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*Original Research Article*

# Gender Discrimination in Relation to Exclusive Breast Feeding Practices amongst Twins in Rural India

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## ABSTRACT

Breastfeeding practices vary among different regions and communities. In India, breastfeeding in rural areas appears to be shaped by the beliefs of a community, which are further influenced by social, cultural, and economic factors. Two hundred mothers along with their twin infants (one male and other female) were enrolled in this study. Only 210 (52 %) neonates had received exclusive breast feeding. Out of the 210 neonates 132 (63 %) male neonates and 78 (37 %) female neonates had received exclusive breast feeding respectively. Gender discrimination regarding feeding practices is prevalent in the rural areas of our country.

**Key words:** Breastfeeding practice, Gender discrimination, Twins.

## INTRODUCTION

World Health Organization (WHO) recommends optimal infant and young child feeding (IYCF) practices for normal growth and development of infants and young children. These practices include initiation of breastfeeding within 1 hour of birth; exclusive breastfeeding for the first 6 months of life; and addition of timely, appropriate, and adequate family foods for complementary feeding after 6 months along with continued breastfeeding. [1] Exclusive breastfeeding is defined by World Health Organization (WHO) as a practice of feeding only breast milk (including expressed breast milk) and allows the baby to receive vitamins, minerals or medicines. Water, breast milk substitutes, other liquids and solid foods are excluded. World Health Assembly of WHO in 2001 made resolution that exclusive breastfeeding for the first six months is the most appropriate infant feeding practice.[2] The benefits of breastfeeding (BF) specially, exclusive breastfeeding (EBF), are well established particularly in poor environments where early introduction of other milk is of particular concern because of the risk of pathogens contamination and over dilution of milk leading to increased risks of morbidity and undernutrition. [3] The WHO estimates that 53% of acute pneumonia and 55% of diarrheal deaths are attributable to poor feeding practices during the first 6 months of life. [4] Breastfeeding practices vary among different regions and communities. In India, breastfeeding in rural areas appears to be shaped by the beliefs of

a community, which are further influenced by social, cultural, and economic factors. Besides, there is also a looming concern over gender disparity as far as neonatal care in rural areas is concerned. A major reason cited for the low girl-to-boy ratio in the population of India (0.93) is the differential in healthcare-seeking behaviour between genders. [5] Consequently, to improve the status of women and girls in India, it is important to develop interventions that reduce the gender differences in care-seeking, especially during times, such as the neonatal period, when the human body is particularly susceptible to illness and consequences of late or inappropriate health services. Although gender-based neonatal care disparities are prevalent in India, very little data are available on such areas of concern for newborns. The objective of the study was to study the feeding practices amongst mothers who had twins with different genders and to evaluate the factors associated with gender disparity regarding feeding in these newborns.

## MATERIALS AND METHODS

This was a prospective study conducted at the Krishna institute of medical sciences, Karad from 2011-2013. Two hundred mothers along with their twin infants (one male and other female) were enrolled in this study after informed verbal consent, in the out-patient and In-patient department of the Pediatric and Gynae-Obs department of the hospital. The inclusion criteria were healthy infants upto 6 month of age delivered vaginally. Both primigravida and multigravida were interviewed regarding the breast feeding practices in their infants. Exclusion criteria were infants delivered by caesarean section, having chronic ailments or congenital anomalies e.g. congenital heart diseases causing growth failure and inborn errors of metabolism. They were interviewed by one of authors using a pretested structured proforma. Confidentiality was assured. Our questionnaire was easily understandable to all mothers, which included demographic profile of the mother, detailed profile of both the babies, the feeds given to them and reasons regarding the given feed. The data was entered into the S.P.S.S. version 13 and analyzed. Fishers exact test was used as and when required.

## OBSERVATION AND RESULTS

In our study 200 mothers along with their twins were enrolled in the study .There were 200 pairs of twins with different genders, 200 male neonates and 200 female neonates. The demographic profile of the mothers has been shown in Table 1. More than half of the mothers (58%) were in the age group of more than 20. A highly significant proportion of mothers (79 %) had low educational status. Similarly 70 % of the mothers also had a low socioeconomic status. Majority of the mothers (70 %) in our study were Hindu by religion. There was a slight difference in mothers who were multigravida (52 %) and primigravida (48 %). Only 24 % of the mothers in our study were working and 74 % were non-working mothers.

Table no 1. Demographic profile of mothers.

| Maternal characteristic | No of cases (n=200) | Percentage. |
|---|---|---|
| Age | | |
| >20 | 116 | 58 % |
| <20 | 84 | 42 % |
| Educational status | | |
| Higher education | 42 | 21% |
| Lower education | 158 | 79 % |
| Socioeconomic status | | |
| High or moderate status | 60 | 30 % |
| Low status | 140 | 70 % |
| Religion | | |
| Hindu | 148 | 74 % |
| Non-Hindu | 52 | 26 % |
| Gravida | | |
| Primigravida | 96 | 48 % |
| Multigravida | 104 | 52 % |
| Working status | | |
| Working | 52 | 26 % |
| Non-working . | 148 | 74 % |

Among the 400 neonates enrolled in the study only 210 (52 %) neonates had received exclusive breast feeding. Out of the 210 neonates 132 (63 %) male neonates and 78 (37%) female neonates had received exclusive breast feeding respectively. Thus out of the total 400 neonates only 132 (33 %) male neonates and 78 (37%) female neonates had received exclusive breast-feeding. The incidence of male neonates receiving exclusive breastfeeding was much higher than female neonates and the difference was highly significant (p= 0.002)

Out of the 210 babies who were given exclusive breast feeding in the study, only 78 female infants had received exclusive breastfeeding. We asked the 132 mothers who had chosen to give exclusive breast feed to the male child to elaborate on the factors responsible for adopting such a feeding practice. The most common responsible were inadequate milk production (55%), advice from the mother-in-law (32 %) and due to the male neonate not gaining weight (27 %).The others factors responsible are presented in table no 2 .

Table no 2. Factors responsible for breast feed.

| Factors | No of mothers who did not give exclusive breast feed to female infant. | Percentage . |
|---|---|---|
| Inadequate milk production | 72 | 55% |
| Maternal health problems | 24 | 18% |
| Maternal employment | 20 | 15% |
| Unaware of benefits | 30 | 22% |
| Influence by family traditions | 22 | 16% |
| Advice of mother-in- law | 42 | 32% |
| Did not want the female child | 18 | 14% |
| Male neonate was not gaining weight . | 35 | 27% |

## DISCUSSION

The global rates of exclusive breastfeeding have remained stagnant since 1990, with only 37% of children younger than 6 months being exclusively breastfed. [6] It has been proved that breast feeding is beneficial for both mother and child. For a child it is a complete food which meets the nutritional requirements of normal infants without any preparation before consumption.[7] Prevalence rate of exclusive breastfeeding by 6 months was 52 %, little higher than national level (46%) as reported by National Family Health Survey 3 (NFHS 3). [8]

Gender disparity regarding exclusive was predominant in our study as 67% mae neonates and 37 % female neonates had received exclusive breatfeeding. Our results are in accordance with other similar studies on the same subject. [9-12] In relation to gender-bias in feeding the study tried to evaluate the factors responsible for such feeding practices in rural areas. In our study the major reason for failure of exclusive breast feeding was inadequate milk production noted in 55% cases. Various studies showed similar results. [12-14] Another significant factor responsible for such feeding practices against the female infant adopted by mothers was due to such advice given by their mother-in-laws. The brutal irony of such gender discrimination is that it is an evil perpetrated against girls by women themselves. The most insidious force is often the mother in law, the domestic matriarch, under whose authority the daughter in law lives. 'Son' or 'male bias' often stems from the belief that men are more likely to enter profitable employment later and will therefore be better able to care for their family in later life. I studies have also found similar influences of the mother-in-law and neighbors regarding exclusive breastfeeding. [15] A noteworthy proportion of mothers (27 %) also stopped exclusive breast feeding in the female neonates because of the other neonate suffering from health problems or had loss of weight. It is important to develop interventions that reduce the gender differ-

ences in care-seeking, especially during times, such as the neonatal period, when the human body is particularly susceptible to illness and consequences of late or inappropriate health services. The likelihood of mothers ignoring the female child's nutritional needs as compared to male newborn infants may be because mothers were more vigilant to the health of their sons. [16,17] Such gender bias in perception of illness is consistent with findings of other neonatal health studies in South Asia. [18] Other reasons for gender bias in feeding practices were maternal health problems (systemic illness as well as breast problems), maternal employment, influence of family traditions and beliefs, unawareness of the benefits of exclusive breastfeeding and the mother not wanting a female child due to family pressures. Similar findings have been reported in other studies. [12,19,20] All these problems can be solved by providing appropriate counseling to the mother and family members. Active support and encouragement by family members, community and the entire health system can play a major role in establishing in bringing about a change in the discrimination of the girl child.

## CONCLUSION

Gender discrimination regarding feeding practices is prevalent in the rural areas of our country. This study emphasizes the need for gender –sensitive breastfeeding intervention programs to increase the awareness and modify the present attitude in the community as a whole, especially for the mothers in rural areas. Breast feeding is not only of nutritional and health advantage but is also vital for infant mother relationship .The results of this study form a strong foundation for future programmes and for research in understanding gender differences in neonatal health care.

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