

Exclusive Breastfeeding Prevalence and Feeding Patterns of Children Living at Rural Areas in Serba Jadi Sub District, Indonesia

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4 Exclusive Breastfeeding Prevalence and Feeding Patterns of Children Living at Rural Areas in Serba Jadi Sub District, Indonesia

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Abstract: Exclusive breastfeeding (EBF) is the most effective strategy to prevent deaths. It is assumed that 13% of children deaths live in low resources setting prevented by EBF. However, the coverage of EBF is still low in rural areas. Deploying midwives at villages is one of the strategies to improve EBF. The challenges come from manufacturing solid foods. The aim of this study to find out the prevalence of exclusive breastfeeding practice and feeding patterns of children in rural areas of Serbajadi sub-district. This is a population-based, cross-sectional study with a questionnaire-based interview of mothers selected purposively. A total of 949 children from eligible households were obtained to be the sample. Only 16.5% of mothers breastfed exclusively infants <6 months. The lowest prevalence found in two villages (2.5% and 5.0%) and the highest is in Serbajadi village is 56.0%. About 63% of mothers have introduced solid food to their babies <4 months of age. Maternal education and family income was significant as the predictors to exclusive breastfeeding and introducing solids food ($p < 0.03$; $p < 0.04$ respectively). The result concludes that exclusive breastfeeding practising was still rare; in contrast, the introduction of manufactured solid foods was so intensive. The skill of village-based midwives in promoting EBF have to be enhanced through peer counselling and home-based counselling.

Keywords: exclusive breastfeeding, village midwives, manufacturing solid foods, rural areas

1. Introduction

Humans in recycling have a particular phase, in which phase they are classified in nutrition-prone groups. One of them is in the baby phase. Breast milk is the best food for babies because it contains nutrients that best suit the needs of babies who are in the accelerating stage of growth and development. Breastfeeding as early as possible and giving exclusive proven to increase baby's immunity, and reduce morbidity and mortality, so that their genetic potential can be developed optimally.

Food consumption factors are a direct cause of incidence of malnutrition in toddlers. This is because the consumption of food that does not meet the amount and composition of nutrients that meet the requirements of balanced nutrition is diverse, as needed, clean and safe so that it will directly affect the growth and development of infants.

Breastfeeding exclusively 6 months is the right of every baby because it can save the baby's life and have a good impact on maternal health. Breastfeeding can reduce the risk of infant death. It is assumed that 13% of children deaths live in low resources setting prevented by exclusive breastfeeding (Jones G. *et al.*, 2003). Based on WHO research in six developing countries, the risk of infant death between the ages of 9-12 months increases by 4% if the baby is not breastfed. For babies under 6 months, the number increases to 48%. In the United States, 400 babies die from vomiting, 300 are not breastfed. Deaths from this disease increased 23.5 times in infants who were given formula milk (Roesli, 2008).

According to WHO and UNICEF, the gold standard for feeding infants and children is to start breastfeeding

immediately within an hour after born. Exclusively breastfeeding babies from 0-6 months, and starting at six months babies get nutritious complementary foods according to growing needs development and continue breastfeeding children until the age of 24 months or more (Ministry of Health RI, 2017). Mothers must exclusively breastfeed their babies and have no food or other fluids other than breast milk (Kramer, M.S., Kakuma, R, 2004; WHO, 2017). However, those challenges come from solid foods manufacturers. They have encouraged mothers to combine solid foods with breast milk living in rural areas.

The consequences, exclusive breastfeeding coverage has decreased to vary substantially across the countries. Coverage of exclusive breastfeeding in Central Africa is 25%, Latin America and the Caribbean 32%, East Asia 30%, South Asia 47%, and developing countries 46%. Overall, less than forty per cent of children < 6 months age were given exclusive breastfeeding (WHO, 2015). While in several industrial countries, breastfeeding continuation up to 6 months tended to be higher; in Southwestern Ontario 22.8% (Clifford, T.J. *et al.*, 2006), in Alberta 37.2% (Yang, Q, *et al.*, 2004) and in Montérégie, Quebec 32% (Halek, L.N. *et al.*, 2007).

World Health Organization (WHO) in 2012 reported that 65% of the world's infant population was one year old or less, only 35% of infants were given EBF at the age of 0-4 months. In 2012 UNICEF reported that 136.7 million babies born in the world only 32.6% were exclusively breastfed until 6 months. A number that reminds all health workers of the importance of developing a strategy to ensure every woman is able and willing to breastfeed her baby from birth to 6 months.

The household survey results mention that achieving EBF in infants only reached 36% compared with an expected target

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of 80% of babies. Infants in Indonesia who are exclusively breastfed only reached 47%. Based on Basic Health Research (Riskesdas) in 2010 shows the achievement of breastfeeding in Indonesia is meagre, the percentage of babies who are exclusively breastfed up to babies aged 6 months is only 15.3 per cent. This matter due to public awareness in encouraging increased breastfeeding still relatively low.

Mothers who do not give breast milk to her baby reaches 4% and around 40% of babies less than two months old have been given complementary foods such as formula milk which reached 9%. While exclusive breastfeeding in Central Java only reached 49.78% (Health Office of Central Java Province, 2004). In 2010 the number of babies aged 0-6 705 months in Rembang Regency babies and those who have breastfed exclusively 277 infants (39.29%). The percentage is still not covered. The expected target is 80% of babies. Whereas in Pamotan Puskesmas only 25 infants (45%) who get exclusive breastfeeding (Rembang District Health Office, 2010).

In a Yenisyiska study (2012), it was stated that breastfeeding was not exclusively given by all working mothers (100%), compared to mothers who did not work (44.7%). Pregnancy is a period when a mother is ready to decide whether to give exclusive breastfeeding to a child or not. There are so many factors that influence the mother in deciding and doing breastfeeding patterns, primarily physical and psychological disadvantages, lack of information and knowledge about the benefits of breastfeeding, lactation management and matters relating to breastfeeding. The mother does not give exclusive breastfeeding to her baby in the first 6 months because of mistaken beliefs and attitudes towards exclusive breastfeeding. Reasons for mothers not giving exclusive breastfeeding include: the fear of breast milk they produce is not enough, or the milk they produce is of poor quality, late breastfeeding has given to babies and the practice of removing colostrum, incorrect breastfeeding techniques, belief that their babies require additional fluids other than breast milk (Gibney et al., 2005). Other factors that influence breastfeeding are socio-economic factors (mother's formal education, family income, and work status), physiological factors (fear of losing attractiveness as a woman, mental stress), physical factors (mother who is sick, for example mastitis, etc.). A factor in the lack of health workers so that the public is less enlightened or encouraged about the benefits of exclusive breastfeeding.

A current national nutritional assessment survey found 29.5% mothers breastfed infants exclusively until all months (Ministry of Health RI, 2016), while district health officials reported that in the last five years the prevalence of breastfeeding initiation ranged from 45-60% (Dinkes Kab. Serdang Bedagei, 2015). However, this achievement still does not guarantee that babies who are breastfed do not receive other food since born. In improving the exclusive breastfeeding coverage, Indonesian government deploys midwives to work at villages to run the maternal child health program. At present, each village has at least one midwife to implement maternal and child health program (Ministry of Health RI, 2015). This is one of the strategies to meet the target of 50% exclusive breastfeeding (Indrayani, 2017). This descriptive study intended to find out the prevalence of exclusive breastfeeding and feeding patterns of infants.

2 Methods

Study area

Serba Jadi-sub district part of Serdang Bedagei District, Indonesia. Serdang Bedagei district is divided into 17 sub-districts, 237 villages and 1,130 sub-villages which is the lowest form level of administration. It is situated about 40 km from Kualanamo International Airport.

At the time of the study, the total population of Serba Jadi sub-district was 22,713 in which 1997 were children under five year live in 1820 households. There were 15 midwives works at village health posts. In each village, there was at least one midwife, depends on the population density. Based on the annual district health report, 45-60% of mothers had been conducting breastfeeding initiation within an hour after birth. More than eighty percent of pregnant mothers visited the village health post to have a routine check-up.

Around 50% of fathers engaged in commercial and non-commercial agriculture at rubber and palm oil plantation and 30% of parents worked as farmers. The average monthly income of a family was 2.5 million rupiahs, similar to 220 USD (1 USD=11.300 IDR)

Study design

The type of this research was a descriptive, cross-sectional study design conducted between January - February 2017. The location took place in ten villages of Serba Jadi namely; Serba Jadi, Kuala Bali, Karang Tengah, Tambak Cekur, Manggis, Kelapa Bajohom, Sibahdua-dua, Tanjung Harapan, Pulau Tagor and Pulau Gambar.

Sample calculation

The sample size was calculated with the formula :

$$n = \frac{z^2 1 - \alpha 2P(1 - P)N}{d^2(N - 1) + z^2 1 - \alpha 2P(1 - P)}$$

n = 870.

Based on the following considerations: 95% confidence; 5% maximum deviation, 29.5% proportion of exclusive breastfeeding from the previous survey; 1997 number of population (N). This formula presented the minimum sample size (n) of 870, increased by 10% so that the total sample was 957 to overcome the high mobility of respondents living in rural areas.

Around fifty percent of total children under five in ten villages were recruited and the distribution of the sample in each village, as shown in Table 1. The sample was selected purposively based on selection criteria including countries(1) standard delivery; (2) living in a nuclear family; (3) absence of chronic disease in the last three month; (4) lived in the village more than one year. Thus, 949 eligible households were enrolled. Participation of respondent was voluntary and the oral informed consent obtained from mothers. Detail sampling processes are presented in figure 1.

Enumerators and Data collection

Twenty field interviewers recruited from Academy of Nutrition who has experience in collecting data about nutrition. The 5-day training was conducted before study implementation. The training was conducted to discuss research objectives, ways of collecting data, interview guides, and recalling infant food patterns.

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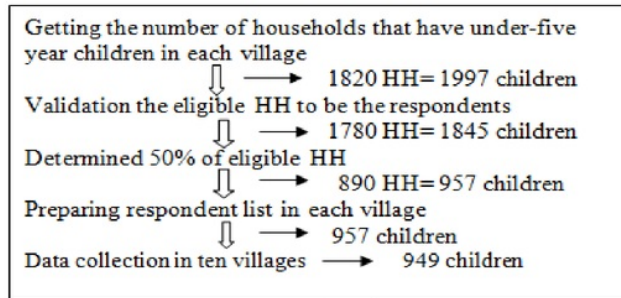


Figure 1: Illustration of sampling processes

The data collected and conducted by interviewing using questionnaires. The duration of the interview was ± 45 min, took place at mothers' home. The questionnaires were divided into four major parts, such as: demographic information, birth and child feeding and maternal knowledge and beliefs about breastfeeding. If a family had two under-five children, the questionnaires were focused on the youngest child.

In collecting data, twenty enumerators were divided into four teams. Each team consisted of five enumerators and a supervisor. The starting point was the house of the village leader. Every three days, the full team conducted a meeting to evaluate the sub-district office.

Focus group discussions

This discussion was held in each village. The participants were community health volunteers, mothers of childbearing age and village women's group leaders. This method presents directly the relationship between researchers with people who will give information, making it possible to get implied things (insight) describes the perceptions and beliefs about exclusive breastfeeding, initiation of breastfeeding, initiation of formula milk, solid food, the benefits and disadvantages of breastfeeding, beliefs, attitudes and taboos about infant feeding, and the types of solid food introduced.

Variables

All variables were compiled from questionnaires that were self-reported by respondents. Outcome variables were the

prevalence of breastfeeding initiation, duration of exclusive breastfeeding, the introduction of solid food. Steps include types and times for introducing solid foods: types of manufactured products, how to prepare porridge, first introduce solid foods <4 months. Research variables include variables related to parents and babies. Maternal factors include socio-demographic factors, attachment, and feeding. Socio-demographic factors include questions about ethnicity, age, education level, occupation.

Data analysis

The data collected is first checked for normality and means. Several characteristics variable; maternal age, maternal education level, mother's occupation, family monthly income and parity were tested to find the predictors of exclusive breastfeeding practising and introduction of solid food. Data processing was carried out with SPSS version 17.0.

3. Result/Discussion

3.1. Result

3.1.1. The characteristics of Socio-demographic respondents and sample

Of the total, 978 participants were eligible for inclusion in this study, 931 were obtained. The majority (42.5%) of mothers are in the age group of 25-29 years.

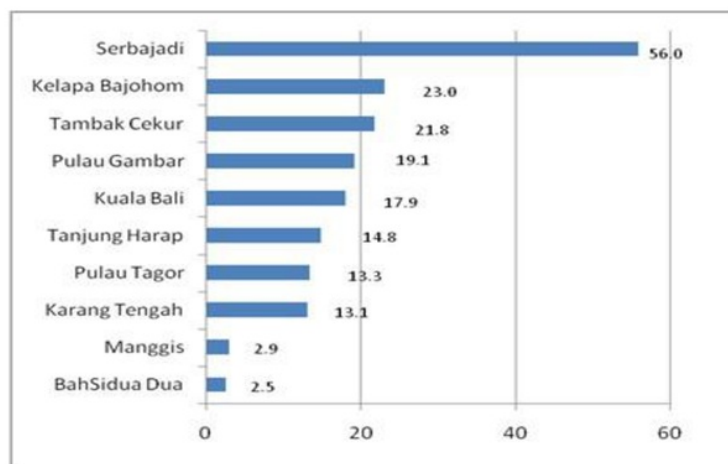


Figure 2. Prevalence of exclusive breastfeeding across the village

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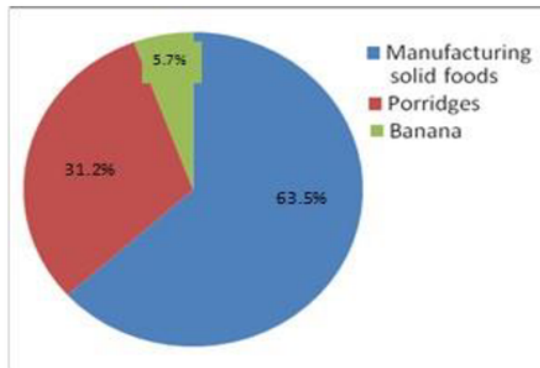


Figure 3. Types of the first sample of solid foods introduced to infants \leq four months (n = 621)

The average age of the mother is 26.5 years. The highest percentage of maternal education is grade 10-12 (36.9%). Only 4.9% of mothers have a higher level of education. Most of the mothers (81.87%) work as housewives to carry out daily activities at home. From 919 fathers, 68.3% of them worked in commercial agriculture and farmers. Only 1.8% had an occupation as the public servants. The average family monthly income was Rp. 2,500,000 (220 USD). This income was a bit higher than the regional minimum salary. Out of 949 children included, fifty-five percent were children aged 24-59 months, and 27% belonged to the 0-23 months. Almost half (49.0%) of respondents were Javanese and 30.0% Bataknese. These two ethnicities were the majority in the present study location.

3.1.2. Feeding patterns of infants

Table 2 demonstrated the patterns of child feeding. It was summarised from mothers' answers to the questionnaires. Out of 949 mothers, only 16.5% breastfed their babies exclusively from birth to 6 months. Others (83.5%) did not exclusively breastfeed their children, and of which almost two-thirds (65.4%) of mothers fed infants with the combination of solid foods and breastfeeding and 18.1% mothers gave formula milk.

3.1.3. Prevalence of EBF across villages

Figure 1. showed that Serbajadi was the village with the highest prevalence of EBF at six months (56.0%) compared to ten other villages. The rate in Manggis and Bah Sidua-dua, on the other hand, was the lowest (2.9% and 2.5% respectively).

3.1.4. Types of solids foods first introduced to ≤ 4 months infants

In study location, there were three kinds of pre-lacteal foods mostly introduced as the first sample of solid food; banana, porridge and manufactured gluten-containing foods. As seen in table 3, amazingly, more than half (63.5%) of children received manufactured solids foods by four months, and only 5.7% of mothers introduced banana.

Table 4. shows that among five potential predictors, only maternal education and family income had a significant effect to exclusive breastfeeding and early introduction of solid food ($p < 0.03$; $p < 0.04$, respectively).

3.2. Discussion

This study aims to find the eating patterns of children in rural areas. The pattern of breastfeeding a baby plays a vital role in a child's growth. Exclusive breastfeeding is that babies are only breastfed for six months without other additional fluids, such as water, oranges, honey, formula milk, tea, and without supporting solid foods such as bananas, papaya, milk porridge, biscuits, and teams, except vitamins, minerals, and medicine (Prasetyono, 2009). Breast milk is the first, the main and best food for natural babies. Babies who had breastfed will get several significant benefits. Namely the baby gets the best nutrition, increases endurance, increases intelligence, and of course, it is instrumental in increasing the fabric of affection between mother and baby (Nuraini, 2009).

The incidence of malnutrition strongly related to patterns of infant feeding, and it is started since the initiation of breastfeeding. District Health Office reported that in the last five years, 45-60% of mothers had been practising the breastfeeding initiation within an hour after delivery. These findings were similar to several studies in rural areas in Tanzania, 52% and Ethiopia 52%, Nigeria 45% and Ghana 41%, Kenya 37%. Our study pointed out that in study location, only 16.5% of mothers breastfed their infants exclusively, while the rests (83.5%) of children were not exclusively breastfed. It was lower compared to the current Provincial Nutritional Assessment that found 29.5% of women conform with the 6-month exclusive breastfeeding⁸. This study also proved that 63.5% of infants had been given solid foods < 4 months. The similar situation also happened for the infants in Scotland, 64% of mothers had introduced solid foods by three months. It meant that the children in the present study location might be suffered from subsequent health and a higher level of morphometric features characteristic of cardiovascular risk

The result in our study is almost similar to other studies in developing countries and developing countries as reported by the World Health Organization. It was estimated, not exceed 20% of mothers in most African countries breastfeed their child exclusively, and around 22-37% develop countries. The present result was broadly in line with the finding of Millar and Maclean twelve years ago in Canada, found only 17% of Canadian women breastfed the 0-6 month infants exclusively. Many factors cause low coverage of Early Breastfeeding Initiation and exclusive breastfeeding in the community. Various reasons put forward by mothers who do not exclusively breastfeed their babies include mothers feeling less milk production, difficulty in sucking babies, working mothers, the desire to be called modern and the influence of advertising and promoting of breast milk substitutes (Roesli, 2005).

It can be assumed that the achieving of breastfeeding initiation does not guarantee that mothers will do EBF. The possible reason for the declining from 45-60% early initiation of breastfeeding to 16.5% exclusively breastfeeding and the earlier introduction of solid foods to infants might be not only due to maternal education and family income. Problems faced by village midwives and the massive marketing of manufactured babies foods through midwives and health providers might be potential causes. Indrayani and Makowiecka stated that village-based midwives face several problems including language and communication, understanding of promotion, workload, compensation and

rewards and lack of experience. The lack of village-based midwives work in the village is also need to be solved.

There are many actions that midwives and other health providers can take to improve EBF, such as home-based intensive counselling and peer-counselling, baby-friendly public health centre-based initiative, mother support group. The most comfortable and most successful breastfeeding is when the mother herself is physically and mentally ready for childbirth and breastfeeding, and if the mother is informed, supported, and feels confident in her ability to care for her baby. Besides the success of nursing, mothers must also be supported by their husbands, families, health workers and the community.

This study also pointed out that low education mothers were significantly affected by EBF practising. It was in line with Indriani (2016) it was found that mothers with low education are not doing EBF, contrast with mothers who had higher education (35.7%). The low level of education results in a lack of knowledge in dealing with problems, especially in exclusive breastfeeding. This knowledge is obtained both formally and informally. Mothers who have a higher level of education are generally open to accept changes or things for the maintenance of health. Education will also make a person want to be curious to find experience so that the information received will become knowledge. The level of education in the family can be a factor that affects the children's nutritional status. The higher the education of parents, their knowledge of nutrition will be better than those with less education. The incidence of malnutrition and poor nutrition is related to the mother's attitude towards food. Attitudes towards food are also related to eating habits, community culture, beliefs and food choices. Culture is the power of the mind in the form of creativity, work and intention. Culture contains social norms that are the joints of society which contain sanctions and penalties imposed on the class when it is considered proper to maintain the needs and safety of the community is violated. The norms are about living habits, customs, or living traditions that are used for generations (Yudi H, 2007).

Food habits are food consumption (quantity and quality), specific food preferences, dietary beliefs, or attitudes towards certain foods. There are good eating habits or can support the fulfilment of nutritional adequacy, and some are bad (can prevent fulfilment nutritional adequacy), such as abstinence, or taboo that is contrary to nutritional concepts. The problem that can cause malnutrition is not enough nutritional knowledge and lack of understanding of good eating habits. Habit household food is essential to note, because food habits affect the selection and use of food, further affecting the high and low quality of household food (Ali Khosman et al., 2006). The problem of malnutrition and malnutrition in infants can be caused by the attitude or behaviour of the mother, who is a factor in improper food selection. Sorting food ingredients, availability of adequate amounts of food and diversity of food is influenced by the level of mother's knowledge about food and nutrition.

Ignorance of the mother can cause food selection errors, especially for children under five, so the nutrients in quality and quantity are not enough to meet body needs (Julita,

2011). Mother's formal education will affect the level of nutritional knowledge, the higher education, the higher ability to absorb practical knowledge and formal education.

We speculate that low EBF coverage and the introduction of solid food which is too early because of the inconsistencies and promotion of EBF given by midwives in the village. In one side they promote EBF, but on another side, they need fee from formula milk company. Although we observed some encouraging signs in several villages, the breastfeeding patterns in rural areas are still far from the norm recommended by WHO and UNICEF. We also observed that there was a lack of knowledge of both mothers and midwives regarding the introduction of solid foods.

4. Conclusion

The present study revealed that exclusive breastfeeding practising is still rare. The presence of village-based midwives still did not effectively improve the coverage of EBF. There is a clear need to enhance the skills of village midwives to run peer counselling and home-based counselling. Further research is needed to measure the work burden of village midwives about the promoting of exclusive breastfeeding.

5. Future Scope

There is a need to investigate how midwives recruited before deploying at the community level. Skill in conducting breastfeeding promotion is compulsory. Limitation of present study involved children aged >24 months made it difficult to recall infant feeding patterns.

6. Acknowledgement

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Appendixes.

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Table 1. Socio-demographic characteristics of participants and infants in Serbajadi, n=949

Variable	n	%
Age of child (months)		
0-5	124	13.1
6-11	133	14
12-23	170	17.9
24-35	143	15.1
36-59	379	39.9
Sex of child		
Boys	491	51.7
Girls	458	48.3
Age of mother (in years)		
19-24	329	34.7
25-29	399	42
30-34	221	23.3
Ethnicity		
Javanese	465	49
Batakese	285	30
Melayunese	113	11.9
Others	86	9.1
Maternal education level		
Grade 6	219	23.1
Grade 7-9	333	35.1
Grade 10-12	350	36.9
Grade > 12	47	4.9
Fathers' education level		
Grade 6	223	24.3
Grade 7-9	295	32.1
Grade 10-12	364	39.6
Grade > 12	37	4
Maternal occupation		
House wife	777	81.9
Government employee	11	1.2
Merchant	30	3.2
Farmer	31	3.3
Commercial agriculture	93	9.8
Skill Labour	7	0.7
Fathers' occupation		
Government employee	17	1.8
Merchant	123	12.1
Farmer	137	14.4
Commercial agriculture	512	53.9
Skill Labour	137	14.4
Others	23	2.4
Income (monthly)		
< Rp. 2,500,000	467	49.2
> Rp. 2,500,000	482	50.8
Parity		
4-Jan	552	68.2
>4	397	31.8

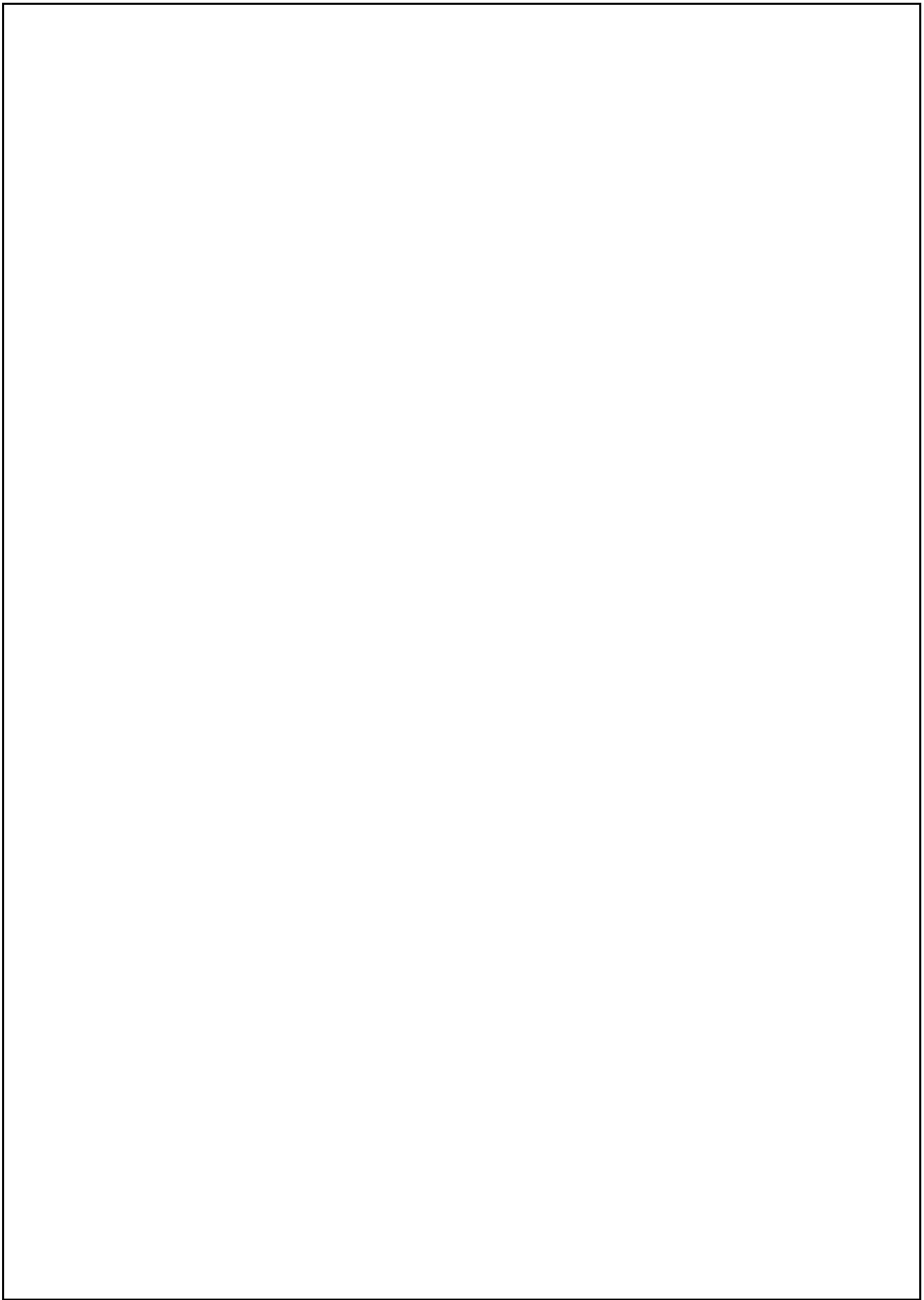
Table 2: Estimated frequency distribution of feeding patterns of infants

Feeding patterns	n (%)
Exclusive breastfeeding for ≥6 months	156 (16.5)
Combination of formula & breastfeeding	124 (13.0)
Formula alone from birth	48 (5.1)
Combination of solid foods & breastfeeding	621 (65.4)

Table 3. Summarizes of statistical test for potential predictors for exclusive breastfeeding practice and introduction of solid food

	Exclusive breastfeeding	Introduction of solid foods
Maternal Age	0.66	0.72
Maternal occupation	0.03	0.06
Maternal education	0.03*	0.43
Family income	0.59	0.04*
Parity	0.63	0.74

*Chi-square test with p-value significant at 0<0.05





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