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Barriers to Breastfeeding in South-Asia: A Systematic Literature Review

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Abstract

Background: Child health in South Asia is a major concern with a great number of children still malnourished. There are various reasons that lead to high occurrence of malnutrition in children and among them breast feeding practices is the most important. Breastfeeding is cost effective, promotes health, and prevents disease.

Aim: The aim of this systematic review was to identify barriers to initiation and continuation of breastfeeding in South Asia covering Maldives, Vietnam, India, Pakistan, Nepal, Sri Lanka and Bangladesh.

Methodology: Extensive search of the major databases was conducted from 1997 to 2017. The search included published studies in English. The eligibility of researches to be included in the review was evaluated on the basis of inclusion and exclusion criteria. Twenty-one studies met the criteria and were included. This review considered any research study design that recognized the barriers to breast-feeding in South Asian countries.

Results: The evidence identified from the studies included the barriers associated with initiation of breastfeeding according to five levels of thematic analysis: socio-cultural, socio-economic, individual, mother's knowledge and health-specific.

Conclusions: Mothers are faced with multiple exclusive breastfeeding challenges at the societal and individual levels and community stakeholders should look into this matter to provide maximum assistance to lactating mothers to achieve the goal of improved child health. Therefore, bringing the practice of EBF in mothers needs rigorous efforts at the micro and macro levels in South Asia.

Keywords: Breastfeeding; Children; Mother; Neonatal deaths; Ovarian cancer

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Introduction

Child health in South Asia is a major concern with a great number of children still malnourished. Approximately 43.6% of <5 years children are underweight in South Asia. There are various reasons that lead to high occurrence of malnutrition in children and among them breast feeding practices is the most important. Breastfeeding is an innate process having multiple advantages for the new born and mother. It is the perfect food that contains all the well-adjusted nutritious elements, for the new born. It is a type of nutrition that gives the same food to all the babies across the globe irrespective of socio-economic boundaries [1]. Research has revealed the important developmental,

psychological, environmental, social, nutritional, immunological, and economical benefits of breastfeeding. It guards babies from acute respiratory infections and diarrhoea, reduces neonatal mortality, enhances response to vaccinations, and boosts their immune systems [1]. Likewise, many researches have mentioned the motherly health advantages of breastfeeding, such as more rapid uterine involution, decreased postnatal bleeding, reduce weight quickly, and less chances of breast and ovarian cancer [2]. Despite the importance of exclusive breastfeeding, barriers to breastfeeding practices continue to pose in numerous countries. Neonatal deaths are on rise in South Asia, and health status of the infants in entire South Asia is alarming. Though breastfeeding is cost effective and the best food that prevent neonatal deaths,

practice of breastfeeding is declining [1]. Practices of infant feeding vary due to changes in tradition, use of healthcare services, knowledge, and financial factors. Women's choice for feeding depends on multiple reasons that are needed to be identified to promote breastfeeding practice. Situation in South Asia depicts a miserable condition, and, thus, this paper aims to study the views of lactating mothers and to explore the factors that impact breastfeeding practices. The purpose of this paper is to provide an overview of the various barriers to breastfeeding in South Asian countries.

Methods

Data sources: Computerized searches on Science Direct, BioMed Central, Sage, and PubMed.

Study selection: An extensive search of the major databases was conducted from 1997 to 2017. The search included published studies in English. The eligibility of researches to be included in the review was evaluated on the basis of inclusion and exclusion criteria. Twenty-one studies met the criteria and were included. This review considered any research study design that recognized the barriers to breast-feeding in South Asian countries.

Criteria

Search terms: Search terms applied were: breastfeeding initiation timings, breastfeeding and South Asian countries.

The various search terms were:

- Breastfeed, breastfed, breast milk
- Initial, colostrum, pre-lacteal, early, delay
- South East Asia, South Asia, Nepal, India, Vietnam, Maldives, Bangladesh, Sri Lanka and Pakistan.

Synthesis of results: The identified barriers to breastfeeding were synthesized into themes. The reasons of this health problem were divided into different levels: socio-cultural, mother's knowledge, health-specific, individual, and socio-economic (Table 1).

Results

Thematic analysis: The barriers associated with breastfeeding practices are listed according to five levels of analysis: socio-cultural, socio-economic, individual, mother's knowledge and health-specific.

Socio-Cultural Factors

The mother's social and cultural environment has an effect on breastfeeding initiation timing and continuation in South Asia (Tables 2 and 3).

Social factors: Family has an extensive influence over the

mother's practice of breastfeeding in Vietnam and studies indicate that family has an important part in promoting the water feeding before breast feeding initiation [3]. Nuclear and small sized families were the least likely to go for early breastfeeding initiation because mothers were alone and had to do all the household work like cleaning, washing and cooking along with breastfeeding their child. Moreover, according to Hirani and Karmaliani [4] employed women not given support at jobs ceased breastfeeding their babies and adopted the practice of formula feeding in Pakistan.

Cultural factors: Delayed initiation of breastfeeding is a common issue associated with tradition of pre lacteal feeding and supplementary feeds in study areas in Pakistan, India, Bangladesh, Nepal and Vietnam. Most participants believed that water, ghutti, honey, infant formula or juices are to be given with breastfeed. The favored choice was buffalo milk. According to Khadduri et al. [5] often during the initial three days water, ghee, animal milk and herbs tea are given to the baby in Pakistan. Breastfeeding initiation was delayed due to the notion that breast milk was not ready few days after delivery and other liquids/foods were fed in India [6]. Commonly, colostrum was discarded before breastfeeding the baby because of the fear that it might deteriorate baby's health, gets bad luck, has zero nutritive value or kills the baby in the study villages of Pakistan and India. The main providers of breast-feeding information were grand-mothers in Pakistan [7]. Another, key cultural barrier that the participants identified was that bottle-fed babies were chubbier than breast-fed babies [4]. Furthermore, according to Muslim tradition, babies are offered something sweet before breastfeeding initiation [8].

Socioeconomic factors: The possible factors for a baby not being exclusively breastfed and fed with diverse complementary foods were higher socioeconomic status, higher family monthly income, period of food sufficiency and living in urban areas in current literature review researches done in Pakistan, India, Bangladesh, Nepal, Sri Lanka and Vietnam.

Individual factors: Working mothers had predominantly higher risk for no early initiation and continuation of breast-feeding because of increased workload in the study areas in Pakistan, India, and Bangladesh. Reasons for reduced rates of EBF of an infant <6 months included lower birth order (as mothers get care free with increasing number of children) and male gender and the causes of formula feeding practices were having a spouse with a high educational level and increased age of a mother in Bangladesh [9]. Also, mother with higher academic educational level was associated with increased risk for bottle-feeding because they believed there are more nutritional elements present in formula milk in the studies published in Bangladesh and India.

Table 1 Criteria.

Inclusion	Exclusion
7 countries in South Asia: Nepal, India, Vietnam, Maldives, Bangladesh, Sri Lanka and Pakistan	Letters, editorials and commentaries
Qualitative, quantitative and mixed method studies published in or after 1997	Researchers conducted among women living in regions other than South Asia

Table 2 Results.

S. no	Data source	Research setting	Reported barriers
1	Moran et al. [25]	Bangladesh	Custom <ul style="list-style-type: none"> Pre lacteal feeding tradition Low milk secretion
2	Fikree et al. [22]	Pakistan	Custom <ul style="list-style-type: none"> Tradition of pre lacteal feeding and supplementary feeds
3	Bandyopadhyay [6]	India	Custom <ul style="list-style-type: none"> Tradition of pre lacteal feeding Supplementary feeds Mother's milk is not ready Colostrum was discarded
4	Khadduri et al. [5]	Pakistan	Custom <ul style="list-style-type: none"> Tradition of pre lacteal feeding Avoidance of colostrum
5	Nguyen et al. [3]	Vietnam	Custom
6			<ul style="list-style-type: none"> Tradition of pre-lacteal feeding Insufficient breast milk Misconceptions about colostrum Delivered by C-section High household SES Infrequent breastfeeding counseling Less support from family
7	Patel et al. [8]	India	Custom <ul style="list-style-type: none"> Tradition of pre-lacteal feeding Lower maternal education Cesarean section delivery Practice of pre-lacteal feeding in tertiary care hospitals Muslim religion
8	Kaushal et al. [24]	India	<ul style="list-style-type: none"> Custom Tradition of pre-lacteal feeding and supplementary feeds Lower maternal education
9	Dibley et al. [21]	India, Nepal, Sri Lanka and Bangladesh	<ul style="list-style-type: none"> Delivered at a health facility Delivery by cesarean section High household SES No antenatal check-up Supplementary feeds
10	Parveen et al. [26]	India	Custom <ul style="list-style-type: none"> Tradition of pre lacteal feeding Supplementary feeds Colostrum was discarded
11	Shaheen et al. [1]	Pakistan	<ul style="list-style-type: none"> Physiological changes after delivery Sociocultural Environment Difficult to manage time and breastfeeding both
12	Badruddin et al. [20]	Pakistan	<ul style="list-style-type: none"> Perception of insufficient breast milk Custom; tradition of pre-lacteal feeding Supplementary feeds Work load of mothers Initiation of breast feeding early -adds to maternal stress
13		Nepal	<ul style="list-style-type: none"> Supplementary feeds Urban area Smaller sized and nuclear families
14	Ali et al. [19]	Pakistan	<ul style="list-style-type: none"> Low maternal awareness Practice of pre-lacteal feeding
15	Subedi et al. [28]	Nepal	<ul style="list-style-type: none"> Supplementary feeds Low maternal knowledge
16		Bangladesh	<ul style="list-style-type: none"> Complementary foods Higher socioeconomic status Lower birth order Male sex Higher educational level Older maternal age No antenatal visits Living in urban areas (specifically in Dhaka) Working mothers
17	Hazir et al. [23]	Pakistan	<ul style="list-style-type: none"> Employed mothers Delivery by cesarean section Four or more antenatal clinic visits Higher socioeconomic status
18	Patel et al. [27]	India	The possible factors for bottle-feeding included <ul style="list-style-type: none"> C-section delivery High education level High socioeconomic status Working mother Absence of postnatal examination Urban resident Lower antenatal care visits
19	Senarath et al. [10]	Sri Lanka	<ul style="list-style-type: none"> Reduced weight at birth Delivery by cesarean section Higher socioeconomic status Urban areas No midwife home visit after child birth Less educated staff Private hospital

20		Bangladesh	<ul style="list-style-type: none"> Healthcare workers low level of interaction despite multiple visits Better household food security status Insufficient milk Lack of mothers knowledge Grandmothers- providers of feeding information
21	Hirani and Karmaliani [4]	Pakistan	<ul style="list-style-type: none"> Working mothers Less workplace support
22	Abdul raheem and Binns [18]	Maldives	<ul style="list-style-type: none"> Caesarean delivery

Table 3 Thematic analysis.

S.no.	Themes	Factors/Barriers
1.	Socio-cultural	<p>Social</p> <ul style="list-style-type: none"> Less support from family Smaller sized and nuclear families Less workplace support <p>Cultural</p> <ul style="list-style-type: none"> Custom- <ul style="list-style-type: none"> Tradition of pre lacteal feeding Supplementary feeds Mother's milk is not ready Colostrum was discarded Grandmothers- providers of feeding information Muslim Religion
2.	Socioeconomic	<ul style="list-style-type: none"> High household SES Urban area
3.	Individual	<ul style="list-style-type: none"> Time management- work load of mothers Working mothers Lower birth order Male sex Child Higher academic educational level Older maternal age
4.	Health-specific	<p>Mother's Health specific</p> <ul style="list-style-type: none"> Cesarean section delivery Physiological changes after delivery Adds to maternal stress <p>Child's Health specific</p> <ul style="list-style-type: none"> Low birth weight <p>Healthcare facility-specific:</p> <ul style="list-style-type: none"> Infrequent breastfeeding counseling Practice of pre-lacteal feeding in tertiary care hospitals Delivery at a health facility
5.	Mother's knowledge	<ul style="list-style-type: none"> Perceived low milk secretion No antenatal check-up No midwife home visit after child birth Private hospital Less educated staff Lower maternal education

Health Specific

Mother's health specific: Breastfeeding is often times delayed because the mothers who have delivered via cesarean section require more time to recover before they feel like holding and

nursing their babies in the study areas in Pakistan, India, Vietnam, Sri Lanka and Maldives. Mothers with physiological changes after delivery example hypertension and diabetes were less willing to breastfeed as it adds to maternal stress in Pakistan [1].

Child's health specific: Low birth weight infants are supplemented **breast milk** with high calorie formula to promote weight gain. Also, they have poor sucking reflex so can't be breastfed by mothers [10].

Healthcare facility-specific: Formula manufacturers have created partnerships with hospitals by providing free formula for their mutual benefits. Tertiary care hospitals encouraged mothers to substitute formula for breast milk and there was infrequent breastfeeding counseling in healthcare facilities in the study areas in Pakistan, India, Sri Lanka, Vietnam and Nepal.

Mother's Knowledge

Women do not attend antenatal care visits due to: overburdened clinics, poor treatment by health-care workers, less educated hospital staff and mothers' cultural beliefs. This results in lower maternal knowledge as mentioned in the researches published in Pakistan, Nepal, Sri Lanka, Bangladesh and India. In Vietnam, due to decrease maternal knowledge, mothers believe they have insufficient milk without thinking of other reasons for decreased milk secretion like delayed feeds by using a pacifier/ pre-lacteal feeding, being separated from your baby after the birth, restricting the length of feeds etc. [3]. Another factor could be decreased post-natal visits by to monitor post-natal care and counsel mothers in the study village in Sri Lanka [10].

Discussion

Exclusive breastfeeding is pivotal to the growth and wellbeing of the baby. It makes the spiritual and physical connection stronger between the parent and baby. Lactating mothers are encountered with numerous hurdles as they attempt to do EBF. The review identified various facilitators and barriers to EBF in South Asia including less support from family, smaller sized and nuclear families, less workplace support, tradition of pre-lacteal feeding, supplementary feeds, belief-mother's milk is not ready, colostrum was discarded, grandmothers- providers of feeding information, Muslim religion, high household SES, Urban area, work load of mothers, working mothers, lower birth order, male sex child, higher academic educational level, older maternal age, cesarean section delivery, physiological changes after delivery, low birth weight child, infrequent breastfeeding counseling, practice of pre-lacteal feeding in tertiary care hospitals, delivery at a health facility, perceived low milk secretion, no antenatal check-up, no midwife home visit after child birth, less educated staff and lower maternal education. These factors are not exclusive to South Asia and are also reported in other parts of the world. In Cameroon, Africa, all women participated introduced supplementary food and water <6 months, with water feeding in initial 1st month in about 38% infants due to tradition enforced by grandparents and family. They also believed that mother's milk does not meet nutritional requirements of a baby, has no effect on baby's weight and prohibits sexual intercourse while breast-

feeding [11]. In southeastern Nigeria, the critical indicators for non-practice of EBF included maternal unwillingness, mother's being stressful and the feeling that EBF is unimportant [12]. In Southwest Nigeria, the barriers to breastfeeding were: maternal health problem, not enough to satisfy baby's hunger, the need to return to work, mother-in-law's demand, breast pain, and a fear of child's breast milk addiction [13]. In Ghana, the four constraints to breastfeeding were: notion that mother's milk was not enough, small maternity leave duration, self-employed and social pressure to introduce artificial feeds and water [14]. In Northeastern Tanzania, the view that mothers' milk is not enough for child's development, incomplete knowledge on exclusive breastfeeding benefits and duration, older mother's age, child remaining thirsty and to give herbal medicine as a cultural practice were the essential reasons [15]. In United States, the major reasons identified for not continuing exclusive breastfeeding were not enough breast milk, return to work and painful or sore nipples [16]. In UK, healthcare workers only promoted the advantages without telling the other consequences of breastfeeding. Due to which they were unprepared when they faced pain and problems with early initiation of feeding. Multiple women were dissatisfied with daily postnatal care and reported that teaching given by professionals was often inadequate. Furthermore, mothers found it comfortable to be surrounded by other breastfeeding mothers as they served as role models for the ones who were developing breastfeeding habit, and acquiring feeding confidence in general areas [17]. The findings identified in South Asian countries are quite similar to those of international research results as mentioned above. In this literature review, the barriers reported would have a positive impact on breastfeeding commencement timings and fulfillment of sustainable development goals. The conditions of South Asia are ever-changing; therefore, the results of these studies cannot show the region as a whole. More South Asian Countries are needed to be included in literature review in future.

Practice Recommendations

The above-mentioned results highlight the importance of

emphasizing post-natal care visits to mothers during antenatal period and soon after deliveries. Also, general discussions about breastfeeding challenges, promoting EBF through education and extending maternity leave are suggested for better outcomes [12-16]. Strategies to clarify the misconceptions about breastfeeding's insufficiency for an infant's growth need to be strengthened. Furthermore, during the antenatal and postnatal care visits the mothers should be emphasized to follow the teachings given by healthcare staff as the most of the mothers rely on birth attendants' advices on child's nutrition. Healthcare professionals should promote evidence based educational strategies and provide individual support to increase EBF initiation and continuation rates and to help women gain confidence in breastfeeding by lessening their fears. For working women, employers should develop flexible schedules and specific places to breastfeed. Another main strategy to promote EBF among low socio-economic status mothers is to build collaboration among legislators, healthcare professionals, community and the employers by uniting together to support breastfeeding. Healthcare professionals' guidance, reassurance and social support could assist mothers to lessen the problems and join hands to attain maternal and child health goals. In future, still a lot of work needs to be done to make the healthcare facilities accessible to mothers in the society [17-28].

Conclusion

Mothers are faced with multiple societal and individual exclusive breastfeeding challenges and community leaders should ponder upon such matters to provide maximum assistance to lactating mothers to achieve the goal of improved child health. The healthcare sector has a significant role to contribute towards the development of a society that supports a woman to breastfeed her baby. Therefore, bringing the practice of EBF in mothers needs rigorous efforts at the micro and macro levels in South Asia.

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