

## **A Cross-Sectional Study On Knowledge And Practice Of Breastfeeding - An Urban And Rural Comparison By Lot Quality Assurance Sampling.**

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### **Abstract**

**Introduction:** Lactation is the ideal way of providing nutrition to the infants. It is the most efficient way to address the energy requirement of the new born and creates a unique bonding between the mother and child. **Objectives:** To compare the knowledge and practices in Breastfeeding in urban and rural areas. **Material and methods:** A community based cross-sectional study was conducted among mothers in Urban and Rural area of Mangalore Taluk, Karnataka. Data was collected by personal interview among 408 mothers using a predesigned pretested questionnaire, information regarding demographic profile, socio-economic status, breastfeeding practices, etc were collected. **Results:** The mean age among the study population was  $25.95 \pm 3.67$  years. Prelacteal feeds are more common among rural mothers 83(68.0%) compared to urban mothers 39(32%). Mothers from rural area 37(13.7%) and urban area 8(5.8%) believed that feeding colostrum can be unhealthy. As many as 129 (69.4%) of rural mothers continued exclusive breastfeeding upto 6months of age compared to 57 (30.6%) urban mothers. **Conclusion:** Although breastfeeding was common, harmful feeding practices like prelacteal feeding and discarding colostrums are still prevalent both in urban and rural areas.

**Key-words:** Breastfeeding, Colostrum, Prelacteal feeding, Exclusive Breastfeeding.

### **INTRODUCTION**

Lactation, is the ideal way of providing nutrition to the young ones.<sup>1</sup> It is the most efficient way to address the energy requirement of the new born with many advantages.<sup>1,2,3</sup> Ideally all mothers can breastfeed, provided they have right information and support from family, the health care system and society at large.<sup>4</sup>

In India, NFHS-4 reported, children under age of 6 months exclusively breastfed were 46.4% and Children under age 3 years breastfed within one hour of birth were 23.4%.<sup>5</sup> As a result children are likely to falter in growth during this critical period of life. The first two years of life provide a critical window of opportunity for ensuring children's appropriate growth and development through optimal feeding.<sup>2</sup> WHO and UNICEF's global recommendations for optimal infant feeding as set out in the Global Strategy are: Exclusive breastfeeding for 6

months (180 days), nutritionally adequate and safe complementary feeding starting from the age of 6 months with continued breastfeeding up to 2 years of age or beyond 3years.<sup>6</sup> Optimal breastfeeding and complementary feeding practices together can prevent deaths and allow children to reach their full growth potential and prevent irreversible stunting, as well as acute undernutrition.<sup>7</sup>

Breastfeeding is further being influenced by many factors like educational level, locality, economic status and women's caste or tribe, place of delivery, prenatal visits to health care facilities and assistance during delivery as well as partner's support.<sup>8</sup> The knowledge regarding existing Feeding Practices among mothers and also the factors influencing these practices can be used to plan measures that concentrate on improving prevalent practices by targeting the socio cultural and economic determinants. The difference in Breast feeding practices

in urban and rural areas are still prevalent even today.<sup>5</sup> Rural women have many drawbacks including socio economic status, decision making capacity in family and many times do not have accesses to right knowledge about breastfeeding. Hence this study was conducted to compare the knowledge and practices in breastfeeding in urban and rural areas and the various factors influencing them.

## MATERIAL AND METHODS

A Community based cross sectional study was conducted among mothers of the children aged 12months – 36 months, for a period of 1 year (Oct 2014- Oct 2015) in Urban and Rural field practice area of Department of Community Medicine, Yenepoya Medical Colleges in Mangalore Taluk. The study areas included Bunder, Bengere, Kudroli, Harekala, Pavour, Iliyarpadavu, Amblamogaru, Kuttara, Deralkatte, Konaje, Kotekar, Kurnad. Study was initiated after approval from the Institutional Ethics Committee, Yenepoya University. Written informed consent was taken from study participants.

By using lot quality assurance sampling (LQAS) methodology, it is possible to use small sample sizes when conducting surveys population-based areas (lots). According to the WHO methodology of Lot Quality Technique<sup>9</sup> and Breastfeeding information from NFHS data<sup>5</sup> considering desired level of confidence interval as 95% and desired level of accuracy as 5%, the initial sample size is 384. The starting point of the study was anganwadi centre (ICDS Block). There are 227 Anganwadi centre in urban Mangalore area and 447 anganwadis in rural Mangalore area.<sup>10</sup> Based on accessibility and duration of the study for convenience of the researchers 10% of the anganwadi centres were selected in the defined study area. Thus total number of lots was 68 (23+45). Initial sample size is 384, and there are 68 lots. Hence each lot sample size is  $384/68 = 5.64$  that is 6 mothers from each lot (anganwadi centre catering area) were selected by simple random method. Thus total number of mothers (study participants) would be  $68 \times 6 = 408$ . Thus the final sample size became 408.

A predesigned pretested questionnaire was formulated and data was collected by first author by personal interview method. The residential address of these mothers was collected from anganwadi workers from the selected ICDS block and house to house visit was conducted. Each house was randomly selected from that area, and from each house only one mother was included based on the inclusion criteria i.e., Mothers of the children aged up to 24 months. The information regarding demographic profile, socio-economic status, Breastfeeding practices, etc was collected.

Data was compiled in an Excel worksheet and SPSS version 16.0 was used to analyze the data of this study. Results were expressed in relevant tables. Descriptive

statistics were reported as Mean (Standard Deviation) for continuous variables, Frequencies (Percentage) for categorical variables. Relevant statistical tests were applied- Chi square test. P Value less than 0.05 considered statistically significant.

## RESULTS

In the present study, the mean age among the study population was  $25.95 \pm 3.67$  years. As many as 202 (49.5%) mothers were Hindus and 177 (43.4%) were Muslims and 29 (7.1%) belonged to Christian and other religion. As discussed in the methodology 270 (66.2%) belonged to rural area and 138(33.8%) belonged to urban area. There were 143 (35.1%) women educated till secondary school, with only 21(5.1%) illiterate. Majority of the women 319(78.2%) were housewives and only 89(21.8%) of them were employed and contributing to the family income among them majority 54(60.6%) of them being daily wage workers. The mean per capita income of these families, per month INR 3013.44 +/- 1386.8, Majority i.e., 342(83.8%) of them belonged to socio-economic class II and III, according to Modified B G Prasads Socio Economic Classification. Majority of the mothers 273(66.9%) belonged to nuclear families, 75(18.4%) belonged to joint families, and only 18(4.5%) belonging to Three generation family.

**Table 1: Distribution of study participants according to the Knowledge and Practice on pre-lacteal foods given.**

Pre-lacteal foods are healthy for the baby	Rural area	Urban area	Total	
	No(%)	No(%)	No(%)	
Yes	51(18.8)	38 (27.5)	<b>89(21.8)</b>	$\chi^2=4.00$ <b>DF=2</b>
No	193(71.4)	88(63.7)	281(68.8)	
Do not Know	26(9.8)	12(8.6)	38(9.4)	<b>p =0.135</b>
Total	270(100)	138(100)	408	
Practice of Pre-lacteal foods	Rural area	Urban area	Total	
	No(%)	No(%)	No(%)	
Given	83(30.7)	39(28.2)	<b>122(29.9)</b>	$\chi^2=0.2$ <b>DF=1</b>
Not given	187(69.3)	99(71.8)	286(70.1)	
Total	270(100)	138(100)	408(100)	<b>p =0.6</b>

We observed no statistical significant difference among practices among urban and rural areas. Pre-lacteal feeds are more common among rural mothers 83/122(68.0%) compared to urban mothers 39/122(32%). **Table 1** The Most common pre-lacteal feeds are Honey 65(53.6%) , Holy water 31(25.3%), Cows milk (12.1%), followed by sweetened water and others(9%).

Mothers from rural area 37(13.7%) and urban area 8(5.8%) believed that feeding colostrum can be unhealthy for their child. On comparison of urban and rural areas we

found a statistical significant difference (p=0.016) in knowledge of mothers about colostrum. **Table 2.** The most common reasons for not giving colostrums (n=39) stated were elderly advice (51.2%), baby ill/in ICU (30.7%), followed by Fear that it may harm baby and influence of friends(18.2%).

**Table 2: Distribution of study participants according to Knowledge and Practice on feeding of colostrum to new born**

Colostrum	Rural area No(%)	Urban area No(%)	Total No(%)	
Healthy	233(86.3)	130(94.2)	363(88.9)	$\chi^2=5.81$
Unhealthy	37(13.7)	8(5.8)	45(11.1)	DF=1
<b>Total</b>		138(100)	408(100)	<b>p =0.016</b>
Colostrum	Rural area No(%)	Urban area No(%)	Total No(%)	
Not Discarded	270(100)	125(90.6)	369(90.5)	$\chi^2=0.005$
Discarded	26(9.6)	13(9.4)	39(9.5)	DF=1
<b>Total</b>	270(100)	138(100)	408(100)	<b>p =0.94</b>

**Table 3: Distribution of study participants according to Knowledge and Practice regarding Exclusive Breastfeeding.**

Knowledge regarding Exclusive Breastfeeding		Rural area No(%)	Urban area No(%)	Total No(%)		
Exclusive Breastfeeding to be continued for	< 6 months	6	93(34.4)	33(23.9)	126(30.9)	$\chi^2=7.34$
	6 months	161(59.6)	100(72.9)	261(63.9)	DF=3	
	>6months	13(4.9)	3(2.2)	16(3.9)	<b>p =0.06</b>	
	Do not know	3(1.1)	2(1.5)	5(1.3)		
	Total	270(100)	138(100)	408(100)		
Practice of Exclusive Breastfeeding		Rural area No(%)	Urban area No(%)	Total No(%)		
Duration of Exclusive breast feeding	< 6months	86(31.9)	58(35.3)	144(35.3)	$\chi^2=4.17$	
	6 months	129(47.8)	57(45.6)	186(45.5)	DF=2	
	>6months	55(20.3)	23(19.1)	78(19.2)	<b>p =0.12</b>	
	Total	270(100)	138(100)	408(100)		

In this study only 219(53.6%) had correct knowledge about Early initiation of Breastfeeding within one hour of delivery i.e, 136/219 (62.1%) rural mothers and 83/219(37.9%) urban mothers. Were as in Practice 135/194 (69.5%) rural mothers initiated breast feeding within one hour of delivery compared to 59/194 (30.5%) urban mothers. As many as 84 (20.5%)

mothers had delayed the initiation of breast feeding beyond four hours. Difference in the practice of initiation of breast feeding among urban and rural mothers was statistically significant (p=0.011). We also observed large gap in knowledge 83(60.1%) and practice 59(42.8%) of early initiation of breastfeeding in urban area. The reasons for late initiation of Breastfeeding were Pain abdomen following delivery (Physical inability) 42%, C- section 33%, Elderly advice 13% and Milk not secreted 12%.

In this study, only 161/261(61.6%) rural mothers had right knowledge about Exclusive breastfeeding upto 6months of age compared to 100/261(38.4%) urban mothers. In practice as many as 129/186 (69.4%) of rural mothers continued exclusive breastfeeding upto 6months of age compared to 57/186 (30.6%) urban mothers .We also observed large gap in knowledge 100(72.2%) and practice 57(45.6%) of exclusive breastfeeding in urban area. (**Table 3**)

Further, 237/355(66.7%) rural mothers had right knowledge about continuation of breastfeeding upto and beyond 1 years of age compared to 118/355(33.3%) urban mothers and in practice 199/233(85.4%) rural mothers had continued breastfeeding upto and beyond 1 years of age compared to 95/233(40.7%) urban mothers. We also observed large gap in knowledge and practice of continuation of breastfeeding in urban and rural areas.

Regarding type of Breastfeeding, majority of the mothers practiced demand feeding 325(79.7%), i.e., 225 (83.3%) rural mothers and 100(72.5%) urban mothers, which is significantly high in rural area (p-0.010) and 95(23.3%) of the study participants stated the use of pacifiers. A majority of 203 (75.2%) rural mothers and 110(79.5%) urban mothers did not practice use of pacifier/ artificial teats. 212(52%) of the respondents stated that they faced problems during breast feeding, which were lack of knowledge/family support(33.5%), baby refusing to take feeds(32%), fever/breast nodule (17.5%), cracked nipple (10%) and others (7%).

Statistical association between various socio demographic variables and breast feeding were not significant. However the practice of giving pre-lacteal feeds reduced with increase in educational status in both urban and rural areas and in rural area as the birth order increased, mothers practice of discarding colostrum decreased.

## DISCUSSION

In this study 21.8% of mothers had believed that pre lacteal feeds can be healthy for their child, a similar study conducted by Eram U et al<sup>11</sup> stated 54% believed pre-lacteal feeds are good for the new born. As many as 30.7% mothers in rural and 28.2% mothers in urban area had given pre-lacteal feeds in this study. The prevailing traditional practices of giving pre-lacteal feeds remain same irrespective of urban and rural areas of Mangalore Taluk. A study done by Ashwini et al<sup>12</sup> in

Belgaum Karnataka, the prevalence of pre-lacteal feeding was observed to be 54.2% in urban and 57.1% in rural areas.

Most common pre-lacteal food given in this study was honey 53.6% followed by holy water 25.3%. A study reported by Eram U et al<sup>11</sup> herbal decotion 30%, Honey 25% followed by glucose water 20%. A study conducted by Nguyen P H et al<sup>13</sup> reported the most common pre-lacteal feeds included honey, glucose water, and other liquids.

In this study 11.1% of mothers were under misconception that colostrum is not good for their child. This misconception was more among rural mothers than urban mothers ( $p=0.016$ ). In practice, out of those who actually discarded colostrums, 66.6% were from rural area and 33.4% were from urban area. A similar study conducted by Eram U et al<sup>11</sup> in India stated 57% believed colostrums was useless and discarded it. A study by Banapurmath et al<sup>14</sup> conducted in Karnataka showed that practice of discarding colostrum was observed by 28.60% of mothers.

The commonest reason for discarding colostrums in this study ( $n=39$ ) was elderly advice 51.2%. In a study carried out by Yadav et al<sup>15</sup> in Bihar it was seen that 62.50% urban and 66.40% rural mothers discarded colostrums and it reported the most common reason for doing so in both urban as well as rural area was elder's advice, similar to our study; this shows the influence and importance the elders receive in decisions regarding feeding practices. So, the elders in the family must be targeted in breaking the myths regarding breastfeeding practices

The percentage of mothers belonging to rural area and nuclear family (18/26) and the percentage of mothers from urban area and the nuclear family (9/13) were same i.e., 69.2%. There is no correlation between type of family and feeding colostrums. This may be due to the fact that though the mother belonged to nuclear family, her decisions are being influenced by various factors including cultural backgrounds, elderly family member's advice and friends in both urban and rural area.

In this study only 53.6% of mothers had right knowledge about early initiation of breastfeeding (within 1 hr) i.e., 62.1% rural mothers and 37.9% urban mothers. The Indian studies conducted in Andhra Pradesh by Sujatha P et al<sup>16</sup> and in Karnataka by Hiregoudar V et al<sup>17</sup> reported correct knowledge to be among 42.7% and 42.5% respectively.

In practice 69.5% rural mothers initiated breast feeding early (within 1 hr) compared to 30.5% urban mothers in this study. This difference was statistically significant ( $p=0.011$ ). There was also large gap between knowledge (60.1%) and practice (42.8%) of early initiation of breastfeeding in urban area in this study. In a similar

study Hiregoudar V<sup>17</sup> et al reported gap in knowledge and practice in initiation of breast feeding within an hour.

Cesarean section was one of the commonest reason for delayed initiation of breastfeeding in many studies<sup>18, 19</sup> including the present study. Other reasons for late initiation of Breastfeeding in this study were Physical inability (Pain abdomen following delivery) 42%, elderly advice/ Family custom 13% and milk not secreted (12%). A study carried out by Gupta et al<sup>20</sup> reported common reasons given for delayed initiation were family custom / belief 52.1%, no secretion of breast milk 31% and discomfort of mother 16.9%.

There was no correlation among the initiation of breastfeeding and various socio demographic factors except for locality of the study participant. A study conducted by Ashwini et al<sup>12</sup> reported that initiation of breast feeding was delayed beyond 4 hours by 24.50% urban and 33.68% rural mothers which was statistically significant.

In a study conducted in Ethiopia by Wolde T et al<sup>21</sup> 87.3% of mothers reported about correct knowledge regarding Exclusive Breastfeeding. In this study 63.9% of total participants had correct knowledge about duration of Exclusive Breastfeeding i.e., 59.6% among rural mothers and 72.9% among urban mothers. However 45.5% mothers practice Exclusive Breastfeeding for 6 months i.e., 47.8% of rural mothers and 45.6% of urban mothers gave exclusive breastfeeding to their infants. This gap between knowledge and actual practice was seen in both rural and urban mothers; more among urban. In this study we observed that though there was better knowledge 58.3% , but practices of Exclusive Breastfeeding was poor 41.6% ( $p=0.055$ ). The practice of Exclusive Breastfeeding in different studies<sup>5,8,22</sup> varies from 9% to 46%. This variation could be due to the influence of the local traditional practices in community.

The practice of continuation of breastfeeding beyond 1 year of age along with complementary feeding in this study is observed among 71.1% of participants. Among rural mothers and urban mothers were 73.7 and 68.8% respectively. We also observed large gap in knowledge and practice of continuation of breastfeeding in urban area of this study. A similar study conducted by Ashwini et al<sup>12</sup> in Belgaum, Karnataka reported that Continued breast feeding for 1 year was 100% in urban and 99.21% in rural area. Few other studies<sup>23,24,25</sup> reported it to be 21.6%, 47% and 72% respectively.

Majority of the mothers practiced demand feeding 79.7% similar to a study conducted by Parekh C et al. 73.6%.<sup>26</sup> In this study i.e., 83.3% of rural and 72.5% urban mothers. Difference in this practice among urban and rural mothers was statistically significant. Probable reason for not practicing demand feeding could be Working women /Help at home or by lack of support from family members.

**CONCLUSION :** Although breastfeeding was observed to be universal practice, harmful Feeding practices like prelacteal feeding and discarding colostrums are still prevalent both in urban and rural areas. There was a gap in knowledge and practices, however the early initiation of breastfeeding, Exclusive breastfeeding, Continuation of breastfeeding after exclusive breast feeding were seen to be in more than 60% of mothers. More than 72% of the mothers practiced demand feeding. We observed gap in knowledge and practices, of breastfeeding more among urban mothers. As there was a gap in knowledge and practice of breast feeding; IEC campaigns should be held on regular basis, as an important component of Obstetric care, Antenatal care and Post natal care to encourage mothers and family members for right breastfeeding practices.

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