RELATIVITIES OF EXCLUSIVE BREASTFEEDING BETWEEN URBAN AND RURAL LACTATING WOMEN IN IMO STATE

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Abstract
The practice of exclusive breastfeeding by urban and rural lactating women in Imo State Nigeria was studied. Structured and validated questionnaires were used to obtain information on the socio-economic characteristics, correct knowledge and practice of exclusive breastfeeding as well as the constraints to the practice. The result of the survey show that about 91% of urban lactating women have correct knowledge of exclusive breastfeeding against the rural counterparts of 89%. Also, the survey revealed that not all that have the knowledge are practicing it in both urban (66.41%) and rural (57.78) areas. However some constraints were identified to be responsible which include poverty, lack of time, knowledge, and some do not believe that only breastmilk is enough to sustain their baby of less than 6months as well as many other excuses. Most importantly, there some of them (18% urban) and (22%) rural women that are not ready to practice in on their subsequent child birth due to their believe. This therefore calls for more intensified effort in the implementation of Baby Friendly Initiative (BFI) guidelines for successful breastfeeding in all health institutions and clinics.

Keywords: Exclusive breastfeeding, urban, rural, lactating women.

Introduction

Optimal infant and young child feeding includes six months' exclusive breastfeeding, starting at delivery, and continued breastfeeding with appropriate complementary foods and feeding for two years and beyond, as well as related maternal nutrition and care.

Several benefits are credited to exclusive breastfeeding for the child. UNICEF (2005) enumerated that exclusive breastfeeding is associated with:

- **Increased survival**: Studies in developing and industrialized countries confirm the life saving benefits of breastfeeding, particularly in preventing diarrhoea, pneumonia and sudden infant death syndrome (SIDS) deaths.
- **Decreased morbidity:** Infectious and chronic illness is reduced by exclusive breastfeeding, beyond the impact of breastfeeding alone.
- **Improved growth parameters:** Exclusive breastfeeding helps overcome low birth weight (LBW) and reduces stunting.
- **Reduced cardiac risk factors:** Early breastfeeding, especially exclusive, is associated with reduced obesity and other factors related to heart disease.
- **Adequacy:** Mean intakes of human milk provide sufficient energy and protein to meet mean requirements during the first six months of infancy. Since infant growth potential drives milk production, the distribution of intakes likely matches the distribution of energy and protein requirements. Some micronutrients are dependent on maternal stores.

As well, the mother has a lot to benefit from breastfeeding exclusively and optimally:

- Protects mother's health

- ❖ Helps reduces risk of uterine bleeding and helps the uterus to return to its previous size.
- ❖ Reduces risk of breast and ovarian cancer.
- ❖ Helps delay a new pregnancy.
- ❖ Helps a mother return to pre-pregnancy weight.
- ❖ Helps the mother form a bond with the child and feel satisfaction of a woman (WHO/UNICEF, 2009).

Statement of the problem

Although the health benefits of breastfeeding are widely acknowledged, opinions and recommendations are strongly divided on the optimal duration of exclusive breastfeeding and the practice of exclusive breastfeeding in different cultures and regions. This has led to many lactating women not practicing exclusive breastfeeding. The manifestation of infant and young child malnutrition is recorded in UNICEF State of World Children 2009 which reveals that in Sub- Saharan Africa only, the survival rate is as follows

Table 1. Survival Rate in Sub-Saharan Africa

Parameter	%
Life expectancy at birth (2007)	50
Neonatal mortality rate (under 28 days), per 1,000 live births (2004)	41
Infant mortality rate (under 1), per 1,000 live births (2007)	89
Under-5 mortality rate, per 1,000 live births (2007)	148
Maternal mortality ratio, per 100,000 live births (2005, adjusted)	920
Percentage of infants with low birthweight (2000–2007*)	15
Percentage of under-5s who are moderately or severely underweight (2000–2007*)	24

Source: UNICEF (2008)

Africa and Asia account for 95 percent of the world's maternal deaths, with particularly high burdens in Sub-Saharan Africa (50 percent of the global total) and South Asia (35 percent).

These dismal statistics above showed while it is important that the major avoidable causes of maternal and infant/child mortality and malnutrition are eliminated by looking into the exclusive breastfeeding practices of women in the urban as well as rural areas in Imo State.

Materials and methods

Study area and population

The study was carried out in Imo state, one of the states located in the southern part of Nigeria at the heart of south-east. The indigenes are Igbo speaking and its capital is located at Owerri which is the major urban city in the state. The state is made up of 27 local governments with three senatorial zones-: Owerri zone, Okigwe Zone and Orlu Zone.

Data collection

Structured and validated questionnaire was used to collect data. The questionnaire was designed to elicit information on personal, socio-economic status, knowledge and practice of exclusive breastfeeding as well as the constraints hindering its practice in the urban and rural areas in the state. The literate lactating women were given the questionnaire to fill while the illiterate lactating ones were interviewed from the questionnaires and the answers recorded.

During the data collection, I made use of Health centers located in different villages within the three geopolitical areas of the state. Also in the urban area which is referred to be Owerri the capital city of the state in this research work, I collected data from Federal medical centre owerri, Umezuruike Hospital, St. David's Hospital on their post-natal days and immunization days.

Data analysis

The data was analyzed using statistical

package for social sciences (SPSS) and the percentages were determined.

Result

Table 2: Source of Data

Geopolitical Zone	Number of Respondent
Owerri (Urban i.e., Owerri Metropolis)	128
Owerri (Rural)	70
Okigwe (Rural)	56
Orlu (Rural)	54
Total Urban	128
Total Rural	180

Table 3: Percentage Of Personal Characteristics Knowledge And Practice Of Exclusive Breastfeeding By The Respondents

Parameter	Urban (Percentage)	Rural (Percentage)
Age		
15-20	5.47	8.33
21-30	71.10	62.22
31-40	20.31	28.89
41-50	2.34	0.56
51-60	0.78	0.00
Total	100	100
Marital Status		
Married	95.31	96.67
Single	2.34	1.66
Widow	1.57	0.56
Separated/divorced	0.78	1.11
Total	100	100
Educational Background		
Informal	0.00	3.33
Primary School	1.57	4.45
Secondary School	41.40	46.11
Post Secondary School	57.03	46.11
Total	100	100
Occupation		
Farmer	2.34	2.78
Business/Trading	35.16	38.89
Civil/Public Servant	21.10	17.78
Skilled Labour	11.72	7.22
Unemployed/student	29.68	33.33
Total	100	100
Religion		
Christian	96.10	87.77
Muslim	0.00	0.57
Traditional	0.00	1.67
Others	3.90	10.00
Total	100	100
Age of their baby(months)		
0-1	23.44	26.11
1-4	60.16	36.67
4-6	10.94	9.44
Above 6	5.46	27.78

Total	100	100
Knowledge		
Those with the correct knowledge of exclusive breastfeeding	90.63	89.44
Those without the correct knowledge of exclusive breastfeeding	9.37	10.56
Total	100	100
Practice		
Those practicing exclusive breastfeeding	66.41	57.78
Those not practicing exclusive breastfeeding	33.59	42.22
Total	100	100
Those willing to practice it on subsequent child births	82.03	77.78
Those not willing to practice it on subsequent child births	17.97	22.22
Total	100	100

Table 3 above reveal that about 8% of teenage lactating mothers are found in the rural area in Imo state while that of the urban area is about 5%. Most of the women in both urban and rural areas are within the age range of 21-30 years. However, exclusive breastfeeding is practice more by urban women (66.41%) more than rural women (57.78%). Also about 10.56% 0f rural women do not have correct knowledge of exclusive breastfeeding against their counterparts in the urban area 9.37%.

During the survey, the following reasons were identified to be the cause of lack the practice of exclusive breastfeeding in both urban and rural areas:

- Poverty (lack of money)
- Lack of husband and family support
- Lack of time
- Lack of knowledge or correct knowledge
- Many do not believe that only breastmilk is enough for their baby
- Many responded that their baby refused to suck early
- Some said that they gave birth to twins
- Some said that their people don't practice it.

Discussion

In table 3 above, the incidence of teenage mothers both in the urban and rural areas calls for a great concern in that breastfeeding infant adds to a teenage girl's nutrition burden, especially if her growth is still incomplete. Simply being young increases the risks of malnutrition and vulnerability to infections

independent of important socio-economic factors (Klein *et al.*, 2005). "Knowledge is power" is a common adage, lack of correct exclusive breastfeeding knowledge and the inability to apply the knowledge in breastfeeding children is a very serious threat to the practice of exclusive and adequate breastfeeding (Okoli, 2009).

The fact that exclusive breastfeeding is practiced by a minority of women may be attributed to a number of factors. Among these are cultural, social, economic and political factors. Cultural factors may be crucial when promoting exclusive breastfeeding everywhere, but are particularly crucial in traditional rural communities. Local perceptions of what constitutes optimal infant feeding practices may differ greatly from international recommendations. Globally, prelacteal feeding is a common practice which includes giving the infant various liquids as well as

water, prior to initiation of breastfeeding (Morse *et al.,* 1990) and continuing throughout the duration of the breastfeeding period.

Davies (1997), in a recent study on socio−cultural factors and the promotion of exclusive breastfeeding in rural communities, concluded that exclusive breastfeeding totally lacked credibility among the locals, with even health workers not believing that it was possible or feasible. Therefore promotion of optimal breastfeeding practices, including exclusive breastfeeding, cannot be successful if the cultural barrier is not adequately addressed.

Exclusive breastfeeding for up to six months requires the mother and her infant to be in close proximity for this period and to use expressed breastmilk for separation of short duration. However, practicing exclusive breastfeeding may be perceived as being non−compatible with working outside of the home, thus creating an economical barrier. This includes mothers working both in the formal and informal sector (Isaton,1998).

This notion may be viewed from two angles. Firstly, from that of the employer, including governments, who may wrongly perceive that the provision of adequate maternity leave, breastfeeding breaks and crèches at the work place would result in losses rather than profits. Secondly, from that of the mother, who may believe that practicing exclusive breastfeeding would limit the time she has for other activities − especially income generating activities.

A sick infant results in a worried mother, which in turn may result in a less productive mother. Absenteeism from work due to a sick infant may have more economical consequences than adequate maternity protection measures for optimal breastfeeding.

The lack of social support systems at the household and community levels is also a barrier to optimal breastfeeding. Mothers require an enabling environment if they are to practice optimal breastfeeding and this can only be possible with full support at both the household and the community levels. The issues to be addressed include the workload of the pregnant and lactating woman, among others (Isaton,1998).

National policies on breastfeeding are important for the promotion and support of breastfeeding at all levels. The lack of political commitment to breastfeeding promotion and support may probably be due to ignorance of its many benefits for the individual (mother and infant), household, community and the nation. Governments have still to understand the health, social and economic benefits of breastfeeding.

In light of all the barriers outlined above, how can we successfully get mothers to practice optimal breastfeeding including exclusive breastfeeding? The baby friendly initiative (BFI) is still the answer which outline the following ten steps to successful breastfeeding WHO and UNICEF (2009):

- Have a written breastfeeding policy that is routinely communicated to all healthcare staff
- Train all healthcare staff in skills necessary to implement this policy
- Inform all pregnant women about the benefits and management of breastfeeding
- Help mothers initiate breastfeeding within half an hour of birth
- Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants
- Give newborn infants no food or drink other than breastmilk unless medically indicated
- Practice "rooming-in"-allow mother and baby to remain together 24 hours a day

- Encourage breastfeeding on demand
- Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants
- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

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