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Original Research Article

Barriers to exclusive breastfeeding encountered by mothers in and around Raichur district

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ABSTRACT

Background: Exclusive breastfeeding (EBF) is the ideal method of infant feeding during the first six months of life, providing optimal nutrition, immune protection, and support for infant growth and development. However, its practice remains suboptimal due to multiple maternal, socio-cultural, occupational, and healthcare-related barriers. Objectives were to assess the prevalence of EBF and identify barriers influencing its practice among mothers in and around Raichur district.
Methods: This community-based descriptive cross-sectional study was conducted over 12 months among 225 mothers with children aged less than 2 years. Data were collected using a pretested semi-structured questionnaire covering socio-demographic details, obstetric and infant characteristics, breastfeeding practices, and barriers to EBF.
Results: The prevalence of EBF was 57.8%. Early initiation of breastfeeding within one hour was reported by 46.2% of mothers, and colostrum feeding was practiced by 69.3%. The most common barriers were lack of counselling (45.3%), inadequate knowledge (36.9%), poor family support (35.1%), perceived inadequate milk production (32.4%), and cultural practices (32.0%). EBF was significantly associated with maternal occupation, antenatal care visits, mode of delivery, prelacteal feeding, bottle feeding, pacifier use, and cultural practices.
Conclusions: EBF prevalence was moderate but below the recommended universal target. Modifiable factors such as inadequate counselling, maternal employment, cesarean delivery, prelacteal feeding, bottle feeding, pacifier use, and cultural practices negatively influenced EBF. Strengthening antenatal and postnatal counselling, improving family support, and addressing harmful traditional feeding practices are essential to improve EBF rates.

Keywords: Exclusive breastfeeding, Barriers, Infant feeding, Maternal counselling, Raichur, Breastfeeding practices

INTRODUCTION

Exclusive breastfeeding (EBF) is widely regarded as the optimal method of infant feeding, ensuring adequate nutrition, growth, and immune protection during early life.

Breast milk is a biologically active fluid containing essential nutrients, immunoglobulins, enzymes, hormones, and growth factors that are uniquely suited to meet the developmental requirements of infants. Its composition dynamically adapts to the changing needs of the growing child, making it superior to any alternative feeding method.[1]

The World Health Organization and United Nations Children's Fund recommend initiation of breastfeeding within one hour of birth, EBF for the first six months of life, and continued breastfeeding up to two years of age or beyond along with appropriate complementary feeding.[2,3] EBF is defined as feeding the infant only breast milk, without any additional food or drink, not even water, except oral rehydration solutions, vitamins, minerals, or prescribed medications.[4]

The benefits of EBF are well documented for both infants and mothers. In infants, EBF reduces the risk of infectious diseases such as diarrhea, respiratory tract infections, otitis media, and necrotizing enterocolitis, and

is associated with improved cognitive development and reduced risk of chronic conditions such as obesity and hypertension later in life.[5] For mothers, breastfeeding contributes to reduced postpartum bleeding, early uterine involution, natural child spacing, and decreased risk of breast and ovarian cancers as well as type 2 diabetes.[6]

Despite these advantages, global prevalence of EBF remains below recommended levels. According to national family health survey (2019-2021), only 63.7% of infants in India are exclusively breastfed for 1st 6 months, with even lower rates observed in certain states such as Karnataka (54.2%).[7] This gap highlights significant barriers that hinder optimal breastfeeding practices.

Multiple studies have identified a range of factors influencing the continuation of EBF. Maternal-related barriers include lack of awareness, perceived insufficient milk production, maternal illness, and breastfeeding-related complications such as cracked nipples and mastitis.[8,9] Socio-cultural factors such as traditional feeding practices, family pressure, lack of maternal decision-making autonomy, and misconceptions about breastfeeding also play a critical role. Additionally, inadequate antenatal and postnatal counselling, low educational status, early return to work, and poor socio-economic conditions have been consistently associated with lower rates of EBF.[10]

Community-based studies conducted in different regions of India have demonstrated variability in EBF prevalence and its determinants. For instance, a study conducted in rural Gujarat reported an EBF rate of 49.7%, with factors such as early marriage, low maternal education, and inadequate antenatal care identified as significant barriers.[10] Similarly, an observational study in Hyderabad found that only 20% of mothers practiced EBF, with socio-economic constraints, lack of counselling, and maternal health issues contributing to early discontinuation.[9] These findings underscore multifactorial and context-specific nature of breastfeeding barriers.

In regions like Raichur district, where socio-economic challenges, limited healthcare access, and educational disparities are prevalent, understanding the local barriers to EBF becomes particularly important. Identifying these determinants will help in designing targeted interventions, improving maternal education, strengthening healthcare support systems, and promoting optimal infant feeding practices.

Therefore, present study aims to identify and analyze the barriers to EBF among mothers in and around Raichur district, thereby contributing to evidence-based strategies for improving maternal and child health outcomes.

METHODS

This community-based descriptive cross-sectional study was conducted over 12 months among mothers residing in and around the Raichur district, Karnataka, India. The study population comprised mothers with children aged less than 2 years. A total of 225 mothers were included in the study. Participants were recruited using non-probability convenience sampling.

Mothers of children under 2 years of age who were residents of the study area and provided written informed consent were included in the study. Mothers who did not consent to participate, those with known physical or mental illness that could interfere with breastfeeding practices, and mothers of children with significant physical or mental illness were excluded.

Data were collected using a pretested, semi-structured questionnaire administered through face-to-face interviews. The questionnaire included details on socio-demographic characteristics such as age, education, occupation, and socio-economic status; obstetric variables such as parity, antenatal care visits, and mode of delivery; and infant-related characteristics such as age, birth order, and health status. Information on breastfeeding practices, including initiation, duration, and exclusivity, was also recorded. In addition, barriers to EBF were assessed across multiple domains, including maternal factors, socio-cultural influences, family support, occupational constraints, and healthcare-related factors.

The primary outcome variable was EBF practice, while the independent variables included socio-demographic, maternal, cultural, healthcare-related, and infant-related factors.

Data were entered into Microsoft excel and analyzed using statistical package for the social sciences (SPSS) software version 25.0. Categorical variables were expressed as frequency and percentage, while continuous variables were summarized as mean±SD. Associations between categorical variables were assessed using Chi-square test or Fisher's exact test, as appropriate. Bivariate and multivariate logistic regression analyses were performed to identify factors associated with barriers to EBF. A p value of less than 0.05 was considered statistically significant.

The study was conducted in accordance with ethical principles for biomedical research involving human participants. Written informed consent was obtained from all participants prior to enrolment, and confidentiality of the collected data was strictly maintained. As this was an observational study, no intervention was carried out.

RESULTS

A total of 225 mothers were included in the study. The age distribution of the participants is presented in Table 1. The majority of mothers belonged to the 21-25-year age group (111, 49.3%), followed by the 26-30-year age group (63, 28.0%). Mothers aged above 30 years

constituted 32 (14.2%), while 19 (8.4%) were below 20 years, indicating that most participants were in the early reproductive age group.

Table 1: Age distribution of study participants, (n=225).

Age group (in years)	Number of mothers
<20	19 (8.4%)
21-25	111 (49.3%)
26-30	63 (28.0%)
>30	32 (14.2%)
Total	225 (100.0%)

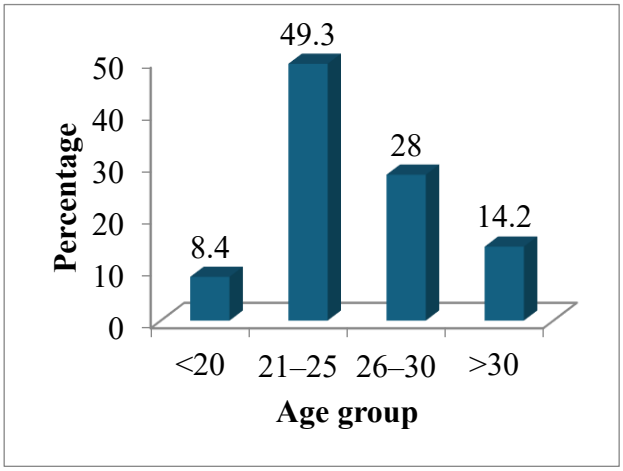

Figure 1: Age distribution of study participants, (n=225).

The socio-demographic characteristics of the study population are shown in Table 2. Most mothers had attained secondary level education (99, 44.0%), followed by primary education (53, 23.6%) and illiteracy (38, 16.9%), while 35 (15.6%) were graduates. A large proportion of mothers were housewives (161, 71.6%), with 64 (28.4%) being working mothers. Nearly half of the study population belonged to the low socioeconomic group (109, 48.4%), followed by middle (81, 36.0%) and high socioeconomic status (35, 15.6%).

Table 2: Socio-demographic characteristics, (n=225).

Variables	Category	N
Education	Illiterate	38 (16.9%)
	Primary	53 (23.6%)
	Secondary	99 (44.0%)
	Graduate	35 (15.6%)
Occupation	Housewife	161 (71.6%)
	Working	64 (28.4%)
Socioeconomic status	Low	109 (48.4%)
	Middle	81 (36.0%)
	High	35 (15.6%)

The obstetric and infant characteristics are summarized in Table 3. Slightly more than half of the mothers were multiparous (118, 52.4%), while 107 (47.6%) were primiparous. A majority of participants had attended four or more antenatal care visits (144, 64.0%), whereas 81 (36.0%) had fewer visits. Most deliveries were conducted by normal vaginal delivery (140, 62.2%), while 85 (37.8%) underwent LSCS. The majority of infants were in the 6-12 months age group (102, 45.3%), followed by <6 months (68, 30.2%) and >12 months (55, 24.4%). NICU admission was reported in 47 (20.9%) cases.

Breastfeeding practices among the participants are depicted in Table 4. A total of 130 mothers (57.8%) practiced EBF, whereas 95 (42.2%) did not. Early initiation of breastfeeding within 1 hour of birth was observed in 104 (46.2%) mothers, 94 (41.8%) within 1-24 hours, and 27 (12.0%) after 24 hours. Colostrum feeding was practised by 156 (69.3%) mothers, whereas 69 (30.7%) did not provide colostrum. Prelacteal feeding was reported in 69 (30.7%) cases. Additionally, bottle feeding was observed in 58 (25.8%) infants, and pacifier use was reported in 21 (9.3%) cases.

The barriers to EBF identified in the study are presented in Table 5. The most common barriers were lack of counselling (102, 45.3%), inadequate knowledge (83, 36.9%), poor family support (79, 35.1%), and perceived inadequate milk production (73, 32.4%). Cultural practices were noted in 72 (32.0%) mothers, while working constraints affected 64 (28.4%) participants.

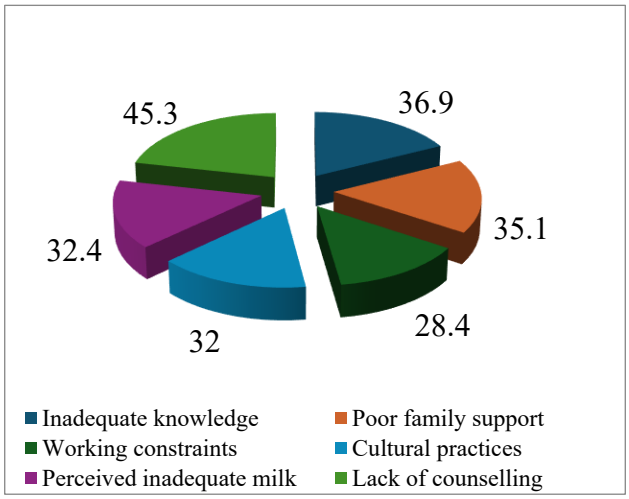

Figure 5: Barriers to EBF, (n=225).

The association between various factors and EBF is shown in Table 6. A statistically significant association was observed between EBF and maternal occupation ($p<0.001$), with 69.6% of housewives practising EBF compared to only 28.1% of working mothers. Similarly, mothers with four or more antenatal visits had higher rates of EBF (63.2% vs 48.1%, $p=0.040$). Mode of delivery also showed a significant association, with 64.3% of mothers who had normal vaginal delivery practicing EBF compared to 47.1% of LSCS mothers ($p=0.017$).

Prelacteal feeding had a strong negative association with EBF, as 73.1% of mothers who did not give prelacteal feeds practiced EBF compared to only 23.2% among those who did (p<0.001). Similarly, bottle feeding and pacifier use were significantly associated with lower EBF rates (p<0.001). No significant association was observed between EBF and maternal age group, socioeconomic status, or NICU admission.

The association between feeding practices, breastfeeding-related problems, and maternal factors with EBF is shown in Table 7. Bottle feeding showed a strong negative association with EBF, with significantly higher EBF rates among mothers who did not practice bottle feeding (75.4%) compared to those who did (6.9%) (p<0.001). Similarly, pacifier use was significantly associated with lower EBF rates (p<0.001), as none of the mothers using pacifiers practiced EBF, whereas 63.7% of those not using pacifiers maintained EBF. Cultural practices and traditional feeding methods were also significantly associated with EBF (p=0.001). Mothers who did not follow such practices demonstrated higher EBF rates (65.4%) compared to those who adhered to traditional feeding practices (41.7%).

In contrast, breastfeeding-related complications, including breast pain (p=0.508), cracked nipples (p=0.202), breast engorgement (p=0.522), mastitis (p=0.687), and latching or suction problems (p=0.868), were not significantly associated with EBF. Although these conditions were reported by a subset of participants, they did not appear to significantly influence EBF practices. Maternal illness also did not show statistically significant association with EBF (p=0.053), although a lower proportion of mothers with illness practiced EBF compared to those without illness (36.8% vs 59.7%).

Overall, the results indicate that although more than half of the mothers practiced EBF, several modifiable factors such as maternal employment, inadequate antenatal care, LSCS delivery, prelacteal feeding, and lack of counselling significantly influenced breastfeeding practices in the study population.

Table 3: Obstetric and infant characteristics, (n=225).

Variables	Category	N
Parity	Primi	107 (47.6%)
	Multi	118 (52.4%)
ANC visits	<4	81 (36.0%)
	≥4	144 (64.0%)
Mode of delivery	Normal	140 (62.2%)
	LSCS	85 (37.8%)
Infant age	<6 months	68 (30.2%)
	6-12 months	102 (45.3%)
	>12 months	55 (24.4%)
NICU admission	Yes	47 (20.9%)
	No	178 (79.1%)

Table 4: Breastfeeding practices, (n=225).

Variables	Category	N
EBF	Yes	130 (57.8%)
	No	95 (42.2%)
Initiation	<1 hr	104 (46.2%)
	1-24 hr	94 (41.8%)
	>24 hr	27 (12.0%)
Colostrum feeding	Yes	156 (69.3%)
	No	69 (30.7%)
Prelacteal feeds	Yes	69 (30.7%)
	No	156 (69.3%)
Bottle feeding	Yes	58 (25.8%)
	No	167 (74.2%)
Pacifier use	Yes	21 (9.3%)
	No	204 (90.7%)

Table 5: Barriers to EBF, (n=225).

Barriers	N
Inadequate knowledge	83 (36.9%)
Poor family support	79 (35.1%)
Working constraints	64 (28.4%)
Cultural practices	72 (32.0%)
Perceived inadequate milk	73 (32.4%)
Lack of counselling	102 (45.3%)

Table 6: Association of factors with EBF.

Variables	Category	EBF Yes	EBF No	P value
Occupation	Housewife	112 (69.6%)	49 (30.4%)	<0.001
	Working	18 (28.1%)	46 (71.9%)	
ANC visits	≥4	91 (63.2%)	53 (36.8%)	0.040
Mode of delivery	Normal	90 (64.3%)	50 (35.7%)	0.017
Prelacteal feeds	No	114 (73.1%)	42 (26.9%)	<0.001

Table 7: Association of breastfeeding practices and maternal barriers with EBF.

Variables	Category	EBF, Yes	EBF, No	P value
Bottle feeding	No	126 (75.4%)	41 (24.6%)	<0.001
	Yes	4 (6.9%)	54 (93.1%)	
Pacifier use	No	130 (63.7%)	74 (36.3%)	<0.001
	Yes	0 (0.0%)	21 (100.0%)	

Continued.

Variables	Category	EBF, Yes	EBF, No	P value
Breast pain	No	111 (56.9%)	84 (43.1%)	0.508
	Yes	19 (63.3%)	11 (36.7%)	
Cracked nipples	No	118 (59.3%)	81 (40.7%)	0.202
	Yes	12 (46.2%)	14 (53.8%)	
Breast engorgement	No	122 (57.3%)	91 (42.7%)	0.522
	Yes	8 (66.7%)	4 (33.3%)	
Mastitis	No	123 (57.5%)	91 (42.5%)	0.687
	Yes	7 (63.6%)	4 (36.4%)	
Latching/suction problem	No	114 (57.6%)	84 (42.4%)	0.868
	Yes	16 (59.3%)	11 (40.7%)	
Cultural practices/traditional feeds	No	100 (65.4%)	53 (34.6%)	0.001
	Yes	30 (41.7%)	42 (58.3%)	
Maternal illness	No	123 (59.7%)	83 (40.3%)	0.053
	Yes	7 (36.8%)	12 (63.2%)	

DISCUSSION

The present study was conducted to evaluate the prevalence of EBF and to identify the barriers influencing its practice among mothers in and around Raichur district. In this study, the prevalence of EBF was found to be 57.8%, which, although moderate, remains suboptimal when compared to the recommendations of the World Health Organization and United Nations Children's Fund, which advocate universal EBF for the first six months of life.[2]

The EBF prevalence observed in the present study (57.8%) is comparable to the findings of the National Family Health Survey (2019-2021), which reported an EBF prevalence of 63.7% in India and 54.2% in Karnataka.[7] This suggests that the study population reflects a trend similar to that in national and regional data.

In contrast, Syed Adnan Ali et al reported a significantly lower EBF prevalence of 20% in a tertiary care hospital-based study in Hyderabad. The discrepancy may be attributed to differences in study settings, socioeconomic factors, and urban lifestyle influences, all of which are known to negatively affect breastfeeding practices.[9]

Similarly, Bhanderi et al reported an EBF prevalence of 49.7% in rural Gujarat, which is slightly lower than that reported in the present study.[10] On the other hand, Venkatachalapathi et al observed a higher prevalence of 73.01% in a rural South Indian population, indicating that regional variations and local healthcare practices play a significant role in determining EBF rates.[11]

The present study demonstrated that the majority of mothers were in the 21-25-year age group (49.3%), consistent with findings by Ali et al in which the predominant age group was 22-25 years (36.7%).[9] However, no significant association was observed between maternal age and EBF in the present study, which is consistent with the findings of Bhanderi et al who also reported no significant relationship between maternal age and EBF. In terms of education, higher educational status was associated with better EBF practices in the present study. This is consistent with the findings of Bhanderi et al who reported a significant association between parental education and EBF (p=0.017). However, some studies have reported conflicting results, suggesting that higher education may sometimes lead to earlier adoption of formula feeding due to greater exposure to alternative feeding options.[10]

Maternal occupation emerged as a strong determinant of EBF in the present study, with significantly lower EBF rates among working mothers (28.1%) than among housewives (69.6%; p<0.001). This finding is in strong agreement with the study by Venkatachalapathi et al in which working mothers had higher odds of non-EBF (OR 3.32; p=0.02).[11] Similar observations were also reported by Bhanderi et al who found maternal employment to be significantly associated with reduced EBF rates (p=0.000).[10]

In the present study, ≥4 ANC visits were significantly associated with higher EBF rates (p=0.040). This finding is supported by Bhanderi et al who also identified fewer ANC visits as a significant barrier to EBF. Adequate antenatal care provides opportunities for counselling and education, which positively influence breastfeeding practices. Mode of delivery also showed a significant association, with higher EBF rates among mothers who had a normal vaginal delivery (64.3%) than among those who had an LSCS (47.1%, p=0.017). This is consistent with several studies, including that of Bhanderi et al in which operative delivery was identified as a barrier to EBF. Delayed initiation of breastfeeding and maternal discomfort following LSCS may contribute to this association.

Although early initiation of breastfeeding and skin-to-skin contact are known to improve EBF rates, these variables were not statistically significantly associated with EBF rates in the present study. This may be due to

variability in implementation and reporting. The present study showed that colostrum feeding was practised by 69.3% of mothers, which is comparable to findings from other Indian studies. However, prelacteal feeding was reported in 30.7% of cases, which is higher than desirable and represents a significant barrier. A strong negative association was observed between prelacteal feeding and EBF ($p<0.001$). This is consistent with the findings of Bhanderi et al who reported prelacteal feeding as a significant determinant of reduced EBF ($p=0.039$).[10] Similarly, bottle feeding (25.8%) and pacifier use (9.3%) were significantly associated with non-EBF ($p<0.001$). Ali et al also reported bottle-feeding in 16.3% and pacifier use in 12.2% of cases, both of which negatively influenced EBF.[9]

The most common barrier identified in the present study was lack of counselling (45.3%), followed by inadequate knowledge (36.9%), poor family support (35.1%), and perceived inadequate milk production (32.4%). These findings are in strong agreement with the study by Ali et al which reported that only 10.3% of mothers received counselling, highlighting the critical role of counselling in EBF.[9] Similarly, Gala et al identified knowledge gaps, maternal illness, and lack of family support as major barriers to EBF.[8]

The perception of inadequate milk supply was also a prominent barrier, consistent with findings by Venkatachalapathi et al in which 58.82% of mothers reported insufficient milk as a reason for discontinuing EBF.[11] This reflects a common misconception that needs to be addressed through education and counselling.

Cultural practices were reported in 32.0% of cases and significantly affected EBF ($p=0.001$). This aligns with the findings of Gala et al who found that traditional beliefs and practices, including prelacteal feeding and delayed initiation, were major barriers.[8] Breastfeeding-related complications such as breast pain (13.3%), cracked nipples (11.6%), and latching problems (12.0%) were observed in the present study. Similar findings were reported by Ali et al who identified cracks, suction problems, and breast pain as common maternal difficulties affecting breastfeeding.[9] Bottle feeding and pacifier use demonstrated a strong negative association with EBF ($p<0.001$), indicating that early introduction of artificial feeding methods significantly disrupts breastfeeding continuity, likely due to nipple confusion and reduced breast stimulation. Cultural practices and traditional feeding methods were also significantly associated with lower EBF rates ($p=0.001$), reflecting the persistent influence of socio-cultural beliefs and family-driven practices on infant feeding decisions. These findings are consistent with previous Indian studies that identify inappropriate feeding practices and cultural norms as major barriers to EBF. In contrast, breastfeeding-related problems such as breast pain, cracked nipples, engorgement, mastitis, and latching difficulties did not show a statistically significant association, suggesting that these challenges, although common, may be effectively managed and do not necessarily lead to discontinuation of breastfeeding when adequate support is available. Maternal illness also did not demonstrate a significant association, though a trend toward lower EBF was observed. Overall, the results underscore that behavioral and socio-cultural determinants exert a greater influence on EBF practices than physiological difficulties, emphasizing the need for targeted counselling and community-based interventions to improve EBF rates.

CONCLUSION

The present study demonstrated that the prevalence of EBF among mothers in and around Raichur district was 57.8%, which, although comparable to national averages, remains below the recommended universal target. The study population was predominantly young mothers in the early reproductive age group, with a considerable proportion from low socio-economic and educational backgrounds. EBF was significantly influenced by multiple modifiable factors. Maternal employment, inadequate antenatal care, and cesarean delivery were associated with lower EBF rates. In addition, prelacteal feeding, bottle feeding, and pacifier use showed a strong negative impact on EBF practices. Among the identified barriers, lack of counselling, inadequate knowledge, poor family support, and perceived insufficient milk production were the most prominent contributors to non-EBF. The findings emphasize that despite reasonable awareness levels, practical and socio-cultural challenges continue to hinder optimal breastfeeding practices. Most of these barriers are preventable and can be addressed through strengthening antenatal and postnatal counselling, improving family and community support systems, and implementing targeted health education programs. In conclusion, enhancing structured breastfeeding counselling, promoting institutional support for working mothers, and addressing misconceptions regarding milk adequacy are essential steps to improve EBF rates and achieve better maternal and child health outcomes.

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