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Original Research Article

Barriers to breastfeeding among daily-wage working mothers who delivered at a tertiary care centre

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ABSTRACT

Background: The primary objectives of this study are to identify the barriers of breastfeeding among daily wage working mothers and to study the infant feeding practices among daily wage working mothers delivered at tertiary care center.
Methods: This prospective observational study analyzed records of 150 daily wage working mothers. maternal characteristics, antenatal care, delivery details, breastfeeding initiation, feeding practices, return to work timing, working hours, work place feeding facilities, breaktime, family support, guilt related to breastfeeding and artificial feeding were assessed. Categorical variables were summarized as frequency and percentage.
Results: The mean maternal age was 23.84±3.6 years. Breastfeeding after birth was initiated by 143 (95.3%). Artificial feeding was reported by 80 (53.3%). Only 39 (26.0%) reported availability of a feeding room, while 114 (76.0%) reported no family support. Return to work was specifically recorded as the reason for artificial feeding in 67 (44.7%). Feeling of guilt was significantly associated with artificial feeding (χ^2 test, $p<0.001$), whereas availability of a feeding room, family support, daily working hours and return to work month were not statistically significant in this study.
Conclusions: Although breastfeeding initiation after delivery was high continuation was challenged by workplace and social constraints, with artificial feeding and reported guilt being common. Interventions for daily-wage workers should emphasize protected feeding/expressing time, private hygienic spaces, practical lactation support, family involvement and measures that facilitate breastfeeding after return to work.

Keywords: Barriers, Breastfeeding, Daily wage working mothers

INTRODUCTION

The World Health Organization recommends exclusive breastfeeding for the first 6 months, followed by continued breastfeeding with appropriate complementary foods.[1] The benefits of breastfeeding extend beyond nutrient delivery and include protection against infections and longer-term health advantages.[2] Despite these recommendations, maintaining exclusive breastfeeding can be difficult when mothers return to paid work, particularly when work environments do not provide time, privacy or practical facilities for breastfeeding or milk expression.[3] Maternal perceptions of insufficient milk supply, infant feeding difficulties and concerns about infant satiety are frequently reported reasons for early supplementation or discontinuation.[4] These concerns may be compounded by the demands of employment. Studies among employed mothers have demonstrated associations between earlier return to work, longer working hours and shorter breastfeeding duration.[5]

Workplace support is potentially modifiable. Research has identified maternity leave, flexible working arrangements, dedicated lactation spaces, opportunities for milk expression and social support as factors that can facilitate continued breast feeding. systematic review of

workplace interventions found that designated spaces, breastmilk-expression breaks and organizational policies were among the most frequently evaluated strategies and were associated with improved breastfeeding-related outcomes.

METHODS

A prospective study was conducted over a period of one year at ESIC medical college and hospital at Kalaburagi Karnataka. Mothers and their babies who came for routine immunization at immunization clinic were registered and based on their working status 150 working women with their babies were included in the present study after obtaining their informed consent.

Information on their sociodemographic profile and breastfeeding practices was obtained using a pretested structed questionnaire. Regular follow up was done at 6, 10,14,18 and 24 weeks at each visit the mothers were questioned about breastfeeding practices, their infant's feeding behavior and problems faced by working mothers when they returned to work.

Continuous variables were summarized using mean and standard deviation, and categorical variables using frequencies and percentages. Associations between selected workplace/social variables and artificial feeding were assessed using Pearson's chi-square test. A two-sided $p<0.05$ was considered statistically significant. Data was entered in excel sheet and analyzed using SPSS software. Results were expressed in terms of percentages and proportions.

RESULTS

Maternal and obstetric characteristics

The study included 150 women. Mean maternal age was 23.84±3.69 years (range 18–37 years). Mean birth weight was 2.74±0.41 kg (range 1.8–3.8 kg). Antenatal clinic attendance was reported in 116 (77.3%) women. Sixty-nine (46.0%) had normal vaginal delivery and 81 (54.0%) had lower-segment caesarean delivery (Table 1).

Table 1: Selected baseline and obstetric characteristics (n=150).

Variable	Category	N (%)
Age, years	18–24	97 (64.7%)
Age, years	25–37	53 (35.3%)
ANC attendance	Yes	116 (77.3%)
ANC attendance	No	34 (22.7%)
Delivery type	Vaginal	69 (46.0%)
Delivery type	LSCS	81 (54.0%)
Birth weight	<2.5 kg	30 (20.0%)
Birth weight	≥2.5 kg	120 (80.0%)

Breastfeeding practices

Breastfeeding after birth was reported by 143 (95.3%) women, while 7 (4.7%) did not breastfeed after birth. Among the recorded breastfeeding practices, 137 (91.3%) reported feeding from each breast. The number of feeds per day ranged from 6 to 10, with a mean of 7.31±0.87 feeds/day. Complementary feeding was most frequently started at six months (data recorded in the source dataset) (Table 2).

Table 2: Breastfeeding and work-related characteristics (n=150).

Variable	Category	N (%)
Breastfed after birth	Yes	143 (95.3%)
Breastfed after birth	No	7 (4.7%)
Artificial feeding	Yes	80 (53.3%)
Artificial feeding	No	70 (46.7%)
Feeding room available	Yes	39 (26.0%)
Feeding room available	No	111 (74.0%)
Family support	Yes	36 (24.0%)
Family support	No	114 (76.0%)
Feeling of guilt	Yes	90 (60.0%)
Feeling of guilt	No	60 (40.0%)
Return to work	3 months	10 (6.7%)
Return to work	4 months	21 (14.0%)
Return to work	5 months	60 (40.0%)
Return to work	6 months	59 (39.3%)

Workplace and social barriers

Most women reported no dedicated feeding room at the workplace: 111 (74.0%). Family support was absent in 114 (76.0%). Daily working hours were 5 hours in 20 women (13.3%), 6 hours in 65 (43.3%), 7 hours in 45 (30.0%), 8 hours in 19 (12.7%) and 10 hours in 1 (0.7%). Return to work occurred by three months in 10 women (6.7%), four months in 21 (14.0%), five months in 60 (40.0%) and six months in 59 (39.3%).

Among reasons recorded for artificial feeding, return to work was documented in 67 women (44.7% of the total cohort), while 13 (8.7%) had an infant-related reason and 70 (46.7%) had no artificial-feeding reason recorded because they were not using artificial feeds. This variable should therefore be interpreted as a recorded reason rather than a mutually exclusive barrier question.

Association between selected barriers and artificial feeding

Return to work occurred at 3–5 months postpartum in 93 (62.0%) mothers and at 6–7 months in 57 (38.0%). Daily working time was 6–7 hours for 126 (84.0%) and 1–5 hours for 24 (16.0%). Most participants worked 6 days/week (110, 73.3%); 24 (16.0%) worked 5 days and 16 (10.7%) worked 7 days (Table 3).

The pattern of barriers indicates that the difficulty was not failure to initiate breastfeeding but maintaining breastfeeding while fulfilling work responsibilities. Three-quarters of mothers lacked a dedicated feeding room and reported no family support during working hours. More than four-fifths worked 6–7 hours per day, while almost two-thirds returned to work by 3–5 months postpartum. The high proportion reporting guilt provides an additional indicator of the psychosocial burden associated with feeding constraints.

Table 3: Barriers of breastfeeding.

Workplace/family barrier	N (%)
No feeding room at workplace	111 (74.0)
Feeding room available	39 (26.0)
Family support available	36 (24.0)
No family support	114 (76.0)
Break 1–1.5 h/day	113 (76.0)
Break 2 h/day	37 (24.7)
Reported guilt about inadequate feeding	90 (60.0)
No reported guilt	60 (40.0)
Returned to work at 3–5 months	93 (62.0)
Returned at 6–7 months	57 (38.0)
Worked 6–7 h/day	126 (84.0)
Worked 1–5 h/day	24 (16.0)
Worked 6 days/week	110 (73.3)
Worked 5 days/week	24 (16.0)
Worked 7 days/week	16 (10.7)

DISCUSSION

The present study demonstrates a high prevalence of breastfeeding initiation among daily-wage working mothers, with all 150 participants reporting breastfeeding after birth. However, the transition from breastfeeding initiation to sustained breastfeeding alongside employment was characterized by important practical barriers. The most prominent barriers in this cohort were return to work, absence of a dedicated feeding space, limited family support and the constraints of working hours. Working part time versus full time and having a flexible work schedule Clinical Barriers to exclusive Breastfeeding also are linked with a longer duration of breastfeeding.[6]

The finding that all participants-initiated breastfeeding is consistent with the observation that breastfeeding initiation may remain high even when continuation is compromised by employment. Mother returning to work within 1 year after giving birth were significantly earlier in weaning than those without returning to work.[7] In a study of women working in tertiary-level hospitals in Nepal, breastfeeding was also universal, while work was reported as a barrier to exclusive breastfeeding and early complementary feeding. In the present study, direct exclusive breastfeeding during working hours was reported by 66.0%, whereas 28.0% used formula. Thus, the workplace appears to influence how breastfeeding is operationalized rather than whether it is initiated. most of the participants embarrassed to feed at working place.[8] Return to work was the most frequently documented specific reason for artificial feeding.[9]

Strong self-determination and a positive attitude towards breastfeeding were expressed among women as the most important elements for the continuation of breastfeeding after returning to work.[10,11] Maternal history of depression at any time and an anxiety during the pregnancy are also significant risk factors for the early discontinuation of breastfeeding.[12] Constraint work schedules, short maternity leaves and working full time are associated with breastfeeding cessation.[13] Three important psychosocial determinants of successful breastfeeding includes-Role modeling and support provided by family and friends, timing of a mother's decision to breastfeed, her intended duration of breastfeeding.[14,15]

Application findings

A strength of this study is its focus on daily-wage working women, a group that is less frequently represented in workplace breastfeeding research. The dataset also captures multiple domains maternal, obstetric, workplace and family factors allowing a multidimensional description of barriers.

Limitations

It is a single-Centre cross-sectional study with a sample of 150 women, limiting generalizability. The dataset does not clearly establish the infant age at assessment or provide a 24-hour dietary recall, so a formal WHO definition of exclusive breastfeeding should not be assigned retrospectively. The study also relies on self-reported information and cannot establish causal relationships. Occupational categories and some reason codes require confirmation from the original case-record form.

CONCLUSION

In this cohort of daily-wage working mothers, breastfeeding initiation was universal, but continuation during working hours was constrained by employment-related and social barriers. Return to work was the most frequently stated reason for artificial feeding, while lack of a workplace feeding room and lack of family support were common structural barriers.

Programs supporting daily-wage working mothers should combine antenatal and postnatal counselling with practical workplace measures that allow breastfeeding or milk expression and safe storage, and should actively involve family members in support.

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Ethical approval: The study was approved by the Institutional Ethics Committee

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