



**BREAST FEEDING AND THE WEANING PRACTICES IN TERMS OF AGE AND
METHODOLOGY OF WEANING INCLUDING THE AGE OF ADMINISTRATION OF
ALTERNATIVE FEEDING**

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ABSTRACT

Breastfeeding and weaning have been a universally accepted practice. Due to awareness in urban areas breastfeeding and weaning are practiced by almost all mothers whereas mothers in rural areas practice lesser. This might be due to varied factors like female literacy, low awareness etc. The survey clusters were selected based on the standard selection method. A study on feeding and weaning practices was carried out in a random sample of 446 household. It was revealed that health status of lactating mothers, malnourishment, environmental sanitation and lack of education in the area of childcare affected the feeding practices among rural women of Kassala district. However, prevalence of superstition was quite common in Kassala district irrespective of education and other related factors. Exclusive breastfeeding before the age of six months was found to be at 71%, however, 48% of children were reported given less fluids, less food, fluids only or nothing during episodes of diarrhoea. Food diversity in the age group six month and more was found to be zero per cent as no child was found to have more than four meal groups per day. Knowledge and behaviour of care takers are exclusively low manifested by the low breastfeeding or food intake during episodes of diarrhoea.

KEYWORDS: Breastfeeding and weaning have been a universally accepted practice.

INTRODUCTION

Breastfeeding and weaning have long been recognized as the most important contributors to child health. New and continuing research is increasing our understanding that the absence of breastfeeding and well weaning are a significant public health issue, and is associated with excess risk of morbidity and mortality in infants and children.^[1]

Breastfeeding and weaning feeding practices refer generally to meet nutritional and immunological needs of the body at different stages of child growth. Breast milk is vital for better child survival.

During infancy, breastfeeding protects against infectious disease^[2-3] and long term, breastfeeding is associated with benefits in several areas, such as cardiovascular risk factors^[4], intellectual capacity^[5,6], and allergy.^[7,8]

Even in the developed world, breastfeeding offers substantial health benefits to infants and young children.^[9,10,11] Both the World Health Organization (WHO)^[12] and the American Academy of Paediatrics^[2] have recommended exclusive breastfeeding for the first six months of life, with continued breastfeeding up to 12 months of age or longer along with the introduction of

solid foods. However, erroneous habits arising from ignorance, superstitions and wrong beliefs are responsible for aggravating malnutrition in communities. The effects of infant and weaning feeding practices are largely socio-economic. Unfortunately a majority of children live under such economic and environmental conditions that hamper their growth and development. The food requirement of a baby increases with the increase in age and to grow healthy and strong, the baby requires different nutrients and which must be provided to a baby through supplementary foods from four months of age.

Mother is the most important person in a baby's life for both its physical as well as its psychosocial care and growth. The mother infant relationship is the most vital formative relationship for the child. From the very first moments of life, a baby begins interacting with its mother. Thus, mother's health, her education, her beliefs & attitude regarding child rearing are important milestones on the road of child's health right from in utero period.

Also, faulty breast-feeding and weaning practices have their roots in socioeconomic and educational status of the parents, their cultural beliefs, number & spacing of

siblings and the employment status of the mother. Improved breast feeding practices & reduction of artificial feeding could save an estimated 1.5 million children a year.^[13]

The delayed introduction of semisolid foods is a major cause of child malnutrition. Most children do not receive semisolids until after 9 months of age, and many not until their second year of life.^[14]

Though the ideal time to educate the women about the merits of breast feeding, is pre-pregnancy or during antenatal period, few receive counseling during pregnancy and most of them after failed lactation.^[15]

MATERIALS AND METHODS

Study design and data collection

The cross-sectional combine quantitative qualitative study was conducted in Kassala state, it is one of the states that are severely affected by poverty and diseases, data on infant feeding practices through survey clusters were selected based on the standard selection method. For the quantitative part of the study, In each cluster, the village leader or sheikh was located and introduced to the data collection team, and study objectives were explained., children from 6 – 59 months were measured, and the questionnaire was filled for the eligible children.

The questionnaire administered to caregiver collected information on the general characteristics of the participants and their children, knowledge, attitude and practices on breastfeeding, exclusive breastfeeding for up to six months, introduction of complementary foods and types of complementary feeds, breastfeeding problems, feeding practices during weaning and episodes of diarrhoea, and how they are addressed and support for breastfeeding.

Selection of households and children

In each cluster, the village leader or sheikh was located and introduced to the data collection team, and study aim was explained. The data collectors then walked along the line determined by the pencil direction, counting and marking all households they passed until they reached the boundary of the area. When they reached this point, they chose a random number between 1 and the total number of households counted along the line, this randomly selected household was considered the first household in the cluster to collect data from.

RESULTS

The results section will start with an outline of the under 5 demographics for the survey area. The breast feeding and the complementary feeding and weaning practices. The final section will present some household information.

1 Infant and young child feeding practices

Results were analysed from 342 mothers since this information was only analysed for those children less than 24 months.

Breastfeeding practices

Early initiation of breastfeeding was found to be high, with initiation of breastfeeding within the first hour being reported in most of the cases (90.6 %), similarly all children less than 24 months were breastfed (Table 1).

Of the children less than 6 months (n=69) 49 were exclusively breastfed during the 24 hours before the study, making the exclusive breastfeeding rate among children less than 6 months 71% (Table 2).

This is a current status indicator based on recall of the previous day. However using the previous day recall period will cause the proportion of exclusively breastfed infants to be overestimated, as some infants who are given other liquids irregularly may not have received them in the day before the survey.

Breast feeding appears to be stopped earlier than recommended by WHO (complementary foods should be introduced at 6 months, with breast feeding continuing up to 2 years of age), and approximately a third of mothers had stopped breastfeeding their children by one year of age, and almost three quarters of mothers had stopped it by the time the child was two years old (Table 1).

Table 1: How soon after birth breast feeding was started.

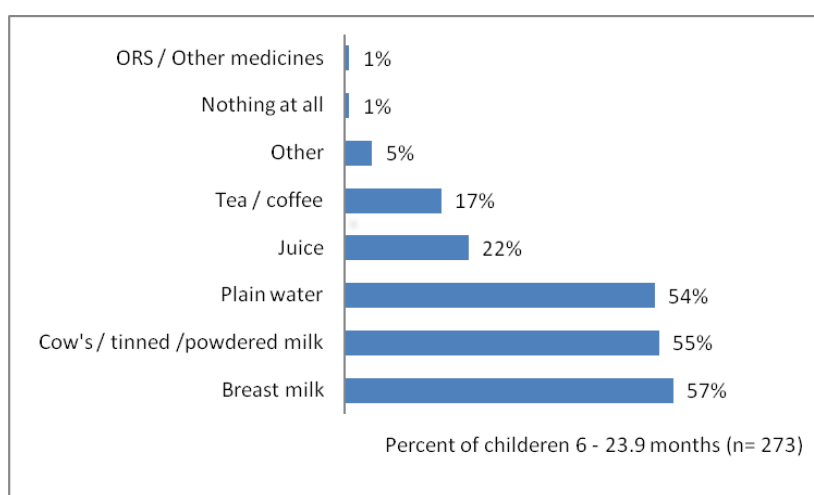
Time of initiation	n	%
Never breastfed	0	0
Within the first hour	310	90.6
Later on the first day	13	3.8
After the first day	19	5.6
Total	342	100

Complementary feeding practices

About two thirds of mothers of children between 6 and 8.9 months reported that their children had eaten on the day before the survey (Table 2), giving an estimation of the timely introduction of complementary foods. However, the sample size for this age-range was small (there were 50 children in this sub-group), meaning that the results are imprecise (as shown by the wide confidence intervals).

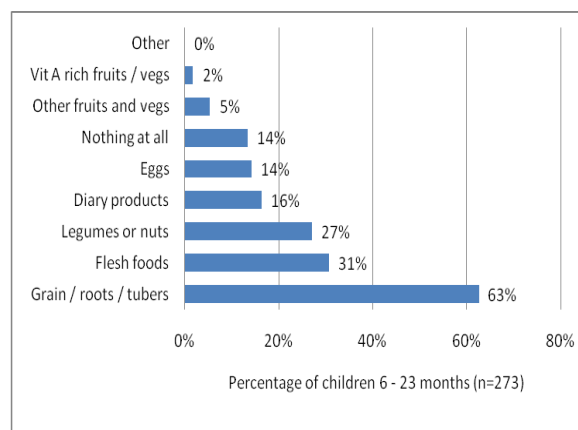
Table 2: Breastfeeding practices and introduction of complementary feeding.

Indicator	Age group	Number in sub-group	n	%
Children ever breastfed	0 - 23.9 months	342	342	100
Initiation of BF in first hour	0 - 23.9 months	342	310	90.6
Exclusive breast feeding	<6 months	69	49	71.0
Eating complementary foods	6-8.9 months	50	33	64.0
Continued breastfeeding at 1 year	12 - 15.9 months	49	34	69.4
Continued breastfeeding at 2 years	20 - 23.9 months	47	13	27.7

**Figure 1: Drinks reported to have been taken on the day before the survey, children 6 – 23.9 months of age (n=273).****Table 3: Number of food groups reported to have been eaten by children 6 – 23.9 months on the day before the survey.**

Number of groups	n	%	95% CI	
None	37	13.6	9.0	18.1
One Group	76	27.8	17.2	38.5
Two Groups	122	44.7	36.9	52.5
Three Groups	38	13.9	7.4	20.4
Four Groups	0	0	-	-
Five Groups	0	0	-	-
Total	273			
Minimum dietary diversity	0 %			
Average number of food groups eaten	1.6			

Reported diet diversity was very poor, the average number of food groups reported to have been eaten on the day before the survey (among children aged 6 months and more) was 1.6, and minimum dietary diversity in the same age group was reported as ZERO % since no one of the 273 children was reportedly confirmed to have eaten from 4 food groups or more in the day before the survey (Table 4.3); minimum dietary diversity is defined by WHO as eating from 4 food groups or more for children aged 6-23.9 months¹). The major food group reported to have been eaten was grains / roots / tubers, likely to be sorghum, the local staple (Figure 4.2). The low consumption of vegetables, fruits and vitamin-rich foods is one of the likely underlying causes of underweight in the area.

**Figure 2: Food reported to have been eaten on the day before the data collection, children 6 months and over (n=273)**

The average number of meals reported to have been eaten on the day before the survey among children 6 months and over (n=269) was 2.3 (Table 4). Breastfeeding was not counted as a meal for this calculation, and WHO defines minimum meal frequency as 4 times a day for non-breast-fed children aged 6- 23.9 months. This low number of child meals, coupled with the poor diet diversity reported in the survey area is likely to be a major contributor to child malnutrition.

Table 4: Number of meals reported to have been eaten on the day before the survey

Number of meals	Frequency	Percent
0	37	13.8
1	11	4.1
2	69	25.7
3	140	52.0
4	11	4.1
8	1	0.4
Total	269	
Average	2.3	

Feeding practices during episodes of diarrhoea

Table 5: Feeding practices during the child's last episode of diarrhoea.

Category of practices	n	%
Positive	174	51.3
Negative	165	48.7
Total	339	100

Positive = giving more fluids, more breastfeeding, more food and/or ORS.

Negative = giving less breast feeding, less fluids, less food, fluids only or nothing at all or the same amount.

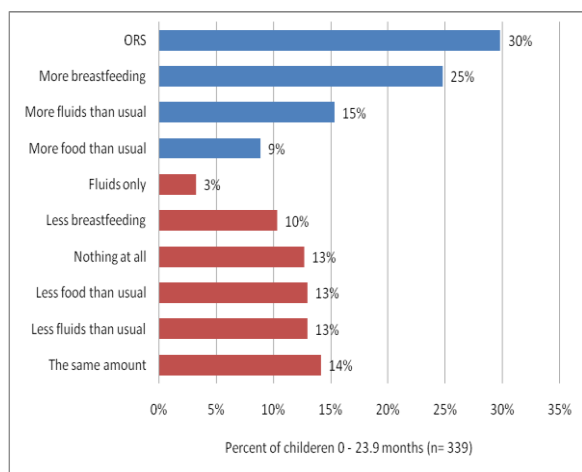


Figure 3: Food and drink offered to the child the last time they had diarrhoea(Blue colour = positive practices, Red colour = negative practices).

Reported feeding practices during episodes of diarrhoea were poor, since almost one half of the mothers reported negative practices. One third of the mothers reported giving ORS to their child the last time that they had

diarrhoea (Figure 3). Taking giving more fluids, more breastfeeding, more food and giving ORS as positive practices during diarrhoea, one half of the mothers showed negative practices (Table 5 above).

DISCUSSION

• Inappropriate breastfeeding practices

Breast feeding is stopped earlier than recommended by WHO. Since one third of mothers had stopped breastfeeding their children by one year of age, and almost three quarters of mothers had stopped it by the time the child was two years old.

• Inadequate complimentary foods

Reported diet diversity was very poor, minimum dietary diversity was found to be ZERO % since no one of the 273 children 6- 23 months was reportedly confirmed to have eaten 4 food items or more in the day before the survey and the average number of food groups reported to have been eaten on the day before the survey (among children aged 6 - 23 months) was 1.6, with a lack of animal products, vegetable and fruits complimenting the base diet of Asida (made from dura) with dried Waika.

Quality of diets is poor. Basic diet Asida has a very low energy density.

More than one third of children 6 - 8.9 months were not given complementary foods on the day before the survey. The average number of meals reported to have been eaten on the day before the survey among children 6 months and over was low (2.3).

• Inappropriate care practices

Almost half (48.7 %) of children were reportedly given less breast feeding, less fluids, less food, fluids only or nothing at all or the same amount when suffering from a diarrhoeal episode, this is thought to contribute to the deterioration of a child's nutritional status.

➤ Recommendation

- Improve knowledge, attitudes and skills of feeding and caring practices of mothers through health and nutrition education (one to one nutrition counselling) in health facilities and in the community through:
 - Identification and support to community nutrition workers to provide basic health and nutrition education including community outreach volunteers.
 - Health personnel implementing IMCI community component also consider advocacy to expand this approach.
 - The use of existing community development initiatives and Women Union and revitalization of child friendly communities and mother support groups to support the education, communication and behaviour change.
- Monitoring the nutrition situation throughout the upcoming hungry season through health and feeding centre records and a repeat nutritional survey should be considered during the hunger gap.

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