
| RESEARCH ARTICLE

Factors Affecting Breastfeeding Initiation and Duration among Mothers in Kwandare, Lafia, Nasarawa State, Nigeria

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| ABSTRACT

This study investigated the factors affecting breastfeeding initiation and duration among mothers in Kwandare community, Lafia, Nasarawa State, Nigeria. A descriptive cross-sectional survey design was employed, involving 100 breastfeeding mothers selected from the community. Data were collected using a structured questionnaire and analyzed using the Statistical Package for Social Sciences (SPSS), with descriptive statistics including means and standard deviations. Findings revealed that mothers demonstrated relatively high knowledge of recommended breastfeeding practices, particularly early initiation within the first hour of birth ($M = 3.64$, $SD = 0.98$) and exclusive breastfeeding for the first six months ($M = 3.58$, $SD = 1.02$). However, knowledge of continued breastfeeding up to two years was comparatively lower ($M = 3.12$, $SD = 1.15$). Despite this awareness, actual breastfeeding practices were influenced by multiple interrelated factors. Socio-cultural influences such as prelacteal feeding practices ($M = 3.42$) and family pressure from elderly relatives ($M = 3.26$) significantly affected initiation and exclusivity. Economic factors, including maternal employment ($M = 3.68$) and poverty ($M = 3.54$), were identified as key barriers to sustained breastfeeding. Conversely, healthcare-related factors such as delivery in health facilities ($M = 3.72$) and family support, particularly from husbands ($M = 3.84$), were found to positively influence breastfeeding practices. The study concludes that while awareness of breastfeeding recommendations is relatively high, optimal practices are constrained by socio-cultural norms, economic challenges, and family dynamics. It recommends comprehensive interventions, including community-based education, male involvement, supportive workplace policies, and strengthened healthcare services, to improve breastfeeding outcomes and contribute to achieving Sustainable Development Goal 3 on child health and well-being.

| KEYWORDS

Breastfeeding, initiation, duration, socio-cultural factors, maternal health, Nigeria

| ARTICLE INFORMATION

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1. Introduction

Breastfeeding is widely recognized as one of the most effective and cost-efficient public health interventions for improving child survival, growth, and development. It provides optimal nutrition, strengthens the immune system, and fosters cognitive development in infants (World Health Organization [WHO], 2023). Early initiation of

breastfeeding defined as putting the newborn to the breast within the first hour of birth is particularly critical, as it facilitates the intake of colostrum, which is rich in antibodies and essential nutrients that protect against neonatal infections (UNICEF, 2021). Evidence indicates that appropriate breastfeeding practices could prevent approximately 820,000 child deaths annually worldwide, particularly in low- and middle-income countries (Victora et al., 2016).

Despite these well-documented benefits, global adherence to recommended breastfeeding practices remains suboptimal. The WHO recommends exclusive breastfeeding for the first six months of life, followed by continued breastfeeding alongside complementary feeding up to two years or beyond (WHO, 2023). However, in many developing countries, including Nigeria, these recommendations are not consistently followed. According to the Nigeria Demographic and Health Survey (NDHS, 2018), only 29% of infants under six months are exclusively breastfed, and early initiation rates remain below global targets. These gaps highlight the persistent challenges in translating knowledge into practice. Breastfeeding practices are influenced by a complex interplay of factors, including maternal knowledge, socio-cultural beliefs, economic conditions, healthcare access, and family support systems. Studies have shown that cultural practices such as prelacteal feeding, misconceptions about breast milk sufficiency, and traditional norms can significantly hinder exclusive breastfeeding (Alemayehu et al., 2018; Ogbo et al., 2017). Additionally, maternal employment and lack of supportive workplace policies often lead to early cessation of breastfeeding (Bako et al., 2020). Healthcare-related factors, such as antenatal counselling and facility-based delivery, have been identified as critical enablers of early initiation and sustained breastfeeding (Ameh et al., 2020).

In rural communities, these challenges are often more pronounced due to limited access to healthcare services, lower levels of education, and stronger adherence to traditional beliefs. Kwandare community in Lafia, Nasarawa State, represents a typical rural Nigerian setting where socio-cultural and economic factors may significantly influence breastfeeding practices. Although some awareness of breastfeeding benefits exists, anecdotal evidence suggests that practices such as delayed initiation and early introduction of water or herbal mixtures remain prevalent.

Furthermore, family dynamics play a crucial role in shaping maternal behaviour. The influence of husbands, grandmothers, and other relatives can either promote or hinder optimal breastfeeding practices (Susin & Giugliani, 2008; Tohotoa et al., 2011). In many cases, mothers may prioritize family expectations over professional health advice, thereby affecting adherence to recommended guidelines. This underscores the importance of examining breastfeeding not only as an individual behaviour but also as a socially embedded practice.

Although several studies have examined breastfeeding practices at national and regional levels in Nigeria, there remains a paucity of context-specific research focusing on rural communities such as Kwandare. Localized evidence is essential for designing culturally appropriate and effective interventions. Without such data, public health strategies may fail to address the unique barriers faced by mothers in these settings.

Therefore, this study aims to investigate the factors affecting breastfeeding initiation and duration among mothers in Kwandare community, Nasarawa State. Specifically, it seeks to assess mothers' knowledge of breastfeeding practices, examine socio-cultural influences, evaluate economic and healthcare-related factors, and explore the role of family and community support. The findings are expected to contribute to the development of targeted interventions that promote optimal breastfeeding practices, improve child health outcomes, and support the achievement of Sustainable Development Goal 3 (Good Health and Well-being).

2. Methodology

A descriptive cross-sectional survey design was adopted for this study to assess breastfeeding practices and factors influencing breastfeeding among mothers in Kwandare community. The design was appropriate because it facilitated the collection of data from respondents at a single point in time, thereby providing a comprehensive picture of the prevailing breastfeeding behaviors and associated determinants. The study involved 100 breastfeeding mothers selected from the community. Data were collected using a structured questionnaire comprising two sections. Section A elicited information on respondents' socio-demographic characteristics, while Section B contained Likert-scale items designed to assess breastfeeding practices and factors influencing breastfeeding. The Likert scale ranged from

Strongly Agree (5) to Strongly Disagree (1). The instrument enabled the researcher to obtain standardized responses that were subsequently analyzed to describe breastfeeding practices and identify key factors affecting breastfeeding among mothers in the study area. The instrument was validated by experts and tested for reliability ($r = 0.81$). Data collection was conducted with trained assistants, and ethical approval with informed consent was obtained. Data were analyzed using SPSS. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used. A mean score ≥ 3.00 indicated agreement.

3. Results

Table 1: Distribution of Respondents by Socio-Demographic Characteristics

Variable	Frequency	Percentage (%)
Age (years)		
18–25	25	25.0
26–35	45	45.0
36–45	20	20.0
46 and above	10	10.0
Educational Level		
No formal education	15	15.0
Primary education	25	25.0
Secondary education	40	40.0
Tertiary education	20	20.0
Occupation		
Farming	30	30.0
Trading	35	35.0
Civil service	20	20.0
Housewives/unemployed	15	15.0

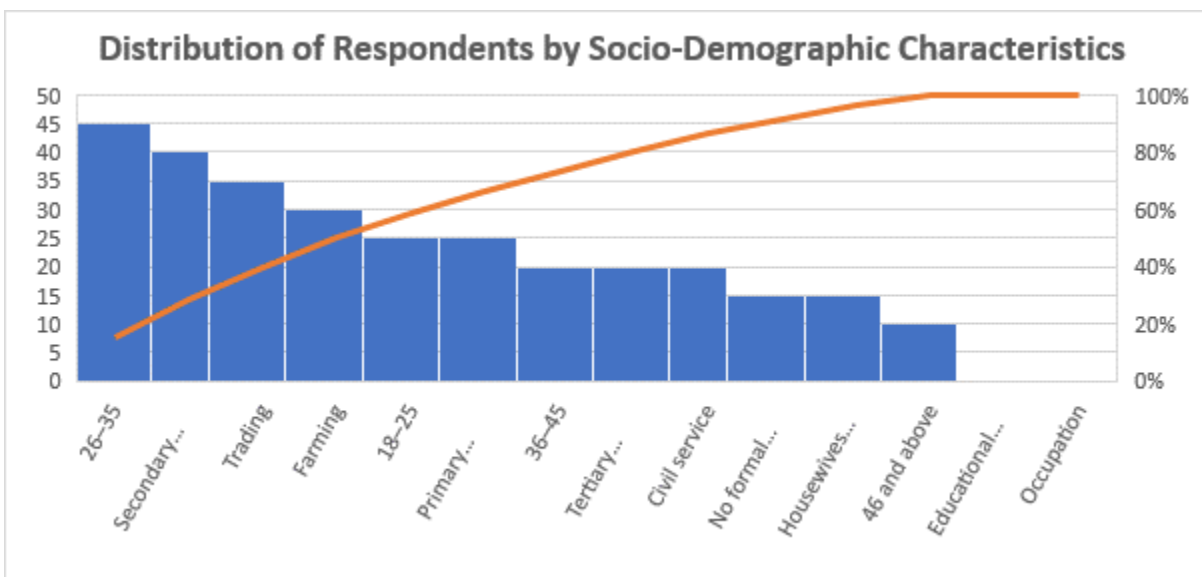


Fig 1

The predominance of mothers aged 26–35 years suggests that the study population falls within the peak reproductive and economically active age group. This age bracket is often associated with increased autonomy in household decision-making, which may positively influence health-related behaviors, including breastfeeding practices.

The relatively high level of education, with 60% of respondents having at least secondary education, indicates a moderate literacy level that can facilitate understanding of health information. Previous studies have shown that maternal education enhances awareness and adoption of optimal breastfeeding practices. However, education alone does not guarantee compliance, as socio-cultural and economic barriers may still limit practice.

Occupational distribution reveals that most respondents are engaged in informal economic activities (trading and farming). These occupations often lack structured maternity benefits, which may negatively impact exclusive breastfeeding duration. This finding highlights the intersection between livelihood patterns and maternal health behaviors in rural communities.

Table 2: Mothers' Knowledge of Breastfeeding Initiation and Duration

Item	Mean	Std. Dev.	Decision
Breastfeeding should be initiated within the first hour after delivery	3.64	0.98	Agreed
Exclusive breastfeeding should last for six months	3.58	1.02	Agreed
Breastfeeding should continue up to two years with complementary feeding	3.12	1.15	Agreed

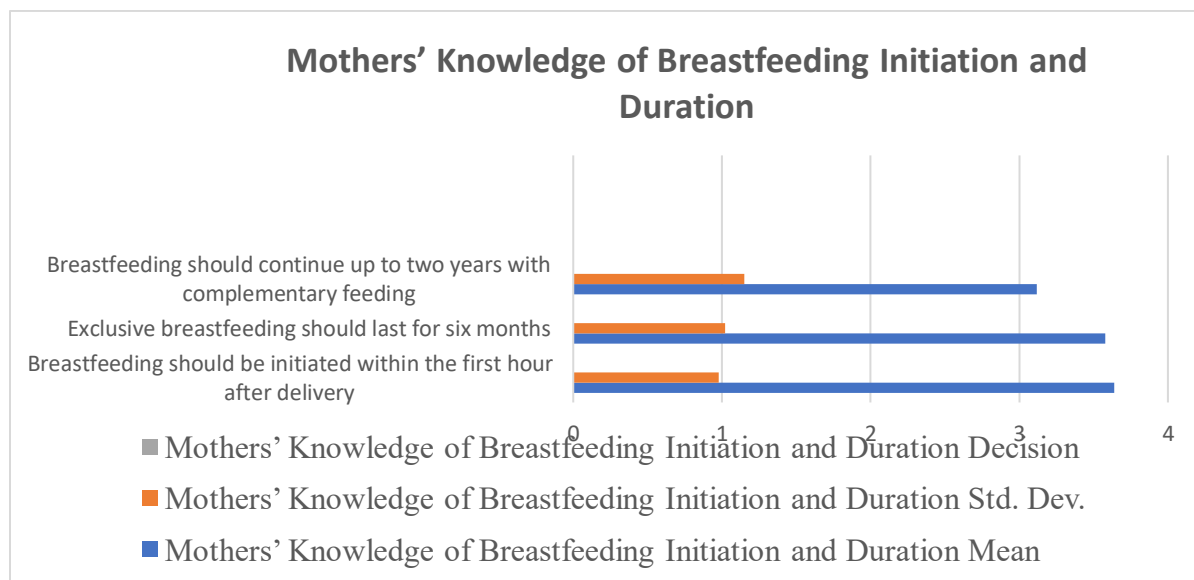


Fig 2

The findings indicate that mothers possess a relatively high level of knowledge regarding recommended breastfeeding practices. The highest mean score for early initiation ($M = 3.64$) suggests strong awareness of its importance, likely influenced by health education programs and antenatal care exposure. Early initiation is critical for neonatal survival, as it promotes colostrum intake and strengthens maternal-infant bonding.

Similarly, knowledge of exclusive breastfeeding for six months ($M = 3.58$) reflects alignment with global health recommendations. However, the slightly lower mean score for continued breastfeeding up to two years ($M = 3.12$) suggests gaps in understanding long-term breastfeeding benefits. This pattern indicates that while initial breastfeeding knowledge is relatively strong, sustained breastfeeding practices may be less emphasized in health messaging. The findings reinforce the need for continuous education that not only promotes initiation but also emphasizes duration.

Table 3: Socio-Cultural Influences on Breastfeeding

Item	Mean	Std. Dev.	Decision
Giving water/herbal mixtures before breastfeeding is common	3.42	1.08	Agreed
Elderly family members influence breastfeeding decisions	3.26	0.95	Agreed
Cultural beliefs discourage exclusive breastfeeding	3.18	1.11	Agreed
Breastfeeding is positively viewed in the community	3.70	0.92	Agreed

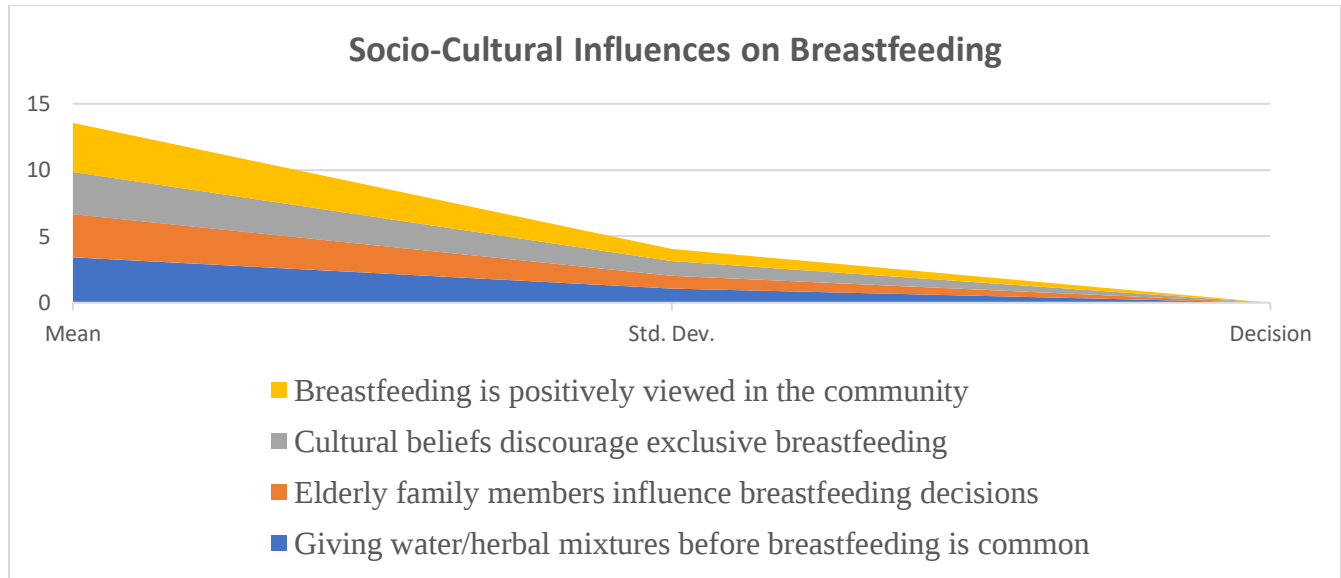


Fig 3

The results highlight the strong influence of socio-cultural practices on breastfeeding behaviors. The agreement that prelacteal feeding (water or herbal mixtures) is common ($M = 3.42$) indicates the persistence of traditional practices that contradict recommended guidelines. Such practices increase the risk of infections and undermine exclusive breastfeeding.

The influence of elderly family members ($M = 3.26$) underscores the role of intergenerational authority in shaping maternal decisions. In many rural settings, grandmothers and older relatives act as custodians of cultural norms, often overriding medical advice. Cultural beliefs discouraging exclusive breastfeeding ($M = 3.18$) further demonstrate that misconceptions such as perceived insufficiency of breast milk remain prevalent. However, the strong agreement that breastfeeding is positively viewed ($M = 3.70$) presents an opportunity. This positive perception can serve as a foundation for culturally sensitive interventions aimed at correcting harmful practices without rejecting community values.

Table 4: Economic and Healthcare Factors

Item	Mean	Std. Dev.	Decision
Mothers with paid jobs find it difficult to exclusively breastfeed for six months	3.68	0.88	Agreed
Poverty limits mothers' ability to maintain proper breastfeeding and nutrition	3.54	1.06	Agreed
Mothers who deliver in health facilities initiate breastfeeding earlier than those who deliver at home	3.72	0.81	Agreed

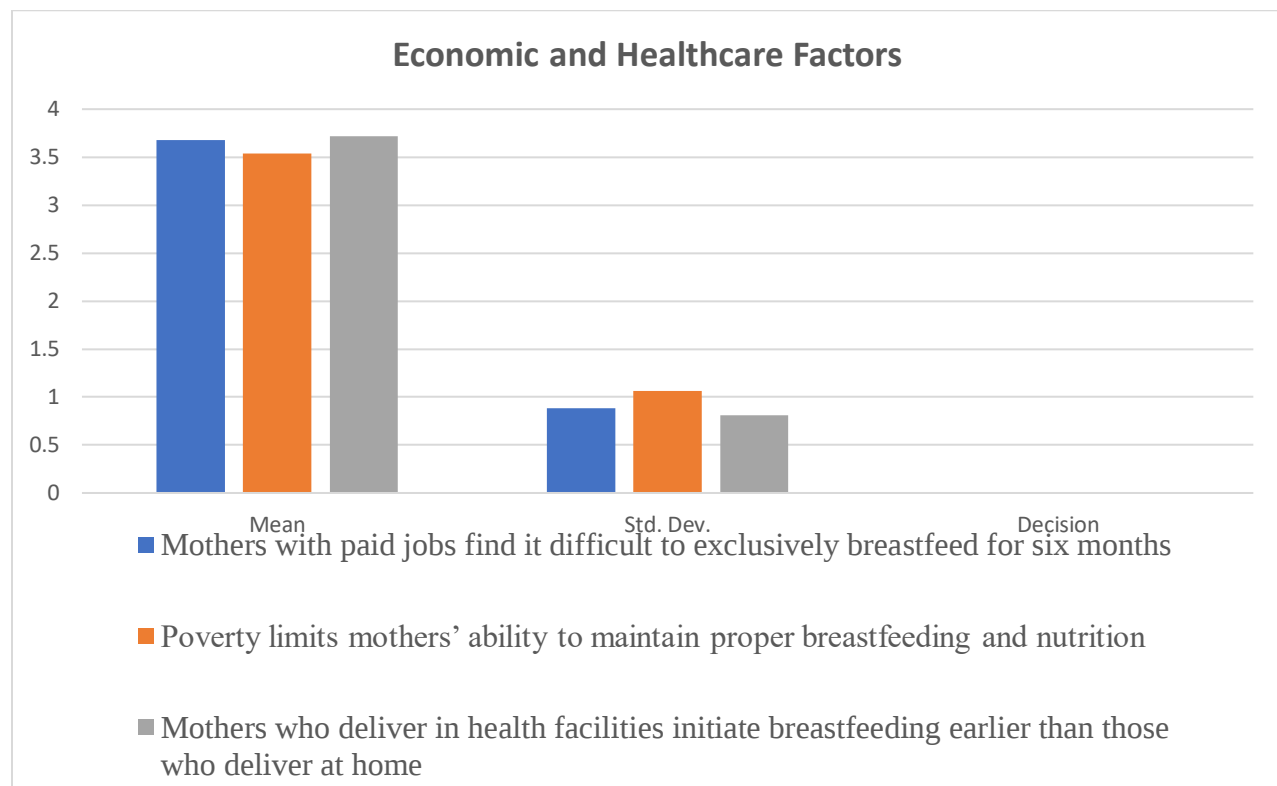


Fig 4

Economic constraints emerged as a major determinant of breastfeeding practices. The high mean score for difficulty among working mothers ($M = 3.68$) reflects the incompatibility between employment demands and exclusive breastfeeding, especially in informal sectors lacking maternity protections.

Poverty ($M = 3.54$) further compounds these challenges by affecting maternal nutrition and access to health information. Poor nutritional status can influence milk production and maternal confidence, thereby affecting breastfeeding duration. Conversely, healthcare-related factors showed a positive influence. Mothers who delivered in health facilities ($M = 3.72$) were more likely to initiate breastfeeding early, highlighting the importance of skilled birth attendance and postnatal counselling. This finding emphasizes the role of healthcare systems as key enablers of optimal breastfeeding practices.

Table 5: Family and Community Support

Item	Mean	Std. Dev.	Decision
Support from husbands encourages mothers to breastfeed longer	3.84	0.75	Agreed
Grandmothers/mothers-in-law pressure early introduction of foods	3.32	0.91	Agreed
Community campaigns promote exclusive breastfeeding	3.10	1.12	Agreed

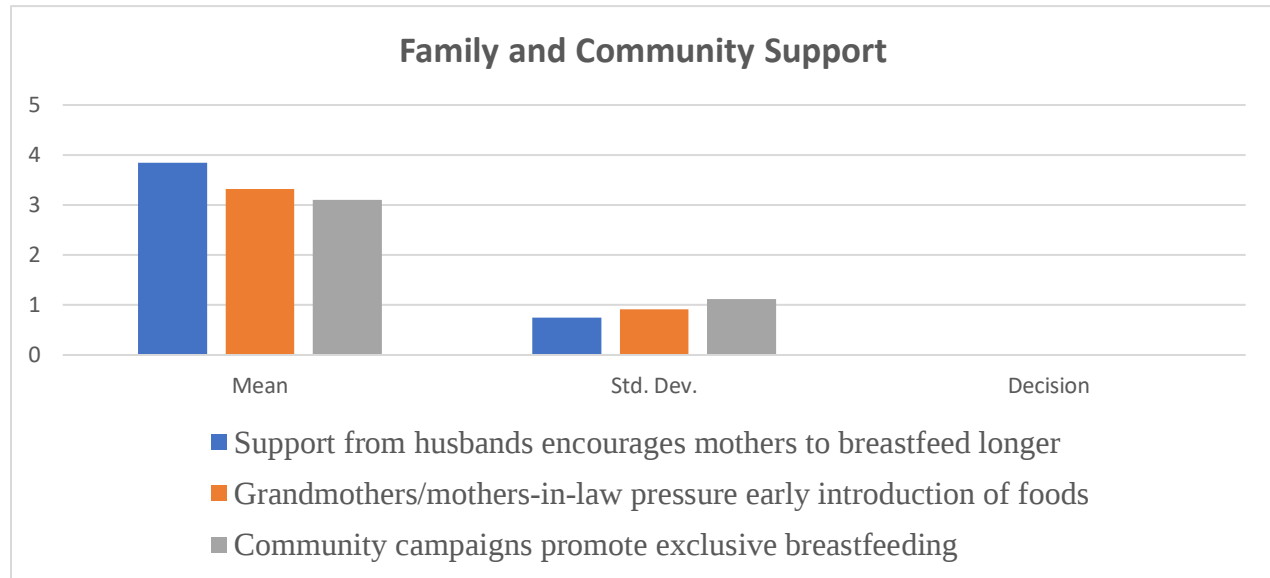


Fig 5

Family dynamics play a critical role in breastfeeding outcomes. The highest mean score in this category was for spousal support ($M = 3.84$), indicating that husbands significantly influence breastfeeding duration. Emotional, financial, and practical support from partners enhances maternal confidence and adherence to recommended practices. However, the pressure from grandmothers and mothers-in-law ($M = 3.32$) highlights a conflicting influence within the family structure. While support systems exist, traditional expectations may promote early introduction of complementary foods, undermining exclusive breastfeeding.

Community campaigns ($M = 3.10$) were acknowledged but had comparatively lower influence, suggesting that formal health interventions may not be as impactful as immediate family dynamics. This underscores the need for community programs to actively involve family members rather than targeting mothers alone. Family influence is critical, with spousal support positive and elder pressure sometimes negative.

4. Discussion

This study examined the factors affecting breastfeeding initiation and duration among mothers in Kwandare, Lafia, Nasarawa State, Nigeria. The findings provide important insights into the breastfeeding experiences of mothers in the study area and contribute to the growing body of evidence on infant feeding practices in Nigeria and Sub-Saharan Africa.

The study found that a considerable proportion of mothers initiated breastfeeding within the first hour after birth. This finding is encouraging because early initiation of breastfeeding is a key public health intervention known to improve neonatal survival and reduce the risk of infections and infant mortality. Similar findings have been reported in Nigeria by Berde and Yalcin (2016), who found that institutional delivery and maternal exposure to health information significantly increased the likelihood of early breastfeeding initiation. Likewise, Ogbo, Agho, and Page (2015) reported that mothers who delivered in health facilities and received breastfeeding counselling were more likely to initiate breastfeeding promptly. Evidence from a multi-country analysis across 35 Sub-Saharan African

countries further demonstrated that breastfeeding within the first hour of birth was associated with significant reductions in infant mortality (Ekholuenetale et al., 2021).

Despite the relatively favourable initiation rates observed in this study, some mothers delayed breastfeeding due to post-delivery fatigue, cultural beliefs, and misconceptions regarding colostrum. This finding agrees with reports from Northern Nigeria and other parts of Sub-Saharan Africa where traditional beliefs continue to influence infant feeding decisions. A scoping review by Shimizu, Nakat, and Takahashi (2023) identified cultural norms, home delivery, lack of skilled birth attendance, and maternal educational status as major determinants of delayed breastfeeding initiation across several African countries. Similar observations have been reported in Ghana, Ethiopia, and Tanzania, where cultural practices such as prelacteal feeding and colostrum avoidance remain barriers to optimal breastfeeding practices.

The findings also revealed that although many mothers continued breastfeeding beyond six months, exclusive breastfeeding for the recommended first six months was not universally practiced. This observation is consistent with previous studies conducted in Nigeria. A systematic review of breastfeeding practices in Nigeria found that while breastfeeding prevalence is generally high, adherence to exclusive breastfeeding recommendations remains relatively low and varies considerably across regions due to sociocultural and economic influences. Similarly, recent reviews have shown that many mothers introduce water, herbal preparations, and complementary foods before six months despite awareness of exclusive breastfeeding recommendations.

Maternal educational attainment emerged as an important factor influencing breastfeeding initiation and duration. Mothers with higher levels of education appeared more likely to adopt recommended breastfeeding practices than those with lower educational attainment. This finding corroborates studies conducted in Nigeria, Ethiopia, and Ghana which consistently demonstrate that maternal education positively influences breastfeeding knowledge, attitudes, and practices. Shimizu et al. (2023) reported that mothers with higher educational status were significantly more likely to initiate breastfeeding early and sustain breastfeeding for longer durations compared with less educated mothers. Educated mothers are often better positioned to access health information, understand breastfeeding recommendations, and utilize maternal healthcare services effectively.

The present study further identified maternal employment as a significant factor affecting breastfeeding duration. Working mothers reported challenges in maintaining exclusive breastfeeding due to limited maternity leave, demanding work schedules, and inadequate workplace support. This finding aligns with previous Nigerian studies which have shown that maternal employment often interferes with exclusive breastfeeding practices, particularly among women employed in the formal sector. Similar findings have been reported in South Africa, Ghana, and Uganda, where workplace constraints were identified as important barriers to sustained breastfeeding. These findings suggest the need for breastfeeding-friendly workplace policies, including extended maternity leave and designated breastfeeding spaces.

Family support was another important determinant of breastfeeding practices identified in this study. Mothers who received encouragement from spouses, grandmothers, and other family members were more likely to initiate breastfeeding early and continue breastfeeding for longer periods. This finding is consistent with evidence from studies conducted in Nigeria and other African countries, which emphasize the role of social support networks in shaping maternal health behaviours. In many African societies, infant feeding decisions are often influenced by family elders whose beliefs and experiences can either facilitate or hinder optimal breastfeeding practices. Consequently, interventions aimed at improving breastfeeding outcomes should extend beyond mothers to include spouses, grandmothers, and other influential family members.

Healthcare providers also emerged as critical influencers of breastfeeding behaviour among mothers in Kwandare. Mothers who attended antenatal clinics and received breastfeeding education from healthcare workers demonstrated better breastfeeding practices than those who did not receive such counselling. This finding supports previous studies indicating that antenatal and postnatal breastfeeding counselling significantly improves breastfeeding initiation and

duration. Evidence from Nigeria, Ghana, and Ethiopia suggests that health education delivered through maternal healthcare services remains one of the most effective strategies for promoting optimal breastfeeding practices. Institutional delivery and skilled birth attendance have also been consistently associated with timely breastfeeding initiation across Sub-Saharan Africa.

Cultural beliefs and traditional infant feeding practices were identified as persistent barriers to optimal breastfeeding in the study area. Some mothers reported giving water, herbal mixtures, or other prelacteal feeds before establishing breastfeeding. Similar findings have been documented in Northern Ghana, Ethiopia, and several West African countries where traditional beliefs continue to encourage the use of prelacteal feeds. Such practices may compromise exclusive breastfeeding and increase the risk of neonatal infections and childhood illnesses. Ogbo et al. (2017) further demonstrated that early initiation and exclusive breastfeeding provide protective effects against diarrhoeal diseases among children in Sub-Saharan Africa, highlighting the importance of discouraging inappropriate infant feeding practices.

Finally, the findings of this study are largely consistent with existing evidence from Nigeria and other Sub-Saharan African countries, indicating that breastfeeding initiation and duration are influenced by a complex interaction of maternal education, healthcare access, employment status, family support, and cultural practices. While encouraging progress has been made in promoting breastfeeding awareness, persistent barriers such as workplace constraints, cultural misconceptions, and suboptimal exclusive breastfeeding practices continue to limit achievement of recommended breastfeeding targets. These findings underscore the need for multifaceted interventions involving healthcare providers, policymakers, community leaders, and families to improve breastfeeding practices and ultimately enhance maternal and child health outcomes in Kwandare and similar communities across Nigeria.

5. Conclusion

A key strength of this study lies in its contribution to the understanding of factors affecting breastfeeding initiation and duration among mothers in Kwandare, Lafia, Nasarawa State. However, like most community-based studies, certain limitations should be acknowledged when interpreting the findings.

First, the study employed a cross-sectional research design, which captured respondents' experiences and practices at a single point in time. While this design was appropriate for describing prevailing breastfeeding practices and associated factors, it does not permit the establishment of causal relationships between the identified factors and breastfeeding outcomes. Consequently, although associations were observed between variables such as maternal education, family support, healthcare access, employment status, and breastfeeding practices, the study cannot conclusively determine whether these factors directly caused the observed breastfeeding behaviours.

Second, the study relied on self-reported information provided by mothers, which may have introduced recall bias and social desirability bias. Some respondents may have had difficulty accurately recalling the timing of breastfeeding initiation or the duration of exclusive breastfeeding, particularly mothers with older infants. Additionally, respondents may have provided answers they perceived to be socially acceptable or desirable rather than accurately reflecting their actual practices. This limitation is common in breastfeeding research and may have influenced the precision of the findings.

Third, the study was conducted exclusively within Kwandare community in Lafia Local Government Area, which may limit the generalizability of the findings to other communities, states, or regions of Nigeria. Breastfeeding practices are often influenced by cultural norms, religious beliefs, socioeconomic conditions, and access to healthcare services, which vary across different geographical settings. Therefore, caution should be exercised when applying the findings to populations with different demographic and cultural characteristics.

Furthermore, although the study identified several cultural and social factors influencing breastfeeding behaviour, the use of a structured questionnaire limited the opportunity to explore in greater depth the underlying beliefs,

perceptions, and experiences that shape maternal decision-making regarding infant feeding. Cultural influences on breastfeeding are often complex and deeply embedded within family traditions, community norms, and intergenerational practices, which may not be fully captured through quantitative survey methods alone.

In view of these limitations, future research should adopt longitudinal study designs to provide a more comprehensive understanding of breastfeeding behaviours over time. Longitudinal studies would enable researchers to follow mothers from pregnancy through the postpartum period and infancy, thereby generating stronger evidence regarding the temporal relationships between maternal characteristics, healthcare interventions, and breastfeeding outcomes. Such studies would also allow for the assessment of changes in breastfeeding practices and the factors influencing them at different stages of child development.

Additionally, future studies should incorporate qualitative research approaches, such as in-depth interviews, focus group discussions, and ethnographic investigations, to explore the cultural, social, and psychological dimensions of breastfeeding behaviour. Qualitative methods would provide richer insights into mothers' lived experiences, community perceptions, traditional beliefs, family influences, and barriers to exclusive breastfeeding that may not be adequately captured through quantitative surveys. Understanding these contextual factors is particularly important in Northern Nigerian communities, where cultural practices and family structures play a significant role in shaping maternal and child health behaviours.

Future research may also benefit from employing mixed-methods approaches, combining quantitative and qualitative techniques to provide a more holistic understanding of breastfeeding practices. Such approaches would not only quantify the prevalence and determinants of breastfeeding behaviours but also explain the contextual factors underlying those patterns. This would enhance the development of culturally appropriate interventions and policies aimed at improving breastfeeding outcomes.

Moreover, comparative studies involving urban and rural populations, different ethnic groups, and multiple states within Nigeria are recommended. Such studies would facilitate a broader understanding of regional variations in breastfeeding practices and help identify context-specific strategies for promoting optimal infant feeding. Further investigation into the effectiveness of breastfeeding counselling programmes, workplace breastfeeding support policies, community-based interventions, and male-partner involvement initiatives would also provide valuable evidence for policymakers and public health practitioners.

Overall, acknowledging these limitations does not diminish the value of the present study; rather, it highlights important opportunities for future research. The findings provide a useful foundation for subsequent investigations and contribute to the growing body of evidence needed to strengthen breastfeeding promotion programmes and improve maternal and child health outcomes in Nasarawa State and Nigeria as a whole.

Recommendations

1. Intensify community-based breastfeeding education targeting mothers and families.
2. Promote male involvement in maternal and child health programs.
3. Engage traditional leaders and elders to address harmful cultural practices.
4. Implement supportive workplace policies such as extended maternity leave.
5. Strengthen healthcare systems to promote facility-based delivery and counselling.
6. Expand community campaigns to reinforce exclusive breastfeeding practices.
7. Develop policies addressing poverty and maternal nutrition in rural areas

References

- [1] Abrahams, S. W., & Labbok, M. H. (2019). Breastfeeding and maternal employment: A systematic review of workplace interventions. *Maternal & Child Nutrition*, 15(3), e12789.
- [2] Adejoh, S. O., & Eze, E. A. (2020). *Determinants of breastfeeding practices among rural mothers in Nigeria*. *Journal of Health Promotion Research*, 8(2), 45–56.

- [3] Adejuyigbe, E. A., & Odebiyi, A. I. (2008). Knowledge and practices of exclusive breastfeeding in the first six months among multiparous women in Ile-Ife, Nigeria. *Journal of Health, Population and Nutrition*, 26(1), 107–113.
- [4] Adepoju, A. O., & Oyewole, O. O. (2014). *Determinants of nutritional status of children in rural households in Oyo State, Nigeria*. *International Journal of Economics, Commerce and Management*, 2(9), 1–14.
- [5] Agu, U., & Agu, M. C. (2019). Barriers to exclusive breastfeeding among working mothers in Enugu, Nigeria. *International Journal of Maternal and Child Health and AIDS*, 8(1), 1–9.
- [6] Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179–211. [https://doi.org/10.1016/0749-5978\(91\)90020-T](https://doi.org/10.1016/0749-5978(91)90020-T)
- [7] Alemayehu, T., Haidar, J., & Habte, D. (2018). Prelacteal feeding practice and associated factors among mothers in Ethiopia. *International Breastfeeding Journal*, 13(1), 1–7.
- [8] Aliyu, A. A., Yusuf, M., & Musa, A. B. (2020). Determinants of early initiation of breastfeeding in rural Northern Nigeria. *African Journal of Reproductive Health*, 24(1), 44–52. <https://doi.org/10.29063/ajrh2020/v24i1.6>
- [9] Ameh, P. O., Bello, B. L., & Yusuf, T. (2020). Maternal factors influencing breastfeeding practices in northern Nigeria. *Nigerian Journal of Nutrition Sciences*, 41(1), 22–33.
- [10] Arfianti, M., & Retni, R. (2025). *Factors Influencing Exclusive Breastfeeding in Developing Countries: A Review*. Ners Akademika.
- [11] Aubel, J. (2012). The role and influence of grandmothers on child nutrition: Culturally designated advisors and caregivers. *Maternal & Child Nutrition*, 8(1), 19–35.
- [12] Bako, A. G., Musa, S., & Sulaiman, I. (2020). Socioeconomic determinants of breastfeeding duration among women in Nasarawa State, Nigeria. *International Journal of Nutrition and Food Sciences*, 9(4), 115–122.
- [13] Balogun, O. O., Dagvadorj, A., Anigo, K. M., Ota, E., & Sasaki, S. (2016). Factors influencing breastfeeding exclusivity during the first 6 months of life in developing countries: A systematic review. *Maternal & Child Nutrition*, 11(4), 433–451.
- [14] Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall.
- [15] Benova, L., et al. (2020). Time trends and determinants of breastfeeding practices in Nigeria. *PMC*.
- [16] Black, R. E., Victora, C. G., Walker, S. P., Bhutta, Z. A., Christian, P., De Onis, M., ... & Uauy, R. (2021). Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet*, 382(9890), 427–451.
- [17] Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.
- [18] Champion, V. L., & Skinner, C. S. (2019). The Health Belief Model. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health behavior: Theory, research, and practice* (5th ed., pp. 75–94). Jossey-Bass.
- [19] Dennis, C. L., & McQueen, K. (2009). The relationship between infant-feeding outcomes and postpartum depression: A qualitative systematic review. *Pediatrics*, 123(4), e736–e751. <https://doi.org/10.1542/peds.2008-1629>
- [20] Ezeh, O. K., Ogbo, F. A., & Agho, K. E. (2020). Cultural beliefs and breastfeeding practices in Nigeria: A systematic review. *BMC Public Health*, 20, 471.
- [21] FAO, IFAD, UNICEF, WFP, & WHO. (2021). *The State of Food Security and Nutrition in the World 2021*. FAO.
- [22] Glanz, K., Rimer, B. K., & Viswanath, K. (2015). *Health behavior: Theory, research, and practice* (5th ed.). Jossey-Bass.
- [23] Ibrahim, M. A., & Sani, S. M. (2021). Breastfeeding knowledge and practices among women in rural Kano: A cross-sectional study. *African Health Sciences*, 21(2), 528–535. <https://doi.org/10.4314/ahs.v21i2.18>
- [24] Lutter, C. K., & Morrow, A. L. (2021). Protection, promotion, and support and global trends in breastfeeding. *Advances in Nutrition*, 12(4), 1125–1135. <https://doi.org/10.1093/advances/nmab034>
- [25] Mogekwu, F. O., Ajayi, A. I., & Omotayo, M. O. (2019). Cultural practices and breastfeeding among Nigerian mothers: A rural perspective. *International Journal of Child Health and Nutrition*, 8(1), 1–9. <https://doi.org/10.6000/1929-4247.2019.08.01.1>
- [26] National Bureau of Statistics (NBS). (2020). *Labour Force Statistics: Employment and Unemployment Report*. NBS.
- [27] NDHS. (2018). *Nigeria Demographic and Health Survey 2018*. National Population Commission (NPC) and ICF. <https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf>
- [28] Nigeria Demographic and Health Survey (NDHS). (2018). *National Population Commission (NPC) and ICF International*. Abuja, Nigeria.
- [29] Oche, M. O., Umar, A. S., Ahmed, H., & Abdulrahman, A. (2011). Knowledge and practice of exclusive breastfeeding in Kware, Nigeria. *African Health Sciences*, 11(3), 518–523.
- [30] Ogbo, F. A., Agho, K. E., Page, A., & Theodora, R. (2018). Determinants of suboptimal breastfeeding practices in Nigeria: Evidence from the 2008 demographic and health survey. *BMC Public Health*, 18(1), 1–14. <https://doi.org/10.1186/s12889-018-6139-9>
- [31] Ogbo, F. A., Page, A., Idoko, J., Claudio, F., & Agho, K. E. (2017). Trends in complementary feeding indicators in Nigeria, 2003–2013. *BMJ Open*, 5(10), e008467.
- [32] Ogundele, B. A., Yusuf, F. A., & Olasinde, J. A. (2021). Mode of delivery and its effects on early initiation of breastfeeding among Nigerian mothers. *African Journal of Midwifery and Women's Health*, 15(2), 87–96.
- [33] Ogundele, O. M., Abdulwahab, A. R., & Salawu, M. M. (2021). Predictors of early initiation of breastfeeding in Nigeria: Evidence from the 2018 NDHS. *BMC Pregnancy and Childbirth*, 21(1), 153. <https://doi.org/10.1186/s12884-021-03676-2>

- [34] Ogunlesi, T. A. (2010). Maternal socio-demographic factors influencing the initiation and exclusivity of breastfeeding in a Nigerian semi-urban setting. *Maternal and Child Health Journal*, 14(3), 459–465.
- [35] Onah, S., Osuorah, D. I. C., Ebenebe, J., Ezechukwu, C., Ekwochi, U., & Ndukwu, I. (2014). Infant feeding practices and maternal socio-demographic factors that influence practice of exclusive breastfeeding among mothers in Nnewi South-East Nigeria: A cross-sectional and analytical study. *International Breastfeeding Journal*, 9(6), 1–10.
- [36] Otoo, G. E., Lartey, A. A., & Pérez-Escamilla, R. (2009). Perceived incentives and barriers to exclusive breastfeeding among periurban Ghanaian women. *Journal of Human Lactation*, 25(1), 34–41.
- [37] Rollins, N. C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., Piwoz, E. G., Richter, L. M., & Victora, C. G. (2016). Why invest, and what it will take to improve breastfeeding practices? *The Lancet*, 387(10017), 491–504. [https://doi.org/10.1016/S0140-6736\(15\)01044-2](https://doi.org/10.1016/S0140-6736(15)01044-2)
- [38] Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the Health Belief Model. *Health Education Quarterly*, 15(2), 175–183. <https://doi.org/10.1177/109019818801500203>
- [39] Susin, L. R. O., & Giugliani, E. R. J. (2008). Inclusion of fathers in an intervention to promote breastfeeding: impact on breastfeeding rates. *Journal of Human Lactation*, 24(4), 386–392.
- [40] Tadesse, F., Alemayehu, Y., Shine, S., & Asresahegn, H. (2019). Exclusive breastfeeding and maternal employment among mothers of infants from 3 to 5 months old in Southern Ethiopia. *International Breastfeeding Journal*, 14(1), 1–8. <https://doi.org/10.1186/s13006-019-0226-9>
- [41] Tohotoa, J., Maycock, B., Hauck, Y. L., Howat, P., Burns, S., & Binns, C. W. (2011). Supporting mothers to breastfeed: the development and process evaluation of a father inclusive perinatal education support program. *Health Promotion International*, 26(3), 351–361.
- [42] UNESCO. (2017). *Literacy rates continue to rise from one generation to the next*. UNESCO Institute for Statistics.
- [43] UNICEF. (2019). *The State of the World's Children 2019: Children, food and nutrition – Growing well in a changing world*. <https://www.unicef.org/reports/state-of-worlds-children-2019>
- [44] UNICEF. (2021). *The state of the world's children 2021: On my mind – Promoting, protecting and caring for children's mental health*. United Nations Children's Fund. <https://www.unicef.org/reports/state-worlds-children-2021>
- [45] Victora, C. G., Bahl, R., Barros, A. J. D., França, G. V. A., Horton, S., Krasevec, J., Murch, S., Sankar, M. J., Walker, N., & Rollins, N. C. (2016). Breastfeeding in the 21st century: Epidemiology, mechanisms, and lifelong effect. *The Lancet*, 387(10017), 475–490. [https://doi.org/10.1016/S0140-6736\(15\)01024-7](https://doi.org/10.1016/S0140-6736(15)01024-7)
- [46] WHO. (2018). *Implementation guidance: Protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services*. Geneva: World Health Organization.
- [47] World Health Organization (WHO). (2020). *Infant and young child feeding: Model chapter for textbooks for medical students and allied health professionals*. WHO Press.
- [48] World Health Organization. (2023). Breastfeeding. Retrieved from https://www.who.int/health-topics/breastfeeding#tab=tab_1
- [49] World Health Organization. (2023). *Infant and young child feeding fact sheet*. Retrieved from WHO website.
- [50] Yoseph, A., Tewabe, T., Gualu, T., & Gashaye, K. (2021). Early initiation of breastfeeding and associated factors among mothers delivered in public health facilities of South Gondar Zone, Northwest Ethiopia. *BMC Research Notes*, 14(1), 17. <https://doi.org/10.1186/s13104-021-05455-7>