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RESEARCH ARTICLE

BREAST FEEDING PRACTICES AND ITS CONSTRAINTS AMONG A RURAL POPULATION IN HARYANA, INDIA

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ABSTRACT

Background: Promotion and support of breast feeding is a global priority and an important child survival intervention. **Objective:** Objective of this study was to find out the breast feeding practices and its constraints among a rural population in Haryana, India. **Methods:** All delivered mothers, from among 5 villages, who had delivered for the first time and had children between 1 – 2 years were included in the study. Consent was taken from them and they were informed well about the purpose of the study. Ethical clearance was obtained for the study. The study period ranged from October 2013 till March 2014. A pre-designed, semi-structured schedule was administered to them and they were interviewed regarding their socio-demographic details, their ante-natal care details, delivery details, breast feeding practices and regarding the services they got from their auxiliary nurse midwife (ANMs). **Observations:** It was found that there were 42(16.1%) mothers who were not breast feeding their babies due to some or other reasons. Rest 218 (83.9%) did feed their child, however. From among them it was found that only 55(25.2%) exclusively breast fed their child. **Conclusions:** It was found that maximum study subjects who exclusively breast fed their child were < 25 years, were educated and belonged to lower socio economic status. Exclusive breast feeding was more among non working females. Similarly, exclusive breast feeding was more in those subjects who delivered in government health facilities, availed complete ante-natal care facilities in subcentre and were counseled about breast feeding practices previously.

INTRODUCTION

Breastfeeding benefits for newborns and infants are well documented. Promotion and support of breast feeding is a global priority and an important child survival intervention.[1] Breastfeeding provides infants with superior nutritional content that is capable of improving infant immunity and possible reduction in future health care spending.[2,3] At the Innocenti Declaration in 1990, the WHO called for policies that would cultivate a breastfeeding culture that encourages women to breastfeed their children exclusively for the first 6 months of life and then up to 2 years of age and beyond.[2,4] However, a recent estimate by the WHO showed that worldwide only 35% of children between birth and their 5th month are breastfed exclusively.[5] Based on the WHO global data on infant and young child feeding in India, 58.3% of children were exclusively breastfed for less than 4 months, while 24.5% were exclusively breastfed for less than 6 months, in the year 2009.There were 15.1% who were bottle fed.

A randomized controlled trial conducted in a tertiary hospital in Singapore has revealed that antenatal breastfeeding education and postnatal lactation support, as single interventions based in hospital, both significantly improved rates of exclusive breastfeeding up to six months after delivery.[1] Lin et al have demonstrated the effectiveness of a prenatal education program in Taiwan on maternal knowledge, attitude and satisfaction towards breastfeeding.[2] Breastfeeding support through an early, routine, preventive visit in the offices of trained primary care physicians has also been found to be effective in France.[3] Hence, antenatal counseling by trained health personnel has a role in promotion of breastfeeding.

In India, the health care provider during the antenatal visits is usually an obstetrician or an auxiliary nurse midwife (ANM). In the rural health set up, ANM is the health functionary closest to the community. ANMs visit homes in their respective allotted villages and provide basic health services and health education. Although opportunities exist during antenatal visits, counseling mothers regarding breastfeeding is often not done adequately.[4] According to a study from west India, conducted in 1996–97, nearly half the pregnant women did not receive information regarding breastfeeding.[5] This deficiency is likely to affect the promotion and support of breastfeeding. No doubt, conditions have

improved since then, but the way to be taken is still long.

This study was undertaken to assess the awareness of breast feeding among rural pregnant mothers and the advice they had received during the antenatal visits. We have tried to explore the beliefs, practices and difficulties to exclusive breastfeeding.

It was undertaken with an objective of exploring the beliefs, customs, practices and the difficulties associated with breast feeding. Pregnant mothers were also checked for, whether they had been adequately counseled about breast feeding during their antenatal period

MATERIALS AND METHODLOGY

It was planned to conduct a descriptive type of cross sectional study. For this, the primary health centre (PHC) Chiri was selected which has a population of 30,435 and 5 villages under it. The PHC is attached to the department of community medicine, PGIMS, Rohtak and is 35 km from the college. There are 5 villages under the PHC – Chiri, Indergarh, Chandi, Khranti and Gharonthi. So it was decided to include all the delivered mothers in the 5 villages, who had children between 1– 2 years and had delivered for the first time. Consent was taken from them and they were informed well about the purpose of the study. Institute ethical clearance was obtained for the study. The study period ranged from Oct 2013 till March 2014.

A due list of all those who had delivered for the first time were obtained from the ANM of the respective subcentres which came out to be a total of 328. Then consent was obtained for the study and those not willing to participate were excluded from the study. There were 21 such mothers. Then the number of still born and the number of infant deaths were obtained from the subcentre register for all the villages which came out to be 27. There were others who had gone to their maternal house to be looked after delivery and besides those unavailable at the time of visit were also excluded. Such mothers were 20 in number. Making all such exclusions, the total number of mothers who were included in the study came out to be 260.

After informing the mothers about the study purpose, a pre-designed, semi-structured schedule was administered to them and they were interviewed regarding their socio-demographic details, their ante-natal care details, delivery details, breast feeding practices and regarding the services they got from their ANMs. The result was then manipulated and analysed using the

microsoft excel sheets and the SPSS 20 software. P value < 0.05 was considered as statistically significant.

RESULTS

It was found that there were 42 (16.1%) mothers who were not breast feeding their babies due to some or other reasons. Rest 218 (83.9%) did feed their child, however. From among them it was found that only 55 (25.2%) exclusively breast fed their child as depicted in Figure 1. Table 1 shows how different socio demographic factors and other ante-natal and delivery practices are related to exclusive breast feeding. It was found that maximum study subjects who exclusively breast fed their child were < 25 years, were educated and belonged to lower socio economic status. However, they all were non significant. EBF was more among non working females and factor with its association was found to be highly significant. Similarly, exclusive breast feeding was more in those subjects who delivered in government health facilities, availed complete ANC facilities in subcentre and were counseled about breast feeding practices previously. These associations were also statistically significant depicting the strength of association. Subjects who were counseled post natally about EBF were more likely to practice it, however the association was not significant statistically.

The responses of mothers to certain questions advocated to them are shown in table 2. These were the various constraints to exclusive breast feeding. It was found that prelacteal feeds and dietary restrictions were found in 82% and 88% of cases respectively. About 47% of mothers gave water to their babies during the first 6 months and 43% gave colostrums to their babies after birth. Thankfully, 80% of mothers continued to breast feed their children during illnesses. But it was sad to know that just 10% were aided by their husbands in their daily activities so that mothers could take out proper time. Mother-in laws compelling their daughter-in laws to advocate to certain ill traditional practices were found in 40% of subjects. About 7% were such mothers who delivered in their maternal house and astonishingly it was found out that the mothers who delivered this way were more likely to exclusively breast feed their child. There were 15% of mothers who had some or other complications and so found it difficult to exclusively breast their child.

DISUSSION

The median exclusive breastfeeding period in months for the year 2009 was 2 months. Within the same period, early initiation of breastfeeding among women in the region was 24.5%. All these figures are far below the 90% level recommended by the WHO.[7] Child mortality remains high in a developing country like ours.[8] India is one among the developing countries having high under-five rural mortality rate.

Successful breastfeeding is crucial to the curbing of infant malnutrition and achieving a state of steadiness both for the mother and the baby. This is as evident from many studies done in some underdeveloped countries in Africa as well.[9-11] Based on available evidence, achievements of the goals are still far from the desired progress. Breastfeeding practices, including initiation and duration, are influenced by multiple factors which are interwoven and depend on one another. These include health, psychosocial, cultural, political and economic factors.[12,13] Among these factors, decisions regarding initiation and duration of breastfeeding in low-income countries are influenced by education, employment, place of delivery, family pressure, and cultural values. [5,14-17] In India, although breast feeding initiation practice has risen, the duration and practice of exclusive breastfeeding among women who had their delivery in a health facility has remained low. The early introduction of complementary feeding, based on erroneous assumptions, affects breastfeeding initiation and sustainability.[5] Among the general population, the common misconception about infant feeding is that exclusive breastfeeding is beneficial to both infants and mothers, but complementary feeding is essential for babies to adapt to other meals with ease. [18-20] Besides normative expectations, personal experiences and networks of support have influence on the forms and quality of breastfeeding practices. Largely, these factors exert pressure on breastfeeding mothers thereby making their experience pleasurable or painful within time and space.[12,21,22]

Despite the available body of knowledge on breastfeeding practices in India, studies interrogating the agency of breastfeeding mothers as lived within their socio-cultural context are limited. As an embodied experience, breastfeeding practices and experiences are context bound and culture dependent.[23] Earlier, Spencer argued that exploring mothers' breastfeeding experiences as defined within a social context could reveal the inherent

complexities mitigating the successfully promotion of sustainable breastfeeding practices.[23] Similarly, certain authors decried the inadequacy of studies investigating breastfeeding mothers' perspectives on breastfeeding barriers and promoting healthy breastfeeding practices.[24]

It was found that there were 42 (16.1%) mothers who were not breast feeding their babies due to some or other reasons. Rest 218 (83.9%) did feed their child, however. Breastfeeding culture is well depicted in the various groups with different ethnicity, but the low practice of exclusive breastfeeding persists. Our study shows that only 22% i.e 55/218 practice EBF. Underdeveloped countries, for example Demographic Health Survey in Nigeria, 2008 showed that only 13% of children below six months are exclusively breastfed while 87% of Nigerian infants below six months receive complementary liquids or foods. There are variations in the exclusive breastfeeding rate found in this study compared with others. The variations in the prevalence rates may be due to the sample size and design adopted.

Table 1 in our study shows how different socio demographic factors and other ante-natal and delivery practices are related to exclusive breast feeding. It was found that maximum study subjects who exclusively breast fed their child were < 25 years, were educated and belonged to lower socio economic status. Moreover, EBF was more among non working females which was highly significant statistically. Similarly, exclusive breast feeding was more in those subjects who delivered in government health facilities, availed complete ANC facilities in subcentre and were counseled about breast feeding practices previously. These associations were also statistically significant depicting the strength of association. Subjects who were counseled post natally about EBF were more likely to practice it.

Findings by studies of breast feeding practices among infants living in slums of Bhavnagar city, Gujarat,[22] national family health survey- 3 data of 2005-2006, India,[23] breast feeding practices in rural areas of West Bengal,[24] dietary and feeding habits of infants in various socio economic group,[25] breast feeding promotion network of India[26] all suggest similar associations all suggest similar associations.

There are various constraints to exclusive breast feeding. It was found that prelacteal feeds and dietary restrictions were found in 82% and 88% of cases respectively. About

47% of mothers gave water to their babies during the first 6 months and 43% gave colostrum to their babies after birth. Thankfully, 80% of mothers continued to breast feed their children during illnesses. But it was sad to know that just 10% are aided by their husbands in their daily activities so that mothers could take out proper time. Mother-in laws compelling their daughter-in laws to advocate to certain ill traditional practices were found in 40% of subjects. About 7% were such mothers who delivered in their maternal house and astonishingly it was found out that the mothers who delivered this way were more likely to exclusively breast feed their child. There were 15% of mothers who had some or other complications and so found it difficult to exclusively breast their child. Studies on infant feeding practices in the rural population of north India[27] and on breast feeding practices and newborn care in rural areas[28] gave similar predictions in their studies citing the possible reasons of the constraints of breast feeding and suggestions to improve them. The minor variations in values of result might be due to the fact that the sample size was different, only rural population is included and Haryana as such is a prosperous state with rich dairy products and preferences to it.

The limitations of the study were: rural practices were looked after not considering the ones followed in urban areas and all villages of only one block were observed to make the study feasible.

CONCLUSION

Improvement can occur by information & education regarding the advantages and duration of breastfeeding to community, training for the traditional birth attendant, ANM, anganwadi worker etc who in return can further motivate, conducting breast feeding camps to denote the importance of it, breast feeding stamp in government institutions after delivery is a good initiative, educating the husband in the family who can help neutralize the ill practices being followed since generations, counseling the mother-in laws about the pros and cons of breast feeding, live demonstrations of ways to proper feeding and latch, post natal counseling ensuring that its properly done by ASHAs and supervised by ANMs, proper ante-natal counseling so that they are less pray to delivery complications and more likely to properly breast feed their child, coverage by mass media, folks, channels etc to change behavior and communication.

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Table 1: Association of exclusive breast feeding practices with different factors

Sl. No	VARIABLE	Exclusive Breast Feeding		Significance
		YES	NO	
1	**Age**			
	<25	41	106	χ^2 =1.695
	>25	14	57	p=0.192
	Total	55	163	
2	**Education**			
	Nil	9	32	C χ^2= 0.2
	Educated	46	131	P=0.5
3	**Socio-economic status**			
	Upper	21	79	χ^2C= 1.7
	Lower	34	84	P=0.18
4	**Occupation**			
	Working	6	62	C χ^2=14.1
	Not working	49	101	P≤0.001
5	**Delivery**			
	Home	41	177	χ^2= 0.4
	Govt.	55	163	p= 0.05
	Private	56	162	
6	**Antenatal Care received at Subcentre**			
	Yes			

	No	51 4	98 65	χ^2= 20.208 p≤ 0.001
7	**Breast feeding Counselling during the ANC** Yes No	 48 7	 79 84	 χ^2 = 25.467 p≤ 0.001
8	**Post natal counseling on breast feeding** Yes No	 32 23	 102 61	 χ^2= 0.335 p= 0.56

Table 2: Mothers response to the various constraints in exclusive breast feeding

Health Information	**Number (n-218)**	**percent**
Initiate Breastfeeding immediately after birth	82	37.6%
Exclusive breastfeeding to be practiced for first 6 months	55	25.2%
No prelacteal feeds to be given	178	81.6%
No dietary restriction for lactating mother	189	86.7%
Water given during the first six months	102	46.8%

Continue breastfeeding during common illnesses in baby	174	79.8%
Colostrum given after birth	94	43.1%
Were helped by their husbands in their daily routine works	22	10.09%
Were compelled by their mother-in laws to follow inappropriate traditional practices	88	40.4%
Delivered and stayed in their maternal house for >=6 months after delivery	16	7.33%
Were admitted in hospital some or other time due to some complications for after delivery in the first 6 months.	34	15.6%

Figure 1: Number of subjects breast feeding their babies at that point of time