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Prevalence and Coping Strategies for Maintaining Exclusive Breastfeeding among Female Bankers in Kwara State

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Abstract

Background: Exclusive breastfeeding (EBF) is essential for infant health and development, yet many working mothers face challenges in maintaining the practice. **Objectives:** This study assessed the coping strategies adopted to uphold EBF among female bankers in Kwara State, Nigeria. Specifically, it assessed the prevalence of EBF and the association between key socio-demographic variables and coping strategies identified. **Methodology:** A descriptive survey research design was employed. The target population included female bankers aged 18–40 years who had breastfed for at least six months and had children aged 6 months to 2 years. Using Yamane's formula, a sample size of 255 was determined. Data were analysed using descriptive statistics, and inferential statistics were tested at the 0.05 significance level. **Results:** A total of 163 (68%) upheld EBF for the first six months out of the 240 respondents sampled. Coping strategies adopted included personal planning, support from family, peers, and workplace 'buddies'. Institutional supports were notably lacking. No significant associations were found between coping strategies and age ($F = 0.575$, $p>0.05$), religion ($t = 1.001$, $p>0.05$), family size ($F = 0.481$, $p > 0.05$), or job position ($F = 0.334$, $p > 0.05$). **Conclusion/ Recommendations:** Participants largely relied on non-institutional strategies to sustain EBF, with workplace-related support being insufficient. It was recommended that employers and policymakers implement structured breastfeeding-friendly policies, including lactation spaces, flexible schedules, and extended maternity leave, to enhance EBF adherence.

Keywords: Infant health, coping strategies, female bankers, workplace buddies, working mothers

Introduction

Breastfeeding involves providing an infant with breast milk, either directly from the breast or through expressed milk. The World Health Organisation (WHO) (2021) recommends initiating breastfeeding within the first hour of a newborn's life and continuing it on demand, as frequently and for as long as the infant desires. The WHO further advises that infants should be exclusively breastfed for the first 6 months and continue breastfeeding while introducing appropriate complementary foods for at least 2 years and beyond. Globally, only 38% of mothers exclusively breastfeed their infants for the first six months, while 58% continue breastfeeding until the child is 2 years old or older (WHO, 2021). Giglia (2014) opined that while any level of breastfeeding offers numerous health benefits for both mother and infant, Exclusive Breastfeeding (EBF) provides greater advantages than partial breastfeeding during the first 6 months of life, particularly in preventing gastrointestinal and respiratory infections (Victora *et al*., 2016), as well as supporting immune system development and cognitive function. Additionally, evidence supports

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that extending EBF up to 6 months results in even greater health benefits (Chowdhury *et al.*, 2015). According to Khan *et al.* (2015), supplementing with other foods or drinks affects milk production and is associated with a shorter duration of breastfeeding, including EBF.

Research indicates that EBF is linked to a reduced risk of chronic diseases later in life, such as obesity, diabetes, and certain allergies (Grummer-Strawn *et al.,* 2016). The authors additionally reported that breastfeeding is ecologically sustainable, requiring no production or transportation, and is economically advantageous for families, providing a cost-effective way to ensure the health of newborns, especially in resource-limited areas. Skin-to-skin contact during breastfeeding enhances maternal milk production, including colostrum, which serves as the infant's first vaccine due to its high concentration of antibodies and nutrients (Chowdhury *et al.*, 2015).

In terms of global breastfeeding practices, Eastern and Southern Africa have the highest rates of breastfeeding within the first hour post-birth, at 66%, while East Asia and the Pacific have the lowest rates, at 32% (WHO, 2020). In Nigeria, the 2018 Demographic and Health Survey revealed that only 29% of infants were exclusively breastfed for the first six months, showing a troubling 71% shortfall in achieving this critical practice. Although this rate increased from 17% in 2013 to the 29% in 2018, the widespread deprivation of breastfeeding benefits in populous African countries remains a significant concern, necessitating robust advocacy and intervention (NPC, 2019).

Despite the well-documented benefits of EBF, the World Health Organisation (WHO) estimates that approximately 78 million infants, or three out of every five newborns, do not begin breastfeeding within the first hour of birth (WHO, 2021). This delay increases their risk of mortality and illness and diminishes the likelihood of continued breastfeeding. Such delays, even if only a few hours, can have severe and life-threatening consequences, especially in low- and middle-income countries such as Nigeria (WHO, 2021).

Reports shows that the practice of EBF is influenced by varying levels of experience, shaping decisions and strategies related to breastfeeding management (Agyekum *et al.*, 2022). Personal experiences and interactions with institutional factors play a significant role in this practice. It is essential that working mothers receive adequate support to successfully navigate breastfeeding. The Centers for Disease Control and Prevention (CDC) outlines developing corporate policies for breastfeeding support, educating employees about breastfeeding, providing designated private spaces for milk expression, allowing flexible work schedules, offering extended maternity leave, providing on-site or near-site childcare, and ensuring access to lactation management services as ways employers can support mothers (Zhou *et al.*, 2024).

In addition to institutional support, family members are crucial in assisting breastfeeding mothers. Partners, in particular, play a significant role in breastfeeding decisions. Research indicates that educating fathers about lactation can significantly increase EBF rates and reduce complications (Zhou *et al.*, 2024). Paternal support, including emotional backing, responsiveness to needs, assistance with household tasks, and support through challenges, improves maternal attitudes and knowledge about breastfeeding (Zhou *et al.*, 2024). Family members, such as grandparents, also influence lactation choices and serve as role models. A study on low-income African American women found that those who initiated breastfeeding were more likely to have a breastfeeding mother, were breastfed themselves, or had a relative who breastfed (Gyamfi *et al.*, 2020).

Coping strategies refer to how individuals manage stressors. According to the Federal Ministry of Women Affairs and Social Welfare (2008), women make up approximately 43% of the workforce in Nigerian banks. It is striking to consider how these women manage the high stress levels associated with banking tasks. New mothers face various pressures, both physical and emotional, including time constraints due to the extensive care and attention required for their children. The additional responsibilities of having more family members can

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lead to a lack of time for other activities. Financial concerns related to childcare, clothing, and other necessities can also add to the stress. Mothers may prioritize their relationship with their infants, often neglecting other relationships, particularly with their partners. Lactating mothers frequently encounter conflicts between meeting their infant's needs and maintaining their relationship with their partner (Asare *et al.,* 2018).

A study carried out to assess the coping strategies of nursing mothers in the banking sector reported[14] that annual leave and receiving assistance from colleagues are among the most common coping strategies used by nursing mothers in the banking sector. It was further noted that mothers with more children may encounter increased difficulty in maintaining EBF while managing work and household responsibilities (Osibogun *et al.*, 2018).

Empirical evidence suggests that institutional interventions are effective in extending the duration of breastfeeding and reducing the early introduction of breast milk alternatives. Key interventions to promote breastfeeding include providing designated breastfeeding areas, allowing time for milk expression, maternity policies and implementing supportive organisational policies (Ibekwe *et al.*, 2022). The experiences of employed women who were breastfeeding, or who had recently given birth, were reviewed, and the importance of dedicated breastfeeding areas and colleague support was highlighted (Castlebon *et al*., 2020). However, the provision of breast pumps and remote work options were less frequently implemented. Despite these recommendations, women in the banking sector often face challenges in breastfeeding due to demanding work schedules and inflexible hours.

Returning to work after a 12-week maternity leave requires significant adjustment, particularly for mothers wishing to continue breastfeeding. Balancing the responsibilities of breastfeeding and job duties can be challenging, potentially leading to stress if a mother cannot effectively manage this balance. Effective coping skills can enhance well-being and productivity (Anibijuwon *et al.*, 2020; Vilar-Compte *et al.*, 2021). Hence, this study explored the coping strategies adopted to uphold exclusive breastfeeding among female bankers in Kwara State by assessing the prevalence of EBF and coping strategies adopted as well as an examination of the association between Socio-demographic variables and coping strategies adopted in upholding EBF among the female bankers studied.

Materials and Methods

This study adopted a descriptive survey research design to explore coping strategies for exclusive breastfeeding among female bankers in Kwara State, Nigeria. The target population comprised all breastfeeding bankers within the age range of 18–40 years working across banks in the state. A sample size of 255 was arrived at using Yamane's formula (1967) for sample size determination:

$$n=N1+N(e)2n = \frac{N}{1 + N(e)^2}n=1+N(e)2N \quad \text{----- (eqn 1)}$$

Where n = sample size, N = estimated population of breastfeeding female bankers in Kwara State (assumed to be 700 based on preliminary inquiries) and e = margin of error (0.05) n=255 Participants were selected based on clearly defined inclusion and exclusion criteria to ensure the relevance and accuracy of the findings. These criteria were essential in ensuring that the study focused on women with relevant and recent experiences of breastfeeding while managing the demands of a professional banking career. Purposive sampling was employed to select female bankers aged 18–40 years who have breastfed for more than 6 months (may or may not be currently breastfeeding). This inclusion criterion ensured that participants had been exposed to more than 6 months of breastfeeding experience. Hence, only mothers whose children were 7 months to 2 years old were included in the study. Specifically, those currently breastfeeding but had not done so up to 6 months were excluded.

Out of the 255 samples, 240 participants consented and completed the questionnaire, resulting in a 94.1% response rate. Official consents were

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obtained from the relevant authorities and bank management. The questionnaire was administered during banking hours in designated staff break rooms to avoid customer interruptions and ensure privacy. Data collected were analysed using descriptive statistics (frequency and percentages) and inferential statistics (t-test and ANOVA) to examine relationships between demographic variables and coping strategies adopted for exclusive breastfeeding practices. All analyses were conducted at a 0.05 level of significance.

Results

Table 1 shows that of 240 female bankers sampled for the study, 119 (50%) were under 30 years of age, 79 (33%) were within 30–35 years of age, and 42 (17%) were over 35 years of age. Additionally, 129 (54%) had 1–2 children, 72 (30%) had 3–4 children, and 39 (16%) had more than 4 children. Also, Muslims made up 137 (57%), and Christians were 103 (43%), while 69 (29%) were executives, 94 (39%) were juniors, and 77 (32%) were managers.

As shown in Table 2, all participants (240) were breastfeeding and had been breastfeeding for over 6 months. However, 163 (68%) of the respondents were able to maintain exclusive breastfeeding for the first 6 months recommended (i.e., breast milk alone without water or formula), while 77 (32%) were not. The prevalence of EBF was determined prior to the identification of coping strategies, which were defined as the proportion of respondents who fed their babies with only breast milk in the first 6 months of life. Hence, the prevalence of EBF among the female bankers studied was 68%. This thus limited the analysis of identifying the coping strategies to the 163 participants who upheld EBF (i.e. breast milk alone without water or formula for the first 6 months) and their coping strategies were subsequently identified as well. Subsequently, planning ahead (77.5%), family support (69.3%), peer support (47.9%), and workplace 'buddies' (38.7%) were coping strategies employed by female bankers in Kwara State to uphold EBF. None had institutional support in place as a coping strategy, even though participants employed multiple coping strategies.

Table 3 shows that there were statistically significant associations between coping strategies adopted to uphold EBF among the female bankers and their current age (having the F-value of 0.575^{a} obtained with a p-value of 0.750 which is greater than 0.05 alpha level); their religion (with the t-value of 1.001^{a} and a p-value of 0.317 being greater than 0.05 alpha level); family size (F-value= 0.481^{a}; $p>0.05$) and work positions (F-value = 0.334^{a}; $p>0.05$) in Kwara State.

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Table 1: Socio-demographic Characteristics of the Respondents (N = 240)

Variables	Frequency	Percentage
Age		
Under 30years	119	50
30–35years	79	33
over 35years	42	17
Family Size		
1–2 children	129	54
3–4 children	72	30
Above 4 children	39	16
Religion		
Christianity	103	43
Islam	137	57
Work Positions		
Executives	69	29
Managers	94	39
Junior	77	32

Table 2: Prevalence of exclusive breastfeeding and coping strategies among female bankers in Kwara State

Variables	Frequency	Percentage
Exclusive breastfeeding for the first 6 months (n=240)		
Yes	163	68
No	77	32
Total	240	100
Coping strategies adopted to uphold exclusive breastfeeding (n=163)		
Planning Ahead		
Yes	126	77.3
No	37	22.7
Family Support		
Yes	113	69.3
No	50	30.7
Peer Support		
Yes	78	47.9
No	85	52.1

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Workplace Buddies		
Yes	63	38.7
No	100	61.3
Institutional Support		
Yes	0	0
No	163	100

Note: Participants were identified to uphold multiple coping strategies

Table 3: Association between Socio -demographic variables and coping strategies adopted in upholding exclusive breastfeeding among female bankers in Kwara State

		Coping Strategies			Statistical Test and
Variables		N	Mean	S.D.	Values
Age	below 30yrs	82	13.12	1.12	F-value = 0.575[a]
	30 - 35yrs	58	12.27	1.16	p-value = 0.750
	above 35yrs	22	13.76	1.08	
	Total	163			
Religion	Islam	95	12.37	1.19	t-value = 1.001[a]
	Christianity	68	14.14	.98	p-value = 0.317
	Total	163			
Family	1 – 2	88	12.74	1.18	F-value = 0.481[a]
Size	3 – 4	45	13.27	1.28	p-value = 0.786
	Above 4	30	13.69	1.18	
	Total	163			
Work	Executive	40	14.09	.96	F-value = 2.225[a]
Positions	Manager	67	13.17	1.16	p-value = 0.324
	Junior	56	12.86	1.24	
	Total	163			

Statistically insignificant (p>0.05)

Discussion

The findings of this study revealed that female bankers in Kwara State breastfeed their children; however, 68% of them were able to exclusively breastfeed for the first 6 months, while 32% of them could not meet up. This outcome reflects broader trends observed in similar empirical studies. Exclusive breastfeeding for the first six months is a critical recommendation by the World Health Organization[1] for optimal infant health. However, sustaining exclusive breastfeeding, especially among working mothers, is often challenged by factors such as work demands, maternity leave policies, workplace support, and personal circumstances. This finding corroborates the study of Osaro *et al.* (2023) that reported a comparable prevalence rate of 61.5% among female workers; however, only 7.4% were able to continue breastfeeding beyond 6 months for up to a year. This result also aligns with the study of Ekanem *et al.* (2012) at reported that while 82.4% of female bankers intended to exclusively breastfeed, only 34.4% among them were able to maintain it for six months in Calabar, Nigeria.

Also, the findings of this study underscore the reliance of female bankers in Kwara State on personal strategies, such as planning ahead, and on social support systems, notably family and peer support, to sustain EBF. This reliance on personal and informal support networks, rather than

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institutional support, is consistent with earlier studies. Abukari *et al.* (2022) observed similar patterns among lactating health workers, where family and co-worker support were pivotal in managing breastfeeding alongside work responsibilities. The absence of institutional support, as identified in the study, often led to the premature cessation of EBF within a few months postpartum, a finding echoed in this study. Similarly, another study by Osibogun *et al.* (2018) reported that low rates of EBF among bankers were linked to insufficient support from institutional structures, emphasising the critical role that institutional policies play in sustaining breastfeeding practices. This finding aligns with broader literature indicating that inadequate institutional policies and support significantly contribute to the challenges faced by breastfeeding mothers (Victora *et al.* 2016). The absence of institutional support reinforces systemic barriers that hinder breastfeeding continuity. Despite global advocacy for breastfeeding-friendly workplaces**,** the banking sector in Nigeria appears to lag in implementing supportive policies.

However, the prominence of personal and social coping mechanisms found in the present study raises important questions. While these strategies are undoubtedly valuable, their predominance may reflect a systemic failure in institutional support. Institutional environments, particularly in sectors like banking, are often not conducive to breastfeeding, despite the well-documented benefits of EBF for both infants and mothers (Grummer-Strawn *et al.*, 2016; Victora *et al.*, 2016), as earlier highlighted Yet, the lack of institutional accommodations, such as designated breastfeeding areas or flexible working hours, continues to be a significant barrier, potentially undermining these health benefits.

Interestingly, demographic factors studied did not significantly influence coping strategies among respondents**,** suggesting that all breastfeeding mothers face similar challenges, primarily stemming from inadequate institutional support. This finding is consistent with a similar study by Brown (2017), which found that demographic variables had minimal impact on breastfeeding support strategies, further emphasising that the issue is less about individual characteristics and more about the need for systemic support. However, this conclusion could be critiqued for potentially overlooking the nuanced ways in which different demographic factors might interact with institutional policies and personal strategies. For example, while age and job-level might not significantly affect the adoption of coping strategies, they could influence the degree of stress or the particular challenges that mothers face, which our study might not have fully captured.

The lack of significant differences based on demographic factors also challenges some conventional assumptions. It suggests that, irrespective of personal characteristics, all breastfeeding mothers may face similar barriers, which primarily stem from inadequate institutional support. This finding aligns with broader research by Emmanuel (2015), indicating that institutional policies are often the most significant factor influencing breastfeeding practices among working mothers. However, some literature suggests that demographic factors, such as education level or socio-economic status, can influence breastfeeding outcomes NPC, 2019; Agyekum *et al.*, 2022), and these variables were not the primary focus of our study. This could be a limitation, as the intersection of these factors with institutional support might yield different insights.

Certain findings, however, negate the findings of this study in relation to the demographic factors used. A study by Vilar-Comte et al. (2021) reported that maternal confidence, influenced by factors such as maternal age, positively correlated and lent support to exclusive breastfeeding. Specifically**,** older mothers tended to cope with breastfeeding exclusively for a longer time. Another study by Rocha *et al.* (2018) also showed that maternal age significantly affected coping strategies employed by nursing mothers by reporting that individuals aged over 40 tended to

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use more emotion-focused coping compared to those aged 21–30 and 31-40 in coping with motherhood challenges, including breastfeeding.

Recent studies further contextualise these findings. According to Alshowkan *et al.* (2023), effective institutional support is crucial for enabling breastfeeding among working mothers, a position that aligns closely with our study's findings. However, they also note that the implementation of such support is often inconsistent, which may explain the continued reliance on personal and family support systems. Echoing these findings was a report by Binns *et al.* (2016) that, while family and peer support remain important, the lack of institutional interventions creates a gap that cannot be fully compensated by personal strategies alone. This resonates with the broader literature on the systemic barriers to breastfeeding, where the absence of comprehensive institutional policies is a recurring theme (Federal Ministry of Women Affairs, 2008; Agyekum *et al.* 2022). Nonetheless, it is also important to consider that other studies have found some success with informal support mechanisms, particularly in cultures where family and community play a strong role in childcare (Ibekwe *et al.*, 2022; Osaro *et al.*, 2023). This suggests that while Institutional support is critical, the effectiveness of personal and familial support should not be underestimated.

Conclusion

This study found that female bankers in Kwara State used planning ahead, family support, peer support, and workplace 'buddies' to sustain EBF, but not institutional support. No statistically significant difference was seen in female EBF coping techniques by age, religion, family size, or employment level. In conclusion, while this study affirms the critical role of family and peer support in sustaining EBF, it also highlights a significant gap in Institutional support, a gap that is well-documented in the literature (Binns *et al.*, 2016; Tomori *et al.*, 2022).

Recommendations

In addressing the conclusion gap, the following recommendations were made:

1. Employers in the banking sector should implement breastfeeding-friendly workplace policies, including flexible work schedules, provision of lactation rooms, and extended maternity leave to enable mothers to sustain exclusive breastfeeding (EBF).
2. Awareness programs should be targeted at partners and family members to strengthen support systems for working mothers in sustaining EBF.
3. Health educators and policymakers should intensify advocacy for the enforcement of national workplace breastfeeding policies, ensuring institutional structures support nursing mothers across all sectors.

Health promotion and education implications

1. The study has implications for policy development, as the findings highlight the urgent need for health educators and policymakers to advocate for breastfeeding-friendly workplace policies that can directly improve maternal and child health outcomes.
2. Behavioural change communication is also implicated, with tailored health education programs needed to emphasise the benefits of exclusive breastfeeding (EBF) and coping strategies, thereby encouraging both mothers and their support networks to sustain the practice.
3. Capacity building cannot be overemphasised, as training programs for health educators and counsellors should incorporate coping strategies and support mechanisms to empower mothers in balancing breastfeeding with work responsibilities.

Limitations of the study

1. The study focused only on female bankers in Kwara State, which may limit generalisation to other professions or regions.
2. The use of self-reported data may have introduced some biases, especially recall bias, where Mothers might not accurately recall their

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exact breastfeeding duration or the specific challenges faced.

3. The study design limits the ability to determine causal relationships between coping strategies and the successful practice of EBF. A longitudinal cohort study that allows the female bankers from childbirth up to 6 months postpartum to observe how exclusive breastfeeding practices change over time, and which coping strategies are effective, would have been richer and enabled the authors to establish temporal relationships (cause and effect)

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Ethical Approval

Permissions to carry out the study were sought from the management of selected banks. Informed consent was obtained from each participant, and confidentiality, privacy, and voluntary participation were strictly ensured throughout the study.

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Conflict of interest/declaration

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. All authors have confirmed that they have no conflict of interest to disclose.

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