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‘‘Exclusive Breast Feeding Practice And Factors Influencing This- A Systematic Review ”

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Abstract

In India, exclusive breastfeeding increased from 46.4% in 2006 to 54.9% in 2016. Early initiation of breastfeeding almost doubled from 23.4% to 41.6% during the same period. In 2018, only 44.6% of mothers initiated breastfeeding within 1 hour of birth. More than half (64.9%) of babies are exclusively breastfed during the first 6 months, and only 50.5% of babies between 6 and 8 months are given complementary feeding. By 2025, India wants to improve the percentage of infants who start breastfeeding at an early age to 90%. One such intervention that has been suggested in light of the benefits of lowering the risks of morbidity and mortality in a baby's first six months of life is exclusive breastfeeding for the first few months of life. The majority of women in royal households in India were unwilling to feed their infants, so instead of depending on cow or buffalo milk, they would send in wet nurses to take care of the task. Later half of (50 %) of 20th century was marked by an extend towards universal breast feeding polices, Hospitals were readjusting the prenatal care to support and enhance breast feeding. Therefore breast feeding help to brings the mother’s body back to its earlier position. The negative effects of artificial nutrition and bottle feeding had raised awareness among women of the superiority of breast milk. The message has been constantly spread in the latter 20th century by committed members of the healthcare system. Despite the fact that breast milk is the best, many infants are unable to consume it. Expressed breast milk was recommended as a replacement for breast milk. This involves the storage of milk for longer time and making it more widely acceptable and usable. Doctors and nurses became more concerned in developing this concept and human milk bank was established in India. Breastfeeding is the common problem that working mothers face every day. Feeding is not be possible for the working mothers during their working hours. Breastfeeding is not a problem for the mothers whose workplace is near their homes. They can get back home in between and feed their baby. But in case of mothers who work at far off places, they go for formula feeding when they are not at home. But studies have suggested that formula feeds are not good for the baby in the long run. Most of the doctors do not recommend formula as they lack all the immunological back up which is generally present in the breast milk.

Keyword: Breastfeeding practice, Factors influencing Breastfeeding practice, India, South Asia, Breastfeeding prevalence, knowledge, attitudes.

INTRODUCTION

Breastfeeding: public health significance

Breast milk is recognised to be the optimal feeding option for infants (Arthur & Richard 2012; Kramer & Kakuma 2012), and epidemiological studies provide evidence for its promotion, protection and support, especially as it relates to timely initiation and exclusivity. Breastfeeding is considered critical for sustaining the health and well-being of newborns and infants (Howie et al. 1990; Arifeen et al. 2001; Ip et al. 2007; Kramer & Kakuma 2012).[1] Besides being a source of adequate nutrition for the breastfed infant, it provides clear short-term benefits by reducing mortality and morbidity from infectious diseases (Arifeen et al. 2001; Kramer & Kakuma 2012). Breastfed infants are also reported to present lower morbidity from allergic diseases (Burr et al. 1993), as well as reduced risk of sudden infant death syndrome (Ford et al. 1993).[2]

Breastfeeding is a child’s first barrier against death and disease, providing protection against respiratory infection, gastrointestinal illness, and other adverse health outcomes. Breastfeeding has also been associated with increased IQ , school attendance, as well as higher income in adult life. The World Health Organization recommends infants exclusively receive breastmilk for the first 6 months of life and consume nutritionally adequate foods in addition to breastmilk for 2 years and beyond in order for children and mothers to reap the optimal health benefits associated with breastfeeding.[3] Nearly 1 million deaths of children under the age of 5 worldwide could be averted through breastfeeding alone, if families adhered to the World Health Organization’s breastfeeding recommendation.[4] Improving maternal compliance to optimal breastfeeding recommendations can also reduce a mother’s risk of ovarian cancer, heart disease, and diabetes and prevent approximately 20,000 maternal deaths from breast cancer alone. Breastfeeding also delays the return of the menstrual cycle which can help with birth spacing. Global adherence to optimal breastfeeding practices can lead to an array of health benefits coupled with economic benefits contributing to a worldwide economic savings of 300 billion U.S. dollars.[5]

Breastfeeding prevalence

As aforementioned, the overall rate of exclusive breastfeeding for infants under 6 months of age is slightly less than 40% despite the known benefits of breastfeeding. However, the least developed countries have experienced the greatest improvement in exclusive breastfeeding rates, where exclusive breastfeeding prevalence at 6 months increased from 38% in 2000 to 50% in 2012. According to the World Health Organization, only 23 countries have achieved at least 60% of infants less than 6 months being exclusively breastfed and nearly 40% of countries have breastfeeding initiation rates above 80%. In Africa, approximately 70% of countries have extended duration rates of continued breastfeeding for at least 1 year. In contrast, only four countries in the Americas have reached such high rates of breastfeeding duration at 1 year. The duration of breastfeeding for 2 years dramatically drops to 45% and no country in the Americas experiences a continued breastfeeding duration of 2 years[6].

Comparatively, fewer studies have been conducted in developing countries to identify the barriers to breastfeeding exclusivity among mothers while available evidence has not been systematically synthesised. This necessitates a review of literature examining factors that contribute to or serve as barriers to a mother's success in breastfeeding. Furthermore, health care professionals and policy makers would be informed on how best to support mothers and enhance the success of breastfeeding promotion interventions in developing countries.This review was conducted to comprehensively delineate factors that facilitate or act as barriers to exclusive breastfeeding (EBF) of infants aged 0–6 months among mothers in developing countries.

Key messages

• Breastfeeding practices among mothers in developing counties are influenced by a variety of socio-demographic, socio-cultural and health-related factors.

• It is imperative that health care providers and policy makers in developing countries understand these factors and provide specific guidance and policies to protect and promote early and exclusive breastfeeding.

• Tailoring interventions to support high-risk groups (such as older mothers and women in employment) is likely to enhance the effectiveness of breastfeeding promotion interventions.

• Research examining the impact of preconception and early prenatal breastfeeding plan as well as maternal self-confidence on breastfeeding duration and exclusivity is needed in developing countries.

MATERIALS AND METHODS

Data Sources

The literature search was conducted in March to october of 2022, using the following databases: PubMed, Google Scholar, Embase, and CINAHL. The following terms and keywords were used: 'Breastfeeding practice,' 'Factors influencing Breastfeeding practice,' 'India,' 'South Asia,' 'Breastfeeding prevalence,' 'knowledge,' 'attitudes.' Literature published between 2001 and 2021 was reviewed.

Study Selection

This review included any relevant studies published between January 2001 tp 2021. Quantitative and qualitative primary studies that focused on factors influencing EBF during the first 6 months of life were included. Studies were excluded if they were based entirely on secondary data or examined breastfeeding determinants too broadly, covering age range from 6 to 24 months. Participants included pregnant women and mothers of infants aged between 0 and 6 months.

Types of Studies

Only articles written in the English language were included. Multiple types of studies and reviews were considered and potentially included.

CURRENT SCENERIO IN INDIA

In India, exclusive breastfeeding increased from 46.4% in 2006 to 54.9% in 2016. Early initiation of breastfeeding almost doubled from 23.4% to 41.6% during the same period. In 2018, only 44.6% of mothers initiated breastfeeding within 1 hour of birth. More than half (64.9%) of babies are exclusively breastfed during the first 6 months, and only 50.5% of babies between 6 and 8 months are given complementary feeding. By 2025, India wants to improve the percentage of infants who start breastfeeding at an early age to 90%. One such intervention that has been suggested in light of the benefits of lowering the risks of morbidity and mortality in a baby's first six months of life is exclusive breastfeeding for the first few months of life.[7]

The majority of women in royal households in India were unwilling to feed their infants, so instead of depending on cow or buffalo milk, they would send in wet nurses to take care of the task.[8] Later half of (50 %) of 20th century was marked by an extend towards universal breast feeding polices, Hospitals were readjusting the prenatal care to support and enhance breast feeding. Therefore breast feeding help to brings the mother's body back to its earlier position. The negative effects of artificial nutrition and bottle feeding had raised awareness among women of the superiority of breast milk. The message has been constantly spread in the latter 20th century by committed members of the healthcare system. Despite the fact that breast milk is the best, many infants are unable to consume it. Expressed breast milk was recommended as a replacement for breast milk. This involves the storage of milk for longer time and making it more widely acceptable and usable. Doctors and nurses became more concerned in developing this concept and human milk bank was established in India. [9]

Breastfeeding is the common problem that working mothers face every day. Feeding is not be possible for the working mothers during their working hours. Breastfeeding is not a problem for the mothers whose workplace is near their homes. They can get back home in between and feed their baby. But in case of mothers who work at far off places, they go for formula feeding when they are not at home. But studies have suggested that formula feeds are not good for the baby in the long run. Most of the doctors do not recommend formula as they lack all the immunological back up which is generally present in the breast milk [10].

DETERMINANTS OF BREASTFEEDING IN DEVELOPING AND DEVELOPED COUNTRIES

Unique factors exist in developing and developed countries that influence breastfeeding behaviors. Research illustrates child and maternal morbidities such as infant colic and maternal infection are critical factors influencing breastfeeding in developing countries in contrast to developed countries. In developing countries, mothers who experience breast infections, swelling, pain, and/or chronic conditions or had infants with congenital or acquired disease were less likely to breastfeed[11]. Environmental factors also have a great influence on breastfeeding in developing countries due to the limited availability of electricity to refrigerate breastmilk and the fear of contamination due to unsanitary feeding environments prevalent in some underdeveloped areas[12]. Unlike developing countries that face major challenges associated directly with maternal and child health, major influences of breastfeeding practices in developed countries stem from health systems, political, and societal factors. However, in both developing and developed countries there is an interaction between individual maternal characteristics, interpersonal, community, and societal factors, such as policies and legislation that impact a mother's decision to start and continue breastfeeding[11,12]. It may be difficult for mothers to sustain breastfeeding even after initiating due to sociodemographic, social-cultural, and systematic factors that are not supportive of breastfeeding practices.

➢ Maternal factors

It Correlates of breastfeeding initiation and duration as indicated in research include maternal marital status, vaginal delivery, previous live birth, multiple live birth (plurality), smoking and drinking habits, prenatal care within the first trimester, conversation with a healthcare provider about breastfeeding, and birth intendedness[13,14]. Additional factors associated with breastfeeding behaviors include maternal age, race and ethnicity, level of educational. employment status, annual household income, and Body Mass Index (BMI). Teenage mothers, specifically those who had a cesarean section, experienced postpartum depression, and/or perceived an inadequate supply of breastmilk reported a shorter duration of exclusive breastfeeding. The ethnicity of mothers also has a significant association with duration of exclusive breastfeeding, which could be related to the traditions of various ethnicities in addition to religious recommendations and views. For example, in the U.S., black women have the lowest breastfeeding initiation and duration rates of all ethnicities. The racial breastfeeding disparity among black women in the U.S. persists due to several cultural misperceptions. For instance, a common cultural belief prevalent in the black community is that the addition of cereal to an infant's bottle will help the infant sleep longer. Furthermore, a mother's pre-existing health issues including obesity, experiencing multiple pregnancy complications, or giving birth to a premature child were also associated with a shorter duration of exclusive breastfeeding. A mother's lack of knowledge regarding breastfeeding, limited breastfeeding guidance, poor family and social support are also associated with a lack or shorter duration of exclusive breastfeeding.[15]

➢ Community factors (cultural values and norms)

Cultural attitudes, lack of public acceptance, and social norms which sexualize breasts may discourage women from breastfeeding in public. Interventions promoting behavior change with regards to breastfeeding should focus on dispelling the negative cultural beliefs and practices that result in suboptimal breastfeeding practices. Infant feeding practices are strongly influenced by family members and spouses who may not be well informed about optimal breastfeeding practices. In some communities, breastfeeding in public is perceived as a culturally unacceptable practice. Therefore, disseminating tailored communication messages addressing prevailing misperceptions that build on the positive aspects of breastfeeding while involving spouses and other family members is also critical in shifting the negative perceptions of breastfeeding.[16]

➢ Organizational factors

Pediatricians, obstetricians, and other healthcare workers are usually the most trusted and credible source on infant health and nutrition. The practices of maternity hospitals regarding breastfeeding and the recommendation of health providers contribute to a mother's decision to breastfeed. New mothers may lack the confidence or relevant knowledge regarding breastfeeding and health workers can play an important role by providing lactation guidance and helping to resolve challenges[16]. Lactation issues that may arise can be addressed through breastfeeding support and counseling. Thus, healthcare workers should be adequately trained to support breastfeeding and help mothers manage common lactation barriers and challenges. The support of healthcare providers enables women to attain the confidence and skills needed to successfully and optimally breastfeed.[17]

However, when health care workers provide expectant and/or new mothers with infant formula promotion materials they mistakably reduce an infant's likelihood of being breastfeed. Studies show mothers who receive discharge packages containing items useful for breastfeeding are more likely to breastfeed than mothers who receive discharge packages including free formula samples and coupons. The sooner a mother opts out of breastfeeding, the more formula is purchased, which creates an incentive for formula companies to market infant formula to women even before giving birth which is usually when prenatal intention to breast or formula feed is established.

➢ Societal factors

The lack of legislative accommodation in the workplace is a significant predictor of shorter duration of exclusive breastfeeding. Key workplace barriers include the lack of flexibility for milk expression in the work schedule, lack of accommodations such as a nursing room equipped to enable mothers to pump or store breastmilk, and concerns about employer or co-worker support. Additional workplace barriers include the perception that breastfeeding may hinder a mothers' job performance, lack of privacy for expressing breast milk or for breastfeeding, and the inability to find a child care facility near the workplace, the high cost of day care, insurance regulations, employer building codes, and other rules that may limit infants and children in the workplace. Studies illustrate that supportive work site environments that provide a private place to express milk and access to a quality breast pump helps women to continue breastfeeding upon return to work[18,19].

Workplace policies such as paid breaks for expressing milk, the provision of lactation rooms, and public awareness of the breastfeeding policies, have the ability to improve the ability of mothers to sustain breastfeeding while working. Using data from 182 countries, Atabay and colleagues (2015) found the prevalence of exclusive breastfeeding among infants 6 months and younger was nearly 9 percentage points higher in countries with guaranteed paid breastfeeding work breaks compared to those without paid breaks. Another study conducted in 2014, found 136 out of 176 countries, or approximately 71% of the world, provided mothers the right to take paid breaks during the workday in order to provide breastmilk for their child until 6 months following birth while four countries permitted shorter or unpaid breastfeeding breaks. However, 51 countries, the remaining 29% of the world, did not have policies that protected the right of mothers to breastfeed[20].

BARRIERS TO EARLY INITIATION OF BREASTFEEDING

The identified barriers to the early initiation of breastfeeding in South Asia have been synthesised as supply side and demand side barriers in terms of accessibility, availability and acceptability, are as-

➢ Barriers to availability

Lack of availability of information for correct knowledge and misperception on breastfeeding was reported as a barrier. Lack of knowledge on the importance of early initiation and the perception that water must be given to the newborn because breast milk alone will not sustain the baby were observed in Bangladesh. However, for the quantitative data the study based findings only on descriptive values without statistical associations.[21]

➢ Barriers to accessibility

Barriers to accessing initiation of breastfeeding in terms of antenatal and postnatal check-up, home delivery, and delivery by non-skilled attendants. No or few antenatal appointments, home delivery, delivery assistance and practices and no post-natal check-up have been reported in literature as supply side barriers to accessibility in terms of facilitation of breastfeeding practice.[22]

DISCUSSION

One of the major findings of this review is the influence of traditional beliefs and role of mother in law on breastfeeding. Traditional feeding practices, such as prelacteal feeds, misperceptions regarding colostrum, and taking advice of priests and mothers in-laws that discourage breastfeeding immediately after birth have been highlighted. Therefore, strategies that engage social and family decision-makers to shape traditional beliefs and attitudes towards safer breastfeeding practices[23]. Policies are in place to support recommended breastfeeding practices in South Asia. With the exception of India, all South Asian countries have a national IYCF strategy officially adapted by government[24]. Similarly, all countries have a National Breastfeeding Committee, have adopted the Baby Friendly Hospital Initiative (BFHI), and implement the International Code of Marketing of Breast milk Substitutes. Yet, the rates of early breastfeeding initiation in the South Asian countries remain some of the lowest in the world. Filling the gap, identified in this review, in evidence concerning socio-economic and political context that influence breastfeeding practices may lead to better informed and more context-specific policies that impact more significantly. Further, the exploration of factors and barriers presented sheds light on the factors and barriers that undermine the effective implementation of policies at the individual level.

CONCLUSION

Breastfeeding is considered the single most effective solution to preventing deaths of children under the age of five globally. Considering the substantial economic and health savings that breastfeeding alone provides, exclusive breastfeeding should be supported and promoted within families, communities, workplaces, and hospital facilities that provide care to mothers and their infants. Understanding and addressing the dynamic interplay between individual, interpersonal, community, organizational and societal factors, such as policies and legislation that impact breastfeeding rates and the health of infants is key to improving breastfeeding prevalence. Below is an example of evidence-informed approaches used to improve the prevalence of exclusive breastfeeding that can be adapted and applied in both developing and developed countries.[25]

KEY STRATEGIES EMPLOYED TO INCREASE GLOBAL EXCLUSIVE BREASTFEEDING PREVALENCE

Increasing Breastfeeding Prevalence in Cambodia

Over the span of a decade, Cambodia's breastfeeding rates increased from 11% in 2000 to 74% by 2010. Implementing the following recommendations that were informed by evidence in Cambodia can accelerate the progress towards reaching exclusive breastfeeding targets. The key strategies employed in Cambodia to increase breastfeeding rates included:

- Recognizing breastfeeding as a key strategy to child-survival interventions;
- Including breastfeeding promotion in all infant and children initiatives;
- Regulating the marketing of infant and children products;
- Initiating a "Baby-Friendly Child Initiative" involving the Baby-friendly Hospital Initiative and establishing maternal peer support groups and counseling services to support breastfeeding;
- Disseminating breastfeeding information through appropriate channels including popular TV and radio shows as well as launching a national breastfeeding advocacy campaign with high political officials [17].

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