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Exclusive Breast Feeding Practices, Knowledge and Challenges amongst Mothers with Children 0-6 Months in the Bamenda II Municipality of the Northwest Region of Cameroon

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

The prevalence of exclusive breastfeeding (EBF) for the first six months of life remains low globally and in Cameroon, despite strong evidence supporting its benefits. This study aimed to assess the practice, knowledge, and challenges of exclusive breast feeding among mothers in the Bamenda II municipality of the Northwest Region of Cameroon. A cross-sectional study design was employed, involving 100 participants. Data were collected using a structured questionnaire covering sociodemographic characteristics, knowledge of exclusive breast feeding, level of practice, and potential barriers to its uptake. Results were analyzed using descriptive statistics and bivariate logistic regression, with significance set at $p<0.05$ at a 95% confidence level. Results showed that, 43% of participants practiced exclusive breast feeding for up to 6 months of life. 95% had heard about exclusive breast feeding, about 97% knew the effects of not Exclusively breast feeding. 83% had a good knowledge on exclusive breast feeding. Results also showed that single or divorced participants were 4times more likely (95% CI =1.3-12.5: P = 0.02) to breastfeed exclusively than married participants. Participants who were multipara, were 0.1time less likely (95%CI = 0.1-0.95: P = 0.045) to breastfeed compared to those who were Primipara. Participants who faced difficulties were 0.4times less likely (95%CI = 0.2-0.96: P = 0.04) to practice exclusive breast feeding compared to those that faced no difficulties. Those who had a good knowledge on exclusive breast feeding were 1.1 times (95%CI=0.4 – 3.2; P=0.86) more likely to practice EBF, but it was not significant. Also participants who lived in rural areas were 3.1 times (95% CI=1.6– 3.7; P=0.002) more likely to practice exclusive breast feeding compared to those that were from urban settings. Despite high levels of awareness and knowledge of exclusive breast feeding among participants, its practice was suboptimal, with only 43% adherence—well below WHO standards. To address this, facilities, programs, and reminder systems should be implemented to monitor and encourage exclusive breast feeding. Additionally, regular campaigns and educational programs should be organized to promote and sustain the practice.

Keywords: Exclusive breastfeeding; prevalence; mothers; knowledge; practice; Bamenda II Municipality.

1. INTRODUCTION

Breastfeeding, also known as nursing, involves feeding infants and young children with milk from their mother's breasts (WHO, 2014). Breastfeeding typically begins within the first hours of a baby's life and continues as often as the baby desires, as recommended by health professionals (American Academy, 2012). A breastfeeding session usually lasts 10–15 minutes per breast, and older children may feed less frequently. Mothers may pump milk for later use when breastfeeding is not feasible.

Exclusive breastfeeding refers to feeding an infant solely with breast milk, without any other liquids or solids, including water, except for oral rehydration solutions, drops, or syrups of vitamins, minerals, or medications (WHO, 2019). This practice is facilitated by breastfeeding on demand—whenever the child desires, day and night—without the use of bottles, teats, or pacifiers. Exclusive breastfeeding is the optimal method of feeding infants and should be complemented with solid foods after six months while continuing breastfeeding for up to two years or beyond. Exclusive breastfeeding significantly reduces infant mortality due to common childhood illnesses like diarrhea and pneumonia and aids in quicker recovery from illness (WHO, 2014).

Although breastfeeding is a natural act, it is also a learned behavior. Some mothers require active support to establish and sustain appropriate breastfeeding practices. To address this, WHO and UNICEF launched the Baby-Friendly Hospital Initiative (BFHI) in 1992 to strengthen maternity practices that promote breastfeeding. The BFHI is based on the Ten Steps to Successful Breastfeeding, which remain effective tools for supporting exclusive breastfeeding (WHO, n.d.).

An estimated 800,000 deaths of children under five could be prevented annually worldwide with increased breastfeeding, given its numerous benefits for both mother and child that infant formula lacks (Victora et al., 2016). For infants, breastfeeding reduces the risk of respiratory tract infections, diarrhea, asthma, food allergies, type 1 diabetes, leukemia, and obesity. It also

improves sensory and cognitive development in both developed and developing countries (American Academy, 2012; WHO, 2014). For mothers, breastfeeding reduces postpartum blood loss, improves uterine contraction, decreases postpartum depression, delays menstruation and fertility (lactational amenorrhea), and provides long-term health benefits such as reduced risks of breast cancer, cardiovascular diseases, and rheumatoid arthritis (Victora et al., 2016).

WHO recommends exclusive breastfeeding for the first six months of life, followed by continued breastfeeding alongside complementary foods. However, only about 38% of infants worldwide are exclusively breastfed during their first six months (WHO, 2014). Medical conditions that contraindicate breastfeeding are rare. Limited alcohol, caffeine consumption, or smoking are generally not reasons to avoid breastfeeding (CDC, 2016).

Children in developing countries are disproportionately affected by life-threatening diseases, poor healthcare, lack of potable water, malnutrition, poverty, and war. Promoting and supporting breastfeeding is vital to improving child survival rates, a goal requiring commitment from governments and medical institutions (Colen et al., 2014).

Despite efforts like the BFHI, poor breastfeeding practices remain prevalent in many African countries, leading to undernutrition, a major cause of over half of all child deaths (Sokol et al., 2007). This research aims to assess the prevalence and knowledge of exclusive breastfeeding, as well as identify factors hindering its adoption. The findings will inform interventions to improve exclusive breastfeeding rates, reduce infant mortality, and contribute to the growing body of knowledge on newborn feeding practices. Furthermore, this study will provide a foundation for future research and health interventions among mothers in the chosen locality.

2. METHODOLOGY

2.1 Study Design and Population

This study employed a descriptive cross-sectional design and included 100 mothers. The research was conducted in Mankon, located in Bamenda II Municipality in the Mezam Division of the North West Region of Cameroon. Communities and participants were randomly selected using stratified randomization method, with 50 women recruited from urban areas and 50 from rural areas, acknowledging that these environments might influence breastfeeding practices.

2.2 Study Site

The study was carried out in Mankon, in the Northwest Region of Cameroon. This region is situated in the mid-to-high altitude zone of the country, between latitudes 5º20' and 7º00' North and longitudes 9º40' and 11º10' East. Altitudes range from 300 to 3000 meters above sea level. The region experiences two distinct seasons: a rainy season from mid-March to mid-November and a dry season from mid-November to mid-April (MINEPIA, 2010). Annual rainfall ranges between 1300 and 3000 mm, with an average of 2000 mm. Daily temperatures range from a minimum of 15.5°C to a maximum of 24.5°C, occasionally exceeding 30°C (World Weather Information Service Bamenda, 2015). These climatic conditions are conducive to food cultivation, ensuring the availability of nutritious foods essential for breastfeeding mothers to maintain their health while providing adequate nourishment to their children. Mankon is a geo-historic community forming a significant part of Bamenda. It is an amalgamation of five distinct ethnic groups, making it a culturally diverse area suitable for examining various breastfeeding practices.

2.3 Sample Size Determination

The number of mothers-sampled from each community was determined using the at 95% confidence interval and the subjects were chosen randomly from the quarters.

$$n = \left(\frac{r+1}{r}\right)\frac{\sigma^2(Z_\beta + Z_{\alpha/2})^2}{(d\text{ifference})^2}$$

For 80% power, Z_β = Desired power = 0.84, for 0.05 significance level, Z_α =1.96, r = ratio of case control = 1, σ=standard deviation, Difference = Expected mean difference between the urban and rural participants

$$n = (2)\frac{10^2(7.84)}{(5)^2} = (2)2^2(7.84) = 100$$

2.4 Sampling Technique

A multistage sampling technique was utilized to select participants for this study. A total of 100 mothers were recruited, with 50 from urban areas and 50 from rural areas. The urban and rural regions were selected through simple random sampling using a raffle draw to ensure impartiality. Within each area, a convenience sampling method was employed to select 10 mothers from five quarters. In the **urban area**, the quarters included: Commercial Avenue, City Chemist/Longla End of Tar Street, Mulang, Ntarinkon, Mile 6 Mankon. In the **rural area**, the quarters included: Alachu, Ntabeng, Ntinkag, Ntamafe, Alabukam. This multistage sampling approach ensured balanced geographic representation from both urban and rural areas of Mankon, while also considering potential environmental influences on breastfeeding practices.

2.5 Inclusion and Exclusion Criteria

Inclusion Criteria:

- Mothers with children aged 0–6 months at the time of the study.
- Mothers who provided informed consent by signing the consent form.

Exclusion Criteria:

- Critically ill breastfeeding mothers.
- Mentally unstable mothers.

2.6 Data Collection

A semi-structured questionnaire was carefully designed and administered during the study to collect comprehensive data. It was divided into four sections to address key aspects of the research. The first section gathered sociodemographic information about participants, including their age, income level, education, and marital status, providing a detailed profile of the study population. The second section focused on evaluating the dietary habits and nutritional intake of breastfeeding mothers to identify patterns that might influence breastfeeding practices and maternal health. The third section assessed participants' understanding of exclusive breastfeeding, including its benefits for both mother and child, as well as the potential consequences of not adhering to recommended practices. The fourth section explored factors that could hinder the practice of exclusive breastfeeding, such as cultural beliefs, workplace challenges, or insufficient social support. To ensure ethical compliance, the questionnaire was administered alongside an informed consent form, and data collection involved visiting individual households within the study areas. This direct engagement with participants enhanced the reliability and accuracy of the data. Only participants who demonstrated a clear understanding of the study's purpose were included, and each was given a maximum of 30 minutes to complete the questionnaire, which was then returned to the Principal Investigator for further processing. This structured approach ensured comprehensive and ethically sound data collection.

2.7 Data Analysis

Data were entered into Microsoft Excel for consistency checks and subsequently exported to the Statistical Package for the Social Sciences (SPSS) version 20, for descriptive and inferential statistical analyses.Bivariate logistic regression was used and all the results were reported at a 95% confidence level, with a p-value of <0.05 considered statistically significant. Findings were presented using frequency distribution tables and charts for clarity and visualization.

3. RESULTS AND DISCUSSION

3.1 Results

3.1.1 Demographic characteristics

Table 1 shows that participants aged 17–25 years constituted the smallest proportion of the sample, representing only 7% (n = 7), indicating limited representation of younger adults in the study. The 26–35 age group was the most dominant, comprising 57% (n = 57) of the sample, which suggested that the study predominantly involved individuals in their late twenties to mid-thirties. Individuals aged 36–45 years formed the second-largest group, accounting for 36% (n = 36), reflecting a substantial proportion of middle-aged participants. Business professionals made up 37% (n = 37) of the population, indicating significant representation of economically active individuals. Farmers accounted for only 6% (n = 6), showing limited participation from agricultural workers. The largest occupational group, categorized as "Others," represented 45% (n = 45), likely encompassing diverse roles not

specified in the data-set. Students comprised 12% (n = 12), indicating a smaller representation of individuals in academic pursuits. A smaller proportion of participants, 22% (n = 22), had primary education, suggesting limited access to higher education within this subgroup. Half of the population (50%, n = 50) had attained intermediate levels of education, constituting the majority. University-educated individuals accounted for 28% (n = 28), reflecting a notable level of advanced education among participants. Almost all participants identified as Christian (98%, n = 98), highlighting a homogenous religious demographic, while a negligible proportion (2%, n = 2) belonged to other religions. A small fraction of participants (7%, n = 7) were first-time mothers, whereas the vast majority (93%, n = 93) had more than one child. Most participants were married (83%, n = 83), indicating a population where traditional family structures were prevalent, while only 17% (n = 17) were single or divorced.

Table 1. Demographic characteristics

Characteristics		Frequency N= 100	Percentage (%)
Age			
	17-25	7	7
	26 – 35	57	57
	36 – 45	36	36
Occupation			
	Business	37	37
	Farmer	6	6
	Others	45	45
	Student	12	12
Level of education			
	Primary	22	22
	Secondary/High	50	50
	University	28	28
Religion			
	Christian	98	98
	Others	2	2
Parity			
	Primipara	7	7
	Multipara	93	93
Marital status			
	Married	83	83
	Single/Divorced	17	17

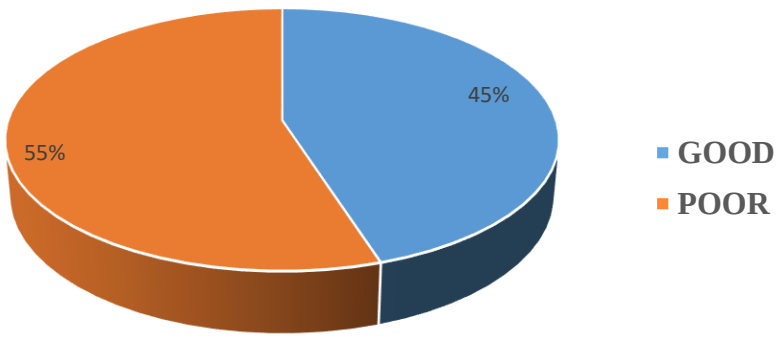

Fig. 1. Level of EBF practice

Table 2. Participants practice towards EBF

Characteristics		Frequency N=100	Percentage (%)
Did you practice EBF			
	Yes	43	43
	No	57	57
Food given to the baby during the 1st six months			
	Breast milk	43	43
	Artificial milk	25	25
	Breast milk/others	32	32
For how long did you practice exclusive breast feeding			
	<6 months	13	13
	6 months	43	43
	>6 months	08	08
	Don't practice	36	36
When did you start giving your baby water and other food			
	<6 months	55	55
	>6 months	45	45

Table 3. Knowledge of participants on EBF

Characteristics		Frequency N=100	Percentage (%)
Have you ever heard of EBF			
	No	5	5
	Yes	95	95
What is EBF			
	Only breast milk for 6 months	97	97
	Breast/Artificial milk	2	2
	Breast milk/other food	1	1
Are there any advantages of EBF			
	No	4	4
	Yes	96	96
Do you know the effects of not exclusively breastfeeding your baby			
	No	13	13
	Yes	87	87

3.1.2 Objective 1: To determine the level of EBF practice

Table 2 shows that a majority of participants (57%) did not adhere to exclusive breastfeeding practices. While 43% adhered to the recommended practice of feeding only breast milk during the first six months, 57% introduced other food sources, either artificial milk or a combination of breast milk and other foods. Only 43% adhered to the WHO-recommended duration of exclusive breastfeeding for six months. A significant portion, 36%, did not practice exclusive breastfeeding at all. A majority (55%) introduced water and other foods earlier than the recommended six months, which deviates from exclusive breastfeeding guidelines.

Level of EBF practice: Fig. 1 shows that the majority of the population surveyed (55%) have poor adherence to exclusive breastfeeding practices. This highlights a potential gap in awareness, resources, or support for exclusive breastfeeding, which could have implications for maternal and child health programs. Interventions might be needed to improve EBF rates through targeted education, support systems, or policy enhancements.

Table 4. Factors influencing the uptake of EBF

Variables		Good practice of EBF	
		Bivariate analysis	
		COR (95%CI)	P-value
Age			
	36 - 45	reference	
	26 – 35	2.2 (0.9 – 5.3)	0.9
	17 – 25	14.5 (0.4 – 4)	0.96
Marital status			
	Married	reference	
	Single/Divorced	4 (1.3-12.5)	**0.02**
Level of education			
	Primary	reference	
	Secondary/High	1.8 (0.6 – 4.9)	0.3
	University	1 (0.3 - 3.1)	0.96
Occupation			
	Business	reference	
	Farmer	0.1 (0 – 3)	0.96
	Others	0.7 (0.3 – 1.6)	0.4
	Student	0.3 (0.1 – 1.2)	0.1
Parity			
	Primipara	reference	
	Multipara	0.1(0.01 - 0.95)	**0.045**
Food type			
	Others	reference	
	Carbohydrate	2 (0.8 - 4.9)	0.13
	Protein	4 (1.1 – 15.2)	**0.04**
	Fatty foods	1 (0.1 – 11.8)	1
Frequency of breastfeeding			
	3-10 times/ a day	reference	
	Often as demanded	1.5 (0.1–17.4)	0.73
Knowledge on EBF			
	limited	reference	
	Good	1.1 (0.4 – 3.2)	0.86
Face difficulties in BF			
	No	reference	
	Sometimes	0.6 (0.1 – 3.9)	0.58
	Yes	0.4 (0.2 – 0.96)	**0.04**
Child ever sick before 6 months			
	No	reference	
	Yes	1.2 (0.6 – 2.7)	0.62
Setting			
	Urban	1	
	Rural	3.1(1.6-3-7)	**0.002**

COR: Crude Odd Ratio, CI: Confidence Interval.

3.1.3 Objective 2: To determine the level of knowledge of participants on EBF

The results of Table 3 reflects high awareness and understanding of EBF among the participants, with 95% having heard of it and 97% correctly defining it. While knowledge of advantages is nearly universal (96%), slightly fewer participants (87%) understood the risks of not practicing EBF. The small gaps in awareness (5%) and knowledge (4% and 13% on advantages and effects of EBF respectively) can be addressed through focused educational programs to ensure comprehensive understanding.

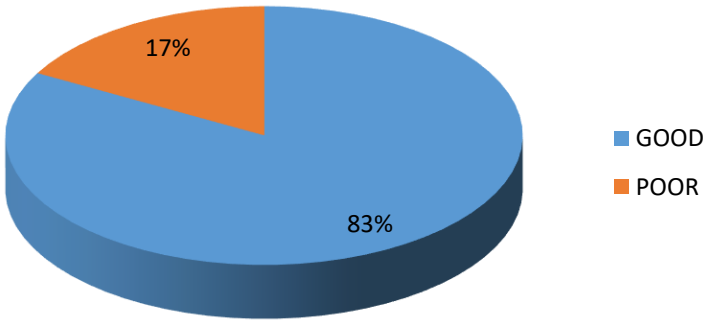

Fig. 2. Level of knowledge of EBF

Level of knowledge of EBF: Fig. 2 indicates that the majority of the participants, 83%, have a good understanding of EBF, suggesting effective awareness or educational programs about its benefits and practices. A smaller proportion, 17%, had low adherence to exclusive breast feeding, highlighting a gap in understanding or access to information about exclusive breastfeeding. The data emphasizes that while most participants are knowledgeable, there is still a need to address the 17% who lack adequate knowledge, possibly through targeted educational interventions.

3.1.4 Objective 3: Factors influencing the uptake of EBF

Finding in Table 4 indicates that Single or divorced mothers were 4 times more likely to practice good EBF compared to married mothers ($p = 0.02$). Mothers consuming protein-rich diets were 4 times more likely to practice good EBF ($p = 0.04$). Mothers in rural areas were 3.1 times more likely to adopt good EBF practices than urban mothers ($p = 0.002$). Multiparous women were significantly less likely to practice good EBF compared to first-time mothers ($p = 0.045$). Mothers facing breastfeeding challenges were less likely to practice good EBF ($p = 0.04$). Variables such as age, education level, occupation, frequency of breastfeeding, knowledge of EBF, child sickness, and most food types (e.g., carbohydrates, fatty foods) showed no statistically significant associations with EBF practices.

3.2 Discussion

The study revealed that only **43% of participants adhered to the WHO recommendation of exclusive breastfeeding (EBF) for six months,** while **57% introduced complementary foods earlier**, with **36% not practicing EBF at all.** These findings align with global challenges, as the global EBF rate is **48%** (UNICEF, 2023), but they fall below success stories in Africa, such as Rwanda's **87% EBF rate** (Mukuria et al., 2021). Comparisons within Cameroon show similar trends, with previous studies reporting EBF rates of **45% in the Northwest** (Chihuri et al., 2018) and early complementary feeding practices of **52% in Yaoundé** (Nguefack et al., 2021).

The finding that 55% of the surveyed population demonstrates poor adherence to exclusive breastfeeding (EBF) practices is significant, as EBF is crucial for infant and maternal health. Poor adherence increases risks of malnutrition, infant illnesses, and adverse maternal outcomes. Globally, EBF rates are 43% (UNICEF, 2021), slightly better than this study's findings. In Africa, EBF rates average 36% (WHO), with disparities based on healthcare system strength, while Cameroon's rate is notably lower at 28.2% (DHS, 2018) due to poor awareness, cultural norms, and weak policy implementation. To address these gaps, recommendations include educational campaigns to promote EBF, policy reforms for extended maternity leave and workplace accommodations, and stronger healthcare interventions like the Baby-Friendly Hospital Initiative (BFHI). These strategies are vital for improving EBF rates and enhancing health outcomes.

The study highlights high awareness and understanding of exclusive breastfeeding (EBF) among participants, with 95% having heard of EBF, 97% correctly defining it, and 96% recognizing its benefits. However, 87%

understood the risks of not practicing EBF, indicating a slight gap. Globally, studies show similar trends, with awareness often exceeding understanding of risks. For example, global awareness ranges from 70-85% (Rollins et al., 2016), while in Ethiopia and Nigeria, awareness and knowledge of risks are slightly lower than in this study (Tewabe et al., 2017; Agunbiade & Ogunleye, 2012). Cameroonian studies report lower awareness (89.5%) and knowledge of risks (72.3%) compared to this study (Chefor et al., 2020). High-income countries like the UK exhibit similar gaps in risk understanding despite high awareness (Brown et al., 2014). The findings suggest that localized health campaigns have been effective but need to address knowledge gaps, especially about the risks of not practicing EBF, through targeted educational programs. These efforts will ensure comprehensive understanding and better adherence to EBF practices.

The findings, indicating that 83% of participants possess a good understanding of exclusive breastfeeding (EBF), align with global trends where awareness of EBF has improved due to widespread educational campaigns (UNICEF, 2020). In Africa, the prevalence of EBF knowledge varies, with higher rates reported in countries with robust public health campaigns, such as Ghana and Rwanda, compared to lower rates in others like Nigeria (Black et al., 2013). In Cameroon, studies reveal mixed outcomes, with urban areas often showing better awareness of EBF compared to rural settings due to differences in access to healthcare services and education (Nguefack et al., 2019). The 17% of participants with poor knowledge underscores a critical gap, consistent with reports from rural and underserved populations globally and within Cameroon, where barriers such as cultural beliefs, misinformation, and inadequate health education persist. Addressing this gap requires culturally tailored interventions to enhance EBF education at community levels.

The findings indicate several factors influencing exclusive breastfeeding (EBF) practices among mothers. To contextualize these results: The observation that single or divorced mothers are four times more likely to practice EBF compared to married mothers ($p = 0.02$) contrasts with findings from Ethiopia, where married mothers were more likely to practice EBF (Jebena & Tenagashaw, 2022). In Cameroon, however, marital status has been shown to have no significant impact on EBF practices (Fombong et al., 2016). This discrepancy may be attributed to cultural and social differences influencing breastfeeding behavior. Mothers consuming protein-rich diets were four times more likely to practice EBF ($p = 0.04$). While few studies directly associate dietary protein intake with EBF, maternal nutrition is broadly recognized as critical to adequate milk production and maternal health (Ruel & Alderman, 2013). The finding that rural mothers are 3.1 times more likely to adopt EBF practices than urban mothers ($p = 0.002$) aligns with research in Ghana, where rural mothers exhibited higher EBF rates due to traditional practices and social support (Mogre et al., 2016). However, studies in Cameroon have noted the reverse trend, with urban mothers practicing EBF more often, possibly due to greater access to healthcare information and services (Fombong et al., 2016). This reflects the complex role of healthcare access and cultural practices. Multiparous women being less likely to practice EBF compared to first-time mothers ($p = 0.045$) is supported by Ethiopian research, which found that higher parity was associated with reduced EBF adherence (Jebena & Tenagashaw, 2022). This may result from increased responsibilities and reduced time for focused breastfeeding. Mothers facing breastfeeding challenges were less likely to practice EBF ($p = 0.04$). This aligns with global studies showing that difficulties such as nipple pain and perceived insufficient milk supply are significant barriers (Victora et al., 2016). Addressing these issues through targeted support is essential to improve breastfeeding rates. Variables such as age, education level, occupation, breastfeeding frequency, knowledge of EBF, child sickness, and carbohydrate or fatty food consumption showed no significant associations with EBF practices. This contradicts some studies where maternal education and knowledge significantly influenced EBF (Mogre et al., 2016). The lack of association here could be due to specific characteristics of the study sample or confounding factors. These findings underscore the multifaceted nature of EBF determinants. Addressing barriers through culturally sensitive and evidence-based interventions is crucial to enhancing EBF rates globally and in Cameroon.

4. CONCLUSIONS

This study highlighted the complex interplay of knowledge, practices, and barriers affecting exclusive breastfeeding (EBF) among mothers in the Mankon community. While knowledge of EBF

is relatively high, with 95% of participants having heard of the practice and 83% demonstrating good understanding, adherence to EBF remains suboptimal, with only 43% practicing exclusive breastfeeding for six months as recommended by WHO. Factors such as cultural beliefs, dietary habits, and marital status significantly influenced breastfeeding practices, emphasizing the need for targeted and culturally sensitive interventions.

Key findings revealed that rural mothers and those consuming protein-rich diets were more likely to adhere to EBF, while multiparous mothers and those facing breastfeeding challenges were less likely to do so. These insights aligned with global and regional patterns, underscoring the importance of addressing both individual and systemic barriers to improve EBF rates.

To bridge the gap between knowledge and practice, this study recommends strengthening local healthcare interventions, such as the Baby-Friendly Hospital Initiative (BFHI), and implementing educational campaigns tailored to the socio-cultural dynamics of the community. Policies supporting extended maternity leave and workplace accommodations could further enhance adherence to EBF. The findings also provided a foundation for future research on maternal and child health in similar settings.

5. RECOMMENDATIONS

1. To improve exclusive breastfeeding (EBF) practices, it is recommended to enhance media coverage by utilizing various platforms to promote awareness programs on the benefits and practices of EBF.
2. Supportive work environments should be established, including breastfeeding-friendly workplace policies, lactation rooms, and on-site daycare centers to assist working mothers.
3. Counseling services at community and institutional levels should be strengthened to provide consistent and culturally relevant guidance to mothers.
4. Parental leave policies should be revised to extend maternity leave to six months and introduce paternity leave for two months to support breastfeeding and parental involvement.
5. Additionally, mechanisms should be developed to monitor and evaluate the implementation of these interventions, engaging stakeholders to ensure effective execution and significant improvement in EBF practices in the community.

6. LIMITATIONS

1. **Sample Size and Generalizability**: The study involved 100 mothers from a single community, limiting the generalizability of findings to other regions or populations.The use of random sampling and geographic representation within Mankon aimed to enhance the study's internal validity.
2. **Cross-sectional Design**: The study's cross-sectional nature limits the ability to establish causal relationships between identified factors and breastfeeding practices. Recommendations for longitudinal studies were included to further investigate causality.
3. **Limited Nutritional Assessment**: While dietary habits were assessed, a detailed nutritional evaluation of mothers' diets and its direct impact on breastfeeding outcomes was not conducted. Future studies could incorporate nutritional biomarkers to provide more precise insights.
4. **Cultural and Contextual Variability**: Cultural practices and beliefs specific to Mankon may not reflect those in other parts of Cameroon or similar settings, limiting external applicability. Emphasis on localized interventions ensures relevance to the studied population, while comparative studies are recommended for broader generalizations.

CONSENT

As per international standards or university standards, written consent was collected and preserved by the author(s).

ETHICAL APPROVAL

This study included the use of human participants. Ethical approval was obtained from the Regional Delegation of the North West, Bamenda.

DISCLAIMER (ARTIFICIAL INTELLIGENCE)

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc) and text-to-image generators have been used during writing or editing of this manuscript.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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