

KNOWLEDGE AND PRACTICES OF EXCLUSIVE BREASTFEEDING AMONG MOTHERS OF NEWBORN BABIES AT CIVIL HOSPITAL SUKKUR

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Abstract

Keywords

Breastfeeding, Mother, Infant, Knowledge, Attitudes, Practice

Article History

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Copyright @Author Corresponding Author: * Dr Anjali Bai **Objective**: To assess the knowledge and practices of exclusive breastfeeding among mothers of newborn babies at the Civil Hospital, Sukkur. **Methods:** This cross-sectional study was conducted at the Department of

Pediatric Medicine, Ghulam Muhammad Mahar Medical College, Civil Hospital Sukkur, from 1st May to 31st October, 2024, using a non-probability consecutive sampling technique. It included mothers of newborns visiting the pediatric outpatient department for routine checkups, vaccinations, or illness. Mothers unwilling to participate, with medical contraindications to breastfeeding, or with adopted children were excluded. Data were collected using a pretested, interviewer-administered questionnaire with 18 questions: 11 on breastfeeding knowledge and 7 on practices. Each correct response earned one point. Knowledge scores were categorized as good (8-11), fair (4-7), or poor (0-3); practice scores as good (5-7), fair (3-4), or poor (0-2) [Annexure- A & B]. Demographic data, including maternal age, number of children, infant's age, weight, length, and vaccination status, were recorded. Weight and height were measured using a Camry analog scale and stadiometer. Socioeconomic status was assessed per the Pakistan Social and Living Measurement Survey.

Results: A total of 100 mothers were enrolled in the study. The average maternal age was 26.90 ± 5.99 years. Breastfeeding knowledge was poor in 44%, fair in 30%, and good in 26%. Practices were good in 34%, fair in 35%, and poor in 31%. Urban mothers showed a non-significant trend toward better knowledge (p=0.056). A significant link existed between occupation and knowledge (p=0.039), favoring working women. Education (p=0.004) and socioeconomic status (p=0.045) were also significantly associated with knowledge. No significant relationship existed for family structure or delivery mode. Regarding practices, housewives showed better outcomes (p=0.022). Education significantly influenced practices (p=0.018), while place of residence, family structure, delivery mode, and socioeconomic status did not show significant effects. Overall, education and occupation strongly influenced both knowledge and practices related to breastfeeding.

Conclusion: The findings highlight the influence of maternal education, occupation, and socioeconomic status on breastfeeding knowledge and practices. Consistent with existing literature, the results emphasize the need for multilevel, community-based interventions addressing educational disparities among working



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and stay-at-home mothers across all income groups. Additionally, cultural factors and modes of delivery warrant further investigation to develop comprehensive, locally tailored strategies to improve breastfeeding outcomes.

INTRODUCTION

Exclusive breastfeeding (EBF) is referred to as one of the most efficacious means of ensuring the health and survival of infants. Exclusive breastfeeding (EBF), meaning feeding the infant breast milk only without additional food, water, or other beverages during the first 6 months of life, is key for optimal infant nutrition and immunity (1). EBF provides substantial protection against neonatal and infant mortality and morbidity, as well as improved cognitive development and mother-child attachment based on evidence from the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Although with proven benefits, the global prevalence of EBF is far from optimum, especially in developing countries where there are diverse social, cultural, economic, and healthcare factors that can challenge its successful practice (2).

Pakistan is a country with one of the greatest burdens of child malnutrition and preventable infant deaths, where exclusive breastfeeding is an elevated public health priority. According to the Pakistan Demographic and Health Survey (PDHS) 2017-18, more than 50% of the infants are not fed according to WHO guidelines (3). This is an increase compared with previous years, but is still well below the global target of 70% or more of the very same indicators, established by the WHO Global Nutrition Targets 2025. There is a significant disparity between urban and rural areas, largely influenced by the level of access to information (4). Urban mothers often benefit from greater exposure to breastfeeding education and healthcare resources, while rural mothers may lack the same opportunities, leading to considerable differences in knowledge and practices (5).

Further analysis of the determinants of breastfeeding practices in Pakistan suggests that maternal awareness occupies a central position. It has been reported in several studies that many of the mothers could not fully grasp the meaning and its benefits of exclusive breastfeeding. For example, many mothers do not start breastfeeding early because they perceive colostrum to be either impure or inadequate (6). This misconception results in the feeding of prelacteal feeds, which may be honey, tea, rosewater, or formula feeds. All these practices undermine the otherwise ideal exclusive breastfeeding, predisposing the infant to infections and digestive disorders. They are frequently steeped in cultural practices and supported by powerful, overbearing family members like grandmothers or mother-in-laws (7).

Knowledge about the recommended practices doesn't automatically translate into action, not even in mothers who know what is recommended. More than 60% of mothers in one study had previously received information about the benefits of EBF, but less than 40% had practiced EBF for the first 6 months (8). This inconsistency may be due to various influences, including inconsistent advice from health care providers, contradictory advice given by family members, maternal tiredness, and concern over a lack of enough breast milk. Furthermore, the social pressure and the absence of support systems for mothers, especially the ones who are employed outside the home, put in place hurdles that many women from all backgrounds find it hard to overcome to continue EBF according to good intentions (9).

Socioeconomic status (SES) and level of education also have an important role in determining the practice of breastfeeding. Mothers of higher education may be more likely to know the benefits of the EBF and search for accurate health information. On the other hand, women with lower income and/or less education may be particularly at risk for cultural misinformation or myths around breastfeeding (10). Another important determinant is employment status. Breastfeeding and working mothers, especially those without access to leave or breastfeeding-friendly work maternity environments, frequently opt for mixed feeding much earlier than advised (11).

Breastfeeding behavior might also be influenced by health care systems. The postnatal care quality and accessibility, availability, and training of health



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workers on breastfeeding counseling are also important factors to encourage EBF (12). In many public healthcare settings, overwhelmed staff and the absence of standardized breastfeeding guidance result in inconsistent and often confusing messages being conveyed to new mothers. There are hospitals promoting milk formula, hence, instead of pursuing breastfeeding, mothers have been made to give up and use milk formula (13).

Among these challenges, the current knowledge and practice of maternal EBF in Pakistan needs to be elucidated. This insight can inform the development of targeted interventions that tackle not just awareness, but also the practical and cultural barriers that mothers face. Programs to promote better breastfeeding practices would need to focus on community-based education and family influence, as well as providing the necessary training for healthcare workers and supporting maternal leave and breastfeeding at the workplace (14).

Methods:

This cross-sectional study was conducted at the Department of Pediatric Medicine, Ghulam Muhammad Mahar Medical College (GMC), Civil Hospital Sukkur, from 1st May to 31st October, 2024, using a non-probability consecutive sampling technique. The study included mothers who had recently delivered a newborn and were visiting the pediatric outpatient department for their child's routine checkup, vaccination, or illness. Mothers who were unwilling to participate, had medical contraindications to breastfeeding, or had adopted children were excluded to minimize bias and control effect modifiers. Data were collected through a predesigned, pretested, interviewer-administered questionnaire consisting of 18 questions, 11 assessing breastfeeding knowledge and 7 assessing practices. Each correct or favorable response was awarded one point, with no deductions for incorrect answers. Knowledge was categorized as good (8-11 points), fair (4-7 points), or poor (0-3 points), while practices were classified as good (5-7 points), fair (3-4 points), or poor (0-2 points) (Annexure- A & B). Demographic information such as maternal age, number of children, infant's age, weight, length, vaccination status, and feeding history was recorded. Weight and height were measured using a Camry

analog scale and stadiometer, respectively. Maternal education and socioeconomic status were assessed via history, with socioeconomic status categorized according to the Pakistan Social and Living Measurement Survey (PSLM). All data were documented in a structured proforma, ensuring consistency and validity in data collection.

RESULTS:

A total of 100 mothers who recently gave birth and will be visiting the pediatric outpatient department for their child's routine checkup, vaccinations, or treatment for illness have been enrolled in the study. The average age of mothers was 26.90 ± 5.99 years. Moreover, the number of children among the mothers ranged from 1 to 4, with the majority having 1 or 2 children. A smaller proportion of mothers had 3 or 4 children (Table 1).

The demographic data gathered in this study offers valuable insights into the participants' backgrounds and socioeconomic conditions, providing essential context for understanding their knowledge and practices related to breastfeeding.

In terms of place of residence, 58% of the mothers lived in urban areas, while 42% were from rural areas. Regarding occupation, 59% were working women, while 41% were housewives. Family structure also varied, with 59% of the mothers coming from joint families and 41% from nuclear or separated family systems.

The mode of delivery data showed that 59% of the mothers had normal vaginal deliveries, while 41% underwent cesarean sections. Maternal education levels were diverse: 30% of the mothers were illiterate, 17% had completed primary education, and 16% had completed secondary education. Altogether, 54% of the mothers had at least some formal education (primary or higher), while 46% had either no formal education or just primary education.

Socioeconomic status analysis revealed that 22% of the mothers belonged to the upper class, 61% to the middle class, and 17% to the lower class.

When examining breastfeeding knowledge, the study found that 44% of the mothers had poor knowledge, 30% had fair knowledge, and 26% demonstrated good knowledge. As for breastfeeding practices, 34%



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of mothers exhibited good practices, 35% had fair practices, and 31% showed poor practices (Table 1).

Socio-Demographics	N (%) / Mean ± SD				
	Total=100				
Age (in years)	26.90 ± 5.99				
Residential status					
Urban	58 (58%)				
Rural	42 (42%)				
Occupation					
Working Women	59 (59%)				
Housewives	41 (41%)				
Family Structure					
Joint Family	59 (59%)				
Nuclear/Separated Family	41 (41%)				
Mode of delivery					
Normal Vaginal Delivery	59 (59%)				
Cesarean Section	41 (41%)				
Maternal Education Level					
Illiterate	30 (30.0%)				
Primary	17 (17.0%)				
Secondary	16 (16.0%)				
Matriculation	15 (15.0%)				
Intermediate	8 (8.0%)				
Graduate	14 (14.0%)				
Socioeconomic Status					
Upper Class	22 (22%)				
Middle Class	61 (61%)				
Lower Class	17 (17%)				
Breastfeeding Knowledge					
Poor	44 (44%)				
Fair	30 (30%)				
Good	26 (26%)				
Breastfeeding Practices					
Poor	31 (31%)				
Fair	35 (35%)				
Good	34 (34%)				

Table 1: Socio-demographic characteristics and breastfeeding knowledge and practices of mothers (N = 100)

The bivariate analysis using chi-square tests explores the relationship between various sociodemographic factors and mothers' knowledge of breastfeeding.

The analysis revealed that among urban mothers, 20 had good knowledge, while 23 rural mothers had poor knowledge. The p-value was 0.056, which is just above the conventional threshold for significance (p \leq 0.05). Although not statistically significant, the

result suggests a potential trend where urban mothers tend to have better breastfeeding knowledge than rural mothers, which may warrant further investigation with a larger sample (Table 2).

A significant association was found between occupation and breastfeeding knowledge, with a pvalue of 0.039. Working mothers were more likely to have good knowledge (20 out of 59) compared to



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housewives (6 out of 41). This suggests that working women may have better access to health education, information, or workplace awareness programs, contributing to improved knowledge.

No significant relationship was found between family structure and knowledge, though the distribution showed some variation. Mothers from joint families showed slightly better knowledge than those from separated families, but this was not statistically significant.

There was no statistically significant association between mode of delivery and breastfeeding knowledge. Both mothers who had normal vaginal deliveries and those who had cesarean sections showed similar levels of knowledge across categories.

A highly significant association was observed between maternal education and breastfeeding knowledge, with a p-value of 0.004. Mothers with higher education levels (matriculation, intermediate, graduate) demonstrated substantially better knowledge compared to illiterate mothers. For instance, 7 out of 14 graduate mothers had good knowledge, while 23 out of 30 illiterate mothers had poor knowledge. This strongly supports the role of education in enhancing maternal awareness and understanding of breastfeeding.

A statistically significant relationship was also found between socioeconomic status and knowledge, with a p-value of 0.045. Mothers from upper and middle socioeconomic classes showed better knowledge compared to those from lower-class backgrounds. Notably, 13 out of 17 mothers in the lower class had poor knowledge, indicating disparities in access to health information and resources (Table 2).

Variables	Categories	Mother's Knowle	P-value		
		Good	Fair	Poor	
Place of Residence	Urban (n = 58)	20 (34.5%)	17 (29.3%)	21 (36.2%)	0.056
	Rural (n = 42)	6 (14.3%)	13 (31.0%)	23 (54.8%)	
Occupation	Working Woman (n=59)	20 (33.9%)	13 (22.0%)	26 (44.1%)	0.039*
	Housewife (n = 41)	6 (14.6%)	17 (41.5%)	18 (43.9%)	
Family system	Joint (n = 59)	19 (32.2%)	13 (22.0%)	27 (45.8%)	0.072
	Separated (n = 41)	7 (17.1%)	17 (41.5%)	17 (41.5%)	
Mode of Delivery	Normal Vaginal (n = 59)	13 (22.0%)	18 (30.5%)	28 (47.5%)	0.529
	Cesarean Section (n = 41)	13 (31.7%)	12 (29.3%)	16 (39.0%)	
Maternal Educational Level	Illiterate (n = 30)	3 (10.0%)	4 (13.3%)	23 (76.7%)	0.004*
	Primary (n = 17)	3 (17.6%)	9 (52.9%)	5 (29.4%)	
	Secondary (n = 16)	5 (31.3%)	5 (31.3%)	6 (37.5%)	
	Matriculation (n = 15)	6 (40.0%)	6 (40.0%)	3 (20.0%)]



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	Intermediate (n = 8)	2 (25.0%)	3 (37.5%)	3 (37.5%)	
	Graduate (n = 14)	7 (50.0%)	3 (21.4%)	4 (28.6%)	
Family Socioeconomic	Upper (n = 22)	7 (31.8%)	7 (31.8%)	8 (36.4%)	0.045*
Status	Middle (n = 61)	16 (26.2%)	22 (36.1%)	23 (37.7%)	
	Lower (n = 17)	3 (17.6%)	1 (5.9%)	13 (76.5%)	

Table 2: Association between socio-demographic variables and mothers' knowledge about exclusive breastfeeding practices (N = 100)

While the analysis of breastfeeding practices about various demographic and socioeconomic variables also provides meaningful insights in our study.

Mothers from urban and rural areas showed comparable breastfeeding practices. In urban areas, 19 mothers had good practices, compared to 15 in rural areas. However, the p-value was 0.488, indicating no significant association between place of residence and breastfeeding practices (Table 3).

Occupation, on the other hand, showed a statistically significant association with breastfeeding practices (p = 0.022). Interestingly, housewives had better practices overall 20 out of 41 demonstrated good practices compared to working mothers, where only 14 out of 59 had good practices. This may suggest that housewives, possibly due to more time spent at home and with their infants, are more likely to follow appropriate breastfeeding practices.

No significant difference was found in practices based on family system. Both joint and separated families showed similar patterns, with good practice observed in 19 joint-family mothers and 15 separated-family mothers (p = 0.487). Mode of delivery also did not show a statistically significant impact on breastfeeding practices (p = 0.263). Both vaginal delivery and cesarean section groups had comparable distributions across good, fair, and poor practices.

Maternal education, however, showed a significant association with breastfeeding practices (p = 0.018). Mothers with higher education levels (particularly secondary and matriculation) tended to report better practices. For example, 10 out of 17 mothers with primary education and 7 out of 16 with secondary education had good practices, while only 7 out of 30 illiterate mothers showed good practices. This further reinforces the influence of education on maternal behavior.

Socioeconomic status did not show a statistically significant association with breastfeeding practices (p = 0.172), though a pattern was observed. Mothers from the upper class had the highest proportion of good practices (8 out of 22), whereas the majority of lower-class mothers had poor practices (9 out of 17). While this trend is suggestive, it did not reach the threshold for statistical significance (Table 3).

Variables Categories		Breastfeeding Pr	P-value		
		Good	Fair	Poor	
Place of	Urban	19 (32.8%)	23 (39.7%)	16 (27.6%)	0.488
Residence	(n = 58)				
	Rural	15 (35.7%)	12 (28.6%)	15 (35.7%)	
	(n = 42)				
Occupation	Working	14 (23.7%)	22 (37.3%)	23 (39.0%)	0.022*
	Woman (n=59)				
	Housewife	20 (48.8%)	13 (31.7%)	8 (19.5%)	



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	(n = 41)				
Family system	Joint (n = 59)	19 (32.2%)	19 (32.2%)	21 (35.6%)	0.487
	Separated $(n = 41)$	15 (36.6%)	16 (39.0%)	10 (24.4%)	
Mode of	Normal	18 (30.5%)	19 (32.2%)	22 (37.3%)	
Delivery	Vaginal				0.263
	(n = 59)				
	Cesarean	16 (39.0%)	16 (39.0%)	9 (22.0%)	
	Section				
	(n = 41)				
Maternal	Illiterate	7 (23.3%)	8 (26.7%)	15 (50.0%)	
Educational	(n = 30)				
Level	Primary	10 (58.8%)	5 (29.4%)	2 (11.8%)	0.018*
	(n = 17)				
	Secondary	7 (43.8%)	8 (50.0%)	1 (6.3%)	
	(n = 16)				
	Matriculation	6 (40.0%)	6 (40.0%)	3 (20.0%)	
	(n = 15)				-
	Intermediate (n	2 (25.0%)	4 (50.0%)	2 (25.0%)	
	= 8)				1
	Graduate	2 (14.3%)	4 (28.6%)	8 (57.1%)	
	(n = 14)	0 (0 (10/)			
Family	Upper	8 (36.4%)	10 (45.5%)	4 (18.2%)	
Socioeconomic	(n = 22)				0.172
Status	Middle	23 (37.7%)	20 (32.8%)	18 (29.5%)	
	(n = 61)		5 (22, 10())	2 (52 22()	4
	Lower (n	3 (17.6%)	5 (29.4%)	9 (52.9%)	
	= 1''				

Table 3: Association between socio-demographic variables and breastfeeding practices (N = 100)

Discussion:

This study is a significant addition to what is known regarding the knowledge of and practices related to breastfeeding of the 100 mothers visiting pediatric outpatient clinics at Sukkur, Pakistan. The study demonstrates the key role of maternal education, occupation, and socioeconomic status (SES) in breastfeeding outcomes, as reported in the literature, and provides points for focused intervention.

A noteworthy result in this study was the significant relationship between maternal education and breastfeeding knowledge and practice. Mothers' higher levels of education significantly improved their knowledge and practices, which is in line with analyses conducted in Pakistan. For example, a study in Rawalpindi demonstrated that having an educated mother was associated with higher odds of exclusive breastfeeding practice, as educated mothers are more aware of its advantages (15). Another study in Dhaka, Bangladesh, also reported maternal education as a strong predictor of both knowledge about and practice of breastfeeding (16). Collectively, these findings underscore the importance of educational interventions for optimal breastfeeding practices.

The study also reported better knowledge among the working mothers, while better breastfeeding practices were observed among housewives. This contrast can be explained by the difference in problems of these last two groups. Most working mothers have a superior ease of access to health information and support, as indicated in studies qualitative nature



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conducted in urban professional women of Pakistan, which elicited workplace support and planning as major facilitators to sustain breastfeeding (17). On the other hand, as housewives might have more time to provide for breastfeeding their babies, they might be deprived of knowledge and support systems, and consequently, differences might also be inconsistent with the practices observed (18).

A significant relationship was also reported between breastfeeding knowledge and socioeconomic status. Breastfeeding awareness was higher in upper and middle-class mothers than in lower-class. This finding is consistent with those of studies conducted in Morocco, which showed strong associations between maternal socio-economic status and BF practices (19). The positive difference is thought to be linked to variations in access to healthcare, nutrition, and breastfeeding support services, suggesting that such a divide exists, and in areas of lower income, action should be directly targeted.

Urban mothers had higher levels of breastfeeding knowledge, but the differences were not statistically significant. This may indicate that factors other than urban-rural residence, such as availability of resources for healthcare and education, are more determining knowledge important in on breastfeeding. Srivastava et al (2024) in their study revealed that family type was not a determinant of breastfeeding knowledge or practice in this study; hence, other variables such as maternal education and occupation might be the influential factors (20). There was no association between knowledge and practices regarding breastfeeding and the mode of delivery in the study. This contrasts with several other studies that reported variations in breastfeeding initiation and exclusivity based on the mode of delivery. Nevertheless, the lack of such a relationship within our study may reflect the limited number of patients, and consequently, more studies are required to clarify this relationship (21).

Although the present study did not refer to cultural practices, literature demonstrates their significant contribution to shaping breastfeeding practices. In the rural areas of Pakistan, for example, giving prelacteal feeds (honey and jaggery) is still prevalent, and this practice is performed with the lens of cultural influences. These practices reduce the time to initiate breastfeeding and influence the duration of exclusive breastfeeding; therefore, culturally appropriate behavior change communication campaign is important to modify these behaviors and to practice optimal practices.

Conclusion

The results of the present study underline the importance of mother education and occupation and maternal socio-economic status in influencing the knowledge and practice of breastfeeding. The results are congruent with the literature, calling for multilevel community-based interventions targeting educational disparities, for both working and athome mothers, and for both rich and poor residential communities. Culture and delivery mode, among other clinical factors, need to be further investigated to develop holistic, locally relevant strategies for enhancing breastfeeding outcomes.

Conflict of interest: - The authors declare no conflict of interest.

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