



Challenges and Barriers of Breast Feeding; Review Article

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Abstract

Background: Breastfeeding education is critical in improving healthcare professionals' competencies in providing breastfeeding care to mothers. Breastfeeding is associated with a decrease in a woman's risk of breast cancer, ovarian cancer, diabetes mellitus, and hypertensive heart disease. Many women experience early and undesired weaning because of persistent pain or nipple injury. A focused history and physical examination are essential to help obstetrician-gynecologists and other obstetric care professionals distinguish the specific cause of their patients' pain and determine appropriate treatment. **Aim:** the aim of this review was to give an overview of common challenges associated with breastfeeding. **Summary:** Studies have shown that pain with breastfeeding may be associated with postpartum depression; therefore, postpartum depression screening is an important part of the medical history when caring for these patients. Some women choose not to initiate breastfeeding, stop breastfeeding sooner than intended, or are unable to complete treatment with prescribed medications because they may have concerns regarding medication use during lactation. Health care professionals prescribing medications during lactation should base their counseling on accurate, current information from resources such as the National Center for Biotechnology Information's Drugs and Lactation database (known as LactMed). Causes of early weaning also may be attributed to societal factors, such as limited access to paid maternity leave and barriers to breastfeeding in the workplace. Obstetrician-gynecologists and other obstetric care professionals are uniquely positioned to support women in these situations.

Keywords: Breast Feeding; Mothers; Lactation; Engorgement; Nursing.

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Introduction

Evidence from several studies indicates that optimal breastfeeding is beneficial to infants, mothers and society. For instance, available evidence suggests that breastfeeding protects against acute otitis media, reduces the risk of diarrhea and respiratory tract infection and improves child cognitive development [1].

Additionally, current evidence in the Lancet series linked the reduction in overweight and diabetes in later life to breastfeeding. For mothers, breastfeeding improves birth spacing, avert breast cancer and may also reduce mother risk of ovarian cancer and diabetes [2].

The WHO in 2023 recommends exclusive breastfeeding for the first 6 months, continued breastfeeding for at least 24 months with the introduction of safe and nutritional adequate complementary feeding. Even though there is overwhelming evidence to support the need to adhere to these recommendations; many developed and developing countries fall short of these recommendations [3].

Nursing mothers are faced with multiple complex challenges in their attempt to adhere to breastfeeding recommendations. Nurses and midwives have a major role in supporting nursing mothers to overcome their

breastfeeding challenges. But, for nurses and midwives to be able to support mothers to overcome their breastfeeding challenges, there is the need for them to be well trained [1].

However, breastfeeding-related education is often not well addressed in the training of healthcare professionals with disparities in breastfeeding curriculum across health training institutions and universities [4].

Evidence suggests that several women report of lack of competencies of health professionals in addressing their lactation challenges. In some situations, the information provided by health professionals contradict other sources of breastfeeding information. Others even go to the extent of discouraging mothers to breastfeed [5].

In this review, we aimed to present the challenges and barriers facing breast feeding.

Breast feeding definitions

Breastfeeding is the process of feeding a newborn with the mother's milk, and it is very important for enhancing child and maternal health. The proportion and duration of breastfeeding may vary by location, and is poorly practiced for cultural, economic, and societal reasons[6].

Breastfeeding is universally acknowledged as providing health benefits for mothers and infants, decreasing infant mortality and morbidity particularly in developing countries, but also in more affluent societies like Canada. Despite strong recommendations from the World Health Organization and many national health bodies in the Western world, breastfeeding rates, and in particular exclusive breastfeeding rates at six months, remain lower than recommended and can be highly variable across cultures and communities [7].

Pumping and bottling or expressing and feeding babies away from their mothers' breasts has become a common method for infant feeding [8].

Barriers/challenges to breastfeeding at the mother-infant level

Maternal confidence in the ability to initiate and keep breastfeeding results from a dynamic interaction between each woman's expectations, the physical aspects of breastfeeding, her baby's breastfeeding behaviour, sources of support, and the complex social context within which breastfeeding and motherhood is embedded.[5] Going into breastfeeding with more realistic than idealistic expectations contributes to more maternal confidence, self-efficacy and ultimately breastfeeding success. Useful information about breastfeeding, intention to breastfeed, and early positive experiences and satisfaction with breastfeeding are also positive contributing factors [9].

Breastfeeding has maternal, infant, and societal benefits. However, many parents experience obstacles to achieving their breastfeeding goals, leading to reduced rates of breastfeeding initiation and continuation.[10]. Despite efforts to increase rates of breastfeeding initiation and continuation, inequities still persist. The factors that influence an individual's desire and ability to breastfeed are varied and include individual parent considerations; practitioner influences; hospital barriers; societal factors, such as workplace and parental leave policies; access to lactation support; and social support of their breastfeeding goals.[11].

A multidisciplinary approach that involves community, family, parents, and health care professionals will strengthen the support for parents and help them achieve their breastfeeding goals.[12].

Breast milk is well established as the best source of nutrition for infants. Breastfeeding has maternal, infant, and societal benefits. Despite efforts to increase rates of breastfeeding initiation and continuation, inequities still persist.[13] The American College of Obstetricians and Gynecologists recommends that practitioners educate parents about the benefits and mechanics of breastfeeding and encourages clinicians, nursing staff, and government assistance agencies to advocate for policy changes that facilitate breastfeeding, including lactation programs, both within hospitals and in the community.[14].

Joint decision making between parents and health care professionals is vital to minimize the risk of coercion. A multidisciplinary approach that involves community, family, parents, and health care professionals will strengthen the support for parents and help them achieve their breastfeeding goals.[15].

Common breast feeding problems and challenging aspects of breastfeeding in mothers

Engorgement

Breast engorgement is the physiologic bilateral breast fullness that occurs most often between day three and day five postpartum. It is typically a reassuring sign that mature milk is being secreted. The distention of the

alveolar ducts with milk causes vascular and lymphatic compression that can vary in incidence and severity. [16]

Factors associated with severely symptomatic breast engorgement may include primiparity, large amounts of intravenous fluids given during labor, history of premenstrual breast tenderness, and a history of breast surgery [17].

For more information regarding issues that may arise with a history of breast reduction, please see ACOG Committee Opinion 756, *Optimizing Support for Breastfeeding as Part of Obstetric Practice*. Women who undergo a cesarean delivery typically experience peak engorgement 24–49 hours later than those who give birth vaginally [18].

Persistent Pain With Breastfeeding

Many women experience early and undesired weaning because of persistent pain or nipple injury. The differential diagnosis includes a wide range of disorders that include latch issues, pump trauma, dermatoses, infection, vasospasm, allodynia or functional pain, oversupply or plugged ducts, and neonatal ankyloglossia [19]. A focused history and physical examination are essential to help obstetrician–gynecologists and other obstetric care professionals distinguish the specific cause of their patients' pain and determine appropriate treatment [20].

Low Milk Supply and Use of Galactagogues

Lactogenesis stage II is initiated by a decrease in progesterone after delivery of the placenta, and after concentrated colostrum is produced, there usually is a transition to higher milk volumes, starting at approximately 4 days postpartum. Perceived or actual milk supply is a common reason for undesired weaning. [21]

Once an evaluation of potential underlying physiologic and psychosocial contributors to perceived insufficient milk supply has been completed, patients should be reassured that their milk supply is adequate if the average feeding frequency is 8–12 times per day (some infants need more frequent feedings), steady weight is gained by day four or day five, and 6–8 wet diapers occur on average per day. [20]

An infant who does not lose excessive weight and is nursing effectively should obtain enough milk to begin gaining weight by day four or day five at a rate of approximately 15–30 g per day, exceeding their birth weight by 10–14 days. Because human milk is easily digested (usually within 1.5–2 hours), frequent feedings are not a sign of insufficient milk volumes. [20].

Occasionally, infants may need supplementation (donor milk or breast milk substitutes) if there is excessive early weight loss (greater than 8% by day four), suboptimal infant growth, dehydration, or hyperbilirubinemia or other medical conditions. Concerning findings should be communicated to the obstetric care professional so that the maternal–infant dyad can receive appropriate care and interventions as needed. Breastfeeding initiation may require additional support for late preterm and early-term infants. [22]

Galactagogues are medications and other substances believed to assist initiation, maintenance, or augmentation of rate of maternal milk synthesis. Pharmaceutical galactagogues include domperidone and metoclopramide; herbal galactagogues include fenugreek, fennel, and milk thistle.

Mastitis

Mastitis is one of the most common complications associated with breastfeeding. Women with a history of oversupply, nipple injury, latch difficulties, or skipped feedings may be at risk for mastitis [23]. Early recognition and treatment may prevent complications, such as breast abscess, sepsis, and early weaning.

Milk stasis is often the initiating factor in mastitis, and the most important management step is frequent and effective milk removal during the treatment. A patient may experience a decrease in her milk supply (this has been documented in animal studies), but this decrease usually will improve once she begins to recover, as long as she continues to breastfeed or adequately express her breast milk [24].

Women should be reassured that the antibiotics and anti-inflammatory medications used to treat mastitis are safe for her infants. Unless otherwise indicated, the patient should be encouraged to either continue breastfeeding her baby or to express her milk.

Medication Use During Lactation

Some women choose not to initiate breastfeeding, stop breastfeeding sooner than intended, or are unable to complete treatment with prescribed medications because they may have concerns regarding medication use during lactation [25].

Health care professionals often incorrectly counsel women regarding medication use and the need for cessation or interruption of lactation [26]. Yet, most medications are safe during breastfeeding. Health care professionals prescribing medications during lactation should base their counseling on accurate, current information from resources

Guidelines for Breastfeeding and Substance Use Disorder

Substance use is common among reproductive-aged women. Women who use nonmedical drugs, such as cocaine and phencyclidine, should be advised not to breastfeed, and use of these drugs should be discouraged. These drugs can be detected in human milk and may affect the infant negatively. Breastfeeding should be encouraged in women who are stable on medication-assisted treatment for opioid use disorders who are not using illicit drugs and who have no other contraindications to breastfeeding. Marijuana use should be discouraged because there is insufficient data to evaluate the effects of marijuana use on lactation and breastfeeding, and marijuana use may compromise caring for a child [27].

Infant exposure to marijuana smoke also should be discouraged. Similar to marijuana, tobacco smoking is not an absolute contraindication to breastfeeding, but tobacco use should be discouraged. Secondhand exposure to tobacco smoke should be avoided to minimize harmful effects on infants, such as respiratory allergies and increased risk of sudden infant death syndrome. For women who successfully quit tobacco use during pregnancy, breastfeeding may be associated with decreased recidivism [28].

Tobacco cessation should be encouraged and facilitated by providing counseling and resources (including nicotine replacements if needed). Alcohol is readily distributed to human milk and the concentration is similar to the concentration in plasma. Alcohol negatively affects milk ejection reflex, which may lead to a reduction in milk production. It can also impair the infant's motor development. Alcohol intake should be occasional, and no more than 0.5 g alcohol per kg body weight should be consumed, which is approximately 8 ounces of wine or 2 ounces of liquor for a 130 –pound woman [29].

Palpable Breast Mass While Breastfeeding

Pregnancy-associated breast cancer includes cancer diagnosed during pregnancy, throughout the first year postpartum, or during lactation [30]. Pregnancy-associated breast cancer accounts for approximately 3% of all breast cancer diagnoses, and the rate is increasing because more women are giving birth later in their reproductive years when breast cancer rates are higher [30]. Pregnancy-associated breast cancer carries a worse prognosis when diagnosed postpartum, and delays in diagnosis may be avoided by prompt evaluation of a palpable mass during lactation [31]

Factors that influence women's engagement with breastfeeding support

There are numerous health benefits of breastmilk on child health, such as reduced risk of hospitalisation due to respiratory tract infections, otitis media and of Sudden Infant Death Syndrome, as well as reduced incidence of gastrointestinal tract infections, clinical asthma and atopic dermatitis [32].

Additionally, obesity rates are significantly lower in children, adolescents, and adults who have been breastfed. The short- and long-term benefits for breastfeeding women include decreased postpartum blood loss and more rapid involution of the uterus, rapid weight loss, a decreased risk of type 2 diabetes mellitus and breast cancer. Crucially, there is a dose–response relationship for many of these outcomes, with the greatest benefits being realised when exclusive breastfeeding is practised for 6 months [33].

The cost-effectiveness of breastfeeding has been highlighted. The prevalence of not breastfeeding is associated with global financial losses of about \$302 billion annually [34] Consequently, different stakeholders have substantial interest in the promotion, protection, and support of breastfeeding. The World Health Organization (WHO) presents optimal breastfeeding as one of the most effective interventions in achieving maternal and child health and advises a period of exclusive breastfeeding of up to 6 months [3]

Despite the numerous benefits identified, initiation rates could be increased. Even when breastfeeding is initiated, continuation rates at an international level are [3]

In most countries, rates of exclusive breastfeeding at 6 months are below 50%. In low- and middle-income countries (LMICs) whilst most women practise some breastfeeding at 6 months, only 35% exclusively breastfeed under 6 months.

In high-income countries (HICs) few women exclusively breastfeed at 6 months, despite over 75% of women initiating breastfeeding. However, even within HIC and LMICs rates of breastfeeding vary, for instance, the prevalence of breastfeeding at 12 months is <1% in the United Kingdom and is 35% in Norway[35].

In addition, rates of breastfeeding also vary within countries according to socio-demographic characteristics. Within HICs breastfeeding rates were higher among high-income, better educated women compared to women from lower-income groups [35].

Conversely, in LMICs breastfeeding rates were higher in women from lower-income groups compared to women from high-income groups. Also, women from other vulnerable groups (e.g., teenage mothers), have lower breastfeeding rates[36]. Despite this, with effective support, women from vulnerable groups can breastfeed exclusively and for longer periods [37].

When women are asked about why they stop breastfeeding, the following reasons are often cited: fatigue, inconvenience, concerns about milk supply, painful nipples or poor guidance from health care professionals[38]. All these may result in early discontinuation of breastfeeding and can often be rectified with skilled support to enable women to continue breastfeeding [37] Such interventions tend to have a positive impact on both the initiation and continuation of breastfeeding .

Despite findings from meta-analyses suggesting that overall breastfeeding support interventions can improve breastfeeding rates [37], there is considerable statistical heterogeneity in the study results and clinical heterogeneity in terms of the interventions and participants. There is therefore a need to better understand why support interventions succeed or fail. Qualitative studies generally give a voice to those who experience an intervention or life situation, allowing them to share concerns and suggestions that relate to their specific needs. Such insights might help develop support programmes that better match the needs of women.

Evidence from qualitative studies can provide valuable insights into barriers and facilitators experienced by women associated with suboptimal uptake, initiation and continuation, and engagement and satisfaction with support programmes. It may further improve the equity of programmes by understanding who is not benefitting and why. In this qualitative synthesis barriers and facilitators are understood as contextual factors, including personal, cultural, political, social, psychological and other factors that impact on women's engagement or responsiveness to support as well as factors that influence their overall satisfaction with support [5].

Conclusion

Supporting women to initiate and continue to breastfeed is a complex process. Practitioners and service developers need to be aware that throughout the whole continuum of maternity care, women's breastfeeding support needs are dynamic, and it is unpredictable and uncertain when challenges and needs arise. The emotional and physical difficulties sometimes associated with breastfeeding may require diverse forms of support, also in combination, to counteract challenges.

Women's need for support was very wide, and support needs did not differ between the type of women. Women have similar core issues; hence breastfeeding support should be understood as a universal public health intervention. They need support and accurate support is often lacking in their living environment. One of the reasons for this is a lack of workforce, both on an institutional and community level. The evidence highlights the importance that emotional and appraisal support, as well as a stress-free environment, have for women. This environment is hard to create within the hospital sector, even more, if support is to be offered universally across private and public health care. The social environment and the community seem to offer that space with informal support mechanisms making up for deficits on the institutional level. Women assign distinct roles to each support provider within their maternity care.

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