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A Study on Breastfeeding Skills and Practice Mechanism among Mothers in Bangladesh

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ABSTRACT

Breastfeeding is universally acknowledged as a critical practice for ensuring optimal health and nutrition for infants and mothers alike. However, in Bangladesh, breastfeeding practices often face challenges stemming from socio-cultural, economic, and educational factors. This study explores the skills and practice mechanisms of breastfeeding among mothers in Bangladesh, aiming to identify the determinants of successful breastfeeding and barriers to its optimal implementation. Data were collected through a mixed-methods approach, including surveys, interviews, and focus group discussions with mothers, healthcare providers, and community health workers. The findings highlight the importance of maternal education, cultural norms, and the availability of support systems in shaping breastfeeding practices. Despite high awareness of breastfeeding benefits, gaps were observed in skill development, early initiation, and exclusive breastfeeding practices. Socioeconomic disparities, misinformation, and limited access to professional lactation support emerged as significant obstacles. This study underscores the need for targeted interventions, such as community-based education programs, enhanced lactation counseling, and supportive policies to empower mothers in developing breastfeeding skills. Strengthening these mechanisms can lead to improved maternal and child health outcomes, contributing to Bangladesh's broader public health goals.

Keywords: *Breastfeeding skills, Maternal health, Infant nutrition, Motherhood practices*

INTRODUCTION

Breastfeeding is widely recognized as a cornerstone of infant nutrition, offering unparalleled benefits for the growth and development of children while also contributing to the health and well-being of mothers. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend exclusive breastfeeding for the first six months of life, followed by continued breastfeeding alongside complementary foods for up to two years or beyond. Despite these recommendations, the practice of breastfeeding varies significantly across regions and communities due to cultural, economic, and social factors.

In Bangladesh, breastfeeding is deeply embedded in cultural traditions and is widely practiced. However, challenges such as lack of proper education, limited access to lactation support, and socio-economic disparities often hinder optimal breastfeeding practices. While many mothers are aware of the benefits of breastfeeding, the skills and mechanisms required to implement these practices effectively are not always adequately developed or supported.

Breastfeeding is the best way of providing ideal food for healthy growth and development of infants, and its advantages range from physiological to psychological for both mother and infants. It is well-known that breastfeeding influences a child's health positively and improves nutritional status. From three developing countries showed that infants who were not breastfed had a 6-fold greater risk of dying from infectious diseases within the first 2 months of life than those who were breastfed. Six months of exclusive breastfeeding and continued breastfeeding in first year of life could also prevent 1.3 million child deaths worldwide according to systematic reviews from the Bangladeshi Child Survival Study Group. In addition, incorrect infant feeding practices pose significant risk for malnutrition among children under the age of 5.

The American Academy of Pediatrics recognizes breastfeeding and human milk as the "normative standards for infant feeding." Given the documented health benefits, the Academy recommends Exclusive breastfeeding for 6 months, followed by continued breastfeeding for at least 24 months as complementary foods are introduced.

Weaning is the term usually used to describe the process of breastfeeding after a period of successful breastfeeding. This usually involves addition of food to infant's diet or replacement of breast milk in infant's diet with another type of milk (formula or whole milk). Maternal physiology, infant nutritional needs, infant development, especially the development of biting and chewing, and cultural issues all play a role in the timing of weaning. The prevalence of breastfeeding differs from one country to another and from one society to another, this of course is due to cultural and religious believes. Delayed breastfeeding initiation, colostrums deprivation, supplementary feeding of breast milk substitutes, early introduction of complementary feeding, and incorrect weaning from breast milk are commonly found practices in communities around the world.

Breastfeeding has always been the ideal feeding practice for infants. There is extensive evidence of short-term and long-term health benefits of breastfeeding for infants and mothers. In addition to specific health advantages for infants and mothers, breastfeeding also benefits the society by reducing health care cost, parental employee absenteeism and associated loss of family income after birth the health of the baby depends upon the nurturing practice adopted by the family. The ideal food for the young infant is human milk which has the specific characteristics that match the growing infants' nutritional requirements. Breastfeeding is a socially constructed and controlled practice. It is often presented as a natural practice. As a global goal for optimal maternal and child health and nutrition, all women should be enabled to practice exclusive breastfeeding, and all infants should be fed exclusively on breast milk, from birth to 6 month of age. According to world health organization (WHO), breast milk has the complete nutritional requirements that a baby needs for health development. Furthermore, it is safe and contains anti bodies that help protect infants and boost immunity. Consequently, breast feeding contributes to reduced infant morbidity and mortality due to diarrhea, respiratory or ear infections and other infectious diseases.

OBJECTIVES OF THE STUDY

The objectives of the study are as follows:

General Objectives

To identify the breastfeeding skill and practices mechanism among mothers.

Specific Objectives

1. To find out knowledge, attitudes, and practices regarding breastfeeding pattern among mothers.
2. To identify the relationship between maternal education level and feeding practices among child.
3. To identify the children's nutritional status and to see the prevalence of malnutrition among child.

Variables of the Study

- Independent variables
- Breastfeeding information
- Breastfeeding Practice & skills
- Dependent variables as demographic factors
- Maternal age
- Socio economic status
- Ethnicity
- Maternal employment
- Maternal attitudes, confidence and intentions
- Parity,
- Number of children

METHODOLOGY OF THE STUDY

Study Area: The study was conducted in M Abdur Rahim Medical College Hospital, Dinajpur, Bangladesh.

Study Design: This Study was a descriptive type of cross-sectional study.

Study population: All those women, who are comes for treatment on outpatient department and department of gynecology & obstetrics at M Abdur Rahim Medical College Hospital, Dinajpur in Bangladesh.

Sampling Method: purposive sampling method was used for the study**.**

Sample size: 200 respondent was selected from the nurses orderly.

Sources of data: Data was collected from primary Sources.

Sources of Primary Data: Primary Data was colleted from the respondents of the study area.

Sources of Secondary Data: Secondary data was colleted from Book, Research Reports, Journals, Magazines, Annual Reports of Bangladesh Bureau of Statistics (BBS), Annual Reports of Directorate General of Health (DG Health), Websites of Ministry of Health and Family Planning, Internet etc.

Tools for Data Collection: Quetionnaire was used for data collection. One sets of Questionnaire was used for the study.

Methods of data collection: Primary Data was collected by face to face interview with respondents. Secondary data was collected from reviewing of secondary data.

Data Analysis: Data was analyzed with the help of SPSS software program and M.S. Excel. Table and graphs and statistical analysis were done by adequate tables and graphs.

RESUTLS AND DISCUSSION

The findings of this study reveal a multifaceted landscape of breastfeeding practices among mothers in Bangladesh, shaped by a complex interplay of socio-cultural, economic, and educational factors. While breastfeeding is widely acknowledged and practiced, significant gaps exist in terms of skill development, adherence to exclusive breastfeeding, and early initiation practices. The results highlight disparities across urban and rural settings, socioeconomic strata, and levels of maternal education. These variations underscore the influence of external factors such as access to healthcare facilities, the availability of professional lactation support, and the presence of traditional beliefs and norms.

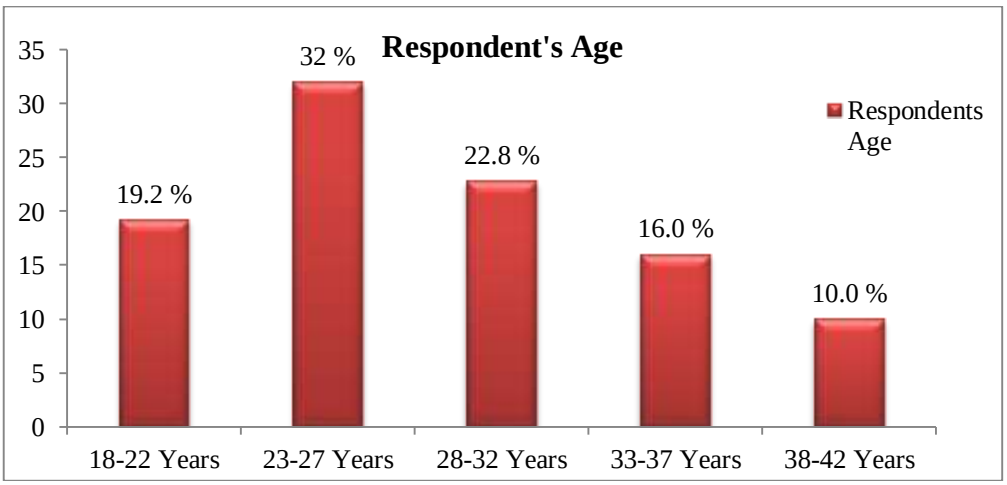


Figure 1: Percentage distributions of respondents by their age.

Figure shows thatthe socio demographic information of the respondent's age. The age of the respondents 18 to 22 years was19.2%. The respondent of 23 to 27 years was32.0%, 28 to32 years of the respondents was22.8% and 33 to 37 of the respondent was16.0% and38 to 42years was 10.0%.

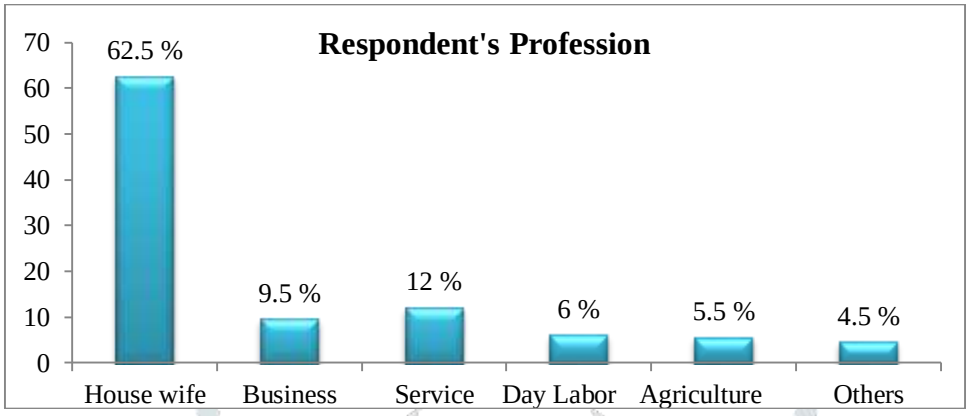


Figure 2: Percentage distribution of respondent's profession.

Result shows the percentage distribution of respondent's profession. From this figure that it has been found highest of the respondent's profession majority 62.5% were house wife, then 12% were service holder, 9.5% were businessman, 6% were day labour, 5.5% were agriculture & 4.5% are engaged in othersdifferent work.

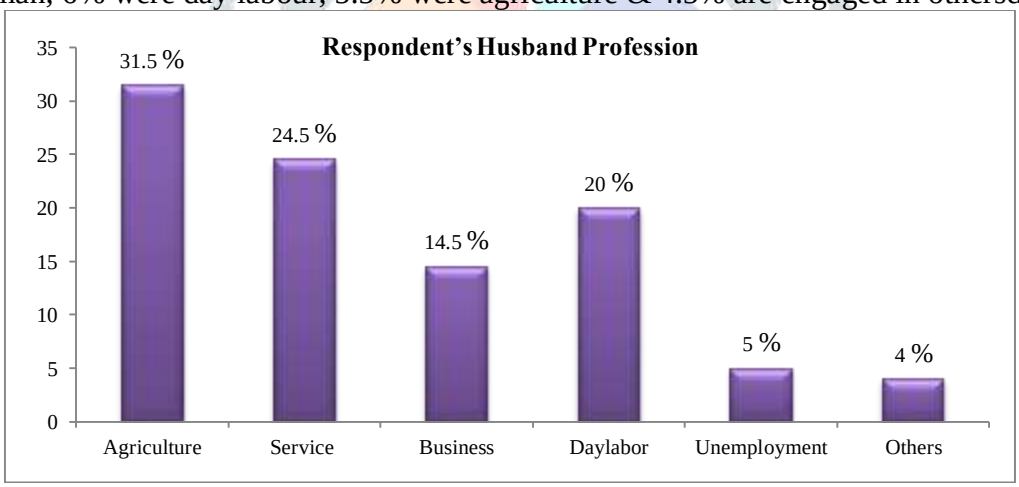


Fig. 3: Percentage distribution of involvement in the profession of the respondent's husband

Figure shows the percentage distribution of involvement in the profession of the respondent's husband. From this figure that it has been found of the respondent's husband 31.5% professionswere agriculture, 24.5% were service level & the 20% respondent's husband involve with day labor. The small sizes of the respondent's husband were business 14.5%, 5% were unemployment & 4% engaged in others work activities.

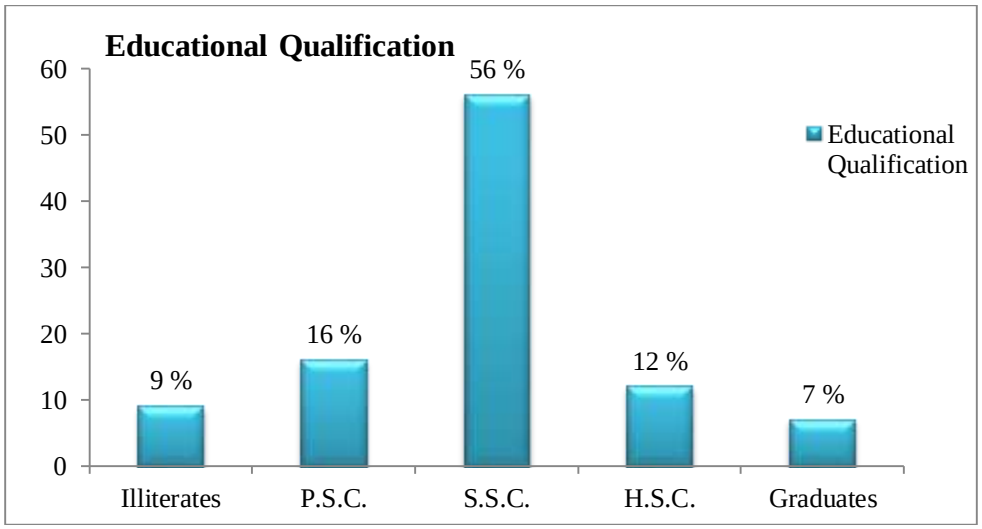


Fig. 4: Distribution of the respondents by their educational background

Shows the level of education of the respondent from this figure it has been found that most of the respondents, which corresponds according to S.S.C. level were 56%, 16%were P.S.C. level, 12% were H.S.C. completed, 9% were illiterate & 7% were respondents graduate.

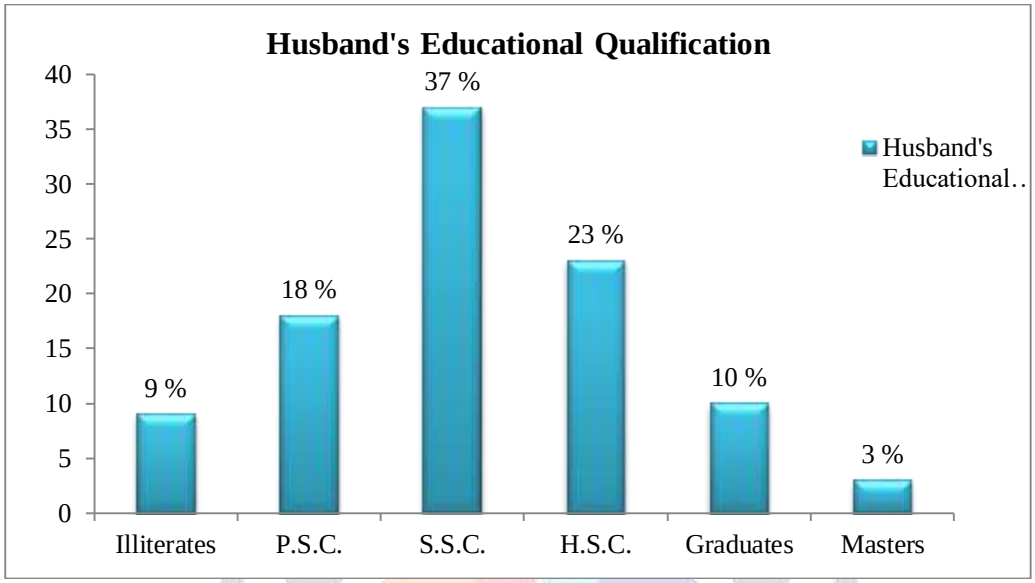


Fig. 5: Distribution of the respondents by their husband's education

Figure revealed that, the result showed that the level of husband education of the respondent's from this figure it has been found that most of the respondents, which corresponds S.S.C level was 37%. Only 23% of the respondents studied were H.S.C. passed. 18% of the respondents were complete P.S.C. level education. 10% respondents wereGraduate passed. Only 9% were illiterates of the respondents & 3%were M.A passed.

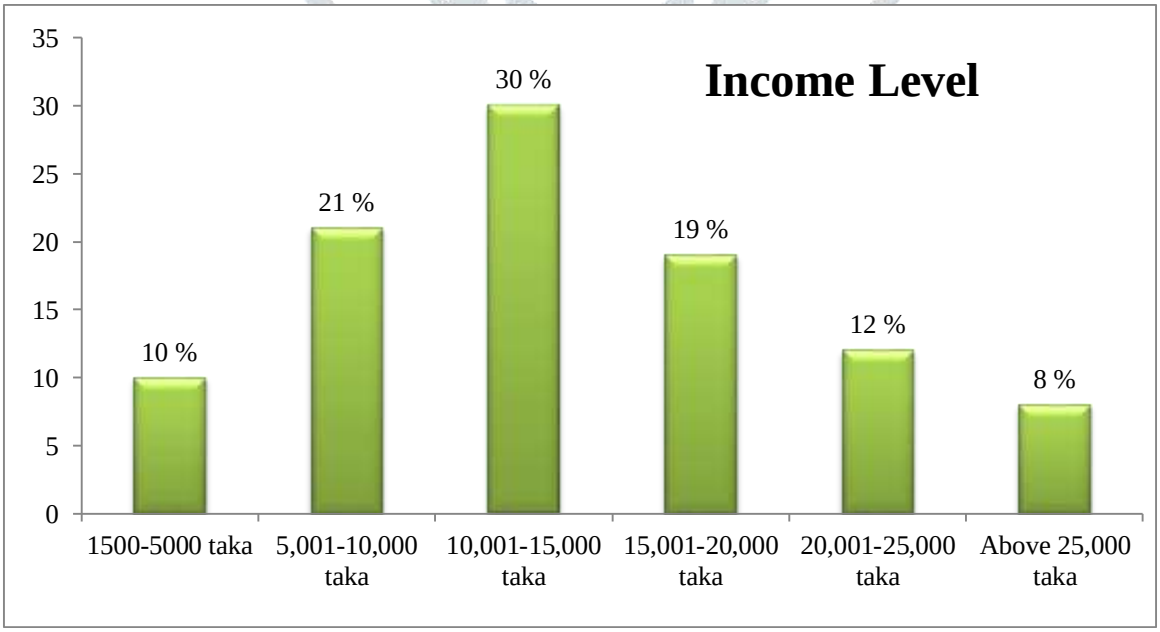


Figure 6: Distribution of the respondent's family income

Figure shows the income distribution of the respondent's family. From this figure it has been found that 10% of the respondent's monthly family income was between 1,500 to 5,000 taka. Next to this, 21% of the respondent's monthly income was 5,001 to10,000 taka. 30% of the respondent's family earns was monthly 10,001 to15,000 taka. 19% of the respondent's income was 15,001 to 20,000 taka and 20,001 to 25,000 taka family income percentage was 12% and above 25,000 taka family income was 8%.

Table 1: Distribution of the respondent's Family member

Name of variable	Parameters	Percentage (%)
Family member	2 members	6
	3 members	14
	4 members	28
	5 members	32
	Above 5 members	20
	Total	**100**

Regarding the table showed that respondent's Family size. The result showed that family members 5 people was highest percentage and it was 32%, family members 4 people was 28% and family members above 5 people was 20%.

Table 2: Distribution of the respondents Number of parity

Name of variable	Parameters	Percentage (%)
Number of Parity	1	15
	2	35
	3	26
	4	16
	> 4	8
	Total	**100**

Results revealed that Respondents Number of parity. That was respondents 1 child has (15%), while 2 child (35%), 3 child has (26%), 4 child has (16%) and more than 4 child has (8%) respondents.

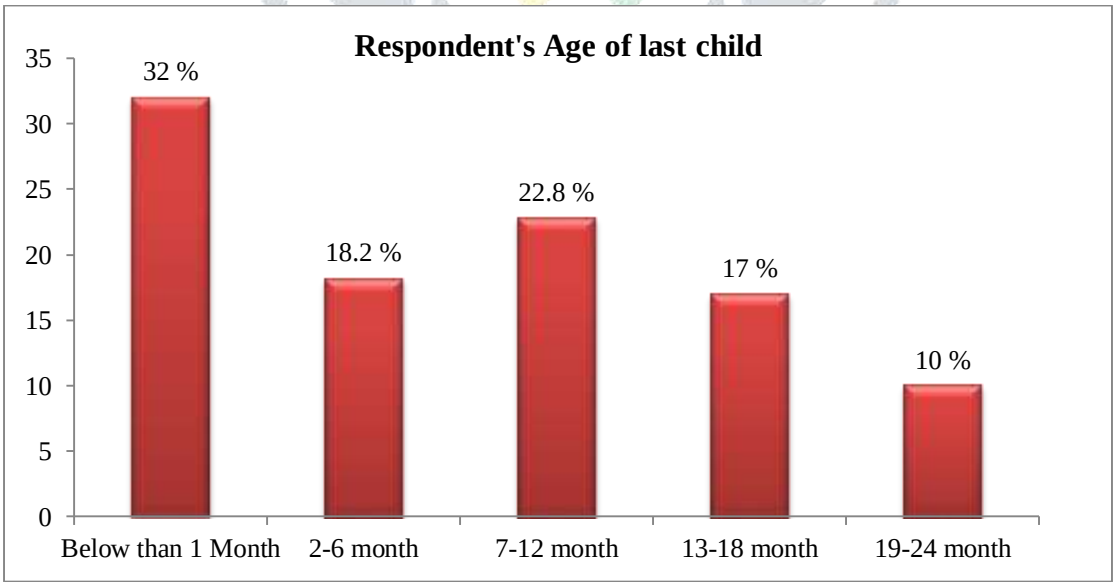


Figure 7: Percentage distribution of respondent'sage of last child.

Figure reveled that the age of the respondents below than 1 Month was 32%. The respondent's child age of 2-6 month was 18.2%, 7-12 month was 22.8% and 13-18 month was 17.0% and19-24 month was 10.0%.

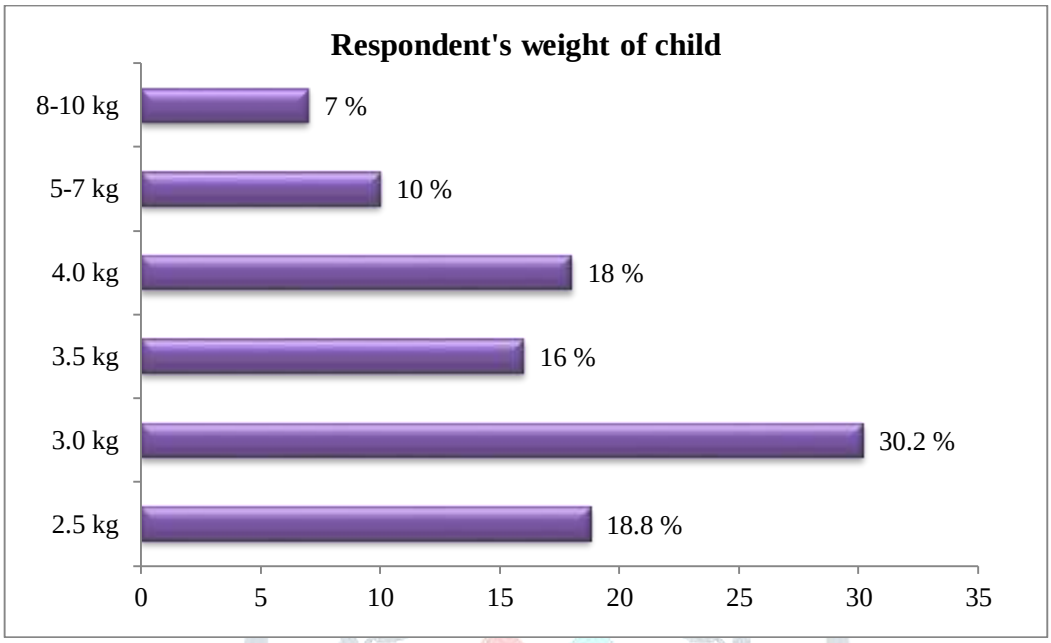


Figure 8: Percentage distribution of respondent'sweight of child

In this figure,the weight of child age of the respondents 2.5 kg was 18.8%,3.0 kg was highest percentage and it was 30.2%, 3.5 kgwas 16.0%, 4.0 kg was 18.0%, 5-7 kg was 10.0% and 8-10 kgwas 7.0% between 0-24 month age children.

Table 3: Distribution of the respondents the place of delivery of the child

Name of variable	Parameters	Percentage (%)
The place of delivery of the child	At home	12
	Govt. Hospital	58
	Private clinic/Hospital	30

Table show that percentage of the place of delivery of the child. Respondent said At home was 12.0%, Govt. Hospital was 58.0% and Private clinic/ Hospital was 30.0%.

Table 4: Distribution of the respondent's opinion about person who conducted the delivery

Name of variable	Parameters	Percentage (%)
Respondent's opinion about person who conducted the delivery	Untrained dais	18
	Trained dais	30
	Nurse/Midwife	40
	Doctor	12

Table show that percentage distribution of respondent's opinion about person who conducted the delivery. Respondent said untrained dais was 18.0%, trained dais was 30.0%, Nurse/ Midwife was 40.0% and Doctor was 12.0%.

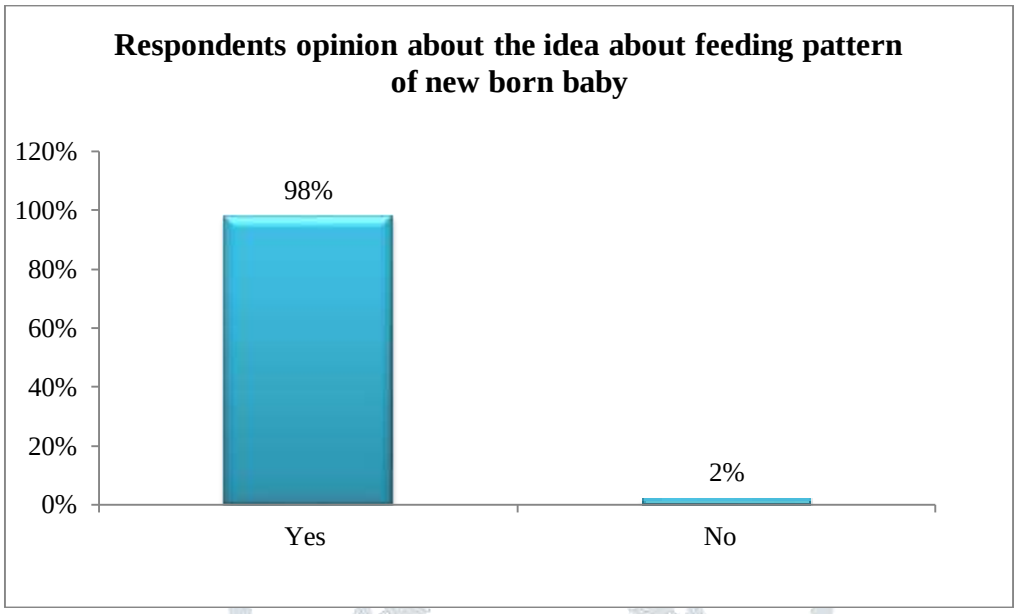


Fig. 9: Distribution of the respondent's opinion about the idea about feeding pattern of new born baby

In this Figure shows that opinion about the idea about feeding pattern of new born baby. Out of all patients 98 % was said and only 2% was said no about idea of feeding pattern of new born baby.

Table 5: Distribution of the respondent's opinion about type of food should given to the new born after born

Name of variable	Parameters	Percentage (%)
Respondent's opinion about type of food should given to the new born after born	Untrained dais	18
	Trained dais	30
	Nurse/Midwife	40
	Doctor	12

Table show that percentage distribution of respondent's opinion about type of food should given to the new born after born. Respondent said untrained dais was 18.0%, trained dais was 30.0%, Nurse/ Midwife was 40.0% and Doctor was 12.0%.

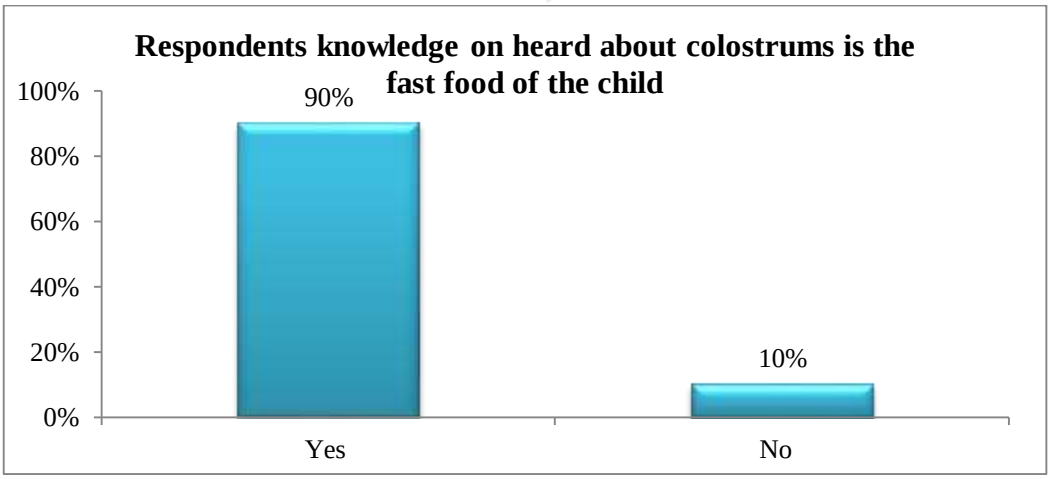


Figure 10: Distribution of the respondent's knowledge on heard about colostrums is the fast food of the child

In this Figure shows thatrespondent'sknowledge on heard about colostrums is the fast food of the child. Out of all patients 90% was said and only 10% was said no that heard about colostrums is the fast food of the child.

Table 6: Distribution of the respondent's opinion about when breast milk is feed to new born after birth

Name of variable	Parameters	Percentage (%)
Respondent's opinion about When breast milk is feed to new born after birth	At once /After half an hour	52.2
	After one an hour	28.8
	After 6 an hour	12.5

	After 12 an hour	6.0
	Others	1.5

Table show that percentage distribution of respondent's opinion about appropriate feeding time of breast milk to new born baby after birth. Respondent said feeding time of breast milk on new born baby At once /after half an hour was 52.2%, after one an hour was 28.8%, After 6 an hour was 12.5%, After 12 an hour was 6.0% and others was 1.5%.

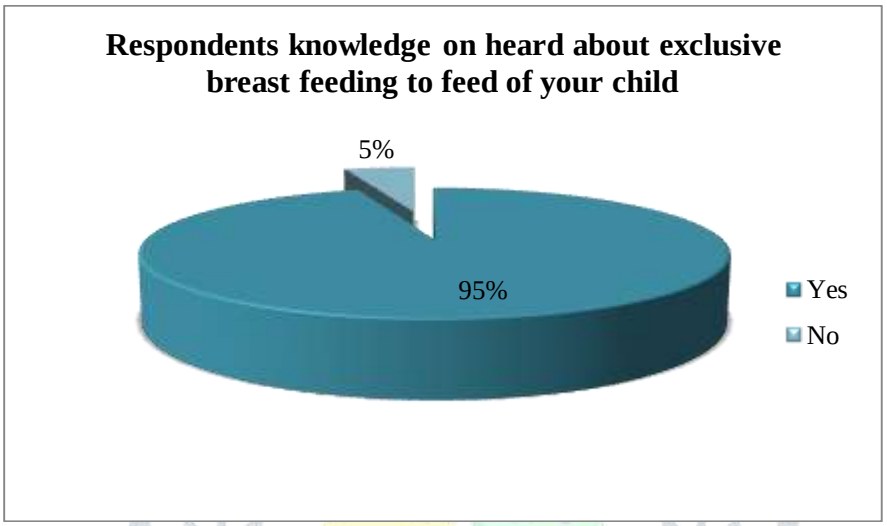


Fig. 11: Distribution of the respondent's knowledge on heard about exclusive breast feeding to feed of your child

In this Figure shows that respondent's knowledge on heard about exclusive breast feeding to feed of your child. Out of all respondent's 95 % was said thatthey have knowledge about exclusive breast feeding and only 5% was said no that they don't have knowledge on exclusive breast feeding.

Table 7: Distribution of the respondent's opinion about meaning of exclusive breast feeding

Name of variable	Parameters	Percentage (%)
Respondent's opinion about meaning of exclusive breast feeding	Only breast feeding up to six months	46.0
	Only breast feeding up to two years	22.5
	Breast milk and cows milk	8.0
	Breast milk and powder milk	12.5
	Colostrums	4.5
	Others	1.5
	Not Applicable	5.0

Table show that percentage distribution of respondent's opinion about mean by exclusive breast feeding. Respondent said only breast feeding up to six months was 46.0%, Breast milk and powder milk was 22.5%, Breast milk and cows milkwas 12.5%, Colostrums was 6.0%, Others was 1.5% and Not Applicable was 5.0% who didn't know meaning ofexclusive breast feeding.

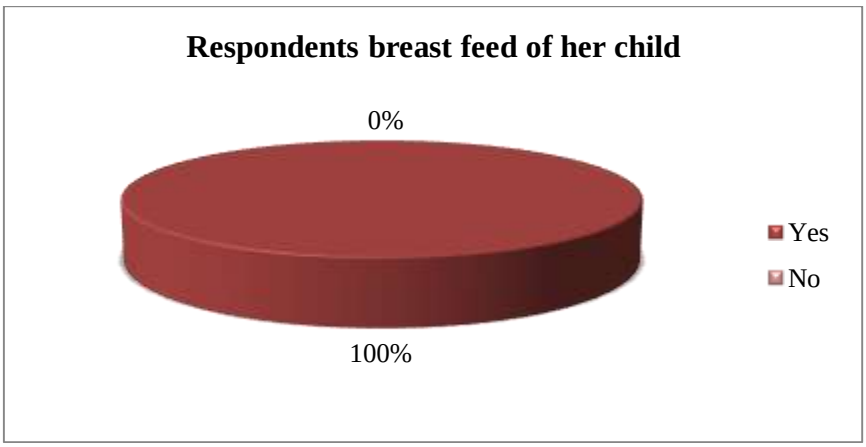


Fig. 12: Distribution of the respondent's breast feed of her child

In this Figure shows that respondent's breast feed of her child. Out of all respondent's 100 % was said thatthey breast feed of her child.

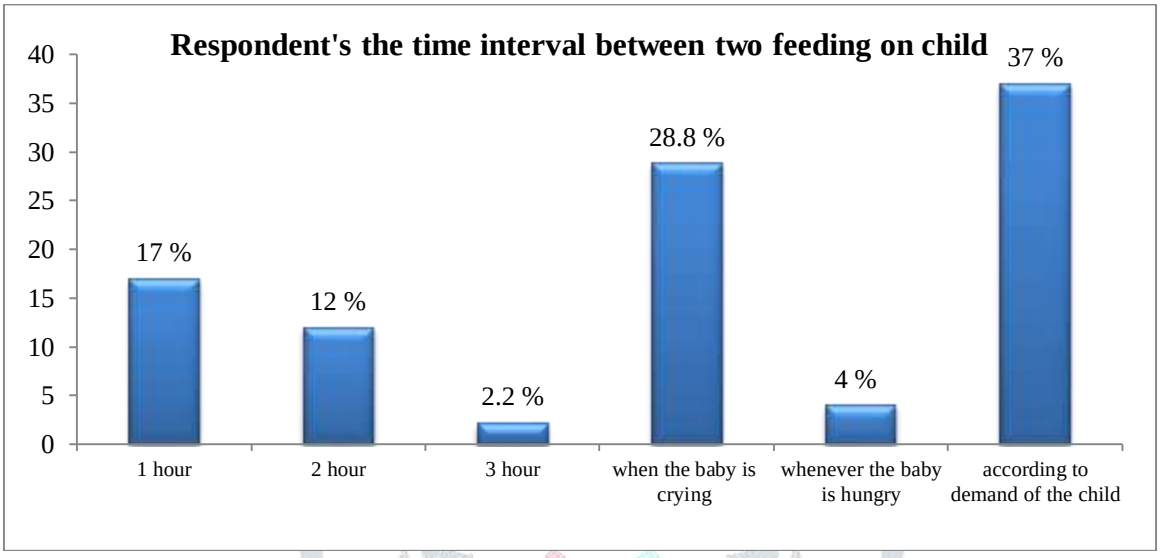


Figure 13: Percentage distribution of respondents the time interval between two feeding on child

In this Figure shows thatdistribution of respondents the time interval between two feeding on child. Out of all respondent's according to 37.0 % was said according to demand of the child, 28.8 % was said when the baby is crying, 17.0 % was said 1 hour, 12.0 % was said 2 hours, 4.0 % was said whenever the baby is hungry and 2.2 % was said 3 hours.

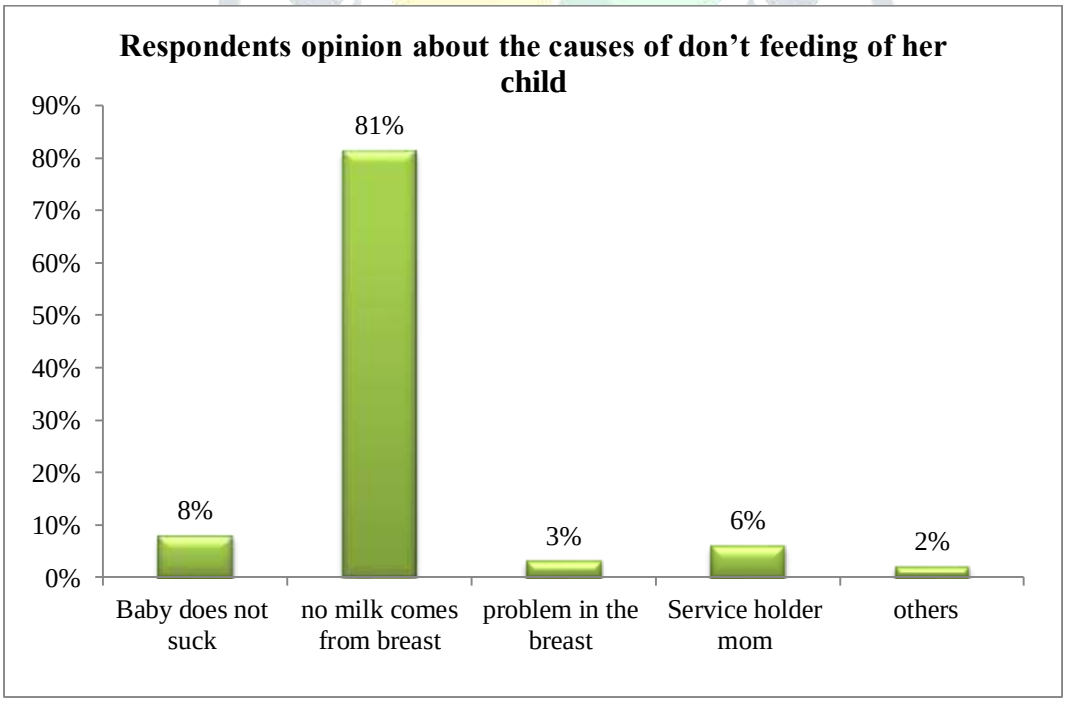


Fig. 14: Distribution of the respondent's opinion about the causes of don't feeding of her child

In this Figure shows that opinion about the causes of didn't feeding of her child. In this figure major percentage was 81.0% and it wassaid no milk comes from breast, 8% was said Baby does not suck, 3% was said problem in the breast, 6% was said Service holder mom and 2.0% was said others cause.

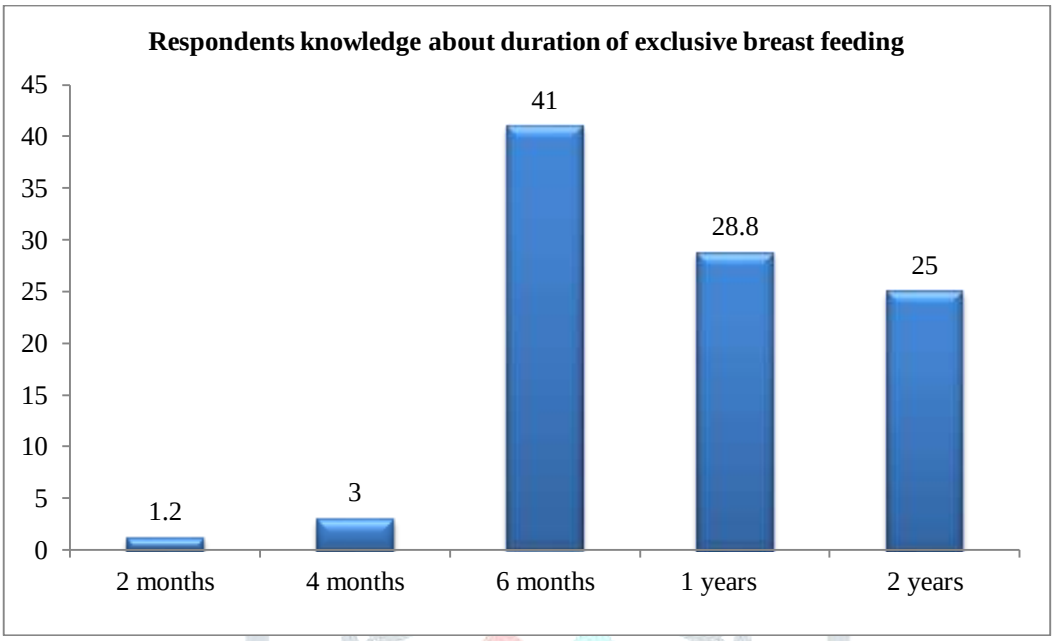


Figure 15: Percentage distribution of respondents knowledge about duration of exclusive breast feeding

In this Figure shows thatdistribution of respondent's knowledge about duration of exclusive breast feeding. Out of all respondent's 1.2% was said 2 months, 3.0% was said 4 months, 41.0% was said 6 months, 28.8% was said 1 year, and 2.2% was said 2 year duration.

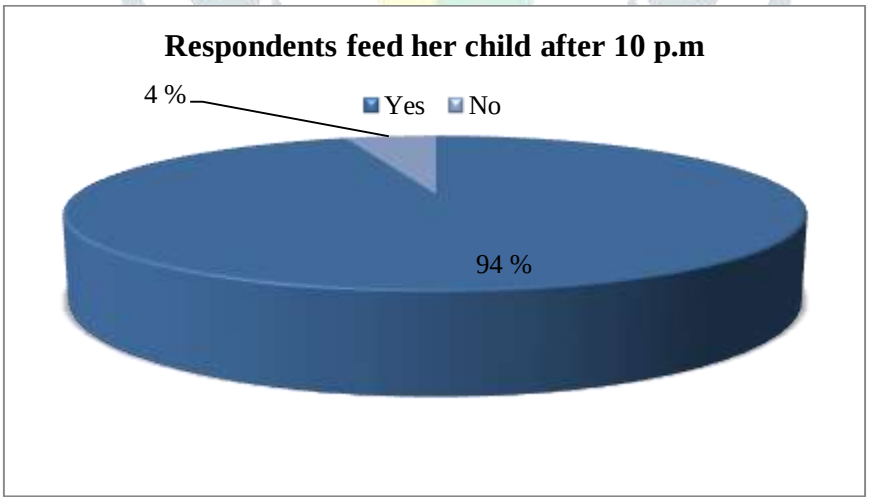


Fig. 16: Distribution of the respondent's feed her child after 10 p.m

In this Figure shows that respondent's feed her child after 10 p.m. Out of all respondent's 96 % was said thatthey feed their babyand only 4% was said that they don't feed their baby after10 p.m.

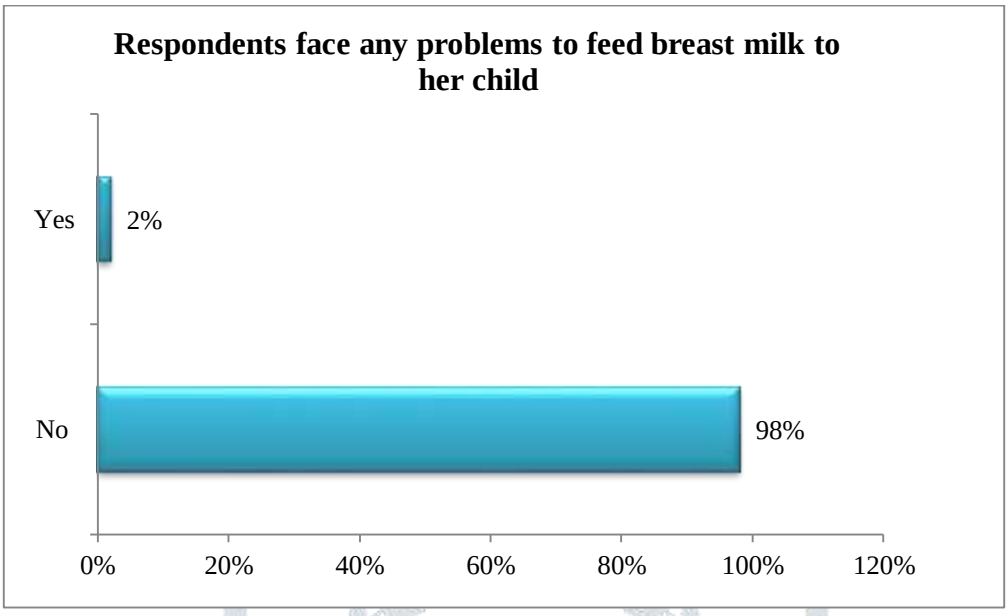


Fig. 17: Distribution of the respondent's face any problems to feed breast milk to her child

In this Figure shows that respondents face any problems to feed breast milk to her child. Out of all patients 92 % was saidnoand only 8% was said yes they face problems to feed breast milk to her child.

Table 8: Distribution of the respondent's the health care provider to her child in case of illness at first

Name of variable	Parameters	Percentage (%)
Respondent's the health care provider to her child in case of illness at first	Kobiraj	20.0
	Hujur	12.5
	Village doctor	26.0
	Registrar doctor	12.5
	Homeophati doctor	10.5

Table show that percentage distribution of respondent's the health care provider to her child in case of illness at first. Respondent said they go Kobiraj was 20%, hujurwas 12.5%, village doctorwas 26%, registrar doctorwas 12.5% and homeophati doctorwas 10.5%.

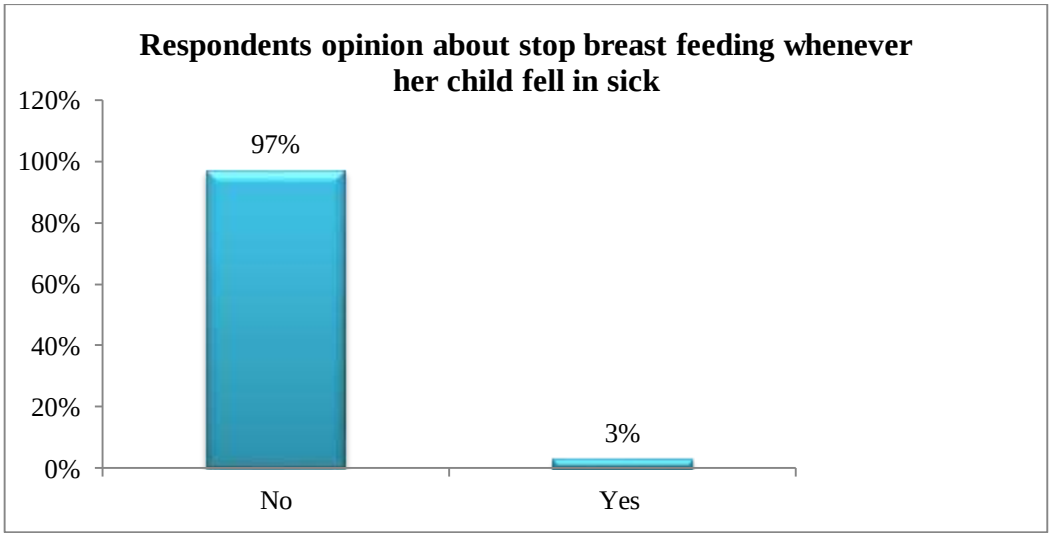


Fig. 18: Distribution of the respondent's opinion about stop breast feeding whenever her child fell in sick

In this Figure shows that opinion about stop breast feeding whenever her child fell in sick. In all respondent's 9% was said no and only 3% was said yesthat they stop breast feeding whenever her child fell in sick.

Table 9: Distribution of the respondent's the benefits of exclusive breast feeding

Name of variable	Parameters	Percentage (%)
	To increases immunity power	30.0

Respondent's the benefits of exclusive breast feeding	To provide nutrient and energy for growth and development	12.5
	Intelligent	26.0
	Bonding	12.5
	To meet hungry	8.0
	Reduce child mortality rate	15.5

Table show that percentage distribution of respondent's the benefits of exclusive breast feeding. Respondent said to increases immunity powerwas 30%, to provide nutrient and energy for growth and development was 12.5%, Intelligent was 26.0%, Bonding was 12.5% and reduce child mortality ratewas 10.5%.

CONCLUSIONS

This is very important for all health workers particularly clinicians with whom the women usually come in contact during the course of pregnancy, delivery and in the post partum period to educate the women about breastfeeding at every contact and avoid missed opportunities. The community and the government should work together to ensure that every girl-child is educated, and that workplace support for breastfeeding mothers are provided and improved upon. This study demonstrates the need to educate women and communities in low-income countries, and worldwide, about good breastfeeding practices such as early commencement of breastfeeding, the dangers of giving pre lacteal feeds and bottle feeding of infants. Targeting pregnant women will potentially help improve maternal and child health. In addition, interventions to improve breastfeeding knowledge and practice among women living in Bangladesh will help to close the identified gaps and improve the wellbeing of both mothers and babies living in such environments.

RECOMMENDATION

In Bangladesh, the median duration of breast feeding is quite long (30 months) but mothers rarely practice exclusive breastfeeding (EBF) (1). As EBF for 6 months has been promoted by WHO as the recommended feeding practice (2), the way Bangladeshi mothers practice breastfeeding is far from this recommendation. Sub-optimal breastfeeding practices are of great importance for Bangladeshi infants as they suffer from wide-spread malnutrition (3) and growth faltering starts as early as three months of age in developing countries of Asia with similar patterns in Bangladesh (4). Improving the breastfeeding practices of the mothers could protect infant health by providing adequate nutrition and preventing illness for the first 6 months (5). In an effort to improve breastfeeding practices, EBF for 5 months have been promoted since 1989 through national campaigns (6). Hospital-based interventions, such as UNICEF's Baby Friendly Hospital Initiatives (7), and community-based counseling initiatives have been shown to result in improved breastfeeding practices (8). Despite the development and testing of different successful programs to support breastfeeding, rates of EBF have remained quite low in Bangladesh (1) and very little is known about how mothers viewed their breastfeeding experiences. In seeking to understand why mothers offered non-breast milk foods to their infants during the first 6 months of age, the specific goals of our research were threefold. First, we wanted to gain an in-depth understanding of how the decisions regarding introducing non-breast milk foods are made from the mothers' perspective. Second, we wanted to examine the adequacy of the theory of breastfeeding self-efficacy and extend the conceptual model based on mothers' experience of breastfeeding practices. Finally, we wanted totest the extended conceptual model against empirical data from Maternal Infant Nutrition Initiative in Matlab (MINIMat).

Based on the findings of this study, the following recommendations are proposed to improve breastfeeding skills and practices among mothers in Bangladesh:

1. **Enhance Maternal Education:**
   - Develop and implement community-based education programs focused on breastfeeding techniques, benefits, and the importance of exclusive breastfeeding.
   - Integrate breastfeeding education into antenatal and postnatal care services to ensure mothers receive timely and practical guidance.

2. **Strengthen Healthcare Support:**
   - Train healthcare providers, including midwives and community health workers, on advanced lactation counseling to offer hands-on support to mothers.
   - Establish dedicated breastfeeding support centers in hospitals and community clinics to provide professional guidance and address challenges faced by mothers.

3. **Promote Early Initiation and Exclusive Breastfeeding:**
   - Raise awareness about the importance of initiating breastfeeding within the first hour of birth and continuing exclusive breastfeeding for the first six months.
   - Implement programs that discourage the early introduction of formula or other substitutes unless medically necessary.

4. **Address Socio-Cultural Barriers:**
   - Engage community leaders and influencers to promote positive cultural attitudes toward breastfeeding and dispel myths.
   - Design culturally sensitive materials and campaigns that resonate with local traditions while promoting optimal breastfeeding practices.

5. **Strengthen Policy and Advocacy Efforts:**
   - Advocate for strict enforcement of the International Code of Marketing of Breast-milk Substitutes to reduce the influence of formula advertising.
   - Introduce workplace breastfeeding policies, including maternity leave extensions, breastfeeding breaks, and lactation rooms, to support working mothers.

6. **Leverage Technology and Media:**
   - Use digital platforms and social media to disseminate breastfeeding information, including instructional videos and success stories.
   - Develop mobile applications that provide breastfeeding tips, track progress, and connect mothers to lactation experts.

7. **Foster Community Support Networks:**
   - Create mother-to-mother support groups to encourage peer learning and emotional support.
   - Engage family members, particularly fathers and grandmothers, in breastfeeding education to ensure a supportive home environment.

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