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RESEARCH ARTICLE

Maternal Nutritional Knowledge, Social Support, and Breastfeeding Outcomes among Nursing Mothers in Ibadan, Oyo State Nigeria

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Abstract:

***Background*:** Maternal nutritional knowledge and social support are key determinants for breastfeeding outcomes in the rural and peri-urban settings.

The present study assessed maternal nutritional knowledge and social support and their relationship with breastfeeding outcomes of nursing mothers in Egbeda LGA, Ibadan, Nigeria.

***Methods*:** A cross-sectional study was conducted among 217 breastfeeding mothers with infants aged 0–24 months, recruited through multistage sampling from four primary health centres. Data were collected using a structured interviewer-administered questionnaire. Data were analyzed using SPSS version 25 with descriptive statistics and chi-square tests; significance was set at $p<0.05$.

***Results*:** Of the respondents, 27.7% had high nutritional knowledge, 52.7% moderate, and 19.6% low. Having a partner who encourages breastfeeding was common (44.2%), but less prevalent were practical support such as help with housework (36.9%) and cooking (42.9%). Child nutritional status showed a double burden: wasting affected 27.3%, overweight 13.9%, and stunting nearly one-third. Maternal knowledge was significantly associated with wasting ($\chi^2=11.000$; $p=0.008$). Household income and parity were strongly associated with maternal knowledge ($p<0.001$).

***Conclusion*:** Maternal nutritional knowledge alone does not guarantee optimal breastfeeding outcomes. Partner involvement, family support, and consistent health worker counselling are essential for sustaining exclusive breastfeeding and improving child health outcomes.

Keywords: Maternal nutritional knowledge, Social support, Child nutritional status.

1. INTRODUCTION

Breastfeeding is one of the most successful interventions for child survival and maternal health globally. The World Health Organization [1] advises exclusive breastfeeding (EBF) in the first six months of life with subsequent continuation of breastfeeding together with complementary foods until two years or later. Despite these guidelines, only 48% of babies globally are exclusively breastfed for six months, and lower prevalence is seen in numerous countries from low- and middle-income countries [1,2].

Nigeria continues to face significant challenges in this regard. In the country, only 29% of babies are exclusively breastfed, and the rates are even lower in the rural regions of the country, where the low educational level of mothers, lack of food, and cultural factors can threaten the best breastfeeding practice. The Infant Mortality Rate of rural Nigerian women is drastically high, that is, 70 out of every 1,000 live

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births, compared with urban areas where the rate was only 49 out of every 1,000 live births [3]. These findings suggest how crucial it would be to delve into knowledge and structural related determinants of breastfeeding practices among rural women.

The practice of breastfeeding is central to maternal knowledge about nutrition, involving knowledge regarding the nutritional needs of breastfeeding women, advantages from breast milk, and appropriate complementary feeding. Good knowledge among breast-feeding women is linked with adherence to EBF, identification of infant feeding signal cues, and avoidance of harmful practices [4,5]. However, in rural Nigerian environments, poor literacy, cultural myths, and inconsistent health education induce knowledge lacunae with long standing implications [6].

At the same time, breastfeeding outcomes depend on the availability of social support. Social support in this study was defined as the emotional, informational, and practical help given to breastfeeding mothers from a partner, relatives, health professionals, and community networks. Practical support by partners and family members, emotional support, and comprehensive counseling by health specialists improve the likelihood of maintaining exclusive breastfeeding [7]. On the other hand, inadequate support or overdependence on traditional advice may cause early stoppage of breastfeeding or inappropriate complementary feeding practices [8,9]. Existing studies mostly focused on urban moms or single determinants of breastfeeding and found little foundational evidence from peri-urban and rural areas from Nigeria. The current study seeks to provide explorative evidence on the inter-connection between maternal nutritional knowledge, social support, and baby outcomes in Egbeda Local Government Area and create ground for future longitudinal and intervention research.

2. MATERIALS AND METHODS

2.1. Study Design

A quantitative cross-sectional survey research design was utilized in examining the association between social support networks, maternal knowledge regarding nutritional matters, and breastfeeding outcomes among breastfeeding resident women in Egbeda Local Government Area (LGA), Ibadan Oyo State, Nigeria. The research design enables data to be collected from breastfeeding women at a single point in time, and this allowed the determination of descriptive patterns and relationships between infant nutrition status, characteristics of the mother, and support.

2.2. Study Setting

The study was conducted in Egbeda local government area (LGA), located on the outskirts of Ibadan, Oyo State. The LGA has an estimated population of 405,500 and a predominantly Yoruba ethnic composition, with minority representation from Igbo, Hausa, and other groups. The area includes both peri-urban and rural settlements and is served by eight functional primary health centres (PHCs): Erunmu, Alakia, Olode, Owobale, Egbeda, Monatan, Ajigbowo, and Gbaremu. These PHCs are the main points of antenatal, delivery, and postnatal services for local women and were therefore selected as sampling sites.

2.3. Study Population and Eligibility Criteria

The study population comprised breastfeeding mothers with infants aged 0–24 months who attended postnatal clinics at the selected PHCs during the study period. Eligible participants were those who had attended at least one postnatal care visit, were actively breastfeeding, and consented to participate voluntarily. Mothers who had ceased breastfeeding, those with infants outside the 0–24 month age range, or those with medical conditions that precluded breastfeeding were excluded.

2.4. Sample Size Determination

The minimum sample size was first estimated using Cochran's formula with $p = 0.29$(exclusive breastfeeding prevalence), $Z = 1.96$, and $e = 0.05$, yielding $n_0 = 316$. Because the accessible sampling frame comprised approximately 700 eligible breastfeeding mothers across the selected PHCs during the

study period, a finite population correction was applied $n = \frac{n_0}{1+\frac{(n_0-1)}{N}}$, giving an adjusted minimum of 217 participants. We adopted 217 as the target sample to accommodate nonresponse.

2.5. Sampling Procedure

A multistage sampling technique was applied. In the first stage, four PHCs (Olode, Alakia, Egbeda, and Gbaremu) were randomly selected from the eight in the LGA using a ballot method. In the second stage, proportionate stratified sampling was used to allocate participants across the four centres based on average clinic attendance records: Gbaremu (80), Alakia (67), Olode (35), and Egbeda (35). Within each PHC, systematic random sampling was used to select eligible breastfeeding mothers during postnatal clinic sessions until the allocated quota was achieved.

2.6. Data Collection Instruments

Data collection involved the use of a structured interviewer-administered questionnaire that attempted to capture the objectives of the study. The questionnaire had four sections:

The first section focused on the socio-demographic characteristics, i.e., age, education, occupation, parity, income, receipt of training in childcare and breastfeeding, and sources of information.

Maternal knowledge of nutrition was also measured by a modified version of a scale developed by Leshi *et al*. [10], which had 20 questions. Each question was scored according to the correct answer given by the mother, with a maximum of 20 points. To facilitate interpretation, total scores were categorized into three levels of knowledge based on percentage thresholds: low knowledge (0–6 points, ≤30%), moderate knowledge (7–13 points, 35–65%), and high knowledge (14–20 points, ≥70%). This classification enabled a structured evaluation of mothers' awareness of exclusive breastfeeding, maternal diet during lactation, benefits of breast milk, and appropriate complementary feeding practices.

Child nutritional status, measured through anthropometry: weight, length/height, and mid-upper arm circumference (MUAC). Measurements followed WHO Child Growth Standards protocols (2006) [11], and z-scores were generated for weight-for-height (WHZ), height-for-age (HAZ), and weight-for-age (WAZ). Even though exclusive breastfeeding is an important recommended practice, this study has adopted child anthropometric indicators as proxy outcome measures to measure the accumulation of the effects of child feeding and caring practices. Anthropometric measurements are important tools of measuring nutritional well-being, though they are influenced by many factors not related to breastfeeding.

The last section assessed social support for breastfeeding and childcare. It was measured using a structured adapted Likert Scale Questionnaire, with the response scale ranging from strongly disagree, associated with the score point of 1, and strongly agree, associated with the score point of 5. The tool measured support across various areas, namely, the involvement of the partner, the support of the family, and the support from the health worker counselors. In analysis, the responses were grouped into the following: namely, the use of the score point of 4 and 5 for agree and strongly agree, respectively, for the presence of support, and the use of the score point of 1 and 2, for strongly disagree and disagree, respectively, for the lack of support. In the analysis of the percentages, the use of the score point of 3 was considered in the non-agreement category.

2.7. Data Collection Procedure

Trained research assistants conducted data collection during routine postnatal clinic days at the four selected PHCs. After informed consent was obtained, the questionnaire was administered in Yoruba or English depending on the participant's preference. Anthropometric measurements were taken using calibrated equipment (SECA weighing scale and stadiometer; UNICEF MUAC tapes). Each measurement was taken twice, and the mean was recorded.

2.8. Data Analysis

Data were entered and analysed using the Statistical Package for Social Sciences (SPSS) version 25. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize

socio-demographic variables, maternal knowledge, social support indicators, and child nutritional status. Associations between categorical variables were tested using Chi-square analysis, with significance set at $p < 0.05$. Due to the exploratory nature of the study, most of the analyses were based on descriptive and bivariate statistical testing. No multivariable modelling was done in order to adjust for plausible confounding variables such as parity, maternal education, and socioeconomic status; such a feat is recommended for future research.

2.9. Ethical Considerations

In compliance with the principles of the Declaration of Helsinki, ethical approval for this study was obtained from the UNIOSUN Health Research Ethics Committee (UNIOSUNHREC) with reference number UNIOSUNHREC/2025/HND/036. Additional permission was granted by the relevant local health authorities in Ibadan. Permission to conduct the study was granted by the heads of the selected PHCs. All participants were informed of the study objectives, assured of confidentiality, and informed that participation was voluntary. Written or verbal consent was obtained prior to enrolment.

3. RESULTS

The cross-sectional design limits the ability to determine temporal relationships or causality between maternal knowledge, social support, and child nutritional outcomes. Observed associations should therefore be interpreted cautiously and may reflect complex bidirectional relationships.

3.1. Socio-Demographic Characteristics

Overall, the data indicated that most of the people were in their early productive or reproductive years, with the largest percentage of the population falling in the 20-29 age bracket at 40.1%, followed by the 30-39 age bracket at 29%. Moreover, the quality of education indicated that the majority of people had completed secondary education, at 43.8%, while very few had proceeded to further education at 18.4%, which is equivalent to one-fifth of the population. With regard to place of employment, the population reported various types of employment, starting from the unemployed at 27.6%, followed by homemakers at 19.4%, then artisans at 18%, followed by students at 17.9%, and finally those in paid employment at 17.1%. Most of the population fell in the category of Nigerians earning between 60,000 and 199,000, with 69.1%. Furthermore, most of the mothers had not received training in caring for infants and breastfeeding at 55.3%, yet the largest source of information on infant care and breastfeeding issues came from health workers at 51.6%. Additionally, there were questions on the number of children between the ages of 0 and 24. Most mothers had one (37.8%) or two (33.6%) children in that age range. About 27.6% had three, and a minimal 0.9% had four.

Only one in four mothers had high knowledge, highlighting persistent education gaps in Table **1**. For perceived support, receiving encouragement from the partner was common, but receiving support with household work, cookery/cleaning, was variable. Family encouragement and feeling comfortable breastfeeding in front of others lagged behind. The primary source of information continued to be health workers; nevertheless, under two out of five recalled receiving instruction from them on the benefits or receiving proper technique for breastfeeding from healthcare workers of PHCs (Table **2**), which may highlight variability in the quality or extent of services offered in different PHCs.

Table 1. Maternal Nutritional Knowledge of Breastfeeding Mothers (n = 217).

Knowledge Level	Frequency	%
Low	43	19.6
Moderate	114	52.7
High	60	27.7

Table 2. Selected EBFSS Items and Association with Maternal Nutritional Knowledge.

EBFSS item	% Agree	χ^2	p-value
Partner helps with housework	36.9	5.50	0.003
Help with cooking/cleaning	42.9	20.69	0.001
Partner encourages breastfeeding	44.2	9.65	0.029
Family assists with baby care	39.2	0.96	0.409
Health workers taught benefits	38.7	0.02	0.890

Note: χ^2 = Chi-square test statistic. $p < 0.05$.

Acute malnutrition (WHZ) was very prominent, 27.3% (moderate or severe), and another 13.9% were overweight, reflecting double burden. Stunting (HAZ) affected nearly one-third and underweight (WAZ) exceeded one-third as shown in Table **3**. These findings demonstrate the coexistence of a double burden of malnutrition alongside moderate maternal knowledge, suggesting that knowledge alone cannot always be sufficient in the presence of practical assistance and other structural burdens. Age, education, occupation, and formal training showed no significant association with knowledge as seen in Table **4**. Two variables did: household income, and number of children The observed income gradient may indicate variations in information and health service use. Higher parity was associated with more maternal knowledge, which may reflect experience in caring for children.

Table 3. Nutritional Status of Children (0–24 months) (n = 217).

Indicator	Category	Frequency	%
Weight-for-Height (WHZ)	Severe acute malnutrition (< -3 SD)	56	15.8
	Moderate acute malnutrition (-3 SD to < -2 SD)	25	11.5
	Normal (-2 SD to +2 SD)	106	58.8
	Overweight (> +2 SD to +3 SD)	30	13.9
Height-for-Age (HAZ)	Severe stunting (< -3 SD)	35	16.1
	Moderate stunting (-3 SD to < -2 SD)	32	14.8
	Normal (-2 SD to +2 SD)	150	69.1
Weight-for-Age (WAZ)	Severe underweight (< -3 SD)	31	14.3
	Moderate underweight (-3 SD to < -2 SD)	41	18.9
	Normal (-2 SD to +2 SD)	132	60.8
	Overweight (> +2 SD)	13	6.0

Table 4. Chi-Square Associations Between Sociodemographic Factors and Maternal Nutritional Knowledge (n = 217).

Factor	χ^2	p-value
Monthly household income	63.51	<0.001
Number of children (0–24 mo)	63.53	<0.001
Age	6.36	0.607
Education	2.16	0.905
Occupation	2.67	0.953
Formal training	0.06	0.972

Note: χ^2 = Chi-square statistic. $p < 0.05$.

Maternal knowledge was significantly associated with WHZ (χ^2=11.000; p=0.008), but not with HAZ (9=0.569) or WAZ (p=0.267). This pattern is coherent with the notion that knowledge can influence short-term feeding and illness-management practices (affecting wasting) more readily than the long-term structural determinants that shape chronic growth faltering (stunting) or accumulated weight deficits (underweight).

4. DISCUSSION

Maternal nutritional knowledge, social support, and breastfeeding outcome of nursing mothers in Egbeda Local Government, Ibadan. The socio-demographic profile of the respondents indicates that most of the mothers belonged to the 20–39-year reproductive age group, consistent with reports from South-West Nigeria [12]. Teenage and older mothers are relatively poorly represented, reflecting changing reproductive pattern and increasing awareness of maternal health services. Educational level varied and about 43.8% completed their secondary school, while close to about 15% had no formal education. This subset is usually very vulnerable considering the established pathway between maternal education and health-seeking behavior, breastfeeding adherence, and infant outcomes [13]. Occupational data indicated a preponderance of unemployed women and homemakers, which underlines dependence on public health services and limited economic empowerment, factors that have been linked to poorer maternal diet and reduced child health outcome [14]. Monthly family income falls within the category of ₦60,000–₦199,000, and it has a significant association with maternal knowledge, which corroborates findings that economic resources predict better dietary diversity and health literacy [15].

Generally, the level of nutritional knowledge that the mothers had was moderate at 52.7%, while nearly a fifth of the mothers had low knowledge of the subject. These findings are almost similar to the study that was done in Ogun State [16]. This may be attributed to the incomplete dissemination of information from the antenatal and postnatal interventions. The high levels of maternal knowledge may be attributed to the education of the mothers or repeated exposure to the information in the health system, but the fact that some mothers had low knowledge may be attributed to poor education levels of the mother, as seen in other low-resource situations [17].

Social support was also experienced unevenly. Although most mothers, i.e., 44.2%, reported being encouraged by their partners to breastfeed, only a smaller percentage benefited from the partners' support in either doing the housework or helping out in the kitchen. This finding is consistent with previous literature arguing that, although men in Nigeria support breastfeeding, they rarely support the practice by helping enable it [18]. Family support was also very poor, and most mothers were uncomfortable breastfeeding before people. This finding also supports previous literature on breastfeeding in the country, in which a cultural stigma was cited as a challenge in the practice of breastfeeding [9]. Significantly, this study has demonstrated that mothers whose partners supported them through home work, encouragement, and support in the kitchen might be the ones with the highest possible knowledge on nutrition, since previous studies demonstrated the correlation between support from home and the ability of women to interact effectively with health information and best practice recommendations for health benefits [19,20].

Child anthropometric results were of concern. Prevalence of wasting was high, standing at 27.3%, which exceeded national prevalence rates [21-22], therefore suggesting a nutrition crisis in the region. On the other hand, stunting prevalence of 30.9% was just below the national average; however, it remains high and has potential effects on child development [23]. Furthermore, the coexistence of wasting and overweight was noted to occur in 13.9% of cases, which is a double burden of malnutrition; this has been characterized by new trends of developing countries or economies in transition [24]. Knowledge was strongly linked to acute malnutrition; however, it was not linked to chronic malnutrition. This result shows that knowledge could be linked to what has been referred to as an immediate outcome; this has also been noted by Afolabi *et al*. [25].

The significant associations observed with parity, income, and partner support indicate that maternal knowledge is both socially and structurally mediated. Multiparous mothers may accumulate knowledge through repeated engagement with health facilities [26], while may influence the ability of mothers to

translate knowledge into feeding practices. These findings suggest that knowledge alone maybe insufficient: translation into improved outcomes requires enabling environments at both household and community levels.

CONCLUSION

This study contributes baseline information on the link between maternal nutrition knowledge, support, and breast-feeding outcome on nursing mothers in Egbeda Local Government Area in Ibadan, Nigeria. Although the mothers showed moderate knowledge, nutrient gaps existed, and nutritional outcome showed the double burden of the disease. Significant associations were found between income, parity, and the support of the partner and knowledge, indicating the social and structural factors of breast-feeding.

Given the cross-sectional design and reliance on bivariate analysis, these findings are exploratory and should be interpreted as hypothesis-generating rather than causal. In addition to this, participants were sampled from mothers attending Primary Health Care facilities. Such sampling might have led to selection bias since not all mothers might use facility-based postnatal care. Therefore, results might not be generalized to every breastfeeding mother in society and other similar settings. However, the findings highlights the importance of strengthening male partner involvement, family support, and regular health worker counseling has to go hand in hand with maternal education. Longitudinal and multivariable studies in the future are needed to confirm these associations in informing the design of gender-inclusive community-based interventions for improving maternal and child health.

AUTHORS' CONTRIBUTIONS

The author confirms sole responsibility for the following: study conception and design, data collection, analysis and interpretation of results, and manuscript preparation.

CONSENT FOR PUBLICATION

Not applicable.

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None.

CONFLICT OF INTEREST

The authors declare that they have no conflict of interest related to this study. The research was conducted independently, without financial or personal relationships that could have influenced the work reported in this paper.

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REFERENCES

[1] World Health Organization. *Infant and young child feeding*. Geneva: WHO; 2021. Available from: https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding

[2] UNICEF. *Breastfeeding: a mother's gift for every child*. New York: UNICEF; 2023. Available from: https://www.unicef.org/reports/breastfeeding

[3] National Population Commission (NPC) [Nigeria], ICF. *Nigeria Demographic and Health Survey 2023: Key Indicators Report*. Abuja (Nigeria), Rockville (USA): NPC and ICF International; 2023. Available from: https://dhsprogram.com/pubs/pdf/PR145/PR145.pdf

[4] Adedokun BO, Yusuf TM. Maternal education and breastfeeding practices in Nigeria: A multilevel analysis. Afr J Reprod Health. 2020;24(1):45–54. doi:10.29063/ajrh2020/v24i1.5

[5] Akinola RA, Ogundele OO, Ojo OE. Education and breastfeeding among Nigerian mothers: An analysis of the 2018 DHS. BMC Public Health. 2021;21(1):1134. doi:10.1186/s12889-021-11134-w

[6] Onasanya BJ, Ibekwe PU. Misconceptions and knowledge gaps on breastfeeding among rural mothers in Nigeria: A qualitative study. Pan Afr Med J. 2023;44:101. doi:10.11604/pamj.2023.44.101.29735

[7] Alidadi-Shamsabadi E, Savabi-Esfahani M. The relationship between maternal perception of social support and breastfeeding patterns. J Educ Health Promot. 2022;11:30. doi:10.4103/jehp.jehp_1467_20

[8] Elahidoust M, Nabavi SH, Gharibi F. The role of social support in exclusive breastfeeding: A qualitative study among working mothers. Iran J Nurs Midwifery Res. 2021;26(5):418–24. doi:10.4103/ijnmr.IJNMR_209_20

[9] Odeniyi AO, Embleton N, Ngongalah L, Akor W, Rankin J. Breastfeeding beliefs and experiences of African immigrant mothers in high-income countries: A systematic review. Matern Child Nutr. 2020;16(3):e12970. doi:10.1111/mcn.12970

[10] Leshi O, Samuel FO, Ajakaye MO. Breastfeeding knowledge, attitude and intention among female young adults in Ibadan, Nigeria. Open J Nurs. 2016;6(1):11–21. doi:10.4236/ojn.2016.61002

[11] World Health Organization. *WHO Child Growth Standards: Length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age: Methods and development*. Geneva: WHO; 2006. Available from: https://www.who.int/publications/i/item/924154693X

[12] Abdelsamiea OM, Khamis MA, Ibrahim WH. Awareness and attitudes of child-bearing postpartum women regarding Billing ovulation family planning method. Assiut Sci Nurs J. 2023;11(40):294–307. doi:10.21608/asnj.2024.239839.1684

[13] Olufunlayo TF, Roberts AA, MacArthur C, Thomas N, Odeyemi KA, Price M, *et al*. Improving exclusive breastfeeding in low- and middle-income countries: A systematic review. Matern Child Nutr. 2019;15(3):e12788. doi:10.1111/mcn.12788

[14] Clark S, Kabiru CW, Laszlo S, Muthuri S. The impact of childcare on poor urban women's economic empowerment in Africa. Demography. 2019;56(4):1247–72. doi:10.1007/s13524-019-00793-3

[15] Ukonu IC, Wallace CA, Lowe NM. Household food security and dietary diversity in south-eastern Nigeria. Matern Child Nutr. 2024;20(3):e13599. doi:10.1111/mcn.13599

[16] Adetula OA, Johnson AT. Maternal nutritional knowledge, feeding practices and nutritional status of infants (0–24 months) in Ilaro, Ogun State. Int J Food Sci Nutr. 2021;6(1):74–79.

[17] Rakotomanana H, Hildebrand D, Gates GE, Thomas DG, Fawbush F, Stoecker BJ. Maternal knowledge, attitudes, and practices of complementary feeding and child undernutrition in the Vakinankaratra Region of Madagascar: A mixed-methods study. Curr Dev Nutr. 2020;4(11):nzaa162. doi:10.1093/cdn/nzaa162

[18] Sholeye O, Otenaike P, Runsewe-Abiodun T. Male involvement in breastfeeding promotion and protection: An assessment of male undergraduates' views in Sagamu, southwest Nigeria. Babcock Univ Med J. 2021;4(1):45–53. doi:10.38029/bumj.v4i1.72

[19] Abageda M, Jena BH, Belachew T. Effectiveness of male partner-targeted breastfeeding education and support interventions on mothers' breastfeeding self-efficacy in central Ethiopia: A cluster-randomized controlled trial. Sci Rep. 2024;14(1):18563. doi:10.1038/s41598-024-68032-3

[20] Bimpong KA, Cheyuo EKE, Abdul-Mumin A, Ayanore MA, Kubuga CK, Mogre V. Mothers' knowledge and attitudes regarding child feeding recommendations, complementary feeding practices and determinants of adequate diet. BMC Nutr. 2020;6:67. doi:10.1186/s40795-020-00393-0

[21] UNICEF. *Nigeria equity profile: nutrition*. Abuja: UNICEF Nigeria; 2016. Available from: https://www.unicef.org/nigeria/media/1646/file/Nigeria-equity-profile-nutrition.pdf

[22] Olorunfemi AE, Omowunmi AT, James MJ, Kolawole SO, Adeol EA. Prevalence and determinants of stunting and wasting among under-5 children in Lagos State, Southwestern Nigeria. J Clin Images Med Case Rep. 2024;5(2):2859. doi:10.52768/2766-7820/2859

[23] Ezeh OK, Abir T, Zainol NR, Al Mamun A, Milton AH, Haque MR, *et al*. Trends of stunting prevalence and its associated factors among Nigerian children aged 0–59 months residing in northern Nigeria, 2008–2018. Nutrients. 2021;13(12):4312. doi:10.3390/nu13124312

[24] Alaba OA, Chiwire P, Siya A, Saliu OA, Nhakaniso K, Nzeribe E, *et al*. Socio-economic inequalities in the double burden of malnutrition among under-five children: Evidence from 10 selected sub-Saharan African countries. Int J Environ Res Public Health. 2023;20(8):5489. doi:10.3390/ijerph20085489

[25] Afolabi KA, Afolabi AO, Omishakin MYJ. Complementary feeding and associated factors: Assessing compliance with recommended guidelines among postpartum mothers in Nigeria. Popul Med. 2021;3:1–11. doi:10.18332/popmed/138939

[26] Shittu F, King C, Rautiainen S, Iuliano A, Bakare AA, Colbourn T, *et al*. Exploring the feeding practices of mothers of under-five children and how household members influence exclusive breastfeeding in Jigawa State, Nigeria: A qualitative study. Glob Public Health. 2024;19(1):2426135. doi:10.1080/17441692.2024.2426135