

**KNOWLEDGE, ATTITUDE, AND PRACTICE OF
EXCLUSIVE BREASTFEEDING**

**(A SOCIOLOGICAL STUDY ON BREAST FEEDING MOTHERS OF
LEKHANATH MUNICIPALITY)**



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ABSTRACT

Exclusive breastfeeding is the basis for appropriate nutrition for infants. However, there are differences in infant feeding knowledge, attitude, and practices in different social groups, age, sex, education, economic condition of family and community. The aim of this study was to find out the determinants of knowledge, attitude, and practice of exclusive breastfeeding and the prevalence of determinants of initiation and continuing exclusive breastfeeding until six months of age in Lekhanath Municipality.

A descriptive, exploratory study of infant feeding practices was undertaken in MCH clinic Sishuwa PHC, Lekhanath municipality. Along with key informant's interview and focus group discussion, one hundred and eight mothers with six-months to under-one-year infants participating in MCH clinic for immunizing their babies were interviewed.

Among large number of breastfeeding mothers learning exclusive breastfeeding from different sources, only sixty (55.6%) gave right meaning of exclusive breast feeding as recommended by WHO. However, only 34(31.5%) mothers exclusively breast fed as recommended. Nearly half of the mothers had good knowledge about the appropriate time to initiate breast feeding while just 35.2 percent mothers initiated breast feeding within one hour after birth. Educated mother were found possessing good knowledge of EBF but with less practice. Nearly all (95.4%) mothers fed colostrums milk to their infant which is a positive indicator in Nepalese cultural context. More than half (52.7%) mothers introduced food/fluid within six months thinking that mother's milk will be insufficient for the infants up to first six months of age. Regarding mother's age, 20-30 years age group mothers were found adequately practicing EBF. Sex discrimination was not noticed in breast feeding practice (30.4% male babies and 32.7% female babies were exclusively breast fed). Very few (3.7%) mothers thought that BF reduces mother's beauty. Only two (1.85%) mothers had positive attitude on expressed breast milk. This indicates negative cultural attitude about expressed breast milk in this community.

Mother's education, family type, cast/ethnicity and mother's parity in some extent are determinants of mother's knowledge of EBF. Negative socio-cultural beliefs and norms towards expressed breast milk and colostrums milk, thought of insufficiency of breast milk are the determinants of mother's attitude resulting poor EBF practice. Early marriage and child bearing, improper positioning and attachment during breast feeding, poor nutritional status of mother, government policy of maternity leave also affects EBF practice.

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ACRONYMS

AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
CBS	Central Bureau of Statistics
DPHO	District Public Health Office
EBF	Exclusive Breast Feeding
EPI	Expanded Programme on Immunization
FCHV	Female Community Health Volunteer
HIV	Human Immune Deficiency Virus
IMR	Infant Mortality Rate
INGO	International Non Governmental Organization
IYCF	Infant and young child feeding
MCH	Maternal and Child Health
MOH&P	Ministry of Health and Population
NDHS	National Demographic Health Survey
NGO	Non Governmental Organization
PHC	Primary Health Centre
TU	Tribhuvan University
UN	United States
UNICEF	United Nation International Child Emergency Fund
VHW	Village Health Worker
WHO	World Health Organization
Na	Not applicable

CHAPTER I

INTRODUCTION

1.1 Background

Breast milk is still the ideal food for a vast majority of infants for at least for the first six months. It contains not only the right amount of nutrients needed to foster normal growth and development; but also the immunological factors from the mother that can protect infants against infections. Breast-feeding creates infant-mother bonding that can enhance a child's emotional bonding. Breast-feeding is associated with a small but detectable increase in child cognitive ability and educational achievement and that these effects are broad and extended into childhood and early adulthood.

Breast milk is a complete food for the six months of an infant's life. Recent research has shown it to be more adequate than vitamin D (Lakdawala and Widdowson, 1977), iron (MacMillan, et al., 1976), and water (Almroth, 1978). It contains a large number of factors that help prevent diseases. Among these are the "bifidus factor", living leucocytes, lactoferrin, lysozyme, various antiviral factors, and all classes of immunoglobulins, none of which is present in any infant formula. Breastfeeding is the only activity that satisfies the needs of food, health, and care at the same time.

It may in fact be impossible to put in economic terms the true value of breastfeeding. Some of the benefits of breastfeeding can be more satisfactorily quantified in non-monetary terms, for example morbidity, mortality, or population growth. Others, such as psychological benefits, cannot be quantified at present. Moreover, it is likely that still other benefits of breastfeeding remain unknown. The distinction between the health producing effects of breastfeeding and the harmful effects of artificial feeding is in many cases arbitrary. However, it is established that the worse environmental and socioeconomic conditions under which families live, the greater the difference in health between breast-fed and artificially-fed infants is likely to be. Studies in many parts of the world have shown that artificially-fed infants suffer

more from malnutrition, and also from diarrhea and other infections than do breast-fed infants.

Trends in society such as modernization, urbanization, and westernization proceed rapidly. Their impact on traditional structures and patterns needs to be examined, particularly those affecting child-bearing practices. Globalization is a manifold and sometimes even an elusive concept for there is no single definition. It has been defined as the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events many miles away and vice versa. The result of this interconnectedness of globalization can have both positive and negative impact on breastfeeding.

The current trend of globalization is predominantly based on structuring a single global economy powered by transnational corporations and financial markets. Increasingly, globalization is shaping a world where trade agreements, world trade organization priorities and the economic interests of transnational corporations hold sway and are no longer accountable to governments, let alone the needs of mothers and children. In a globalized world, policy makers face new obstacles in implementing the International Code of Marketing of Breastmilk Substitutes and the relevant subsequent Resolutions of the World Health Assembly. Spreading privatization of health care and hospitals may well put profits ahead of public health needs and breastfeeding friendly practices. Global deregulation and harmonization are overriding national policies to regulate the marketing and labeling of infant feeding products and genetically modified ingredients, gradually making their way into infant foods, are claiming the product to be closer to breastmilk than ever before. Although the agenda of globalization may set economic goals above health, we can at the same time utilize its tools and structures to create peace and justice and a better world for all. Mothers, parents, women's groups, health care workers, institutions, and environmental networks are indeed resorting to new and creative ways to ensure that the protection for infant and child health that is conferred through breastfeeding remains safe and sound.

The role of lactation in establishing social relationships is not peculiar to humans. Whereas infant rodents such as mice and voles may not recognize specific other

individuals, and be aware only of the presence of nest-mates, lactation has a strong influence on socialization in primates (Shillito-Walser, 1977). Infants macaques reared in isolation were subsequently deficient in all categories of social interaction (Evans, 1967), whereas guinea pigs reared in the same conditions showed no such defects (Harper, 1968). Once again, therefore, the social dimension of human breastfeeding has its precursors in our recent evolutionary heritage. In our own species infant nutrition, central to early socialization, comprises an ideal vehicle for exploitation in multiple symbolic contexts. One illustration of this is the tendency in various societies for non-maternal nursing to contribute to alternative social structures in the form of “milk kinship” (Hollis, 1905; Parkes, 2004).

Islamic law for example defines three types of kinship, by blood, marriage and milk; all three types of relationship preclude marriage between certain categories of people (Khatib-Chahidi, 1992). Milk kinship may then be exploited for political purposes, as for example reported among the Masai where it symbolized the making of peace between “enemy tribes” (Hollis, 1905). More generally, breastfeeding comprises a fundamental component of processes through which identity of both the mother and her offspring are constructed (Maher, 1992), (cited in Jonathan wells, 2006)

In many populations, the quality of breast milk is believed to influence character or health of the infant. In Nepal, goat’s milk is used to counteract the effect of “negative qualities” in maternal character (Burghart and Reissland, 1987), while the Khmir of Tunisia attribute certain infant illnesses to “bad milk” provided by overworked mothers (Creyghton, 1992). However, it is within the context of contest over women’s identity that the social element of breastfeeding becomes critical. Breastfeeding is not merely a passive vehicle on which symbolic and cultural phenomena are projected, but a battleground through which power relations are generated, maintained and disputed.

International recommendations for the feeding of infants (0-6 months) call for exclusive breastfeeding for six months, or from four to about six months. The World Health Organization’s definition of exclusive breastfeeding is the feeding/nourishing of a child on breast milk alone, with no other liquids, not even water, or solids. Drops or syrups, vitamins, mineral supplements, or medicines that are medically

prescribed are allowed. Exclusive breastfeeding also applies to a child who receives only expressed breast milk or is fed only breast milk from a wet-nurse.

To enable mothers to establish and sustain exclusive breastfeeding for 6 months, WHO and UNICEF recommend:

-) Initiation of breastfeeding within the first hour of life
-) Exclusive breastfeeding – that is the infant only receives breast milk without any additional food or drink, not even water
-) Breastfeeding on demand – that is as often as the child wants, day and night
-) No use of bottles, teats or pacifiers

Exclusive breastfeeding confers many nutritional and health benefits for the child. Breast milk is a hygienic/clean source of energy, all essential nutrients, and water. Breast milk is a living substance containing immune factors and many other components that are beneficial for infants and young children. It meets all nutrient and fluid needs and changes to meet the changing requirements of the child. The health benefits include reduced mortality and reduced morbidity from diarrhea, respiratory infections, and other causes. Exclusively breastfed infants are protected because they are exposed to fewer bacterial contaminants. Artificially-fed babies get diarrhea more often than breastfed babies because artificial feeds lack anti-infective factors and are often contaminated with harmful bacteria.

1.2 Statement of Problem

Although the agenda for globalization may set economic goals above health, we can utilize its tools and structures to work toward peace and justice and a better world for all. In the last two decades, the global community has developed, ratified and/or adopted a variety of supportive legal instruments, technical documents, strategies, guidelines and global networks through which breastfeeding supporters can work. These instruments can offset the negative effects of globalization and provide tools to create breastfeeding cultures.

According to the research conducted by Plan International in 2008, around 60 percent of all deaths in children under five are caused by malnutrition and over 60 percent of these occur in the first year of life as a result of inappropriate feeding practices. Another study conducted by WHO in 2004 shows that breast feeding protects babies from illness and death even when they are premature and receiving special care. If every baby was breast fed, more than 1.3 million deaths could be prevented each year. Yet, only one third of babies are exclusively breast fed for six months of life.

There is high quality evidence that infant not exclusively breastfed are at increased risk of death from diarrhoea, pneumonia and neonatal sepsis. It is proposed that exclusive breastfeeding for 6 months, followed by continued breastfeeding to 12 months, could prevent 1,301,000 deaths or 13 percent of all child deaths under 5 years in a hypothetical year (**Annette and Lisa 2007**).

The NDHS 2006 report of Nepal states that “In Nepal children born in the five years preceding the survey (98%) were breastfed at some time. However, contrary to WHO’s recommendations, only around half of the children under six months (53%) are exclusively breastfed.”

Breast-feeding in Nepal has special cultural value. Being a developing country, we have higher infant mortality rate. Such a tremendous case will definitely leave its impacts in other sectors of life. One of the vital causes for high infant mortality is undoubtedly being the improper breastfeeding practices, it is essential in Nepal to make people aware about the importance of exclusive breast-feeding as recommended.

Breast feeding behavior of mothers is found varying on individuals of different ethnic groups, different education levels, their personal physical conditions, culture and beliefs, their availability for feeding, nature of job/business the mother are involving, and more significantly by their socio-economic and cultural beliefs. One of the vital factors that cause discrimination in feeding practice may be gender inequality, which significantly exists in our society as one of the cultural barriers.

The Nepalese economy is highly dependent of agriculture (80% of the people in Nepal are dependent on agriculture for their livelihood). Most breastfeeding mothers often don't have enough time to feed their infants due to the workload at home. Negligent family support, minimum awareness may also cause reduced breastfeeding. We have many cases of early marriage, low birth spacing, and having many children, especially in deprived ethnic groups that may also led to young children being depressed of being breastfed.

Many researches and recommendations have been made so far on exclusive breastfeeding; however, most of the researches are focused on the health related issues of EBF. Very few works have been carried out to identify the underlying sociological/ anthropological factor of breastfeeding and its economical benefits. There are so many inter related sociological, cultural, religious, ethnic factors that determine mother's attitude and practice of infant feeding that may lead great sociological impacts in development, thoughts and rights of upcoming generation. In this context, the proposed research is intended to provide some logical solutions to those shadowed issues and find out the answers of those questions,

- (a) Is there any relationship between the mother's acquired education and her knowledge on exclusive breast feeding?
- (b) What are the different attitudes towards breast feeding?
- (c) Is there any relationship between mother's knowledge on EBF and the practices she is doing?
- (d) Is there any discrimination between male and female infants in breast feeding?

1.3 Research Objectives

The general objective of the study is to identify the knowledge, attitude and practice of exclusive breast feeding among mothers having six months to under-one-year infants.

The specific objectives of this study are:

-) To find out the knowledge of mothers about exclusive breast feeding
-) To identify attitude of mothers towards breast feeding behavior.
-) To analyze mothers' practices of exclusive breast feeding

-) To quantify the underlying social, cultural, religious, educational factors that influence mothers' breastfeeding behavior.

1.4 Operational Definition of the Terms

- a. Exclusive Breastfeeding:** Exclusive breast feeding (EBF) means giving the infant no other food or drink, not even water, apart from breast milk (including expressed breast milk), with the exception of drops or syrups consisting of vitamins, mineral supplements, or prescribed medicine till six months as recommended by WHO.
- b. Infant Morbidity:** Infant morbidity means to define any departure subjective/objective from a state of physiological well being as a result of disease injury or impairment of under-one-year age in a given year.
- c. Infant Mortality:** Death under one year of age in given year to the total no. of live birth in a year is called infant mortality. It is usually expressed as a rate of per 1000 live birth.
- d. FCHV (Female Community Health Volunteer):** Female Community Health Volunteer is a woman who gets formal basic training of health and works to promote health of community.
- e. Colostrums Milk:** Colostrums milk is the breast milk that women produce in the first few days after delivery. It is thick and yellowish or clear in color.
- f. Expressed breast milk:** Mothers milk collected to feed the infant whenever she is not readily available for breastfeeding.
- g. Knowledge about breast feeding**
 - i. Good knowledge**
 -) She could define exclusive breastfeeding as recommended by WHO.
 -) She could tell the initiation of breast feeding within one hour after birth.
 -) She could state the frequency of breast feeding that is demand feeding- as baby want, at least every 4 hours during the day and night time feeding at least 6 hours.
 -) She could state at least 2 advantages of exclusive breast feeding to baby.

ii. Fair knowledge

-) She could answer at least one right answer of knowledge related questions.
-) She could state one advantage of exclusive breast feeding to baby.

iii. No knowledge

-) She could not answer any of the knowledge related questions.

h. Practice about exclusive breast feeding

i. Adequate practice

-) She exclusively breast fed as recommended by WHO
-) Initiated breast fed within one hour after birth.

ii. Inadequate practice

-) Mother exclusively breastfeeds but she feeds less time than recommended by WHO (EBF less than 6 months).

iii. No practice

-) She started to give additional food/water/liquid immediately after child birth.
-) She did not feed breast milk exclusively.

1.5 Significance of the Study

The findings will provide baseline information for further research. The findings of the research may help people to know about the determinant factors of exclusive breast-feeding. The concerned institutions will be benefitted from this research work in planning for further health action.

1.6 Limitations of the Study

Basically it is an academic study which has been conducted for partial fulfillment of Masters Degree in Sociology. It has been undertaken within the boundaries of limited time, budgets and other resources. So this is small scale descriptive exploratory study only from attending on maternal and child health clinic of Sishuwa Primary Health Centre, Kaski. Thus, the findings and conclusion drawn from this study may not be widely generalized exactly in the same manner for other breast feeding mothers and in other places.

CHAPTER II

LITERATURE REVIEW

2.1 Theoretical Overview

2.1.1 Medical Sociology

Medical sociology is an area of the study that focuses on the social aspect of the causes and effects of health and illness within society. In doing so, medical sociologists attempt to explain the complex relationships between social characteristics and the development, treatment and curing of illness; they also analyze the organization of health (Frank, 2003).

Medical sociology is the study of the social facets of health and illness. It applies sociological principles to the study of topics such as the organization of health professionals, socio-cultural responses to illness, the nature of the patient-practitioner relationship and virtually every other health-related subject. Sociologist Robert Straus suggested that medical sociology could be divided into two subcategories representing two different approaches in studying similar phenomena. The first he called the sociology of medicine. This category comprises the application of the basic sociological theories and principles to the study of medical issues. The second category is the sociology in medicine, which includes those who work in medical environments attempting to use sociological principles to help solve medical or patient care problems and represents an applied research approach (Frank, 2003).

Like sociology in general, subgroups within medical sociology vary according to dichotomies such as human agency versus social structure, conflict versus consensus, and idealism versus realism. Subgroups also vary according to subject matter, thus the sociology of medicine can be distinguished from the sociology of health and illness, the sociology of healers, and the sociology of the health care system. Medical sociologists also distinguish interrelationship among the sociology of health, the study of health, illness, and health care to further sociological theory; and sociology in health, the use of sociological insights to complement biomedicine's objectives and priorities. There are four often interrelated areas of

research in medical sociology: the social production of health and illness, the social construction of health and illness, postmodern perspectives on health and illness, and the study of the health care system and its constituent parts (Gerry, 2010).

Social relations (such as social support for individuals and social capital or social cohesion for communities) have been investigated as determinants of the health of individuals and communities. There is also strong empirical support for the importance of lifestyle practices and behaviors embedded in social environments and cultural contexts. On a global scale, some authors argue that capitalist imperialism influences the presence and distribution of illness in developing nations, through the transfer of modern medicine, industry, and technology from the West, which is motivated in part by profit-driven pharmaceutical companies, for example. Finally, some authors investigate the role of Western medicine in creating as well as preventing illness. They argue that improvements in health have come mainly from nonmedical factors, and that medicine reproduces the legitimacy of the dominant social order by serving as a means of social control (Gerry, 2010).

2.1.2 Sociology in Public Health

Public health has been and remains a much applied field. It is also characterized by a population-based approach to health, and statistical methods are deemed the appropriate underlying method for the field. It is viewed as a science that seeks to intervene, control, and prevent large-scale processes that negatively affect the public's health. By these criteria, there is a strong logical fit of sociological principles and practices within public health. Nonetheless, sociology has not been the key social science discipline in public health. That position has gone to psychology, where the emphasis on individual behavior resonates more with a biomedical model. Despite this, many of the primary concerns of present-day public health, with large-scale variables such as social capital, social inequality, social status, and health care organization and financing, remain topics best suited to the sociological perspective and methodology. The emphasis in public health is thus shifting toward a sociological perspective (David, 2009).

2.1.2.1 Sociological Concepts in Public Health

Sociology in public health is reflected in the myriad of sociological concepts that pervade the practice of public health. More than any other social sciences, sociology has the discussion of socioeconomic status at its very core. Social-class variation within society is the key explanatory variable in sociology—for everything from variation in social structure to differential life experiences of health and illness. Indeed, there appears to be overwhelming evidence that Western industrialized societies that have little variation in social class experience have far better health outcomes than societies characterized by wide social-class dispersion. In short, inequalities in health are directly related to social and economic inequalities. Much of later-twentieth-century public health is devoted to the reduction of these inequalities (David, 2009).

2.1.3 History of Breastfeeding

Breastfeeding is the feeding of breast milk to a child directly from mouth to breast contact. Various substitutes for breast milk have been introduced around the world, most notably infant formula.

2.1.3.1 Early History

In the Egyptian, Greek and Roman Empires, women usually fed only their own children. However, breastfeeding began to be seen as something too common to be done by royalty, and wet nurses were employed to breastfeed the children of the royal families. This was extended over the ages, particularly in western Europe, where noble women often made use of wet nurses. The Mocheartisans of Peru (1-800 A.D.) represented women breastfeeding their children in ceramic vessels. Shared breastfeeding is still practiced in many developing countries when mothers need help in feeding their children (Larko, 2001).

India: According to some Brahminical literature, breastfeeding was practiced in second century in India only after the fifth day, allowing the colostrums to be discarded and the true breast milk to flow.

Japan: Traditionally, Japanese women gave birth at home and breastfed with the help of breast massage. Weaning was often late, with breastfeeding in rare cases continuing until early adolescence. After Second World War western medicine was taken to Japan and the women began giving birth in hospitals, where the baby was usually taken to the nursery and fed formula. In 1974 a new breastfeeding promotion by the government helped to boost the awareness of its benefits and the uptake has sharply increased. Japan became the first developed country to have a baby-friendly hospital, and as of 2006 has another 24 such facilities (Poyne et.al, 2003))

2.1.3.2 Eighteenth Century

In the 18th century male medical practitioners started to work on the areas of pregnancy, birth and babies. These areas traditionally were dominated by women. Also in the 18th century the emerging natural sciences argued that women should stay at home to nurse and raise their children, like animals. Governments in Europe started to worry about the decline of the workforce because of the high mortal rates among newborns. Wet nursing was considered one of the main problems of the high mortality rates among newborns. Campaigns were launched against the custom among the higher class to make use of a wet nurse. Women were advised or even forced by law to nurse their own children (Schiebinger,1993 p69). The biologist and physician Linnaeus, the English doctor Cadogan, Rousseau and the midwife Anel le Robours described in their writings the advantages and necessity of women breastfeeding their own children and discouraged the practice of wet nursing. Linnaeus wrote in 1752 a pamphlet against the use of a wet nurse. Linnaeus considered this against the law of nature. A baby not nursed by the mother was deprived of the laxative colostrums. Linnaeus thought that the lower class wet nurse did eat too much fat, drank alcohol and had contagious (venereal) diseases, therefore producing lethal milk (Schiebinger, 1993 p 68).

Mother's milk was considered a miracle fluid which could cure people and give wisdom. The mythical figure Philosophia-Sapientia, the personification of wisdom, suckled philosophers at her breast and by this way they absorbed wisdom and moral virtue. On the other hand lactation was the practice that connected humans with animals. Linnaeus - who classified the realm of animals - did not by accident rename

the category 'quadrupedia' (four footed) in 'mammalia' (mammals). With this act he made the lactating female breast the icon of this class of animals in which humans were classified (Schiebinger, 1993 p 40).

2.1.3.3 Nineteenth Century

Historian Rima D. Apple writes in her book *Mothers and Medicine-A Social History of Infant Feeding, 1890-1950* that in the United States of America most babies got breastmilk. Dutch historian Van Eekelen researched the little evidence of breastfeeding practices in The Netherlands. Around 1860 in the Dutch province Zeeland about 67% of babies were nursed, but there were big differences within the region (Knecht, Eakelen, 1814 p222). Women were obliged to nurse their babies: “Every mother ought to nurse her own child, if she is fit to do it, no woman is fit to have a child who is not fit to nurse it.” (Apple, 1987 p6-3) Mother's milk was considered best for babies, but the quality of the breast milk was found to be varied. The quality of breast milk was considered only good if the mother had a good diet, had physical exercise and was mentally in balance. In Europe (especially in France) and less in the United States of America it was a practice among the higher and middle class to hire a wet nurse. If it was too difficult to find a wet nurse, people use formula to feed their babies, but this was considered very dangerous for the health and life of the baby (Apple, 1987 cited in Wikipedia Encyclopedia, 2010).

2.1.3.4 Prevalence of Breastfeeding in the 20th and 21st Century

Canada: A 1994 Canadian government health survey found that 73% of Canadian mothers initiated breastfeeding, up from 38% in 1963. It has been speculated that the gap between breastfeeding generations in Canada contributes to lack of success of those who do attempt it: new parents cannot look to older family members for help with breastfeeding since they are also ignorant on the topic (Canadian Parental Health Report, 2003). Western Canadians are more likely to breastfeed; just 53% of Atlantic province mothers breastfeed, compared to 87% in British Columbia. More than 90% of women surveyed said they breastfeed because it provides more benefits for the baby than does formula. Of women who did not breastfeed, 40% said formula feeding was easier (the most prevalent answer). Women who were older,

more educated, had higher income, and were married were the most likely to breastfeed. Immigrant women were also more likely to breastfeed. About 40% of mothers who do breastfeed do so for less than three months. Women were most likely to discontinue breastfeeding if they perceived themselves to have insufficient milk.

A 2003 La Leche League International study found that 72% of Canadian mothers initiate breastfeeding and that 31% continue to do so past four to five months (Breast feeding Statistics, 2003).

A 1996 article in the Canadian Journal of Public Health found that, in Vancouver, 82.9% of mothers initiated breastfeeding, but that this differed by Caucasian (91.6%) and non-Caucasian (56.8%) women. Just 18.2% of mothers breastfeed at nine months; breastfeeding practices were significantly associated with the mothers' marital status, education and family income (Willian, Innis, vog, 1996).

Cuba: Since 1940, Cuba's constitution has contained a provision of officially recognizing and supporting breastfeeding. Article 68 of the 1975 constitution reads, in part: During the six weeks immediately preceding childbirth and the six weeks following, a woman shall enjoy obligatory vacation from work on pay at the same rate, retaining her employment and all the rights pertaining to such employment and to her labor contract. During the nursing period, two extraordinary daily rest periods of a half hour each shall be allowed her to feed her child (Shriton, 2003).

Developing Nations: In many countries, particularly those with a generally poor level of health, malnutrition is the main cause of death in children under 5, with 50% of all those cases being within the first year of life. International organizations such as Plan International and La Leche League have helped to promote breastfeeding around the world, educating new mothers and helping the governments to develop strategies to increase the number of women exclusively breastfeeding.

Traditional beliefs in many developing countries give different advice to women raising their newborn child. In Ghana babies are still frequently fed with tea alongside breastfeeding, reducing the benefits of breastfeeding and inhibiting the

absorption of iron, important in the prevention of anemia (Elot, Jane, 2003, cited in Wikipedia Encyclopedia, 2010).

Nepal: In Nepal breast-feeding has special cultural value. Being a developing country, the rate of increase in infant mortality rate is higher and it is very important in Nepal to make people aware about the importance of exclusive breast-feeding till six months and beyond.

A small scale descriptive, comparative research study was done by Khadka Laxmi Shrestha in twenty five illiterate mothers and twenty five literate mothers of 4-6 months old child attending at M.C.H. clinic of Kanti Children Hospital regarding knowledge, attitude and practices and its outcomes about exclusive breast feeding shows that only eight percent of mothers of literate group knew about EBF. Hundred percent illiterate mothers did not have knowledge about exclusive breast feeding. The rate of breast feeding was higher among the children of literate mothers than illiterate mothers of up to 4 to 6 months old child (literate 100 percent and illiterate 92 percent). But they did breast feeding along with additional supplementary feeding due to inadequate and lack of knowledge about breast feeding. There was no significant difference between ethnic group, types of family, age of mother and occupation among literate and illiterate mothers about knowledge, attitude, and practices of breast feeding (Shrestha, 2055).

2.1.4 Publicity, Promotion and Law in Breastfeeding

In response to public pressure, various health departments of the government have recognized the importance of encouraging mothers to breastfeed. The required provision of baby changing facilities was a large step towards making public places more accessible for parents and in many countries there are now laws in place to protect the rights of a breastfeeding mother when feeding her child in public.

The World Health Organization (WHO), along with grassroot non-governmental organizations like the International Baby Food Action Network (IBFAN) has played a large role in encouraging these governmental departments to promote breastfeeding. Under this advice they have developed national breastfeeding

strategies, including the promotion of its benefits and attempts to encourage mothers, particularly those under the age of 25, to choose to feed their child with breast milk.

2.1.5 Breastfeeding in Public

A breastfeeding mother in public with her baby will often need to breastfeed her child. A baby's need to feed cannot be determined by a set schedule, so legal and social rules about indecent exposure and dress code are often adapted to meet this need. Many laws around the world make public breastfeeding legal and disallow companies from prohibiting it in the workplace, but the reaction of some people to the sight of breastfeeding can make things uncomfortable for those involved. Some breastfeeding mothers feel reluctant to breastfeed in public (Jordan and Pile, 2002).

USA: A United States House of Representatives appropriations bill (HR 2490) with a breastfeeding amendment was signed into law on September 29, 1999. It stipulated that no government funds may be used to enforce any prohibition on women breastfeeding their children in Federal buildings or on Federal property. Further, U.S. Public Law, Sec. 647 enacted in 1999, specifically provides that "a woman may breastfeed her child at any location in a Federal building or on Federal property, if the woman and her child are otherwise authorized to be present at the location." A majority of states have enacted state statutes specifically permitting the exposure of the female breast by women breastfeeding infants, or exempting such women from prosecution under applicable statutes, such as those regarding indecent exposure.

Laws protecting the right to nurse aim to change attitudes and promote increased incidence and duration of breastfeeding. Recent attempts to codify a child's right to nurse were unsuccessful in West Virginia and other states. Nowhere is breastfeeding in public illegal.

UK: A UK Department of Health survey found that 84% (about 5 out of 6 people) find breastfeeding in public acceptable if done discreetly, however 67% (2 out of 3) mothers are worried about general opinion being against public breastfeeding (UK

Department of Health,2004). To combat these fears in Scotland, a bill safeguarding the freedom of women to breastfeed in public was passed in 2005 by the Scottish Parliament (Breast feeding ect. Scotland act, 2005). The legislation allows for fines of up to £2500 for preventing breastfeeding in legally permitted places (MSPs Approve Breastfeeding Move, BBC news, 2004).

Canada: In Canada, the Canadian Charter of Rights and Freedoms gives some protection under sex equality. Although Canadian human rights protection does not explicitly include breastfeeding, a 1989 Supreme Court of Canada decision (Brooks v. Safeway Canada) set the precedent for pregnancy as a condition unique to women and that thus discrimination on the basis of pregnancy is a form of sex discrimination. Canadian legal precedent also allows women the right to bare their breasts, just as men may. In British Columbia, the British Columbia Human Rights Commission Policy and Procedures Manual protects the rights of female workers who wish to breastfeed (Wikipedia Encyclopedia, 2010).

2.1.6 Benefits of Breastfeeding

The decision to breastfeed is a very important one that can mean better health of mother and the baby both now and in the future. In fact, given the choice, it is very likely that all babies would choose to be breastfed.

Breastfeeding has many advantages for babies, their mothers, for society and for the environment. Some of these advantages are listed below.

Benefits for Babies:

Breast feeding has numerous advantages for breastfeeding mother, her baby, and society in many ways. Some of the major advantages according to Nancy are given below.

Breast milk prevents from:

-) Stomach upsets
-) Coughs and colds
-) Ear infections

-) Diabetes
-) Asthma and eczema
-) Obesity (being very overweight)
-) High blood pressure later in life
-) Breastfed babies also have better mental development
-) Better mouth formation and straighter teeth

Benefits for Mothers:

-) Less risk of breast cancer
-) Less risk of ovarian cancer
-) Less risk of bone thinning (osteoporosis) in later life
-) Stronger bones in later life
-) Faster return to pre-pregnancy figure

Breastfeeding has other benefits too:

-) It creates a special bond between mother and baby.
-) It is cheaper because less equipment is needed, and
-) It saves your time because you do not have to prepare bottles.

Benefits to the Environment

-) Breast milk needs no packaging.
-) Breast milk requires no bottles or teats.
-) Breast milk does not need to be transported to the consumer.

Benefits to Society

-) With mum and baby healthier, health care costs are reduced.
-) Breastfeeding women in the paid workforce have less absenteeism

2.1.7 Importance of Exclusive Breastfeeding

Breast-feeding has an economic impact on health and food security for the mother and child. According to the basic assumption, mothers should be free to choose how

to feed their children without any commercial pressure or from any family member with the full knowledge of the health benefits of breast-feeding.

Partially breast-fed and weaned infant gained weight more slowly than those exclusively breast-fed infants. According to the research done by South Africa Vitamin A Study Group, infants exclusively breast-fed for 3 months or more had no excess risk of HIV infection for over 6 months than those never breast-fed. Observational studies suggested that breast-feeding benefits the visual development of children, which has been attributed to the presence of docosahexaenoic acid (DHA) in breast milk.

Behavioral research has identified a number of specific practices and interventions that contribute to successful exclusive breastfeeding.

-) *Immediate initiation of breastfeeding:* Post-delivery stimulates the release of oxytocin, which in turn stimulates strong uterine contractions. This may help to control postpartum bleeding. To encourage immediate initiation, the mother should remain with the newborn for at least several hours following delivery.
-) *Feeding colostrum* provides immunologic benefits to the baby and may help to discourage the feeding of pre-lacteal feeds (water, sugar-water or other substances given before the start of breastfeeding). Pre-lacteal feeds can damage the baby's gut/intestine and expose the newborn to pathogens.
-) *Frequent, on-demand breastfeeding* day and night ensures that the mother will make enough milk to match the baby's needs. Breastmilk is produced on a "supply and demand" basis. The more the baby suckles the more breastmilk the mother produces. Frequent breastfeeding decreases the risk of engorgement, which can lead to breast inflammation and mastitis. It also prolongs lactational amenorrhea. Lactational amenorrhea is associated with reduced fertility and increased birth spacing.
-) *Proper positioning and attachment* to the breast ensure that breastfeeding is comfortable and efficient and may help reduce the problem of "insufficient milk" that many women report. Proper positioning also decreases the risk of

nipple problems. Interventions in health facilities and the community can both promote and support exclusive breastfeeding (WHO,2002).

2.1.8 Breastfeeding contributes to poverty reduction

The importance of breastfeeding in human life cannot be understated. This basic act, that nurtures life, is an important bond between the mother and the newly born baby. The warm contact provides the new born with not only sustenance but also love and security. Breastfeeding provides protection from diseases and malnutrition, gives infants a head start in life and also saves money which artificial or bottle feeding entails. Bottle feeding on the other hand perpetuates poverty. BPNI in 1998 calculated that the estimated cost of bottle feeding a baby was Rs 1,100 per month. To an average Indian family, artificial feeding may mean spending half to one third of their income. Poor families' spending money on artificial feeding from their tight budgets may have to actually reduce expenditure on nutrition of other family members, especially girls. The whole family falls into the downward spiral of malnutrition, greater incidence of disease, increased medical expenditure and decreased finances. The other ramification is that the baby being brought up on expensive artificial bottle feed has increased chances of succumbing to infections, entailing even greater spending on health care and treatment for the sick child. All this perpetuates poverty (Gupta, 2003).

Inappropriate feeding practices and their consequences are major obstacles to sustainable socio-economic development and poverty reduction. Governments will be unsuccessful in the efforts to accelerate economic development in any significant long-term sense until optimal child growth and development, especially through appropriate feeding practices, are ensured (WHO 2002).

2.1.9 Impact of Globalization on Breastfeeding

There has been misleading and inappropriate advertisements by manufacturers to promote their products. Such kind of labeling and advertisement should be prohibited- the product decreases the incidence of diarrhoea, contains all the extra nutrition babies need for all-round visual, mental and psychomotor development,

promotes a healthy heart in later life etc. Infant food manufacturers are increasingly using health claim to promote market of the product; such claim could mislead the perception that breast-milk and infant formula are equal. Seeing good photos of healthy babies on the product, most of the consumers are motivated towards giving their child complimentary food which may lead to diarrheal diseases, acute respiratory infection and so on.

Some infant formula manufacturers are making claims such as product is nutritionally close to breast milk, especially processed, easier to digest, closer than it has ever been to breast milk, supports visual, cognitive and psychomotor development, close to that of breast-fed infant. This is contrary to the international code which aims to promote breast-feeding and provide accurate and reliable information to new parents.

2.1.10 Alternatives of Breastfeeding

Feeding vessels dating from about 2000 BC have been found in Egypt. A mother holding a very modern-looking nursing bottle in one hand and a stick, presumably to mix the food, in the other is depicted in a relief found in the ruins of the palace of King Ashurbanipal of Nineveh—who died in 888 BC (Brennemann,1923). Clay feeding vessels were found in graves with infants from the first to fifth centuries AD in Rome.

Valerie Fildes writes in her book *Breasts, Bottles and Babies: A history of Infant Feeding* about examples in the 9th till 15th century of children getting animal's milk. In the 17th and 18th century Icelandic babies got cow's milk with cream and butter (Hastrup, 1992).

The feeding of flour or cereal mixed with broth or water became the next alternative in the 19th century, but once again quickly faded. Around this time there became an obvious disparity in the feeding habits of those living in rural areas and those in urban areas. Most likely due to the availability of alternative foods, babies in urban areas were breastfed for a much shorter length of time, supplementing the feeds earlier than those in rural areas.

Though first developed by Henri Nestlé in the 1860s, infant formula received a huge boost during the post World War II Baby Boom. When business and births decreased, and government strategies in industrialized countries attempted to highlight the benefits of breastfeeding, Nestlé and other such companies focused their aggressive marketing campaigns on developing countries. In 1979 the International Baby Food Action Network (IBFAN) was formed to help raise awareness of such practices as supplementary feeding of new babies with formula and the inappropriate promotion of baby formula, and to help change attitudes that discourage or inhibit mothers from breastfeeding their babies (Wikipedia, Encyclopedia, 2010).

2.2 Previous Studies in Exclusive Breastfeeding

WHO has an estimation that up to 1.45 million children die annually in poor countries because of low breast-feeding rates. Thailand has the lowest exclusive breast-feeding rate in Asia; only 5.4 percent of mothers nurse their babies on breast milk alone in the first six months of their child's life. Vietnam's rate has fallen from 29 percent in 1998 to 15 percent in 2002, while Indonesia dropped from 42 percent in 1997 to 40 percent in 2002. In the Philippines, the rate of exclusive breast-feeding at four to five months of a child's life fell from 20 percent in 1998 to 16 percent in 2003. It is estimated that 16,000 deaths of children under five in the Philippines are caused by inappropriate feeding practices, including the use of infant formula (Imelda, 2007).

In PR China, any breastfeeding' rates were high before discharge at all three locations: 96.5 percent in city, 96.8 percent in suburb and 97.4 percent in the rural area. The 'exclusive breastfeeding' rates in the city, suburban and rural areas before discharge were 38.0 percent, 63.4 percent and 61.0 percent respectively. By sixth months the 'any breastfeeding' rates had declined to 62.8 percent, 76.9 percent, and 83.6 percent and the 'exclusive breastfeeding' rates had fallen to 0.2 percent, 0.5 percent and 7.2 percent in city, suburb and rural areas respectively. There were differences in feeding practices between the three locations, including the use of prelactal feeds and the introduction of supplementary feeds (Liquian et al. 2007).

A research carried out in 219 breast feeding mothers of a Muslim community shows the median duration of exclusive breastfeeding was four months (95% CI 3.75, 4.25). The rates of exclusive breastfeeding at 4 and 6 months were 61.6 percent (135/219) and 15.5 percent (24/155) respectively. Vicariate analysis showed that the Muslim ethnicity ($p = 0.004$), lower levels of parental education ($p < 0.001$) and being an unemployed mother ($p = 0.021$) were important associations of early cessation of exclusive breastfeeding. At the time of the study, 62 percent (135/219) of infants were receiving feeds via a bottle and 23 percent (51/219) were receiving infant formula. Muslim ethnicity was significantly associated with bottle and formula feeding ($p < 0.001$). Bottle feeding was also significantly higher among mothers with a low level of education and among employed mothers (Agampodi, 2006).

A community-based cross sectional study was done in urban slums of Gwalior, India. Only 11 (3.8%) mothers knew that exclusive breast feeding (EBF) should be done till six months and 22 (7.8%) actually practiced EBF. A total of 178 (63.8%) and 212 (76.0%) newborns were given pre- and post-lacteal feeds with 26.2 percent discarding colostrums. Only 22 (7.8%) practiced EBF. The early **breastfeeding** (BF) initiation, Ante Natal Clinic (ANC) visits, mothers' education and immunization visits were significantly associated with higher probability of EBF. There were a number of myths and misconceptions about BF in this urban slum population. The correct information about BF was more common amongst the women who had frequent contacts with health facilities due to any reason or during ANC or immunization visit. Similarly, it is the continuum of good health and **feeding** practices and the mothers who start early BF or get their child immunized regularly are more likely to be EBF their children. Considering the widely prevalent myths and low rate of utilization of health services along with high potential benefits of EBF, every opportunity of mothers' interaction with the health facility should be utilized for promoting correct and EBF practice (Tiwari et al. 2006).

In Chandigarh, India, number of infants who were given colostrums were 80.9 percent and 26.9 percent were put on breast feed within 1-2 hours of birth. The reference population comprised of mothers of newborn aged 0-3m. In pilot study it

was found that 44 percent mothers in urban area and 48 percent in slums were not doing exclusive breast-feeding, taking 46 percent as average mothers not resorting to exclusive breast feeding (Puri, 2006).

In different health institutions, majority (93%) of mothers and all the nursing directors were positive towards giving exclusive breast feeding, only some (16.66%) mothers had given exclusive breast feeding until 6 months of age of their infants. The majority of mothers had given infant formula milk and other complementary food due to various reasons (Thapa, 2006).

Almost all children born in the five years preceding the survey (98%) were breastfed at some time. Initiation of breast feeding within one hour of birth was 35.4 percent. However, contrary to WHO recommendations, only around half of the children under six months (53%) are exclusively breastfed. The median duration of breastfeeding in Nepal is long - 34.3 months. The proportion of children exclusively breast fed decreases at 6 months of age, as solid and mushy food are introduced. This could be because in many cultures in Nepal, the first time solid food is given is solemnized with a formal ceremony called Pasanee, or the rice feeding ceremony. Two in three children under six months whose mothers have a primary education are exclusively breastfed; only one in three children of mother with SLC and higher level of education are exclusively breastfed. Further, children in lowest wealth quartile are more likely to be exclusively breast fed than children in the highest wealth quartile (67% and 38% respectively) (NDHS, 2006).

A research in Taiwan reported that among the mothers who initially intended to exclusively breast fed, 39.3 percent changed formula feeding while 7.1 percent of the mother who intended to mixed feeding and 4.8 percent of the mother who intended to formula feed changed to exclusive breast feeding at one month postpartum, 9 percent of the breast feeding mothers weaned within the first week, 9.2 percent between the first and second week, 8.4 percent weaned between the second and third week, while another 14.8 percent weaned between the third and fourth week. It concluded that successful breastfeeding not only depends on factors related to the mother, but also on the environment. Education regarding

breastfeeding should be provided to the entire family including the mother and father (Chen and Chi, 2003).

In Jordan, full breastfeeding was reported by 58.3 percent, mixed feeding was reported by 30.3 percent and infant formula feeding was reported by 11.4 percent. Almost one third of the full breastfeeding group did so for 6–12 months, and almost two thirds did continue breastfeeding for more than one year. Employed women were more likely not to practice full breastfeeding compared to unemployed women (odds ratio 3.34, 95% CI 1.60, 6.98), and women who had caesarian delivery were more likely not to practice full breastfeeding compared to those who had vaginal delivery (odds ratio 2.36, 95% CI 1.17, 4.78). Jordanian women had a positive attitude but work place and short maternity leaves had a negative impact on breastfeeding (Khassawneh et al. 2003).

A research report on “Maternal recall of exclusive breast feeding duration” carried out in the area of high HIV prevalence rate in South Africa reports that forty six percent ($n = 61$) of infants received other fluids or feeds in addition to breast milk in the first 48 hours of life, and were therefore classified as mixed feeders. Most infants had dropped out of the EBF category by 2 weeks of age. Only 17 percent ($n = 23$) of infants were EBF to 2 weeks, 10 percent ($n = 14$) to 6 weeks, and 6 percent ($n = 8$) to 16 weeks of age (Bland et al. 2002).

In a Finnish study, 198 women intended to breastfeed for 10 months. The number of exclusively breastfed infants was 116 (58%) at 6 months, 71 (36%) at 7.5 months, 36 (18%) at 9 months, and 7 (4%) at 12 months. The reason given for introducing complementary feeding before the age of 4 to 6 months was the infant’s demand appeared greater than the supply of human milk. This was decided by the mother in 77 cases and by the investigators in 7 cases. Of 23 percent of mothers added solids to their infant’s diet at 4.5 months; 55 percent added solids at 6 months and 93 percent added solids at 7 months. Since exclusive breastfeeding is rare in developing countries, the number of observational studies on human-milk intakes of exclusively breastfed infants is limited. An intervention study was conducted in Honduras where one group ($n=50$) was required to breastfeed exclusively for 6 months. Although this is an important study, it may not be totally representative of all mothers and infants

in that community. Sixty-four women were ineligible to participate because they did not maintain exclusive breastfeeding through 16 weeks for the following reasons: insufficient milk ($n=26$), personal choice ($n=16$), maternal health ($n=12$), and family pressure not to breastfeed exclusively ($n=10$) (Nancy et al. 2002).

A hospital based study in Nepal found that all mothers knew that they have to breast feed their babies but they did not have adequate knowledge about the appropriate knowledge of breast feeding. Only 14.9 percent knew that they have to initiate breast feeding within half an hour of birth, 6.3 percent knew meaning of exclusive breast feeding and none of the mothers had idea on importance on night feeding. Coming to the practice it was seen that 10.3 percent mother initiated breast feeding within half an hour of birth, colostrums was fed 98.8 percent, 48.8 percent practicing exclusive breast feeding, mother with higher education background were using more bottle feed and was least among the farmer and sweeper mothers (Malla et al. 2002).

2.3 Conceptual Framework

Breast feeding behavior in human has been influenced by various social and anthropological factors. In health related issues, proper knowledge is an essential factor; however, there are environmental, socio-cultural, socio-economic, demographic, situational, and other human factors that may create deviations on knowledge, attitude, and practices of mother on her breast feeding behavior.

Whatsoever are the causes so far, if the infants are breastfed exclusively as recommended, it can help to decrease infant mortality and morbidity.

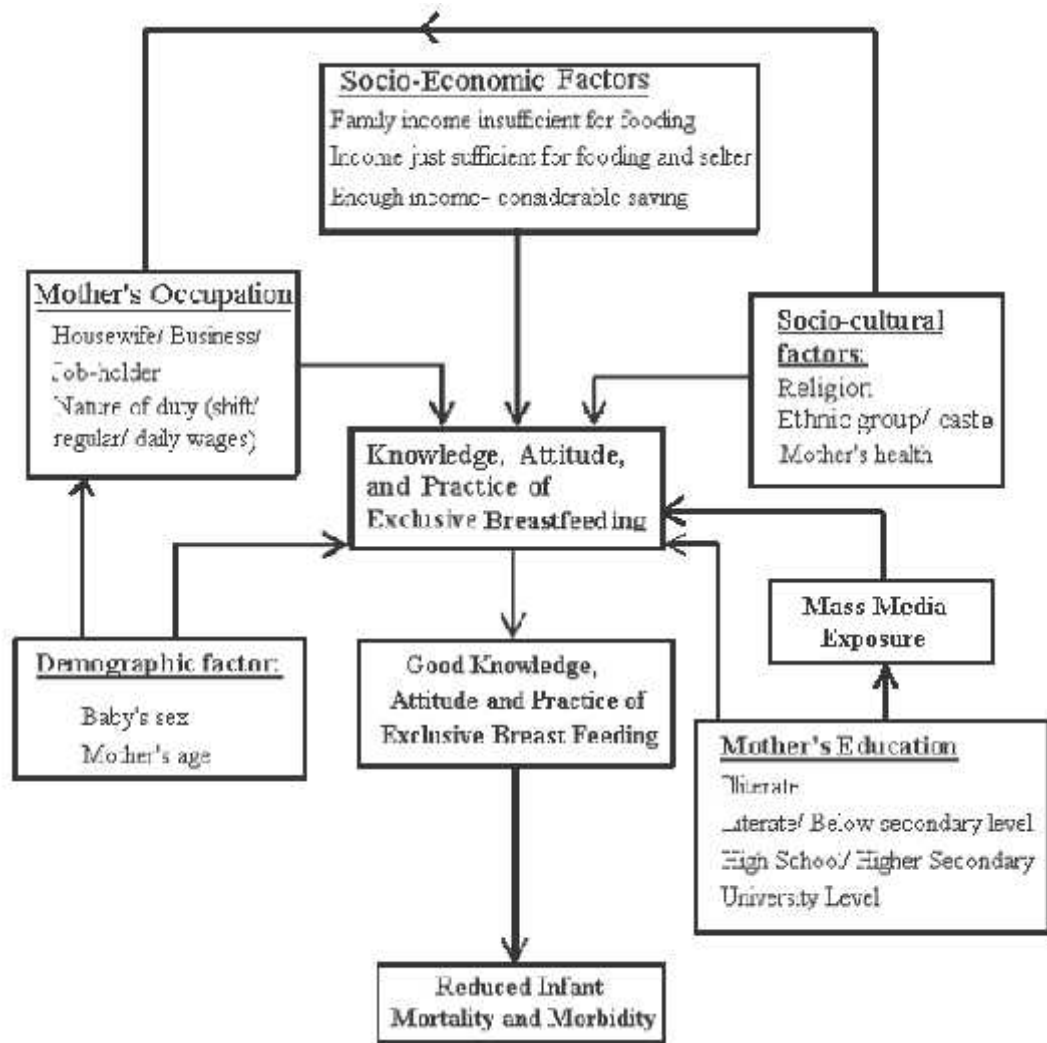


Fig 1.1 Conceptual Framework

Breast feeding is socially constructed and controlled practice, so social groups, caste/ethnicity, religion, culture, traditional practice directly and indirectly affect practices of exclusive breastfeeding. If all the social systems plays positive role towards EBF, all the infants become healthy and society saves time and money for childhood diseases.

CHAPTER III

RESEARCH METHOD

3.1 Rational of the Selection of Study Area

The study area of this research was the Maternal and Child Health Clinic (MCH) of Sishuwa Primary Health Centre, Lekhnath Municipality, Kaski. It covers ward no. 1, 8, 12, 13, 14 and, ward no. 15 of Lekhnath Municipality. Almost the entire breast feeding mothers of under-one-year children with diverse ethnic and economic group reach there every month for immunization. Selection of MCH clinic therefore was a suitable area to get different kind of diversity among breastfeeding mothers. Also it made research data collection work managed and easier because searching the diversified data in community takes more time.

Again, being the area my home community, I could better understand their language, feelings and needs, which made our communication easy. During data collection the breastfeeding mothers and their family members felt free to talk to me.

3.2 Research Design

The objectives of this study is to find out the knowledge, attitude and practice of exclusive breast feeding of breast feeding mothers .Thus the nature of this study is both exploratory and descriptive research design. The exploratory research design was used to explore the attitude regarding exclusive breast feeding, whereas the descriptive research design was implemented to analyze various statistical quantitative data related to exclusive breast feeding.

3.3 Nature and Source of Data

In the study, I was involved myself in each and every event, therefore these are the primary data collected from breast feeding mothers who have 6 months to under-one-year infants. For the reliability of the obtained data, I had managed group discussions among Community Health Volunteer (often she is female) and members of mother's group. For the analytical support, the secondary source of data was collected from National Demographic Health Survey, Annual Health Report and other related report, researches, and studies in the internet.

3.4 Population Universe and Sample Size

According to immunization record 2064/2065, around 150 mothers of six-to-under-one-year infants attended in first three months in immunization clinic. The sample size was fixed to 108 breast feeding mothers from that population universe.

3.5 Data Collection Technique

This study is first and foremost based on primary data source. These data were collected using different data collection techniques. Depending on the nature of problem, data were collected from direct interview, observation, key informant interview and focus group discussion.

3.5.1 Interview Schedule

The relevant data was collected from 108 breast feeding mothers whose infants were from 6 months to one year of age. The interview was taken from semi structured interview schedule.

3.5.2 Observation

Observation method is a well accepted and pragmatic method for data collection. So I used this method to find out position and attachment between baby and mother during breast feeding because proper positioning and attachment helps better secretion of milk with prolactine hormone stimulation. I observed this behavior during and immediately after interview.

3.5.3 Key Informants' Interview

Key informant's interview helps to find out the importance of EBF to Nepalese society as well as mother and child health. Interview was taken with Staff Nurse of Sasthagat clinic, District nutrition Department head (HA), Facilitator of DACAW programme, Lekhnath Municipality and Village Health Worker and FCHV of Sishuwa PHC.

3.5.4 Focus group discussion

This method was used to collect qualitative data about importance of exclusive breast feeding (EBF) to mothers and babies. Individuals as well as community attitude towards the benefits of EBF was discussed on mother's group and Female

Community Health Volunteers (FCHV). Four mothers and four FCHV took participation on group discussion.

3.6 Data Management and Analysis

Accurate and complete data should be consistent with objectives of the study. SPSS for windows software was used to process and analyze the quantifiable raw data gathered. The data are tabulated and represented graphically according to their practicability. Descriptive analysis such as mean and frequency were calculated for quantitative data. Non quantifiable qualitative data has been managed manually and analyzed descriptively.

CHAPTER IV

BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

4.1 Introduction of Study Area

The study area of this research is Maternal and Child Health Clinic (MCH) of Sishuwa Primary Health Centre, Lekhnath Municipality, Kaski, which covers ward no. 1, 8, 12, 13, 14 and 15 of Lekhnath Municipality. MCH runs six mobile clinics in different areas every month where maternal mothers gather to immunize under-one-year infants. Sishuwa P. H. C. record shows that nearly one hundred and fifty infants aged 6 months to less than one year immunized every four months. Nepal, as such has economic, demographic, geographic, socio-cultural, ethnic, and religious diversities. The study area selected in this research, too, reflects that type of diversities among population. As described in proceeding sub-sections, the research area reflects this type of assortment in age, caste/ethnicity, educational and social status, socio-cultural beliefs and values among the breast feeding mothers. This characteristic is value added advantage for a sociologic study because the results derived here can be generalized for most of the developing countries.

4.2 General Characteristics of the Study Population

4.2.1 Age of Respondents

Age of mothers is an important indicator during child bearing and lactation time. Twenty to below thirty-five years of age is proper for child bearing. However, different socio-cultural and religious factors vary the child bearing time of the maternal mothers. The child bearing practice, like other factors, depends highly upon mother's age because peoples' interests, thoughts, and behaviors keep on changing with time. Age reflects the thoughts and beliefs of different time. Therefore age is considered one of the vital sociological determinants. Table 4.1 shows the division of respondents according to their age group. In the focus area most of respondents (mothers) 48(44.44%) were 20-24 years age group whereas a

single respondent was above 40 years. The mean age of respondents was 24.20 years.

Table 4.1: Distribution of Respondents by Age

Age of Respondents	Number	Percentage
15-19 years	11	10.19
20-24 years	48	44.44
25-29 years	38	35.19
30-34 years	6	5.55
35-39 years	4	3.70
40 years and above	1	0.93
Total	108	100.00

Source: Field Survey, 2009

4.2.2 Parity of Respondents

A woman who has given birth to an infant or infants is called para. If a mother gives birth to one live infant, it is called primy-para and if she gives birth to more than one live children, it is called multi-para. Most of respondents (57 out of 108, 52.78%) were multi para.

Table 4.2: Distribution of Respondents by Parity

Parity of Respondents	Number	Percentage
Primy Para	51	47.22
Multi Para	57	52.78
Total	108	100.00

Source: Field Survey, 2009

4.2.3 Educational Status of Respondents

Webster defines education as the process of educating or teaching the purpose of which is to develop knowledge, skill, or character of students. This is the process of imparting or acquiring general knowledge, developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually for mature life.

It may be formal or informal. Knowledge may be one of the outcomes of education but knowledge arises in the mind of an individual when that person interacts with an idea or experience. Therefore this is one of the key determinants of an individual's thought and behavior. Education level of the respondents was categorized as literate and illiterate. Most of the respondents (97, 89.81%) were literate. Among literate, most of the respondents (55, 50.94%) had only completed school level education.

Distribution of Respondents by Educational Status

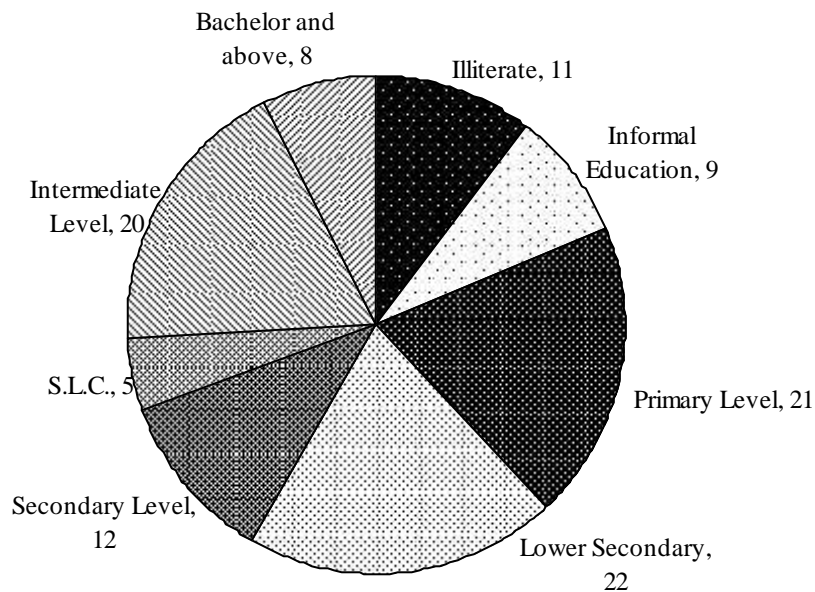


Fig: 4.1 Distribution of Respondents by Educational Status

4.2.4 Caste and Ethnicity of Respondents

Caste is an endogamous and hereditary social group limited to persons of the same rank, occupation, economic position, etc., having mores distinguishing it from other such groups. Castes are more socially separated from each other than are social classes. It is the social class separated from others by distinctions of hereditary rank or profession or wealth. Ethnicity defines individuals who consider themselves, or are considered by others, to share common characteristics which differentiate them from the other collectivities in a society, within which they develop distinct cultural behavior. Caste is extreme form of social class organization in which the position of individuals in the status hierarchy is determined by descent and birth. Caste refers to

a hierarchical system or social control with each sub group assigned with a ranked status depending on its origin and religion strictness. Cast and ethnicity are therefore the determinants of individual's social behavior.

Most of respondents (40, 37.04%) were Bramhin or Kshetry. Similarly there were 26 (24.37%) Dalit mothers respondents in this study. In addition to this there were single respondent from each of Kumal and Rai caste.

Table 4.3: Distribution of Respondents according to Caste and Ethnicity

Caste and Ethnicity	Number	Percentage
Brahmin/ Kshetry	40	37.04
Dalit	26	24.07
Gurung	22	20.38
Tamang	9	8.33
Magar	9	8.33
Kumal	1	0.93
Rai	1	0.93
Total	108	100.00

Source: Field Survey, 2009

4.2.5 Religion of Respondents

A **religion** is a set of beliefs concerning the cause, nature, and purpose of the universe, especially when considered as the creation of a supernatural agency or agencies, usually involving devotional and ritual observances, and often containing a moral code governing the conduct of human affairs. Aspects of religion include narrative, symbolism, beliefs, and practices that are supposed to give meaning to the practitioner's experiences of life. The term "religion" refers to both the personal practices related to communal faith and to group rituals and communication stemming from shared conviction. "Religion" is sometimes used interchangeably with "faith" or "belief system," but it is more socially defined than personal convictions, and it entails specific behaviors, respectively. "Religion is universal, permanent, pervasive and perennial interests of man"(Rao, 2002).

The majority of respondents (79 or 73.15%) had religious belief on Hinduism, the second being Buddhist (27 or 25.00%), and the least were Christian (2 or 1.85%).

Table 4.4: Distribution of Respondents by Religion

Religion	Number	Percentage
Hindu	79	73.15
Buddha	27	25.00
Christian	2	1.85
Total	108	100.00

Source: Field Survey, 2009

4.2.6 Type of Family of Respondents

Family is a primary social unit living together. It is basically a group of people who are important to each other and offer each other love and support, especially in time of crisis. The different types of families occur in a wide variety of settings, and their specific functions and meanings depend largely on their relationship to other social institutions. Basically the family types found are: nuclear family and extended family.

The type of family is categorized as nuclear and joint. Most of the respondents (60 or 55.56%) belonged to a class of nuclear family.

Distribution of Respondents by Types of Family

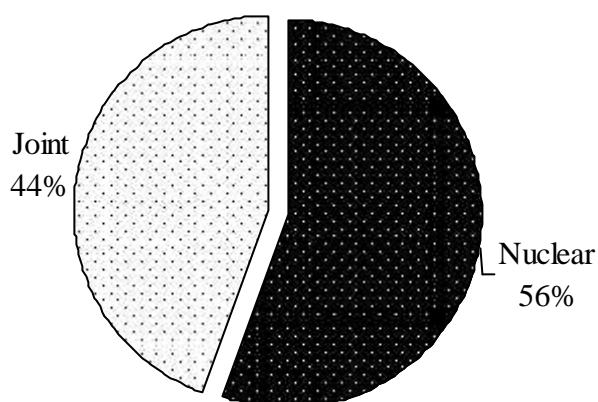


Fig: 4.2 Distribution of Respondents by Types of Family

4.2.7 Occupation of Respondents

An occupation is used mostly to refer to specialized and established kind of work. It refers to some kind of work with which an individual becomes completely engaged.

Table 4.5: Distribution of Respondents by Occupation

Occupation	Number	Percentage
Housewife	72	66.67
Agriculture	17	15.74
Daily wages	7	6.48
Business	4	3.70
Service	3	2.78
Students	5	4.63
Total	108	100.00

Source: Field Survey, 2009

Occupation denotes the habitual employment, profession, craft or trade of an individual. It takes up much of his time and attention. In modern connotations it means an instrument of livelihood. It is usually associated with one or the other kind of organization; agriculture, industry, governmental organization, etc. (Rao, 2002). In others words, an occupation is the principal activity that a person does in his life to earn money.

In this survey, I found different breast feeding mothers with different occupational groups; some of them were students, business holders, those involving in public services, agriculture, and most of them (72 or 66.67%) were housewives.

4.2.8 Occupation for Family Livelihood

Livelihood is the financial means whereby one lives. Abroad employment was one of the major resources of economic dependence of most of the family (41 or 37.96%) in the survey area, a small number of families (10 or 9.26%) were depending on agriculture.

Table 4.6: Distribution of Respondents by Occupational Status

Occupation	Number	Percentage
Foreign Job	41	37.96
Service	24	22.22
Daily wages	22	20.37
Business	11	10.19
Agriculture	10	9.26
Total	108	100.00

Source: Field Survey, 2009

CHAPTER V

KNOWLEDGE OF EXCLUSIVE BREAST FEEDING

5.1 Introduction

Knowledge is the perception of the agreement or disagreement of two ideas (John Locke 1689). Similarly, knowledge is information that changes something or somebody -- either by becoming grounds for actions, or by making an individual (or an institution) capable of different or more effective action (Peter F. Drucker in *The New Realities*).

Achterbergh and Vriens (2002) further write that the function has two main parts. First, it serves as a background for the assessment of signals, which in turn, allows the performance of actions. As to the first part, they write, "To determine whether a signal is informative, an observer has to attach meaning to it," e.g., to perceive and interpret it. Once perceived and interpreted the observer may evaluate whether the signal is informative and whether action is required.

And secondly, "The role of knowledge in generating appropriate actions is that it serves as a background for articulating possible courses of action (articulation), for judging whether courses of action will yield the intended result and for using this judgment in selecting among them (selection), for deciding how actions should be implemented and for actually implementing actions (implementation)."

Personal knowledge is embedded in individual experience and involves intangible factors, such as personal beliefs, perspective, and the value system. Tacit knowledge is hard to articulate with formal language (hard, but not impossible). It contains subjective insights, intuitions and hunches.

5.2 Respondents Understanding About EBF

The study shows that (97/89.8%) respondents had heard about exclusive breast feeding from different sources.

5.2.1 Distribution Regarding Sources of Information about EBF

Among the respondents receiving information, the study shows majority of respondents 38 (39.10%) had received information about exclusive breast feeding from health personal, and the number of respondents receiving information from mother and mother in law was least, (1.03% and 2.06% respectively).

Table 5.1: Distribution of Respondents by Sources of Information about Exclusive Breast Feeding **n=97**

Sources of Information	Number	Percent
Health Personnel	38	39.10
Television	23	23.71
Radio	15	15.46
Newspaper/Book	12	12.37
Peer Group	6	6.19
Mother in law	2	2.06
Mother	1	1.03
Total	97	100.0

Source: Field Survey, 2009

5.2.2 Knowledge of Exclusive Breastfeeding

The knowledge, as already stated, is the combination of how people came to know and how they perceive the information. Among all 108 respondents, the study was conducted to identify the proper knowledge about the definition of exclusive breast feeding. Among them 77 (71.30%) thought that EBF is breast feeding without giving food, liquid, or water, 15 (13.388%) respondents thought that EBF is breast feeding with water plus, 4 (3.70%) thought breast feeding with other milk, 1 (0.93%) thought breast-feeding with complementary food, and the remaining 11 (10.19%) had no idea about the question. Only 60(55.6%) can define properly about “Exclusive Breast Feeding” as per WHO recommendation.

Distribution of Respondents' Knowledge about EBF

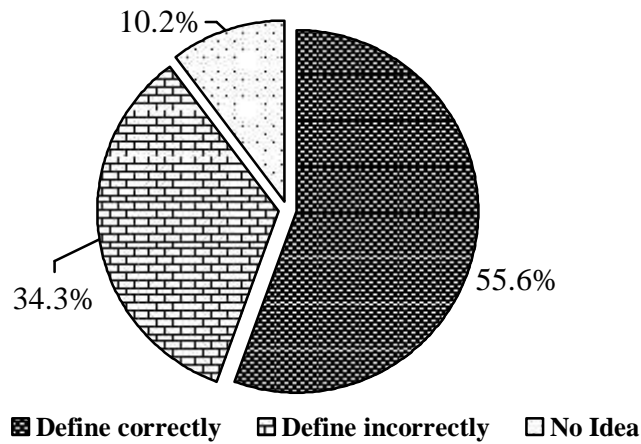


Fig 5.1: Distribution of Respondents' Knowledge about EBF

5.2.3 Knowledge about Appropriate Time to Start Breastfeeding

Among the respondents, 55 (50.93%) think that the best time to start breast feeding after birth is within one hour, 31(28.70%) think that it should be between 1-4 hours, and 16 (14.81%) had no idea about the appropriate time to start breast feeding. Table 5.2 shows the respondents' knowledge about the after-birth starting time of breast feeding to their baby.

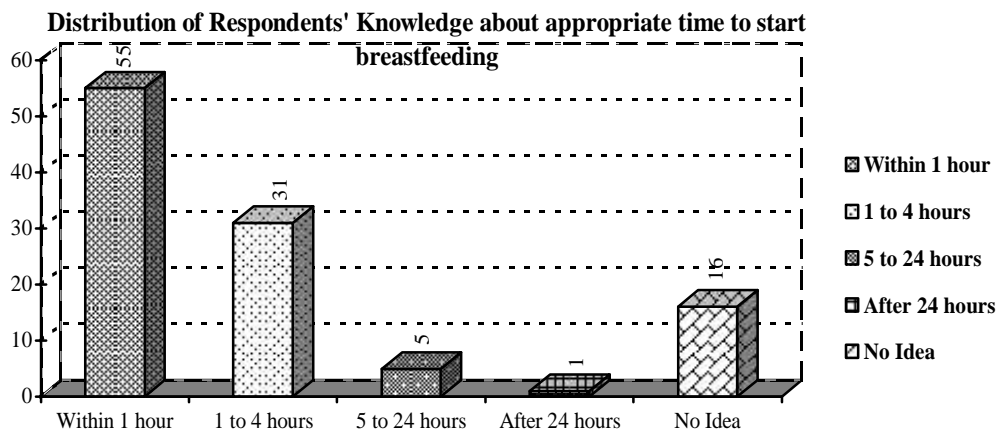


Fig5.2: Distribution of Respondents' Knowledge about the Appropriate Time to Start Breastfeeding

5.2.4 Knowledge about the Frequency of Breast Feeding within Twenty-four Hours

Respondents' opinion about the frequency of breast feeding to below six-month baby was taken during survey. The result shows that majority of the breast feeding mother (45.4%) think that it should be repeated every one to two hours on day time and 41.7 percent think that it should be repeated on every two to three hours at night time. Four of the respondents had no idea about the frequency of breast feeding at either of the day or night time.

Table 5.2: Distribution of Respondents Knowledge about the Frequency of Breast Feeding in Day Time

Frequency of Breast-Feeding within 24 hours	Number	Percent
Every one to two hourly	49	45.37
Every three to four hourly	26	24.07
More than four hourly	0	0.00
As baby wants	29	26.85
No idea	4	3.71
Total	108	100.0

Source: Field Survey, 2009

Table 5.3: Distribution of Respondents' Knowledge about the Frequency of Breast Feeding in Night Time

Frequency of Breast-Feeding within 24 hours	Number	Percent
Every two to three hourly	45	41.67
Every four to five hourly	47	43.52
More than six hourly	3	2.77
When baby wake-up	9	8.33
No idea	4	3.71
Total	108	100.0

Source: Field Survey, 2009

5.2.5 Knowledge about Advantages of Exclusive Breast Feeding to Baby

Table 5.4 shows the respondents' opinion about the advantages of exclusive breast feeding. Majority of the respondents (59.26%) think that exclusive breast feeding prevents babies from illness / infection and 62(57.40%) think that it can provide adequate nutrition. Eleven respondents had no-idea about the advantages of exclusive breast feeding.

Table 5.4: Distribution of Respondents' Knowledge about the Advantages of Exclusive Breast Feeding to Baby **n=108**

Advantages of Exclusive Breast-Feeding to Baby	Number	Percent
Prevent from infection/ illness	64	59.26
Adequate nutrition to baby	62	57.40
Prevents from malnutrition	39	36.11
Easily digestible	8	7.40
No idea	11	10.18
Total		

Number exceeds more than 108 since it is based on multiple responses. *Source: Field Survey, 2009*

5.2.6 Knowledge about Advantages of Exclusive Breast Feeding to Mother

Table 5.5 shows the respondents' opinion about the advantages of exclusive breast feeding to mother. Majority of the breast feeding mother (76 out of 108 respondents) were unknown about the advantages of exclusive breast feeding to them. Only few respondents can answer the advantages of exclusive breast feeding to mother.

Table 5.5: Distribution of Respondents' Knowledge on Advantages of EBF to mother **n=108**

Advantages of Exclusive Breast-Feeding to mother	Number	Percent
Act as natural contraceptive device	12	11.11
Less risk to breast cancer	9	8.34
Prevents from breast engorgement	5	4.63
Mother satisfaction	4	3.70
Baby and child relation	3	2.78
Less risk to ovarian cancer	2	1.85
Faster return to per-pregnancy figure	2	1.85
No idea	76	70.37
Total		

Number exceeds more than 108 since it is based on multiple responses. *Source: Field Survey, 2009*

5.2.7 Relationship between Type of Family and Knowledge of EBF

Studies show that the knowledge of breastfeeding also depends upon the type of family of breastfeeding mother. Mothers living in joint family have better chances sharing knowledge with family members. This study also showed that most mothers (64.58%) living in joint family were found having good knowledge about EBF whereas this was only 40 percent among mothers living in nuclear family.

Table 5.6: Relationship between Type of Family and Knowledge of EBF

Family Type	Number	Good Knowledge	Fair Knowledge	No Knowledge
Nuclear	60	24 (40.00)	27 (45.00)	9 (15.00)
Joint	48	31 (64.58)	15 (31.25)	2 (4.17)
Total	108	55(50.93)	42 (38.89)	11 (10.18)

Figures in the parenthesis indicate percentage.

Source: Field Survey, 2009

5.2.8 Relationship between Education and Knowledge of EBF

Mother's education is not found directly correlated with her knowledge in exclusive breast feeding. Table 5.7 shows that mothers with higher education (above SLC) were found possessing good knowledge (as mentioned in operational definition), and one in every two informally educated mothers had good knowledge of EBF. But mothers with under SLC were found having poor knowledge about the subject matter. The study, however, has shown that very few literate mothers (7.22%) are unknown about EBF, where as this is 36.36% among illiterate mothers.

Table 5.7: Relationship between Education and Knowledge of EBF

Education Status		Number	Good Knowledge	Fair Knowledge	No Knowledge
Literate		97	51 (52.58)	39 (40.20)	7 (7.22)
	Informal	9	4 (44.45)	3 (33.33)	2(22.22)
	Primary	21	5(23.81)	14 (66.67)	2 (9.52)
	Lower secondary	22	12(54.55)	8(36.36)	2(9.09)
	Secondary	12	4(33.33)	7(58.33)	1(8.34)
	SLC	5	3(60.00)	2(40.00)	-----
	Certificate	20	16(80.00)	4(20.00)	-----
	Bachelor & above	8	7(87.50)	1(13.50)	-----
Illiterate		11	4 (36.36)	3 (27.28)	4(36.36)

Figures in the parenthesis indicate percentage.

Source: Field Survey, 2009

5.2.9 Relationship between Mother Parity and Knowledge of EBF

Table 5.8 shows the dependency of mother's parity to their knowledge about exclusive breast feeding. The study did not found any significant difference between the mother's parity and their knowledge. *(The test of mothers' knowledge is carried out according to the questionnaire attached in Annex)*

Table 5.8: Relationship between Mother Parity and Knowledge of EBF

Para	Number	Good Knowledge	Fair Knowledge	No Knowledge
Primi Para	51	25(49.02)	22(43.14)	4 (7.84)
Multi Para	57	30 (52.63)	20 (35.09)	7 (12.28)
Total	108	55 (50.93)	42(38.89)	11(10.18)

Figures in the parenthesis indicate percentage. *Source: Field Survey, 2009*

5.2.10 Relationship between Occupation and Knowledge of EBF

Table 5.9 shows the relationship between the mother's occupation and her knowledge about EBF. It clearly shows that the mothers who are in contact with educated circle acquire better knowledge than the housewives and those involved in daily wages. Besides these category mothers, the rest had either good or fair knowledge.

Table 5.9: Relationship between Occupation and Knowledge of EBF

Para	Number	Good Knowledge	Fair Knowledge	No Knowledge
House wife	72	34 (47.22)	31 (43.06)	7 (9.72)
Agriculture	17	8(47.06)	9 (52.94)	----
Business	4	4 (100.00)	----	-----
Service	3	3 (100.00)	----	----
Daily Wages	7	2 (28.57)	1 (14.29)	4 (57.14)
Students	5	4 (80.00)	1 (20.00)	-----
Total	108	55(50.93)	42 (38.89)	11 (10.18)

Figures in the parenthesis indicate percentage.

Source: Field Survey, 2009

5.2.11 Relationship between Caste / Ethnicity and Knowledge of EBF

Table 5.10 shows the variability in knowledge between the breastfeeding mothers of different caste and ethnicity.

Table 5.10: Relationship between Caste / Ethnicity and Knowledge of EBF

Caste/Ethnicity	Number	Good Knowledge	Fair Knowledge	No Knowledge
Bramhin/Kshetry	40	27 (67.50)	13 (32.50)	-----
Dalit	26	9 (34.62)	13 (50.00)	5 (19.23)
Gurung	22	11 (50.00)	8 (36.36)	3 (13.64)
Tamang	9	3 (33.33)	3 (33.33)	3 (33.34)
Magar	9	3 (33.33)	6 (66.67)	-----
Kumal	1	1 (100.00)	-----	-----
Rai	1	1 (100.00)	-----	-----
Total	108	55(50.93)	42(38.89)	11(10.18)

Source: Field Survey, 2009

Relationship between Cast/Ethnicity and Knowledge of EBF

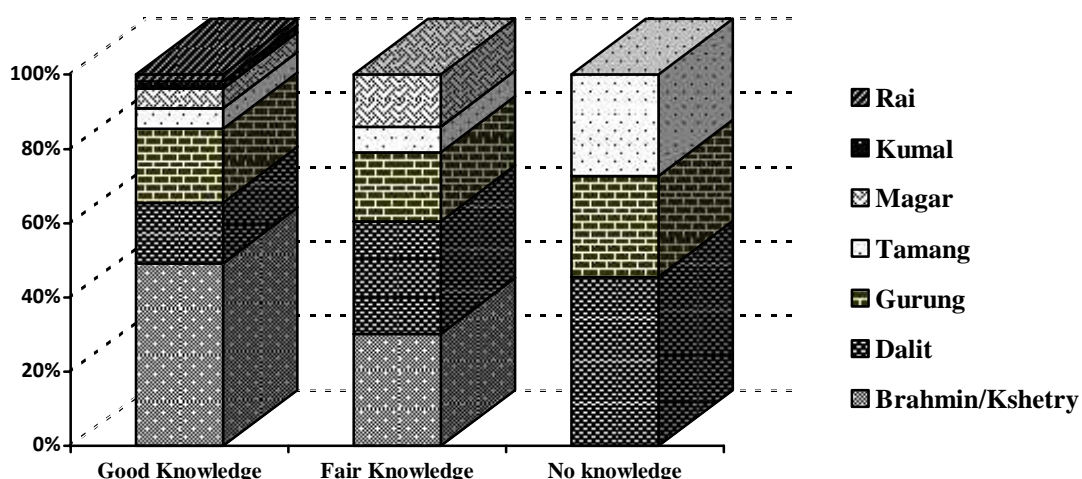


Fig 5.3 Relationship between Caste/Ethnicity and Knowledge of EBF

Figure 5.3 shows that the higher caste people have good knowledge about EBF. Twenty seven (67.50%) Brahmin/Kshetry mothers had good knowledge of exclusive breast feeding. Then Gurung (15 or 50.00%) had good knowledge of EBF. It has been shown that the knowledge of child bearing and EBF is poor in Dalit and Tamang mothers. Single number of each Kumal and Rai mothers were possessing good knowledge.

CHAPTER VI

ATTITUDE OF MOTHERS' ABOUT EXCLUSIVE BREAST FEEDING

Attitude is manner, disposition, feeling, position, etc. with regard to a person or thing, tendency or orientation, especially of the mind. It is the understanding derived from various sociological, cultural, ethnic, educational, and perceptual background.

It has been realized that even knowledge and education (qualification) are not enough for mothers to manage breastfeeding. There is a need to understand the mothers' belief patterns about breastfeeding followed by interventions to modify their beliefs, practices and their responsibilities. In this research, the attitude of breast feeding mothers is collected using structured questionnaire with perceptual outcomes of the surveyor.

Breast Feeding as Child Rights

One third (33.33%) of the interviewed mothers strongly put forward their opinion of breast feeding as child rights. Remaining two third (66.67%) also agreed on this fact.

Breast Feeding versus Family Expenses

Breast feeding can greatly reduce the feeding expenses to baby. However the breastfeeding mother needs some additional diet for which it needs some additional expenses but it is essential for her health. In the survey, eighty-eight (81.48%) mothers agreed that breast feeding can reduce family expenses. Remaining 20 (18.52%) mothers had strong positive opinion about this. Nobody argued on this issue.

Breast Feeding and Mother's Beauty

Studies and researches show that most of the mothers leave breast feeding thinking that this causes reduction in their beauty. Unlike this, nearly all 104(96.30%)

mothers in this research do not agree this opinion however only a few mothers 4(3.70%) think that breast feeding reduces mother’s beauty.

Table 6.1 Attitude of mothers on Breastfeeding and mothers Beauty

SN	Particulars	No of Mothers	Percentage
1	BF reduces mothers beauty	4	3.70
2	BF doesn’t reduce mother’s beauty	104	96.30
	Total	108	100

Source: Field Survey, 2009

Easiness of Breastfeeding

Only 9 (8.33%) mothers thought that breast feeding was dreary and considered that infant formula was easy despite the majority 81 (75%) strongly agreed on the easiness of breastfeeding and the remaining had positive attitude about the fact.

Sufficiency of Breast Milk

WHO has recommended that only the breast milk is sufficient for infants below six months of age. However, most of the mothers (71 or 65.74%) in research area do not think this is true. Only two (1.85%) mothers strongly agreed to WHO recommendation.

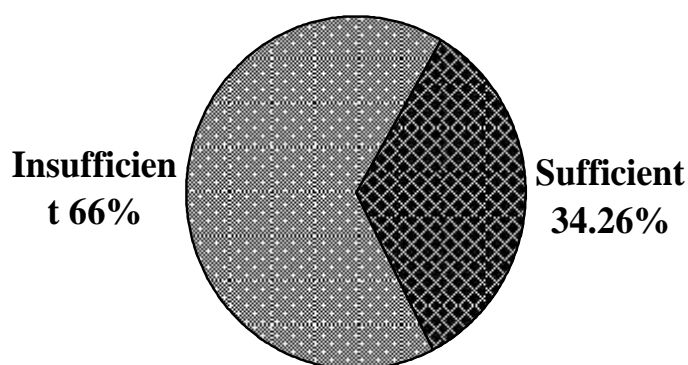


Fig 6.1: Mothers attitude towards sufficiency of breast milk

Bottle Feeding versus Breastfeeding

Bottle feeding is definitely not as good as breast feeding. Moreover, there is a doubt about the cleanliness of the bottle used. Therefore, various precautions and procedures are adapted for bottle feeding. However, nearly half (51 or 47.22%) of the mothers had no idea or disagreed the fact. Fifty seven (52.78%) mothers accepted the fact.

Effect of Prelactal Food on Health

Prelactal food is harmful to baby, it may affect digestive system of infants as well as it interrupt for exclusive breast feeding. Most of the mothers (60 or 55.5%) had no idea about prelactal food, eight mothers (7.41%) disagreed and forty (37.03%) agreed on the fact.

Opinion about Expressed Breast Milk

Mothers expressed breast milk is safe and this can be useful if the breast feeding mother has to leave her infant due to various reasons. Nearly all (102) mothers disagreed that expressed breast milk was safe, four mothers had no idea about this and only 2(1.85%) mothers thought that it was safe.

Sufficiency of Maternal Leave for Adequate Breastfeeding

Nepal Government and most of other organizations give only two months maternity leave to child bearing mothers. It may be the barrier for exclusive breast feeding up to six months of baby's life. So that Maternity leave is not enough to successful breast feeding. About 39 (36.11%) mothers have no idea, 24 (22.22%) mothers agree with government policy and less than fifty percent (45 or 41.67%) mothers disagree with government policy.

Need for Additional Diet to Breastfeeding Mothers

Every Mother needs additional diet while breast feeding and all mothers agree about that statement although a few mothers take additional diet after one or two months of delivery.

Attitude Related Questions:

SN Particulars	Strongly Agree	Agree	Disagree	No Idea
1. Breast feeding is child right	36	72	---	---
2. BF reduces family expenses	20	88	---	---
3. BF is easier than using infant formula	18	81	9	---
4. BF decreases mother's beauty	---	4	104	---
5. Only breast milk is sufficient for the infants for the first 6 months	2	35	71	---
6. Bottle feeding may be harmful to baby	6	51	26	25
7. Mothers need additional diet while breast feeding	10	98	---	---
8. Prelactal food is harmful to babies	---	40	8	60
9. Two months maternity leave is enough for breast feeding	---	24	45	39
10. Express breast milk is safe for baby	---	2	102	4

Total number exceeds more than 108 since it is based on multiple responses.

Source: Field Survey, 2009

CHAPTER VII

PRACTICE OF EXCLUSIVE BREAST FEEDING

7.1 Practices about Place of Delivery

Maternal mortality is very high (281/1000 live birth, NDHS 2006) in Nepal due to lack of institution delivery or assistance by unskilled person. Our culture, customs and believes directly influence practice of delivery also directly and indirectly influence economic status. Now, Family Health Division(FDH) , Department of Health Service (DOHS) depicts the total deliveries, caesarian sections and referral in 60 district of Nepal under the Maternity Incentive Scheme. Safe motherhood program runs “Skill Birth Attainment” training to health personal.

In our society people do not give more emphasis to mother during delivery because they thought it is normal phenomena and need not invest money without any complication occur. Even though government policy for giving incentive to mother in institution delivery. Table shows 63 (58.33%) had Health Institution Delivery and 45 (41.67%) had still in home delivery.

Table 7.1 Distribution of Respondents Practice Regarding Place of Delivery

Place of delivery	Number	Percentage
Health Institutions	63	58.33
Home	45	41.67
Total	108	100.00

Source: Field Survey, 2009

7.2 Assistance during Home Delivery

Home delivery increase maternal mortality. Its main cause is unskilled assistance and secondary cause is lack of needed health facilities. Table 7.2 shows mother in law 18 (40.00%) and neighbor 16 (35.56%) assisted during home delivery which reflect traditional dependency based on social structure in Nepalese society. Only 3 (6.66%) mothers were assisted by trained T.B.A. One mother said that nobody was

there during delivery so his husband assisted her otherwise our culture forbidded to husband or male person during delivery.

Table 7.2 Distribution of Respondents about Assistance during home delivery

Assistance	Number	Percentage
Mother in law	18	40.00
Neighbor	16	35.56
Other relatives	7	15.56
Trained T.B.A.	3	6.66
Husband	1	2.22
Total	45	100.00

Source: Field Survey, 2009

7.3 Practices about Colostrums Feeding

Colostrum is the breast milk that women produce in the first few days after delivery. It is thick and yellowish or clear in color. It has antibody which protect baby from many diseases. In our traditional practice, breast is squeezed until white milk comes because it is thought that first thick milk is dirty and produces indigestion problem and diarrhea.

Distribution of Respondents Practicing Colostrum Feeding to Baby

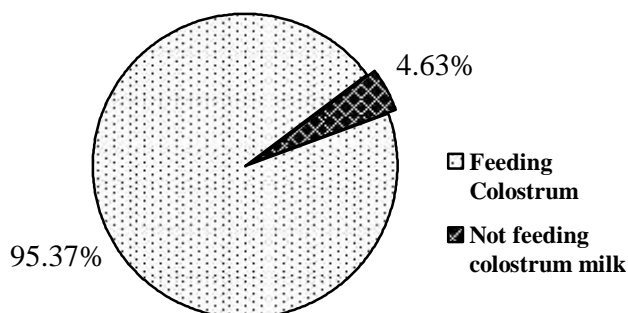


Fig 7.1 Distribution of Respondents Practicing Colostrum Feeding to Baby

Research shows almost 95.37 percent of the breast feeding mothers fed colostrums milk to their babies. Five (4.63%) mothers didn't feed first mother milk. Among them two mothers thought that baby could not digest, two mothers babies were premature and one mother get her relatives advised her not to feed. It indicates people have changed their attitude about colostrums milk and accepted scientific knowledge.

7.4 Practices on Initiation of Breast Feeding after Birth

Initiation of breast feeding within one hour is recommended by WHO. Early initiation of breast feeding can stimulate prolactin hormone for producing breast milk, stimulate oxytocin hormone which control uterine bleeding and build up baby and mother relationship.

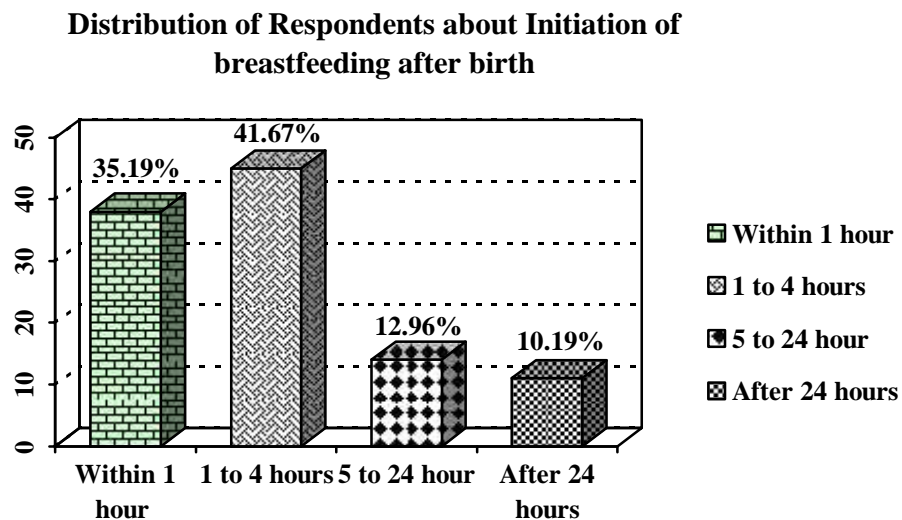


Fig7.2 Distribution of Respondents about Initiation of breastfeeding after birth

Figure 7.2 shows only 38 (35.19%) mothers initiate breast feeding within one hour. forty five (41.67%) mothers initiated one to four hours after birth. Remaining 13 (23.15%) and 11 (10.9%) mothers start breast feeding after four hours and after twenty four hours after birth respectively. It indicates still people are not ready to early initiation of breast feeding. Because still we follow traditional culture and found Dhai Ama (First breast feeding relative mother). Among 108 babies 48

(44.45%) get first breast milk from other mother, 25 (23.15%) fed formula milk and 2(1.85%) fed animal milk before getting own real mother.

7.5 Frequency of Breast Feeding within Twenty-four Hours

Respondents' opinion about the frequency of breast feeding to below six-month baby was taken during survey. The result shows that majority of the respondents breast fed repeated every one to two hours on day time and nobody think that it should be repeated on every hour at night time.

Table 7.3 Distribution of Respondents' Practice about the Frequency of Breast Feeding in Day Time

Frequency of Breast-Feeding within 24 hours	Number	Percent
Every one to two hourly	47	43.50
Every three to four hourly	31	28.70
More than four hourly	0	0.00
As baby wants	30	27.80
Total	108	100.00

Table 7.4 Distribution of Respondents' Practice about the Frequency of Breast Feeding in Night Time

Frequency of Breast-Feeding within 24 hours	Number	Percent
Every two to three hourly	30	27.78
Every four to six hourly	63	58.33
More than six hourly	3	42.78
When baby wake-up	10	9.26
Not fed	2	1.85
Total	108	100.00

Source: Field Survey, 2009

7.6 Practice of Exclusive Breastfeeding

Among 108 respondents, 11(10.2%) fed additional food since birth. Most of the respondents practiced exclusive breast feeding for less than 6 months to their baby.

Ten (9.26%) mothers exclusively breast fed their baby for less than two months, 17(15.74%) fed for 2-3 months, and 36(33.33%) exclusively breast fed for 4-5 months. Only 34 (31.48%) mothers had exclusively breast fed up to 6 months to their baby as per WHO recommendation. Six mothers fed EBF more than six months among 34 mothers; it is also harmful to baby, need to complementary food for better growth and development. Mean duration of exclusive breast feeding was found to be 3.65 months. Fig 7.3 depicts the exclusive breast feeding practice according to WHO recommendation.

Distribution of Respondents about Practice of EBF according to WHO recommendation

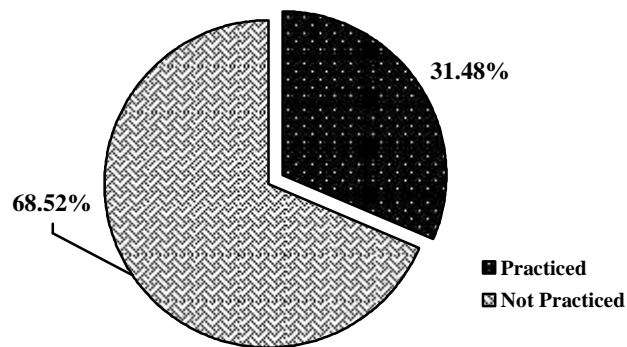


Fig 7.3 Distribution of Respondents about Practice of EBF according to WHO recommendation

7.7 Practice of Giving Additional Food/Fluid to Baby within Six Months after Birth

Out of 108 respondents 74 (68.62%) gave additional food/fluid to their babies. Among mothers supplying additional food/ fluid, 33 (44.60%) gave other milk (formula milk or animal milk) and only two respondents gave non-milk liquid (fruits juice) to their baby within 6 month of life.

Table 7.5 Respondents Practiced Giving Additional Food /Fluid to Baby within Six Month of Life **n=74**

Type of Additional Food/Fluid	Number	Percent
Other milk	33	44.60
Complementary feeding	25	33.78
Plain water	14	18.92
Non-milk liquid	2	2.70
Total	74	100.00

Source: Field Survey, 2009

7.8 Reasons for Not Exclusively Breastfed According to WHO Recommendation

Only breast milk up to six months of baby life is sufficient for healthy growth and development. Although majority of respondents 74 (68.52%) do not exclusively breast fed their baby according to WHO recommendation. Table 7.6 shows various reasons for not exclusively breast feeding. Most of respondents thought only breast milk are not sufficient to baby up to six months of their life; so they gave additional food/fluid to their baby.

Table 7.6 Respondents' Reasons for Not Exclusively Breast Feeding according to WHO Recommendation **N=74**

Reasons	Number	Percentage
Think not enough for 6 months	39	52.70
Insufficient milk production	21	28.38
Lack of knowledge	6	8.11
Baby unable to properly suck	4	5.41
No enough time to breast feed	3	4.05
Breast infection	1	1.35
Total	74	100.00

Source: Field Survey, 2009

7.9 Practice Regarding Bottle Feeding

Bottle feeding means breast feeding means feeding a baby from a bottle, whether is in the bottle including expressed breast milk. Bottle feeding is dangerous to baby because it is difficult to clean so baby suffer from diarrhea and dysentery. Modernization affects to mothers practices and they attract on bottle feeding. Research found 34 (31.48%) babies get bottle feeding. Exploring reasons for bottle feeding; 31 mothers thought that it is easily introduce to baby and remaining mothers told that baby liked it.

Table 7.7 Distribution of Respondents Reasons for bottle feeding

Reasons for bottle feeding	Number	Percentage
Easily introduce	31	91.18
Baby like	3	8.82
Safe for baby	-	-
Total	34	100.00

Source: Field Survey, 2009

7.10 Relationship between Mother's Age and Practice of EBF

Age at marriage is also closely linked with education and hence the numbers of children that are born. NDHS (2006) reveals that women who have attended high school or college marry three and a half years later than those with no education or have only primary education. Additionally, men from highest wealth quintile marry about three years later than those from lower wealth quintile. Similarly, women with secondary school education marry two years later than those with no education. Women from highest wealth quintile marry one to two years later than women in lower wealth quartile.

Early marriage results early pregnancy and early child birth. Below 20 years of age is not suitable for delivery because she is not physically and psychologically ready for child bearing. Table 7.8 shows mothers below-twenty-years feebly practice exclusive breast feeding, which is 2 (18.88%) for this category. Furthermore 20 to30 years' age group mothers exhibit reasonable EBF practice.

Table 7.8 Relationship between Mother's Age and Practice of EBF

Mother's Age	Number	Adequate Practice	Inadequate practice	No Practice
15-19 years	11	2 (18.88)	6 (55.55)	3 (27.27)
20-24 years	48	18 (37.50)	26 (54.17)	4 (8.33)
25-29 years	38	13 (34.21)	24 (63.16)	1 (2.63)
30-34 years	6	0 (00.00)	5 (83.33)	1 (16.67)
35-39 years	4	1 (25.00)	1 (25.00)	2 (50.00)
40 and above years	1	0 (00.00)	1 (100.00)	0 (00.00)
Total	108	34	63	11

Figures in the parenthesis indicate percentage.

Source: Field Survey, 2009

7.11 Relationship between Mother's Education and Practice of EBF

Samanata studies (1999, 2001) reveal that knowledge and education are factors that determine the behavior of women in seeking for care. Perceptions and knowledge regarding breastfeeding are confusing to women and they generally do not know how to differentiate between adequate and inadequate feeding behavior. Women are most often guided and advised by older and experienced women who lack adequate, correct and factual knowledge concerning reproductive and child care issues.

Educated women are better motivated for child care in comparison to women who are not educated. In addition, women with educated husbands have better chances of receiving health care services. Even in households where children are educated, women receive better health care ideas.

As far as the practice of exclusive breast feeding is concerned, the significance difference is not observed between literate and illiterate mothers. Among others, mothers with informal education 44.44 percent were found practicing adequately (as mentioned in operational definition), the least being SLC and above SLC mothers. Among mothers with SLC above education, the mothers with bachelor and above qualification did not adequately practice exclusive breast feeding.

Table 7.9 Relationship between Mother's Education and Practice of EBF

Education Status	Number	Adequate Practice	Inadequate Practice	No Practice
Literate	97	31 (31.96)	56 (57.73)	10(10.310)
Informal	9	4 (44.44)	5(55.56)	-----
Primary	21	10(47.62)	10 (47.62)	1(4.76)
Lower Secondary	22	9(40.91)	10(45.45)	3(13.64)
Secondary	12	-----	10(83.33)	2(16.67)
SLC	5	1(20.00)	3(60.00)	1(20.00)
Certificate	20	5(25.00)	12(60.00)	3(15.00)
Bachelor and above	8	2(25.00)	6(75.00)	-----
Illiterate	11	3 (27.27)	7(63.64)	1(9.09)

Figures in the parenthesis indicate percentage.

Source: Field Survey, 2009

7.12 Relationship between Sex of Baby and Practice of EBF

Table 7.10 shows that there is no significant different between baby sex and practice of exclusive breast feeding although slightly difference due to cultural practice because of male baby *pasni* in 6 month and child baby *pasni* (food introducing ceremony) in 5 month.

Table 7.10 Relationship between Baby Sex and Practice of Exclusive Breast Feeding

Sex of Baby	Number	Adequate Practice	Inadequate Practice	No Practice
Male	56	17 (30.36)	33 (68.92)	6 (10.72)
Female	52	17 (32.69)	30 (57.69)	5 (9.62)
Total	108	34 (31.48)	63 (58.33)	11 (10.19)

Figures in the parenthesis indicate percentage.

Source: Field Survey, 2009

7.13 Relationship between Mother`s Occupation and Practice of EBF

In rural Nepal, women bear responsibility for agriculture farm work, in addition to household tasks. Lack of time from household and farm chores is one of the factors for women`s inability to breastfeed their children. In many districts, husbands migrate to cities or India to work in non-agriculture jobs. This overburdens the women and limits them to seek health care for themselves and their children. Heavy workload is the main problem that women faced (Shrestha 1995, Samanata 1999, 2001).

Due to the mentioned circumstances practice of EBF is highly dependent on the occupation of breastfeeding mother. In spite of their knowledge, most of the educated mothers are not able to care their infants because of the nature of their job. This means EBF practice is influenced by the nature of mothers work. For example in Nepal the government grants only two months of maternity leave to the maternal mothers. While they return back to job after the leave, they do not have time to care their infant therefore they are forced to escape breast feeding on their office time. In spite of all these, most of the housewives were found inadequately practicing exclusive breastfeeding.

Table 7.11 Relationship between Mother`s Occupation and Practice of EBF

Occupation	Number	Adequate Practice	Inadequate Practice	No practice
House wife	72	23(31.95)	40(55.55)	9(12.50)
Agriculture	17	4(23.53)	13(76.47)	-----
Daily Wages	7	3(42.86)	4(57.14)	-----
Students	5	2(40.00)	1(20.00)	2(40.00)
Business	4	2(50.00)	2(50.00)	-----
Service	3	-----	3(100.00)	-----
Total	108	34	63	11

Figures in the parenthesis indicate percentage.

Source: Field Survey, 2009

Table 7.11 shows the relationship between mothers' occupation and their practice of exclusive breast feeding. This finding shows that none of the mothers involved in service practiced exclusive breast feeding. Business mothers (retailer) did more practice than agriculture women.

7.14 Relationship between Caste/Ethnicity and Practice of EBF

Although caste/ethnicity does play some role for breastfeeding and child care where the dominant caste/ethnic groups were found better practicing, it can also be said that knowledge, education, supportive family and liberal traditions is also a crucial factor in her practice.

Table 7.12 shows caste/ethnicity insignificantly affects the practice of exclusive breast feeding. Among various casts, Brahmin/Kshetry 11(27.50%) was found adequately practicing exclusive breast feeding where as this data is 34.61 percent among Dalits. This shows conflicts between knowledge and practice. However, cast/ethnicity should not be studied in isolation as other variables do play vital role on breastfeeding behavior and practice.

Table 7.12 Relationship between Caste/Ethnicity and Practice of EBF

Caste/Ethnicity	Number	Adequate Practice	Inadequate Practice	No Practice
Brahmin/Kshetry	40	11(27.50)	25 (62.50)	4 (10.00)
Dalit	26	9 (34.61)	14 (53.85)	3 (11.58)
Gurung	22	7 (31.82)	12 (54.55)	3 (13.64)
Tamang	9	4(44.44)	4 (44.44)	1 (11.12)
Magar	9	3 (33.33)	6 (67.67)	0 (00.00)
Kumal	1	0 (00.00)	1(100.00)	0 (00.00)
Rai	1	0 (00.00)	1 (100.00)	0 (00.00)
Total	108	34 (31.48)	63 (58.33)	11 (10.19)

Figures in the parenthesis indicate percentage

Source: Field Survey, 2009

7.15 Relationship between Mother Parity and Practice of EBF

Generally multi-para mother have past experience of breast feeding practice. Researcher, therefore, tried to find out the relationship between breastfeeding practices among primi-para and multi-para mothers.

Table 7.14 Relationship between Mother Parity and Practice of Exclusive Breast Feeding

Parity of mother	Number	Adequate Practice	Inadequate Practice
Primi Para	51	15 (29.41)	29 (56.86)
Multi Para	57	19(33.33)	34 (59.65)
Total	108	34 (30.00)	63 (70.00)

Figures in the parenthesis indicate percentage.

Source: Field Survey, 2009

Table 7.14 shows multi para mothers (33.33%) practiced adequately than primi para mothers (27.59%).

7.16 Relationship between Knowledge and Practice of EBF

This study show faint positive relationship between knowledge and practice of exclusive breast feeding. However, mothers having inadequate or no knowledge of exclusive breast feeding were also found adequately practicing exclusive breast feeding. Therefore this variable should be related to other variables for the consistency and reliability of the surveyed data.

Relationship between Knowledge and Practice of EBF

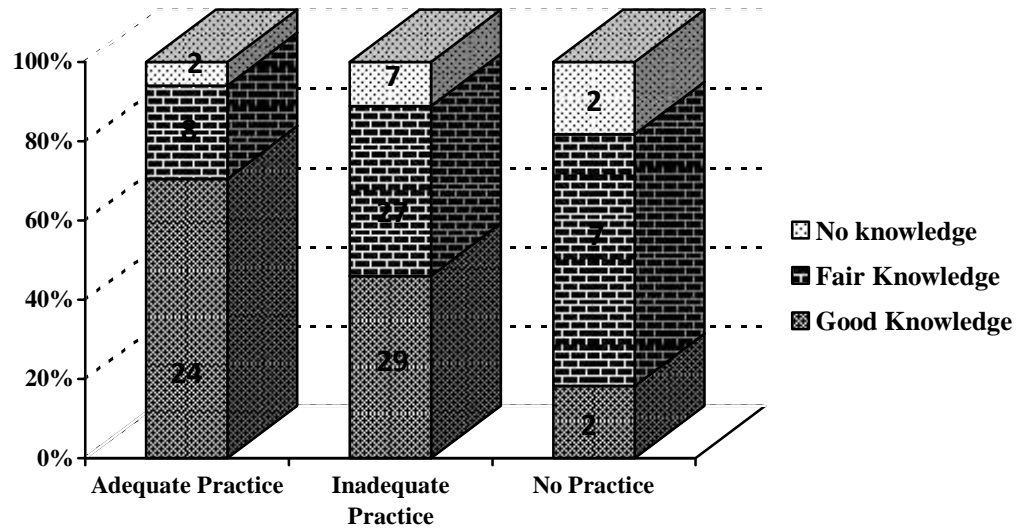


Fig 7.4: Relationship between Knowledge and Practice of EBF

Figure 7.4 shows that out of 55 mothers possessing good knowledge about EBF, only 24(43.63%) found adequately practicing EBF. Remaining 56.37 percent mothers either inadequately practiced (see operational definition) or didn't practice exclusive breastfeeding. This finding shows denial among mothers about the positive relationship between knowledge and practice of exclusive breastfeeding.

CHAPTER VIII

SUMMARY, CONCLUSION AND RECOMMENDATION

8.1 Summary of Findings

The study entitled ‘Knowledge Attitude and Practice of Exclusive Breast Feeding having Under One Year Children Attending in MCH Clinic of Sishuwa Primary Health Centre, Lekhnath Municipality’ was conducted among 108 mothers who have six months to less than one year children by applying descriptive exploratory research design with overall objective to find out the knowledge, attitude and practice of exclusive breast feeding. Non-probability (purposive) sampling technique and technique of structure interview schedule, focus group discussion, and key informant interview were used for data collection. The main findings of this study have been summed up below:

-) Most of the respondents 48(44.44%) were 20-24 years. However, 11(10.19%) mothers were below twenty years and 5(4.63%) were above 35 years age group. Fifty one (47.22%) mothers were primi-para. Majority children of participant mothers were 10-12 months (57.41%) of age, and among all children 51.85 percent were male.
-) As per the educational status is concerned, 97 (89.81%) of mothers were literate. Among the educated mothers majority (55 or 50.92%) were formally educated up to high school level education, 5(4.33%) mothers completed SLC, 20(18.52%) certificate level and 8(7.41%) bachelor and above education. Nine (8.33%) mothers could just read and write Nepali language. Thus the female literacy rate of the research area seems higher than national female literacy rate (43%).
-) As per the family type is concerned, 60 (55.56%) mothers were from nuclear family.
-) To talk about the caste/ethnicity diversity of mothers, 40(37.03%) were Bramhin/Kshetry, 26(24.07%) were Dalit, 22 (20.38%) were Gurung. Tamang and Magar were same in number (9 each), Rai and Kumal were one each.

Seventy Nine (73.15%) mothers were Hindu, 27 (25.00%) Buddhist and Christian were two in number.

-) Similar to the trend of Nepalese women, majority of the mothers (72 or 66.67%) were house-wives. Five mothers were students, seven involved in daily wages, four were retail shopkeeper and three were job holders. It shows economic dependence of most mothers on their husband's income. Some mothers had left the job to care their children after their delivery.
-) Major income source of most of the families were foreign job (37.96%) and service (22.22%).
-) Majority of respondents 97(89.81%) heard exclusive breastfeeding from different sources, among them 38 (39.10%) heard from health personal. Seventy seven (71.30%) respondents gave meaning of exclusive breast feeding (Brest feeding without giving food or liquid or water) and 60 (55.6%) gave correct meaning of exclusive breast feeding as recommended by WHO (exclusive breast feeding up to 6 months of baby life).
-) Fifty five (50.93%) mothers thought that the appropriate time to start breast feeding was within one hour but 16(14.81%) mothers had no idea. Majority of respondents (80.37%) thought every 1 to 4 hourly or demand feeding was necessary up to 6 months and 92(71.19%) thought that every 2 to 6 hourly breast feeding was sufficient in night time.
-) Almost 94 percent mothers could give 1 to 3 advantages of exclusive breast feeding to babies but 76 (70.37%) mothers did not know the benefits of exclusive breast feeding to their own. Furthermore, research shows that below-twenty years and above-35 years mothers had less knowledge of EBF than 20 to 34 years age group mothers. It has been also found that mothers who belong to joint family (64.58%) had better knowledge than the mothers of nuclear family (40.00%).
-) Mother's education is not found directly related with her knowledge in exclusive breast feeding. Mothers with higher education (above SLC) were found possessing good knowledge, and one in every two informally educated mothers had good knowledge of EBF. But mothers with under SLC were found having

poor knowledge about the subject matter. The study, however, showed that very few literate mothers (7.22%) were unknown about EBF, whereas this was 36.36% among illiterate mothers. Again the mothers who were in touch with educated circle had acquired better knowledge than the housewives and those involved in daily wages. Besides these category mothers, the rest had either good or fair knowledge.

-) The variability in knowledge between the breastfeeding mothers of different caste and ethnicity is demonstrated in Table 7.12. The result obtained truly reflects the social discrimination among the deprived caste. Dalits, who are supposed to be low caste, are less participating in academic activities, and having feeble access on resources due to their poverty which results possessing less knowledge on EBF. The result showed higher caste people with good knowledge about EBF. Twenty seven (67.50%) Brahmin/Kshetry were possessing good knowledge of exclusive breast feeding. It reflected that the knowledge of child bearing and EBF is poor in Dalit and Tamang mothers. However, this study also showed that the knowledge merely is not the precondition for the adequate practice of EBF (see Fig: 7.4).
-) Most of the mothers (72 or 66.67%) agreed that breast feeding is child rights. Only 36 (33.33%) mothers strongly agreed on that statement. Similarly most of the mothers (88 or 81.48%) agreed that breast feeding reduce family income. But only 20 (18.52%) strongly agreed on that statement.
-) One of common negative attitude about breast feeding is that breast feeding reduce mothers' beauty. However, among the respondents only a few (4 or 3.70%) thought that its true. Majority mothers (104 or 96.30%) disagreed with this myth.
-) Only a few mothers (9 or 8.33%) disagreed that breast feeding is easier than using infant formul and others agreed or strongly agreed that statement.
-) World Health Organization recommended "Only breast milk is sufficient to infant for six months of life" but most of the mothers (71 or 65.74%) disagreed on that truth and 35 (32.41%) mothers agreed and 2 (1.85%) strongly agreed with WHO recommendation.

-) Bottle feeding may be harmful to baby because it is difficult to clean. Although 25 (23.14%) mothers were unknown about this and 26 (24.08%) mothers disagreed that bottle feeding may be harmful to baby and 57 (52.78%) accepted it.
-) Prelactal food is harmful to baby, it may affect digestive system of infants as well as it interrupts for exclusive breast feeding. Most of the mothers (60 or 55.5%) were unknown about prelactal food. Eight mothers (7.41%) disagreed and forty (37.03%) agreed on it.
-) Expressed breast milk is safe for baby, if mother do not have time to breast feed her baby because of work load and other reason. Four mothers were unknown about this, almost all mothers 102 (94.45%) disagreed and only 2 (1.85%) mothers agreed on it.
-) Nepal Government and most of other organizations give only two months maternity leave to child bearing mothers. It may be barrier for exclusive breast feeding up to six months of babies. So that maternity leave is not enough to successful breast feeding. About that 39 (36.11%) mothers were unknown, 24 (22.22%) mothers agreed with government policy and less than fifty percent (45 or 41.67%) mothers disagreed with government policy.
-) Every mother needs additional diet while breast feeding. All mothers agreed about that statement although no mother took additional diet after one or two months of delivery.
-) In present context of Nepal, practice of institution delivery is increasing because of awareness, financial support, and encouragement provided by the government. This study found 63(58.33%) mothers delivering at health institution, however 45 mothers delivered at home. In home delivery, almost all mothers delivered with the assistance of unskilled person (Mother-in-laws, neighbor, relatives and husband). Home deliveries are usually opted for in anticipation of the care and support from family and community. Besides, pregnancy and childbirth are still perceived as natural phenomena, not requiring formal health services (UNICEF 1998).

-) Initiation of breast feeding within one hour after birth reduces postnatal bleeding, increase flow of breast milk and prevents neonatal death. Most of the people thought breast milk is not come immediately after birth. So, Nepalese community has a practice of giving first breast milk of other female (*dudh khuwaune ama*). However, less than half (35.19%) of the mothers initiated breast feeding within 1 hour after birth in contrary to the NDHS 2006 report of 35.4 percent. Forty five mothers initiated after 1 to 4 hours, fourteen mothers (12.96%) initiated 5 to 24 hours after birth and 11 (10.19%) initiated breast feeding after 24 hours. Majority of mothers (103 or 95.37%) fed colostrums milk to baby. This is similar to the finding of Malla KK et. al. It indicates people are aware about importance of colostrums milk and have left traditional believes and practice.
-) Only 34 (31.48%) mothers have exclusively breast fed as recommended by WHO. This data is very near to the WHO 2004 report about exclusive breast feeding: only a third of babies are exclusively breast fed for their first six months of life. Majority of the mothers were not able to feed own breast milk to child exclusively for 6 months. Different socio economic status, traditional practice and believes directly and indirectly affected this result. Maternal nutrition, positioning and attachment during breast feeding directly affect the secretion of breast milk. Mothers have no knowledge about the advantages and technique to store expressed milk.
-) Advertisements of formula milk and complimentary food encourage mothers to give additional food/liquid to baby. Out of 35 giving additional food/fluid to baby within six months, majority of the respondents (15 or 42.9%) gave other milk (formula milk or animal milk), 10 (28.6%) gave complimentary food, 9 (25.7%) gave only plain water, and 1 (2.9%) gave non milk juice. The reason behind supplying additional food to babies was mainly due to two reasons: first, 30% of the mothers thought that mother milk is insufficient to their infants for almost 6 months and some mothers thought that water is necessary to baby immediately after birth. Some maternal mothers left EBF because of insufficient milk secretion.

-) In spite of its harmfulness, thirty four (31.48%) mothers practiced bottle feeding to baby. Exploring behind the cause of bottle feeding, most of the mothers (91.18%) felt bottle feeding is convenient and rest of mothers answered that their baby likes bottle feeding.
-) This research found below 20 years and above thirty years mothers did less exclusive breast feeding practice than 20 to 29 years mothers.
-) This research did not notice any sex discrimination on EBF practice up to six months of baby although most of the female babies get solid diet after the completion of 4 months and male baby get solid diet after the completion of 5 due to their culture.
-) Informally educated and low level educated mother were found doing comparatively more adequate practice of EBF than formally educated mothers at medium and higher levels. Similarly, illiterate mothers were also found weakly practicing EBF.
-) This research found positive relationship between knowledge and practice of exclusive breast feeding. Mothers with good knowledge about exclusive breast feeding (43.63%) practiced adequately than mothers with fair knowledge (19.05%).

8.2 Conclusion

The study entitled ‘Knowledge Attitude and Practice of Exclusive Breast Feeding having Under One Year Children Attending in MCH Clinic of Sishuwa Primary Health Centre, Lekhnath Municipality’ was conducted among 108 mothers who have six months to less than one year children by applying descriptive exploratory research design with overall objective to find out the knowledge, Attitude and Practice of exclusive breast feeding. Non-probability (purposive) sampling technique and technique of structure interview schedule, focus group discussion and key informant interview were used for data collection.

Almost all mothers agree that breast feeding is child’s right and it reduces family expenses which is positive attitude towards breast feeding. However, very few

mothers think that BF reduces mother's beauty. Most of the mothers are unknown about the consequences of introducing prelactal foods. Therefore majority of the mothers are found introducing prelactal food/ shared breast milk to their babies. Most of the mothers do not agree that only breast milk is sufficient to infants for 6 months, so they give complementary feeding within 6 months of baby which results inadequate exclusive breast feeding (as recommended by WHO). Almost all mothers have negative attitude for expressed breast milk because they have no culture of this kind. Most of the mothers think that breast milk is immediately damaged, so it is not possible to store and feed to baby.

Nearly one third mothers (35.19%) initiate breastfeeding within one hour after delivery, however 76.86 percent mothers initiate within 4 hours; which reflects premature delivery, case of scissoring, less or delayed milk secretion due to malnutrition of pregnant women and so forth. This research finds that 95.37 percent mothers feed colostrums milk to their babies (which is similar to the finding (98.8%) presented by Malla KK et. al. 2002). Similar to that reported by WHO-2004 ("Only a third of babies are exclusively breastfed for their first six months of life."), only 31.48 percent of mothers are found exclusively breastfeeding as recommended. Among mothers supplying additional food/fluid, majority of them (78.38%) feed other milk (formula milk or animal milk) and complimentary food thinking that breast milk is insufficient.

Mother's occupation is also a determinant in the practice of breast feeding. Mothers involving in business, daily wages and students do more adequate practice than house wives and agriculture women. None of the employed mothers are found exclusively breast feeding as recommended (for 6 months), they stop EBF after 2 months of delivery. This is exactly same as the result reported by Khassawneh et. al 2003 Jordan- "employed women were more likely not to practice full breastfeeding compared to unemployed women".

In spite of cultural practice of *pasni* (most of female baby introduces solid food after four months of age, and male baby after five months) in Nepalese society, this study did not notice significant relation between breast feeding behavior and baby's sex within study area. Furthermore, noticeable positive correlation between exclusive

breast feeding behavior and educational status of mothers is not observed. This is similar to the trend reported by NDHS 2006 (mothers with higher education practice less than the mothers with low level of education). Maternal education has been associated with higher breast feeding rates in industrialized countries and with lower rates in developing countries (Forman, 1984). Most of the mothers above SLC academic qualification either continue their higher study or are engaged in the job; therefore they are not readily available for breastfeeding in their duty time. In spite of their awareness about the advantages of EBF, these circumstances significantly reduce the rate of EBF in educated mothers.

The researcher find that most of the mothers are unknown about proper meaning of exclusive breast feeding. Women's status starting with lack of education is linked with early marriage and childbearing; inability to take decisions regarding health care, social gender discrimination, particularly in the peak reproductive years, and poorer access to nutrition. These all factors significantly affect EBF practices. In the due course of research, it has been noticed that the main reason behind inadequate EBF is the thought that only mother's milk is insufficient for their babies for almost six months. However, those mothers were suggested to do so (practice EBF as recommended by WHO). With no doubt it can be said that the proper education and counseling from health personnel will be able to change their thoughts, believes as well as practices of EBF.

Finally, the research topic here presented is able to extract the underlying factors about the determinants of knowledge attitude and practices of exclusive breast feeding. So it will be very helpful tool for the further researchers being it is a noble subject of chief global concern. The findings here presented are derived with utmost care and precision as defined by universal data measures. However some deviations may occur in another population due to the variations in sample space, difference in socio-cultural beliefs, different economic and academic environments and so further.

8.3 Recommendations

-) This study is carried out from descriptive cross sectional exploratory study from small sample size so it is recommended to further researcher to find out this topic in large sample size.
-) This research finds that service women have no practice of exclusive breast feeding as WHO recommendation, so it is recommended to further researcher to find out women works and breast feeding practice.
-) Health personal is a main source to increase practices of exclusive breast feeding, so it is recommended to different health institution to strengthen health education about breast feeding from each MCH clinic by using different audiovisual aids.
-) This study reassures to breast feeding mothers, their families and community that exclusive breast feeding for six months of baby life is sufficient to baby and teach how to store express breast milk without contamination.
-) It is also recommended for the government to run breast feeding counseling training to each health personal even FCHV, and then to monitor the performance.
-) The study encourages NGO/INGO for running awareness programme of exclusive breast feeding in slum and even urban areas.
-) Mass media exposure can be one of the effective means of encouraging mothers and male partners for exclusive breast feeding. Therefore, mass media exposure regarding EBF should be promoted.