusive breast practice ( $P < 0.001$ ). However, the finding contradicts that of Ojong, Chiotu and Nlumanze (2019) that revealed a no significant relationship between education and practice of exclusive breastfeeding.

The coefficient of household size (-0.480) was negative and statistically significant at 10% level. This implies that mothers with less children tend to exclusively breastfeed more than the ones with many children, this can be because they are not driven away from their babies by the increasing responsibilities of the older ones. Also, a lack of domestic support and having more than one child to take care of increases women's domestic burden and reduces their concentration on

exclusive breast-feeding. This is similar to the finding of Ishola et al (2019) that having fewer children predicted more positive attitudes toward exclusive breastfeeding among nursing mothers in Ibadan metropolis. Since 5 of the variables were significant, only 2 were not, therefore the null hypothesis was rejected and the alternative hypothesis which states that mothers' practice of exclusive breastfeeding is significantly influenced by their socioeconomic characteristics was accepted.

**Table 5: Logit Regression Result of the Influence of Socio-Economic Characteristics on Exclusive Breastfeeding**

Variables	B Statistic	Standard Error	P-Value
Age	0.013	0.169	0.939
Occupation	0.490	0.115	0.000**
MaritalStatus	0.609	0.186	0.001**
Education	0.250	0.135	0.064*
Household size	-0.480	0.289	0.096*
Income	-0.015	0.108	0.889
Constant	-4.100	0.937	0.000**
-2 Log likelihood	283.884		
Cox & Snell R Square	0.113		
Pseudo R Square	0.170		
Chi-Square	17.410		

Source: Researcher's computation with SPSS 25.0, detailed in Appendix

\*\*significant at  $p \leq 0.05$ , \* significant at  $p \leq 0.1$

**Relationship Between Knowledge and Practice of Exclusive Breastfeeding in the Study Area**

**H0<sub>2</sub>:** There is no significant relationship between knowledge and practice of exclusive breastfeeding in the study area.

Result in Table 4.9.2 showed the correlation coefficient (r) of the variable knowledge and practice of exclusive breastfeeding as -0.057 and a p-value of 0.336 that is greater than the significance level of 0.05. This negative correlation coefficient showed an inverse correlation between knowledge level of the mother and practice of exclusive breastfeeding but not statistically significant. Findings of the study suggest that adequate knowledge on the benefits of exclusive breastfeeding alone is not a determinant factor among women to continue exclusive

breastfeeding. This finding is not surprising because knowledge is not synonymous to practice (Bhavana, 2010; Okon, 2015; Oyewo & Taiwo, 2010). Having knowledge of a thing can be hindered from putting the knowledge to action by certain beliefs, lack of support and lack of resources. However, the above study is not supported by a study conducted by Maduforo *et al* (2013) among lactating mothers in Owerri metropolis who discovered a significant association between knowledge and practice of exclusive breastfeeding. However, the finding of this study contradicts that of Ojong and Chukwudozie (2019) who found that mothers' level of knowledge of exclusive breastfeeding is significantly associated with the practice of exclusive breastfeeding.

**Table 6: Pearson Product Moment Correlation of Relationship Between Knowledge and Practice of Exclusive Breastfeeding**

Variable		Knowledge	Practice of Exclusive Breastfeeding
Knowledge	Pearson Correlation	1	-.057
	Sig. (2-tailed)		.336
	N	291	291
Practice of exclusive breastfeeding	Pearson Correlation	-.057	1
	Sig. (2-tailed)	.336	
	N	291	291

Source: Field Survey, 2021

**Conclusion And Recommendations**

The findings revealed that rural women were aware and knowledgeable about exclusive breastfeeding practice,

but its practice was poor. The women were aware of the benefits of exclusive breastfeeding to the child, mother and community at large. These include exclusive breastfeeding help build infants immunity, it saves money and healthy mothers and children. In conclusion, breastfeeding mothers in Rivers State were confronted by many militating factors as they exert themselves to practice exclusive breastfeeding. It can be seen that there is low rate of exclusive breastfeeding practice in the study area which was as a result of health related problems, lack of husbands support, refusal of breast milk by some children, not enough breast milk production and resumption to work. Based on the findings of this study, the following recommendation was made: Baby friendly hospital initiative should be established in all the health facilities and should be encouraged in getting all the mothers involved in the practice of exclusive breastfeeding.

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