INTRODUCTION

Exclusive breastfeeding (EBF) means an infant receives only breast milk from his/her mother or a wet nurse for the first six months of life without other solids or liquids. The World Health Organization (WHO) recommends EBF for the first six months of life. Complimentary foods can thereafter be added at six (6) months of age with the continuation of breastfeeding up to two years and beyond. It is evident from the literature that EBF offers both long and short-term benefits both to the mother and the infant. The benefits of EBF to the infant include a reduction in the vulnerability to infectious diseases, steady infant growth and cognitive development, as well as a reduced risk of childhood hypertension, obesity and diabetes mellitus. For the mother, the benefits of EBF include the strengthening of mother-child bond, and a reduction in post-partum blood loss, depression, type 2 diabetes, breast and ovarian cancer. Despite these benefits, global trends suggest that early cessation of breastfeeding, and poorly timed introduction of liquids, solid and semi solid foods is the norm in many communities across the globe. The United Nations Children's Fund (UNICEF) reports that 40% of infants aged six (6) months and younger are exclusively breastfed globally. Of this estimate, only 23 countries across the globe have achieved the UNICEF and WHO recommendation of EBF for 60% of infants six (6) months and younger. According to the Global Burden of Diseases,
In sub-Saharan Africa, there is a disparity in the uptake of EBF with the prevalence ranging from 23.7% in Central Africa to 32.6% in West Africa, 53.5% in East Africa and 56.6% in Southern Africa. The countries with the lowest prevalence in each region were Gabon – 6.0% (Central Africa), Cote d'Ivoire- 13.2% (West Africa), Comoros-13.5% (East Africa) and Namibia- 48.7% (Southern Africa). In Nigeria, the estimated prevalence of EBF was 17.5%, a proportion that is lower than the minimum 60% recommended by the World Health Organization and UNICEF. Despite the baby-friendly hospital initiative that was introduced in 1991 by UNICEF, Nigeria reports sub-optimal practice of EBF among nursing mothers. Evidence however suggest that the reported low uptake of EBF in Nigeria could be an outplay of some underlying factors.

Previous studies conducted in Edo, Osun, Imo, Cross-River, and Anamba States have investigated the association between various factors and EBF. Findings from these studies suggest that maternal factors such as maternal age, maternal education, socioeconomic status, marital status, parity, and familial predisposition towards EBF were associated with EBF. In addition, infant-related factors such as infant age and proximity of the mother to the baby were also identified as factors that predict EBF. Other identified factors were health service-related factors such as the use of health facility based antenatal care, delivery at a government facility and breastfeeding education from a government health facility. Most of these studies have however been conducted in few states and also just urban regions hence, there exists a dearth of literature on EBF in Ondo State and semi-urban areas in Nigeria at large. A yearly breastfeeding program was instituted by the Federal Medical centre, Owo, Ondo State in 1994. The programme was geared towards improving the practice of EBF among nursing mothers, however, the effectiveness of the breastfeeding program has not been assessed since its commencement. The current prevalence and predictors of EBF in Owo several years after commencement of the annual breastfeeding week remains unknown. A study of this nature is needed to provide data required for nationwide comparison of the prevalence of EBF in Nigeria. Also, this study could provide statistics for subsequent evaluation of the annual breastfeeding program. This would subsequently inform on the strategies for improving EBF practice across Nigeria. Therefore, this study aimed to assess the prevalence and predictors of EBF in a semi-urban Nigerian community.

METHODS
Study Design and Area
This was a cross-sectional study conducted at the Federal Medical Centre (FMC), Owo. The FMC, Owo is a tertiary health facility located in Owo Local Government Area of Ondo State, Nigeria. FMC, Owo provides healthcare services at all levels to residents of Ondo and neighbouring states. The FMC, Owo is sited close to the highway and so admit patients from the Federal Capital Territory and farther areas in the country. It is approved by the West African Postgraduate College and the National Postgraduate College as a training centre for Resident Doctors in some specialties and sub-specialities of medical services. Presently, the centre has 21 clinical and 7 non-clinical departments. FMC, Owo is a 250-bed tertiary health centre with a bed occupancy of about 70% always. The average monthly attendance, by all age groups, at the outpatient department is about 4,980. The centre has a staff strength of 1200 workers.

Study Population
The target population included nursing mothers attending the immunization clinic at FMC, Owo whose babies were below 2 years.

Sample Size Calculation
A minimum sample size (n) of 382 nursing mothers was estimated using the formula for the estimation of a single proportion. This took into consideration few assumptions including the standard normal deviate (z) corresponding to a confidence level of 95% (1.96), prevalence rate (p) of 52.9%, and 5% level of precision (d).

Sampling Technique
Systematic random sampling was used to recruit the women attending the immunization clinic. About 98 women are seen weekly at the immunization clinic for children older than 6 months. Clinic holds once a week, with approximately four clinic days in a month. The sampling frame at the clinic over three months was 1,176 ((98 mothers) *(12 days) *(3 months)). The sampling interval, i.e., sampling frame/sample size was 1,176/382 = 3. The first mother was recruited using simple random sampling to select one out of every first 3 women on every clinic day. Depending on the number selected first, every third woman was recruited. Only 32 women were recruited once in a week, giving an average of 128 women enrolled monthly.
Data Collection Instrument
A questionnaire containing the WHO indicators for assessing breastfeeding practices was adapted. The semi-structured questionnaire was used to interview mothers of infants attending immunization clinic on scheduled days. The questionnaire included questions on sociodemographic characteristics of mothers and infants (age, sex, mothers’ age, religion, occupation, marital status, education, and family income), feeding practices (breastmilk, mixed (breastmilk plus artificial feeding), or solely artificial feeding) and other details of breastfeeding practices, such as the time of breastfeeding initiation, the duration and frequency of feeding. EBF was defined as giving breast milk alone in the first 6 month of life. The check questions included “At what age did you add water?” and “At what age did you commence complementary feeds?” Those defined to have practiced EBF were nursing mothers who did not give water or other feeds until after six months of life.

Statistical Analysis
The statistical analyses were done using the Statistical package for Social Sciences (SPSS) version 17. Sociodemographic characteristics such as age, level of education, employment status, marital status, number of children, average monthly income, and smoking status during pregnancy were presented in frequency tables. The minimum wage in the country as at the time the study was conducted was 18,000 naira, and was used to dichotomize average income. Mothers who stated that EBF meant placing the baby exclusively on breastmilk for the first six months of life were said to have “correct knowledge” of the meaning of EBF. Persons who defined EBF as the combination of breast milk with formula feeds or animal milk were said to have “wrong knowledge” of the meaning of EBF. Mothers who correctly defined EBF and the recommended duration (i.e., 6 months) for which it should last were said to have “adequate knowledge” of EBF. Those who stated otherwise were said to have “inadequate knowledge” of EBF. The association between sociodemographic characteristics and EBF practice among mothers attending the immunization clinic were tested with Chi-square test. Logistic regression analyses were conducted on variables that were statistically significant at the bivariate level to identify the predictors of EBF. Statistical significance was considered at p-value <0.05.

Ethical Approval
Permission to conduct the study was obtained from the Health Research Ethics Committee of Federal Medical Centre, Owo, Ondo State, Nigeria. Verbal informed consent was obtained from the mothers before the questionnaires were administered. No form of harm was inflicted on the individuals who participated in the study.

RESULTS
Table 1 shows the sociodemographic characteristics of the respondents. The mean age of the 386 women was 30.8 ± 5.0 years. Among them, 149 (36.8%) were below 30 years, 226 (58.5%) had completed tertiary

| Variable                        | Frequency | Percentage |
|--------------------------------|-----------|------------|
| Mean age: 30.8 ± 5.0 years     |           |            |
| Age (Years)                    |           |            |
| <30                             | 149       | 38.6       |
| ≥30                             | 237       | 61.4       |
| Level of education              |           |            |
| Secondary or lower              | 160       | 41.5       |
| Tertiary                        | 226       | 58.5       |
| Employment status               |           |            |
| Employed                        | 242       | 62.7       |
| Not employed                    | 144       | 37.3       |
| Marital status                  |           |            |
| Married                         | 364       | 94.3       |
| Others                          | 22        | 5.7        |
| Number of children              |           |            |
| <4                              | 332       | 86.0       |
| ≥4                              | 54        | 14.0       |
| Median average monthly income: #20,000 (Range = ₦2,000 - ₦1,000,000) | | |
| Average monthly income (₦)      |           |            |
| < 18,000                        | 82        | 21.2       |
| ≥18,000                         | 304       | 78.8       |
| Smoking status during pregnancy  |           |            |
| Smoking                         | 11        | 2.8        |
| Not Smoking                     | 375       | 97.2       |
education, and 242 (62.7%) were employed. Also, 364 (94.3%) were married, 332 (86%) had less than 4 children, and 304 (78.8%) earned an average monthly income of \( \mathrm{N}\)18,000 or more. The median income was \( \mathrm{N}\)20,000 and ranged between \( \mathrm{N}\)2,000 and \( \mathrm{N}\)1,000,000.

Among the women, 259 (67.1%) commenced breastfeeding within 30 minutes after delivery. Table 2 shows the antenatal-related characteristics of the mothers attending the immunization clinic at the FMC, Owo. Among them, 316 (81.9%) had no health problems during pregnancy. Also, 345 (89.4%) mothers had ANC visit at least four times, 333 (86.3%) had physicians as their ANC care providers, and 342 (89.3%) had their babies delivered in hospital settings. Vaginal delivery accounted for 316 (81.9%), while 271 (70.2%) of the babies were not hospitalized after birth, and

**Table 2:** Antenatal related characteristics of mothers attending the immunization clinic at the Federal Medical Centre Owo, Ondo State, Nigeria.

| Characteristics                               | Frequency (N=386) | %     |
|-----------------------------------------------|-------------------|-------|
| Health problems during pregnancy              |                   |       |
| Yes                                           | 70                | 18.1  |
| No                                            | 316               | 81.9  |
| Had at least four ANC visits                   |                   |       |
| Yes                                           | 345               | 89.4  |
| No                                            | 41                | 10.6  |
| ANC care provider                              |                   |       |
| Non-Physician                                  | 53                | 13.7  |
| Physician                                     | 333               | 86.3  |
| Place of delivery (N=383)                      |                   |       |
| Hospital or Clinic                             | 342               | 89.3  |
| Traditional birth Attendance                   | 9                 | 2.3   |
| Home                                          | 11                | 2.9   |
| Missionary Homes                               | 21                | 5.5   |
| Type of delivery                               |                   |       |
| Vaginal                                       | 316               | 81.9  |
| Caesarean                                      | 53                | 13.7  |
| Assisted (Forceps delivery)                    | 17                | 4.4   |
| Hospitalization of baby after delivery         |                   |       |
| Yes                                           | 115               | 29.8  |
| No                                            | 271               | 70.2  |
| Index baby’s sex                               |                   |       |
| Male                                          | 195               | 50.5  |
| Female                                        | 191               | 49.5  |
| Index baby’s age                               |                   |       |
| Nine months                                    | 343               | 88.9  |
| Others                                        | 43                | 11.1  |
| Mother resumed work < 6 months after delivery  |                   |       |
| Yes                                           | 270               | 69.9  |
| No                                            | 116               | 30.1  |
| Age at first pregnancy                         |                   |       |
| \( \leq 19 \)                                  | 25                | 6.5   |
| 20-29                                         | 259               | 67.1  |
| 30-39                                         | 94                | 24.4  |
| 40                                            | 8                 | 2.1   |
| Gestational age at birth                       |                   |       |
| 27 and below                                   | 12                | 3.1   |
| 28-36                                         | 73                | 18.9  |
| 37-40                                         | 269               | 69.7  |
| 41 and above                                   | 32                | 8.3   |
| Weight of baby at birth                        |                   |       |
| \( \leq 2.4 \)                                 | 42                | 10.9  |
| 2.5-3.5                                       | 246               | 63.7  |
| \( \geq 3.6 \)                                 | 98                | 25.4  |
the index baby’s sex was male in 191 (50.5%) deliveries. At the time of this study, 343 (88.9%) of the babies were 9 months old, and 257 (71.4%) mothers had resumed work less than 6 months after delivery.

Table 3 shows breastfeeding knowledge and practices among the mothers. The prevalence of EBF was 52.6%. Among the breastfeeding mothers, 350 (90.7%) breastfed their babies as often as the babies wanted. (23.6%) suggested extended paid maternity leave would improve breastfeeding practice. Overall, 218 (56.5%) mothers had adequate knowledge of EBF.

Table 4 shows the factors associated with EBF practice among the mothers interviewed. One hundred and forty-four (62.1%) nursing mothers aged 30 years or older practiced EBF compared to 72 (48.3%) persons below 30 years ($X^2 = 6.290, p = 0.012$). Also, 38 (70.3%) mothers who have delivered four or more

| Practices                                      | Frequency | %  |
|------------------------------------------------|-----------|----|
| **Breastfeeding alone for 6 months**           |           |    |
| Yes                                            | 203       | 52.6|
| No                                             | 183       | 47.4|
| **Type of feed introduced among those who breastfed for 6 months** |           |    |
| Artificial feeds                                | 44        | 21.7|
| Natural feeds                                  | 159       | 78.3|
| **Pattern of breastfeeding daily**             |           |    |
| < 6 times                                       | 15        | 3.9 |
| 6 to 8 times                                   | 13        | 3.4 |
| >8 times                                       | 8         | 2.1 |
| As often as the baby wants                     | 350       | 90.7|
| **Reason for choosing breastfeeding**          |           |    |
| Affordable                                     | 39        | 10.1|
| Healthy Growth                                 | 258       | 66.8|
| Bonding                                        | 30        | 7.8 |
| Child Spacing                                  | 29        | 7.5 |
| None                                           | 30        | 7.8 |
| **Spouse’s Support**                           |           |    |
| Provision of needs                             | 252       | 65.3|
| Helping with home chores                       | 80        | 20.7|
| No support                                     | 54        | 14.0|
| **Suggested support to improve breast feeding practice** |   |    |
| Extended paid maternity leave                  | 91        | 23.6|
| Break for breast feeding during working hours  | 40        | 10.4|
| Closing from work earlier to breastfeed the baby | 24   | 6.2 |
| More enlightenment                             | 86        | 22.3|
| Provision of employment                        | 145       | 37.5|
| **Best time to make decision about breast feeding** |   |    |
| Before pregnancy                               | 60        | 15.5|
| During pregnancy                               | 97        | 25.1|
| After the baby is born                         | 229       | 59.3|
| **Adequate knowledge of exclusive breast feeding** |   |    |
| Yes                                            | 218       | 56.5|
| No                                             | 168       | 43.5|

Among the 203 (52.6%) mothers that breastfed their babies for six months, 159 (81.6%) introduced complementary feeds 6 months after EBF. In addition, 258 (66.8%) mothers chose breastfeeding to achieve babies’ healthy growth, Also, 252 (65.3%) gained spouse’s support for the provision of needs, and 91 children practiced EBF compared to 180 (54.2%) with fewer children ($X^2 = 5.437, p = 0.020$). Furthermore, 174 (55.1%) of mothers with no health problems during pregnancy practiced EBF compared to 45 (64.3%) with health problems during pregnancy ($X^2 = 2.501, p = 0.114$).
Table 4: Factors associated with exclusive breastfeeding practice among mothers attending the immunization clinic at the Federal Medical Centre Owo, Ondo State, Nigeria.

| Variable                        | Exclusive breastfeeding | X² | p-value |
|---------------------------------|-------------------------|----|---------|
| **Age (Years)**                 |                         |    |         |
| <30                             | 72 (48.3)               | 6.290 | 0.012   |
| ≥30                             | 144 (62.1)              |      |         |
| **Levels of education**         |                         |    |         |
| Secondary or lower              | 84 (52.5)               | 0.838 | 0.360   |
| Tertiary                        | 132 (58.4)              |      |         |
| **Employment status**           |                         |    |         |
| Employed                        | 138 (57.0)              | 0.006 | 0.939   |
| Not Employed                    | 82 (56.9)               |      |         |
| **Marital status**              |                         |    |         |
| Married                         | 208 (57.1)              | 0.193 | 0.661   |
| Not married                     | 12 (54.5)               |      |         |
| **Median number of children = 2 (Range: 1 – 6)** | | |
| Number of children              |                         |    |         |
| <4                              | 180 (54.2)              | 5.437 | 0.020   |
| ≥4                              | 38 (70.3)               |      |         |
| **Health problems during pregnancy** |                      |    |         |
| Yes                             | 45 (64.3)               | 2.501 | 0.114   |
| No                              | 174 (55.1)              |      |         |
| **Adequate knowledge of EBF**   |                         |    |         |
| Yes                             | 128 (58.7)              | 0.667 | 0.414   |
| No                              | 92 (55.8)               |      |         |

Table 5: Determinants of Exclusive Breastfeeding among mothers attending the immunization clinic at the Federal Medical Centre Owo, Ondo State, Nigeria.

| Variable                        | Adjusted Odds Ratio | 95% CI for Adjusted Odds Ratio | p-value |
|---------------------------------|---------------------|-------------------------------|---------|
| **Age (Years)**                 |                     |                               |         |
| <30                             | 1                   |                               |         |
| ≥30                             | 1.358               | 0.886 – 2.081                 | 0.160   |
| **Number of children**          |                     |                               |         |
| <4                              | 1.079               | 0.594 – 1.959                 | 0.802   |
| ≥4                              | 1                   |                               |         |

Table 5 shows the determinants of EBF among the mothers interviewed. Nursing mothers aged 30 years or older had 36% higher odds of practicing EBF compared to younger persons (Adjusted Odds Ratio = 1.358, 95% CI = 0.886 – 2.081, p = 0.160).

DISCUSSION

This study was conducted to determine the prevalence and predictors of EBF among women attending the immunization clinic at the FMC, Owo, Ondo State. The prevalence of EBF in Owo was found to be 52.6%. The finding in this study was higher than the 16.4% EBF prevalence reported in the Nigeria Demographic and Health Survey (NDHS) in 2018. The prevalence of EBF observed in this study is also higher than 20% reported in a study in Benin city, Edo State, Nigeria. A lower prevalence of EBF has been recorded in Calabar (22.9%) and the United States (19%). Though the uptake of EBF prior to the commencement of the annual breastfeeding week in Owo is not known, the higher prevalence of EBF compared to other regions in the country could possibly be ascribed to the annual breastfeeding week. The week usually involves breastfeeding campaigns, and incentives awarded to nursing mothers who had practiced EBF. These activities could have therefore resulted in mothers being more informed and also better motivated to practice EBF.
The practice of EBF in Owo, a semi-urban community could have further contributed to the results obtained in this study. The difference may be due to the promotion of EBF among Owo residents, and the political will associated with the annual breastfeeding program in Owo, a feat that has not been recorded elsewhere. However, a study from Kano reported a high prevalence of 70.0% which was a hospital-based study among health workers. The prevalence of EBF recorded in our study is lower than the 60% cut-off recommended by the UNICEF and WHO. This therefore highlights the need for continuous promotion of EBF in Owo community. The proportion of mothers who practiced EBF in this study was also low compared to the 89.9% who had correct knowledge of EBF. This shows an existing gap between knowledge and practice and underscores the need to intensify the practice of EBF among nursing mothers.

In our study, majority of the mothers (67%) commenced breastfeeding immediately after delivery which is in tandem with the 70% reported from a similar research conducted in a rural setting in Ife, Osun State, Nigeria. Our results are however higher than what was reported in an urban setting in Edo State, Nigeria (44.5%), and a multicentred study in Nigeria (36%). Our findings could be an outplay of a higher proportion of natural deliveries in rural and semi-urban communities compared to urban communities. The cultural acceptability of breastfeeding is further strengthened in our study in the introduction of natural feeds (56.5%) as a complimentary feed, similar to maize-based diet (53.5%) in a multicentred study in Nigeria. The use of natural feeds as complimentary feed in our study could also be due to the high poverty level of the respondents and therefore adoption of cost-effective and easy-to-get nutritious feeds.

Majority (59.8%) of the mothers in our study opted for breastfeeding because breastmilk enhances babies’ growth and wellbeing. This is similar to a report from the United Nations Children’s Fund (UNICEF) and a study from Calabar, Nigeria. The agreement between these studies therefore suggests that besides the cost-intensive nature of breastfeeding, nursing mothers are aware of the potential benefits EBF presents. Improved health education in this regard would therefore be important to prevent the occurrence of many childhood illnesses and improve the likelihood of child survival, as elucidated by the child survival strategies.

From our study, older women had higher odds of practicing EBF compared to younger persons. This finding could be attributed to the engagement of a higher proportion of young persons in career building pursuit, and reduced time and commitment to EBF practice. This result is consistent with the findings in the literature that younger women are more likely to cease EBF prior to the attainment of the 6-month benchmark. Although educational attainment has been reported elsewhere as a predictor of EBF practice among mothers, the present study however found no association between maternal education and EBF. In Ethiopia, higher educational status has been described as a predictor of EBF. In Nigeria however, older maternal age, higher parity, delivery at a government facility, a positive family attitude towards EBF, and breastfeeding education from a government health facility were factors that determined EBF. Other studies conducted in Nigeria reported high socioeconomic status, four or more antenatal visits, female gender and living in the North Central geopolitical region as predictors of EBF.

It intrigues to know that mothers with four or more children had higher odds of practicing EBF. This implies that the those with fewer children were more likely to attend ANC clinic regularly and adhere to all breastfeeding instructions issued by instructors during antenatal health education. Therefore, breastfeeding education delivered at ANC clinic should be adequately packaged and delivered by seasoned professionals who have adequate understanding of the community and have undergone trainings on antenatal health education. Findings in our study revealed that adequate knowledge of EBF does not translate into practice. Therefore, context-based assessment of how EBF practice could be promoted should be immediately undertaken to ensure child health.

No single factor could be a predictor of EBF. Therefore, understanding the importance of breastfeeding and the responsibility of promoting EBF practice does not rest solely on the mother. Rather, spousal support should be provided to encourage EBF among nursing mothers. Also, the political, social, and environmental frameworks to improve the uptake of EBF in Nigeria should be built and sustained.

CONCLUSION

This survey revealed that gaps exist regarding the adoption and practice of EBF among nursing mothers in Nigeria. To achieve the WHO recommended target of ensuring that 90% of nursing mothers practice EBF, incentives can also be given to encourage mothers who conscientiously practice the breastfeeding policy. Spousal support of EBF should be promoted, and advocacy/health education must be intensified by national and professional stakeholders.
Author Contributions
AMA, OOA, and BAO conceived the study and supervised data collection. OSI, DTF, SOO, AOK, IFA, FOA, and AAA participated in data collection, data analysis and writing of the first draft of the manuscript. AMA, OSI, and AAA revised the manuscript for critical intellectual content. All authors approved the final version of the manuscript.

Competing Interests
The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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