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Midwives' Perspectives on Exclusive Breastfeeding Support in Umuahia North, Nigeria: A Qualitative Study

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Abstract:

➢ ***Background:***

Exclusive breastfeeding for the first six months of life lowers infant illness and death, yet uptake in Nigeria remains below global targets. Midwives are the health workers most consistently placed to counsel and support mothers on this practice, but their own perceptions and experiences of providing this support are rarely examined on their own terms, particularly across different tiers of care. This study explored how midwives working in primary and tertiary health facilities in Umuahia North Local Government Area, Abia State, perceive and experience their role in supporting exclusive breastfeeding.A qualitative descriptive design was used. Eight midwives working in antenatal, postnatal, immunisation and maternity units across two primary health centres and one tertiary hospital were purposively selected and interviewed using a semi-structured guide until no new information emerged. Interviews were audio-recorded, transcribed verbatim and analysed thematically. Two broad themes emerged, comprising five barrier subthemes and four facilitator subthemes. Under barriers, midwives described pressure from family members and cultural custom, the pull of paid work on new mothers, the emotional strain mothers carry after delivery, maternal misconceptions about the adequacy of breast milk, and thin staffing with heavy caseloads. Under facilitators, midwives pointed to their own continuous reassurance and follow-up, stronger maternity-leave and workplace policies, structured antenatal and postnatal counselling, and encouragement from husbands and relatives. Midwives in this setting see themselves as central to exclusive breastfeeding promotion but describe their effectiveness as bounded by staffing levels, time, and the social pressures mothers face outside the clinic. Strengthening staffing, in-service training and family-inclusive counselling could improve breastfeeding support at both levels of care.

Keywords: *Exclusive Breastfeeding; Midwives; Breastfeeding Support; Qualitative Study; Primary Health Care; Nigeria.*

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I. INTRODUCTION

Feeding an infant on breast milk alone for the first six months of life, without water, other liquids or solid food, is the standard the World Health Organization and the United Nations Children's Fund hold up as the safest way to nourish a newborn (WHO, 2023). The case for it is not in dispute: infants fed this way suffer fewer diarrhoeal and respiratory illnesses, and mothers who breastfeed exclusively recover faster after delivery and carry a lower long-term risk of certain cancers (Rollins et al., 2023; WHO, 2023). Despite this evidence, global uptake sits at roughly 48%, still short of the 50% target set for 2025 (WHO & UNICEF, 2023).

Nigeria mirrors this shortfall. National prevalence rose only modestly, from 29% in 2018 to about 34% in the most recent Demographic and Health Survey (National Population Commission [NPC] & ICF, 2019, 2024), and Abia State sits below even that modest national figure. Explanations offered in the literature cluster around a familiar set of forces: early return to paid work, the belief that breast milk alone will not satisfy a hungry baby, pressure from older relatives to introduce water or herbal preparations, and gaps in the counselling mother receive from the health system (Adebayo et al., 2020; Kinshella et al., 2021; Seabela et al., 2023).

Midwives sit at the centre of this last factor. They are usually the first, and often the most consistent, professional

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contact a mother has across pregnancy, delivery and the weeks after birth, and their counselling, demonstrations and reassurance shape whether a mother begins and continues exclusive breastfeeding (Dwiyanti,et al, 2019). Yet much of what is known about midwives' contribution comes from studies that measure mothers' outcomes and treat the midwife as background, or that combine mothers' and midwives' accounts into one dataset without separating out what midwives themselves make of the work (Alabrah, et al, 2023). Fewer studies ask midwives directly, in their own words, what helps and what gets in the way, and fewer still do so across more than one tier of the health system at once.

This gap matters because primary health centres and tertiary hospitals differ in patient volume, staffing ratios and the resources available for counselling, so a midwife's experience of supporting breastfeeding may not look the same in both settings. In South-East Nigeria specifically, and in Abia State in particular, this angle has received little dedicated attention. Amat Camacho et al. (2023) examined health workers' perceptions in a humanitarian setting in North-East Nigeria, and Alabrah et al. (2023) studied a single general hospital, but neither compared tiers of care within one local government area, and neither focused on midwives as a standalone group.

This study addresses that gap. It asks: how do midwives working in primary and tertiary health facilities in Umuahia North Local Government Area, Abia State, perceive and experience their role in supporting exclusive breastfeeding, and what do they identify as the main barriers and facilitators to providing that support effectively?

II. METHODS

➢ *Study Design*

This paper reports the qualitative arm of a larger convergent mixed-methods study on exclusive breastfeeding in Umuahia North Local Government Area. A qualitative descriptive design was chosen for this component because the goal was to capture, in midwives' own language, what shapes their day-to-day support for breastfeeding mothers, rather than to test a predefined hypothesis.

➢ *Setting*

The study was conducted in Umuahia North Local Government Area, Abia State, in South-East Nigeria. Three health facilities with high maternal and child health attendance were purposively chosen to capture both levels of care available to mothers in the area: Adelabu Primary Health Centre, World Bank Primary Health Centre, and the Federal Medical Centre, Umuahia, which served as the tertiary-level site.

➢ *Study Population and Sampling*

The population of interest was registered midwives providing antenatal, delivery, postnatal or child-welfare services in the three facilities, of whom roughly 45 were in post across the sites at the time of the study. Purposive sampling was used to select midwives who worked directly in antenatal, postnatal, immunisation or maternity units, since these are the points of contact where breastfeeding counselling is most likely to occur. Midwives were eligible if they had worked in their facility for at least six months and consented voluntarily; student midwives, interns and staff not directly involved in maternal or child health services were excluded.

Sample size was guided by the principle of data saturation rather than a fixed statistical target. Interviews continued until successive transcripts stopped producing new codes or subthemes, which occurred after the eighth interview. This number sits within the range that qualitative methods literature considers adequate for a relatively homogeneous group of participants responding to a tightly focused topic guide (Guest,et al 2006), and is consistent with Malterud,et al (2016) argument that a narrow study aim, a knowledgeable and specific participant group, and a theory-informed analysis together lower the number of interviews needed to reach adequate information power.

➢ *Recruitment and Interviewer Characteristics*

Eligible midwives were identified with the assistance of the heads of the antenatal, postnatal, immunisation and maternity units in each facility, who introduced the study to staff meeting the inclusion criteria. Interested midwives then contacted the lead researcher directly to arrange a convenient time. All interviews were conducted by the lead researcher (NMC), a postgraduate nursing student trained in qualitative interviewing through the ACE-PUTOR postgraduate research methods programme. The researcher was not a staff member of any of the three study facilities and had no prior clinical or supervisory relationship with any participant; she was introduced to participants only in her capacity as a researcher, and this was stated explicitly before consent was obtained. Interviews were conducted in English, which is the language of clinical documentation, in-service training and inter-professional communication in Nigerian health facilities, and no participant requested a different language. The parent study did not maintain a separate log of midwives who were approached but declined to participate; this is noted below as a limitation of the reporting rather than an indication that no refusals occurred.

➢ *Data Collection*

Data were collected using a semi-structured interview guide developed around five areas: midwives' general understanding of exclusive breastfeeding, their experience of promoting it, the barriers they encounter, the factors that make their work easier, and their recommendations for improving practice in the study area. The guide was reviewed by the research supervisors for face and content relevance before use and was not formally piloted with a separate midwife sample. Interviews were conducted face-to-face in a private room within each facility, at a time and location convenient to each participant, audio-recorded with permission, and supplemented with brief field notes capturing non-verbal observations and contextual detail. Each interview lasted approximately 30 to 45 minutes. No repeat interviews were conducted.

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26jul327

➢ *Data Analysis*

Audio recordings were transcribed verbatim by the lead researcher within one week of each interview. Transcripts were not returned to participants for member checking, and this is acknowledged as a limitation. Analysis followed the six-step thematic analysis approach described by Braun and Clarke (2006): familiarisation with the data through repeated reading; generation of initial codes; searching for candidate themes by collating codes with shared meaning; reviewing themes against the coded extracts and the full dataset; defining and naming themes; and producing the final narrative. Coding was carried out manually, using a coding table constructed in a word-processing document rather than qualitative data analysis software, given the modest dataset size. Coding was performed by the lead researcher; a second member of the supervisory team (FD) independently reviewed a sample of transcripts and the coding table, and discrepancies in coding and theme labelling were resolved by discussion until agreement was reached. This process, together with regular debriefing meetings with both supervisors across the analysis period, served as the primary peer-debriefing and dependability check for the study, though a full independent double-coding of all eight transcripts was not undertaken.

➢ *Trustworthiness*

Trustworthiness was addressed using Lincoln and Guba's criteria of credibility, dependability, confirmability and transferability. Credibility was supported through verbatim transcription, prolonged engagement during data collection (interviews continued until no new codes emerged), and debriefing with the supervisory team on the coding table and emerging themes. Dependability was supported by maintaining an audit trail consisting of the interview guide, raw transcripts, the coding table and successive versions of the theme structure, so that the analytic path from data to theme could be traced. Confirmability was supported by grounding every theme and subtheme in direct participant extracts rather than in the researcher's prior assumptions, and by the second reviewer's independent check of a transcript sample. Transferability is addressed through the thick description of the study setting, participant roles and facility context provided above, which allows readers to judge the relevance of the findings to their own context; the small, single-local-government sample means transferability should be judged cautiously. Formal member checking (returning themes to participants for confirmation) was not carried out and is identified as a limitation in the Discussion.

➢ *Ethical Considerations*

Ethical approval was granted by the Research Ethics Committee of the Africa Centre of Excellence for Public Health and Toxicological Research (ACE-PUTOR), University of Port Harcourt (approval number and by the Research Ethics Committee of the Federal Medical Centre, Umuahia with approval granted prior to data collection in 2025/2026. Written informed consent was obtained from every participant before the interview, after the purpose of the study, the voluntary nature of participation, and the right to withdraw at any stage without consequence were explained. Identification codes rather than names were used throughout data handling and reporting to protect confidentiality, and audio files and transcripts were stored on a password-protected device accessible only to the research team.

Reporting of this qualitative study was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong, Sainsbury & Craig, 2007), addressing domains covering the research team, study design, and analysis and findings, as reflected in the subsections above.

III. RESULTS

➢ *Participant Characteristics*

Eight midwives working across the three study facilities took part: staff drawn from antenatal, postnatal, immunisation and maternity units at Adelabu Primary Health Centre, World Bank Primary Health Centre and the Federal Medical Centre, Umuahia. These eight were purposively selected from the twenty midwives who had earlier completed the quantitative questionnaire; selection for interview was based on direct involvement in antenatal, postnatal, immunisation or maternity-unit care rather than on any other criterion. Interviews continued until the eighth participant, at which point no new codes were emerging from the data, indicating that saturation had been reached for the scope of this study. Table 1 summarises the demographic and professional characteristics of the eight interviewed midwives.

Table 1 Summary Characteristics of Midwife Participants (N = 8)

Characteristic	Category	n	%
Age (years)	25–34	2	25.0
	35–44	4	50.0
	≥45	2	25.0
Marital status	Married	7	87.5
	Single	1	12.5
Years of professional experience	1–5	2	25.0
	6–10	3	37.5
	>10	3	37.5
Highest educational qualification	RN/RM	3	37.5
	BNSc	4	50.0
	Postgraduate	1	12.5

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- Note. Percentages are calculated on the total sample of eight interviewed midwives. All participants were female.

➢ *Overview of Themes*

Analysis of the transcripts generated two broad themes: barriers midwives associate with supporting exclusive breastfeeding, and facilitators that midwives associate with successful support. Table 2 summarizes the themes and subthemes, and the narrative that follows presents each with a supporting quotation. Because the coding process combined transcripts from all three facilities rather than analysing each tier separately, the themes below represent perceptions shared across the study area as a whole; this is noted in the Discussion as a boundary of the present analysis.

Table 2 Overview of Qualitative Themes and Subthemes

Theme	Subthemes
Barriers to exclusive breastfeeding support (5 subthemes)	1. Sociocultural and family influence; 2. Work-related constraints; 3. Maternal stress and emotional strain; 4. Mothers' perception of insufficient breast milk; 5. Health-system constraints (staffing and workload)
Facilitators of exclusive breastfeeding support (4 subthemes)	1. Health-worker encouragement and follow-up; 2. Maternity-protection policies; 3. Antenatal and postnatal breastfeeding education; 4. Family and partner support

➢ *Theme 1: Barriers to Exclusive Breastfeeding Support*

- *Sociocultural and Family Influence*

Midwives frequently traced the early introduction of water or herbal preparations back to advice from grandmothers and mothers-in-law, whose views on infant feeding often carried more weight in the household than clinical counselling. Even mothers who intended to breastfeed exclusively described changing course once other relatives became involved:

"Many mothers want to practise exclusive breastfeeding, but once they get home, older family members discourage them and introduce water or herbal mixtures before six months." (MW2)

- *Work-Related Constraints*

Participants also linked early cessation to mothers' paid work. Short maternity leave, rigid schedules and the absence of breastfeeding-friendly arrangements at many workplaces were described as leaving mothers with little choice but to introduce formula once they resumed employment:

"Working mothers often tell us that their employers do not provide enough time or a suitable environment for breastfeeding or expressing milk, making exclusive breastfeeding difficult." (MW5)

- *Maternal Stress and Emotional Strain*

Midwives observed that mothers who were physically exhausted or emotionally unsupported in the days after delivery found it harder to establish and sustain a consistent feeding routine, regardless of how much counselling they had received antenatally:

"Mothers who are emotionally exhausted or lack support often lose confidence in breastfeeding and begin introducing other feeds much earlier than recommended." (MW4)

- *Mothers' Perception of Insufficient Breast Milk*

Participants described a recurring pattern in which mothers, faced with a crying infant, concluded that their milk was not enough and turned to water or other feeds well before six months:

"Many mothers complain that breast milk is not enough, especially when the baby cries often. Because of this, relatives advise them to introduce water or pap early." (MW3)

- *Health-System Constraints (Staffing and Workload)*

Staffing shortages and heavy caseloads were raised as a direct limit on the quality of counselling midwives could provide:

"Our workload is too much. Sometimes there are few midwives attending to many mothers, so adequate counselling becomes difficult." (MW6)

➢ *Theme 2: Facilitators of Exclusive Breastfeeding Support*

- *Health-Worker Encouragement and Follow-Up*

Repeated, personal contact across antenatal, postnatal and child-welfare visits was described as reinforcing mothers' confidence over time, more so than any single counselling session on its own:

"Regular counselling and follow-up help mothers overcome challenges. When we reassure them and provide practical support, they are more likely to continue exclusive breastfeeding." (MW1)

- *Maternity-Protection Policies*

Participants pointed to adequate maternity leave and breastfeeding-friendly workplace arrangements as necessary complements to clinical counselling, particularly for mothers who intended to return to paid work before six months:

"When employers provide adequate maternity leave and breastfeeding-friendly workplaces, mothers are better able to sustain exclusive breastfeeding for six months." (MW4)

- *Antenatal and Postnatal Breastfeeding Education*

Participants consistently pointed to structured counselling during antenatal and postnatal visits as the single most useful tool available to them:

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"Mothers who receive proper counselling during antenatal clinic are more confident and more likely to practise exclusive breastfeeding." (MW2)

- *Family and Partner Support*

Where husbands and family members actively backed a mother's decision to breastfeed exclusively, midwives noted that counselling was far more likely to translate into sustained practice:

"Support from husbands and family members helps mothers continue exclusive breastfeeding for longer periods." (MW5)

IV. DISCUSSION

This study set out to understand how midwives working across primary and tertiary facilities in Umuahia North Local Government Area perceive and experience their role in supporting exclusive breastfeeding. Two things stand out from the findings. First, midwives in this setting locate the main obstacles to breastfeeding not in mothers' lack of interest but in a mismatch between what mothers are told in the clinic and what they hear at home, at work, and from relatives. Second, midwives describe their own capacity to counsel effectively as constrained less by their own knowledge and more by staffing and time.

The finding that mothers' belief in insufficient milk supply drives early supplementation echoes a pattern reported widely across Nigeria and neighbouring countries. Amat Camacho et al. (2023), working with health workers and caregivers in a humanitarian setting in North-East Nigeria, similarly found that community misconceptions about milk adequacy and inherited newborn-feeding customs undercut breastfeeding messaging delivered in health facilities. The present findings extend this observation by showing that midwives themselves recognise the limits of one-off counselling against such deeply held beliefs, and several participants suggested that messaging aimed only at mothers, without engaging the wider family, is unlikely to hold.

The influence of grandmothers and mothers-in-law reported here aligns closely with Alabrah, et al (2023) study in a Nigerian general hospital, which found that breastfeeding decisions were rarely made by mothers alone. Taken together with the present findings, this suggests that breastfeeding counselling that stops at the mother's bedside is addressing only part of the decision-making unit, and that involving spouses and senior female relatives directly in antenatal education sessions, rather than treating them as an external barrier to be overcome, may be a more realistic strategy.

Staffing shortages and heavy workload emerged here as a limit on counselling quality, a finding that mirrors Alabrah et al.'s (2023) report that Nigerian midwives' ability to provide individualised breastfeeding support was constrained by staffing and competing clinical duties. It is also consistent with the broader conclusion reached by Wang,et al (2023) in their review of breastfeeding training programmes for midwives: training improves knowledge and counselling skill, but its effect on actual breastfeeding outcomes is modest unless the wider institutional environment, including staffing ratios and time available per patient, is also addressed. The present study did not find a clear difference between the tertiary facility and the two primary health centres on this point; midwives at both levels described staffing pressure, suggesting that this is a system-wide rather than facility-specific constraint in the study area.

Midwives' emphasis on continuous, repeated contact with mothers as more effective than a single counselling encounter is consistent with the findings of Bäckström et al. (2010), who reported that individualized and ongoing breastfeeding support from midwives strengthened mothers' confidence and breastfeeding experiences. The present findings similarly suggest that sustained support across the antenatal and postnatal continuum is more effective than isolated counselling sessions.. It also supports Nwokoro,et al (2023) observation, drawn from first-time mothers in Aba, Abia State, that respectful, consistent communication from nurses and midwives shaped how confident mothers felt about continuing to breastfeed. Read alongside the present findings, this points to continuity of contact, rather than the content of any single session, as the more important lever for practice.

The call from participants for stronger maternity-leave and workplace provisions reflects a consistent thread in the wider literature on working mothers and breastfeeding in Nigeria (Adeyanju, 2023) and situates the midwife's counselling role within limits that clinical practice alone cannot resolve. Midwives in this study appeared aware that even well-delivered counselling cannot substitute for the practical time and space a mother needs to sustain exclusive breastfeeding once she returns to paid work.

- *Implications for Policy, Midwifery Education and Global Breastfeeding Initiatives*

These findings carry practical implications beyond the study setting. For national policy, Nigeria's Infant and Young Child Feeding strategy and its workplace maternity provisions are unlikely to shift practice on their own if implementation at facility level remains under-resourced; the staffing pressure midwives described here suggests that policy commitments to breastfeeding promotion need to be matched with staffing establishments that allow time for individual counselling, not only with guideline documents. For midwifery education, the gap participants identified between formal knowledge and the practical work of persuading a sceptical grandmother or a mother anxious about milk supply suggests that pre-service and in-service curricula could usefully include structured practice in family-inclusive counselling and in responding to common misconceptions, rather than knowledge content alone. For global initiatives such as the Baby-Friendly Hospital Initiative, the findings suggest that the Ten Steps are necessary but not sufficient in settings where staffing ratios limit their delivery in practice; monitoring of BFHI implementation in similar low-resource facilities may need to track staff time available per mother alongside the presence of a written policy.

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26jul327

Several limitations should be considered. The sample of eight midwives, while consistent with recognised guidance on saturation for a narrowly focused qualitative study (Guest, et al, 2006; Malterud, et al 2016), reflects perspectives from across primary and tertiary facilities in Umuahia North rather than a formal comparison between the two tiers; coding was not stratified by facility type, and no such comparison is claimed. The study also relied on self-report, which may be shaped by participants' wish to present their professional role favourably, a risk that was not offset by triangulation with direct observation of counselling encounters. Formal member checking and full independent double-coding of all transcripts were not performed, which limits the confirmability of the analysis beyond what supervisory debriefing and partial independent review could provide. One quotation is presented per subtheme in this report; richer reporting, drawing on additional extracts from the original transcripts where a given subtheme is supported by more than one participant, would strengthen future work from this dataset. Finally, findings reflect one local government area in Abia State and may not transfer directly to other parts of Nigeria with different staffing levels or cultural norms around infant feeding.

These limitations point to useful next steps. A larger, purposively stratified sample could support a direct comparison of midwife experience by facility tier. Future work might also usefully pair midwife interviews with structured observation of counselling sessions, to compare what midwives report doing with what mothers actually receive, and could test whether family-inclusive antenatal sessions measurably improve exclusive breastfeeding continuation compared with mother-only counselling.

V. CONCLUSION

This study asked how midwives working in primary and tertiary health facilities in Umuahia North Local Government Area perceive and experience their role in supporting exclusive breastfeeding. Midwives described themselves as central to breastfeeding promotion but working within real constraints: mothers' belief in insufficient milk supply, competing advice from family members, mothers' return to paid work, thin staffing, and the emotional demands of the early postnatal period. Set against these, structured antenatal and postnatal counselling, family involvement, continuous follow-up, and stronger maternity-leave provisions were identified as the factors that make their work more effective.

The main contribution of this study is to give midwives' own account of this work independent standing, rather than folding it into mothers' accounts or national-level statistics. Its principal limitation is a sample too small to compare facility tiers formally. Strengthening staffing levels, building family-inclusive counselling into routine antenatal care, and improving workplace protections for breastfeeding mothers are the directions midwives in this study most consistently pointed toward, and each offers a concrete, testable target for future intervention research in this setting.

➢ *Author Contributions*

- Martins-Okonji N.C.: Conceptualization, Methodology, Investigation, Formal analysis, Writing – original draft. Diorgu F.: Supervision, Methodology, Validation, Writing – review & editing, independent coding review. Ogolo B.A.: Supervision, Validation, Writing – review & editing.

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➢ *Informed Consent Statement*

Informed consent was obtained from all participants involved in the study prior to data collection.

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- *Declaration of Conflict of Interest*

The authors declare no conflict of interest.

REFERENCES

[1]. Adebayo, O. O., Omolade, D. G., Kehinde, A. C., Folashade, S. F., & Chiemeka, N. C. (2020). Knowledge, practice and challenges of exclusive breastfeeding among working mothers attending antenatal clinic in Lagos University Teaching Hospital, Idi-Araba. Scientific Research Journal, 3(2), 45–74.

[2]. Adeyanju, C. A. (2023). Barriers and enablers to exclusive breastfeeding practices among women working in formal and informal sectors in Nigeria: A literature review [Master's thesis, Vrije Universiteit Amsterdam].

[3]. Alabrah, J. A., Diorgu, F. C., & Onasoga, O. (2023). Maternal experiences and midwives' perspectives on breastfeeding support in a general hospital setting: A qualitative study. Journal of Public Health and Toxicological Research, 1(1), 24–29

[4]. .Amat Camacho, N., Chara, A., Briskin, E., Pellecchia, U., Kyi, H. A., de Rubeis, M. L., Hussain, F., Ahmed, T., Ogundipe, O. F., Burzio, C., Kamis, U., Bukar, L. M., Von Schreeb, J., Kolokotroni, O., Della Corte, F., & Sunyoto, T. (2023). Promoting and supporting breastfeeding in a protracted emergency setting—Caregivers' and health workers' perceptions from North-East Nigeria. Frontiers in Public Health, 11, 1077068. https://doi.org/10.3389/fpubh.2023.1077068

[5]. Bäckström, C. A., Hertfelt Wahn, E. I., & Ekström, A. C. (2010). Two sides of breastfeeding support: Experiences of women and midwives. International

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26jul327

Breastfeeding Journal, 5, 20. https://doi.org/10.1186/1746-4358-5-20
[6]. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
[7]. Dwiyanti, N. K. N., Sari, K. A. K., & Duarsa, D. P. (2019). Exclusive breastfeeding: The role of midwives at pregnancy, childbirth and postpartum. Public Health and Preventive Medicine Archive, 7(2), 127–134.
[8]. Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. Field Methods, 18(1), 59–82.
[9]. Kinshella, M. O., Prasad, S., Hiwa, T., Vidler, M., Nyondo-Mipando, A. L., Dube, Q., Goldfarb, D., & Kawaza, K. (2021). Barriers and facilitators for early and exclusive breastfeeding in health facilities in Sub-Saharan Africa: A systematic review. Global Health Research and Policy, 6, 21.
[10]. Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. Qualitative Health Research, 26(13), 1753–1760.
[11]. National Population Commission (NPC) [Nigeria] & ICF. (2019). Nigeria demographic and health survey 2018. NPC and ICF.
[12]. National Population Commission (NPC) [Nigeria] & ICF. (2024). Nigeria demographic and health survey 2023/24: Key indicators report. NPC and ICF.
[13]. Nwokoro, R. O., & Akunneh-Wariso, N. B. (2023). First time mothers' perception and experience about breastfeeding support received from nurses in health facilities in Aba. International Journal of Nursing, Midwife and Health Related Cases, 9(2), 16–28.
[14]. Rollins, N. C., Piwoz, E. G., Baker, P., Kingston, G., Mabaso, K. M., McCoy, D., Neves, P. A. R., Pérez-Escamilla, R., Richter, L., Russ, K., Sen, G., Tomori, C., Victora, C. G., Zambrano, P., & Hastings, G. (2023). Marketing of commercial milk formula: A system to capture parents, communities, science, and policy. *The Lancet*, *401*(10375), 486–502
[15]. .Seabela, E. S., Modjadji, P., & Mokwena, K. E. (2023). Facilitators and barriers associated with breastfeeding among mothers attending primary healthcare facilities in Mpumalanga, South Africa. Frontiers in Nutrition, 10, 1062817.
[16]. Wang, T., Shang, M., & Chow, K. M. (2023). Effects of breastfeeding training programmes for midwives on breastfeeding outcomes: A systematic review and meta-analysis. BMC Pregnancy and Childbirth, 23, 262. https://doi.org/10.1186/s12884-023-05540-6
[17]. Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Sage Publications.
[18]. Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care, 19(6), 349–357. https://doi.org/10.1093/intqhc/mzm042
[19]. World Health Organization. (2023). Exclusive breastfeeding for optimal growth, development and health of infants.
[20]. World Health Organization, & United Nations Children's Fund.(2023) Global breastfeeding scorecard 2023: Rates of breastfeeding increase around the world through improved protection and support (WHO/HEP/NFS/23.17).