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FAILURE TO EARLY INITIATION OF BREASTFEEDING AS A RISK FACTOR FOR EXCLUSIVE BREASTFEEDING FAILURE: A SECONDARY ANALYSIS OF THE 2017 INDONESIAN HEALTH DEMOGRAPHIC SURVEY

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ABSTRACT

Early Initiation of Breastfeeding (EIBF) is a factor that determines the success of exclusive breastfeeding. This study aims to determine the relationship between EIB and exclusive breastfeeding in children aged 6-24 months in Indonesia. This study, using the 2017 Indonesian Health Demographic Survey (IDHS) with a cross-sectional study design approach. The sample is children aged 6-24 months in Indonesia. The independent variable is the provision of Early Initiation of Breastfeeding. The dependent variable is exclusive breastfeeding. The *confounding* variables are family characteristics (economic status, place of residence), children (child sex, child birth weight), and mother (mother's age, mother's education, birth attendant, paritas, mother's occupation). The results of the study show 56.2% of mothers had EIB and exclusive breastfeeding coverage was 57.4%. There was a significant relationship between EIB and exclusive breastfeeding (p=0.000). Mothers who did not do EIB had a 2.855 times risk of not exclusive breastfeeding compared to those who did EIB (OR 95% CI: 2,552–3,194) after controlling for factors of residence, socio-economic and parity. There is a need for a socialization and education movement about the importance of EIB for the success of exclusive breastfeeding so that children can grow and develop optimally according to the child's age.

Keywords:*Early Initiation of Breastfeeding (EIB), Exclusive Breastfeeding, Children aged 6-24 months, Women of Childbearing Age, IDHS 2017*

INTRODUCTION

Exclusive breastfeeding will affect the growth and development of the child. One of the factors that influence exclusive breastfeeding for infants is Early Initiation of Breastfeeding (EIBF). Exclusive breastfeeding until the child is 6 months old is useful for protecting babies from various infectious diseases as the cause of infant mortality. Breastfeeding in Indonesia is still very low even though breastfeeding is very beneficial for babies, mothers and family members.[1] Recommendations from the United Nations International Children's Emergency Fund (UNICEF), one of the efforts to prevent infant mortality is to provide exclusive breastfeeding for infants. Children who are exclusively breastfed are 14 times more likely to survive in the first six months of life than children who are not exclusively breastfed. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend that the time for exclusive breastfeeding should be until the baby is six months old.[2]

The results of the 2017 Indonesian Health Demographic Survey (IDHS) show that half (52%) of children aged 0-6 months are breastfed. With increasing age, exclusive breastfeeding coverage decreases from 67% at the age of 0-1 months, to 55% at the age of 2-3 months, then decreases to 38% at the age of 4-5 months. Preferably, the percentage of children who are not breastfed increases with age, from 8% at 0-1 months to 41% at 18-23 months.[3]

Early Initiation of Breastfeeding (EIBF) is a factor that determines the success of exclusive breastfeeding.[4][5][6]Failure to give IMD can have an impact on the failure of exclusive breastfeeding.EIBF has many benefits for mothers and babies, besides that EIBF can prevent the occurrence of infectious diseases that increase the risk of infant and child mortality,

it also increases the risk of neurological cancer, leukemia, and several other diseases due to decreased baby's immune system.[7][8][9][10]Failure to give EIBF can increase the Newborn Mortality Rate (IMR) up to 22%. Currently, the under-five mortality rate in Indonesia is very worrying. Almost every 2.5 minutes 1 toddler in Indonesia dies, meaning that 430 toddlers die every day.[11] Several research results conducted in several regions of Indonesia show that there was a relationship between EIBF and exclusive breastfeeding, the low level of giving EIBF was one of the factors related to the failure of exclusive breastfeeding.[12][13][14][15] However, the results of research in Rural Haiti showed no significant relationship between EIBF and EBF(RR=1,35; 95% CI: 0.84-2.18).[16] However, there are very limited national studies to prove the mechanism of this relationship. This study aims to determine the relationship between EIBF and exclusive breastfeeding for children aged 6-24 months using the 2017 IDHS national survey data.

RESEARCH METHODS

Data Source

The study used 2017 IDHS data with a cross sectional research design. The population of this study were all mothers who had children under five aged 6-24 months who received exclusive breastfeeding. The sample used is mothers who have children under five aged 6-24 months and children born alive who are born and are the last child of mothers who have experienced birth. The unit of analysis for this study was all children born alive from all live births from mothers who had already experienced birth, then the last child was sampled and weighed at birth. The sample in this study were all mothers and children who met the inclusion and exclusion criteria. The number of samples is 5,458 children.

Measures

The data collection instrument used a structured questionnaire with the interview method. The questionnaire used in the IDHS has gone through a trial process by Central Bureau of Statistics. In order to collect data, trainings have been carried out starting from the level of supervisors, examiners, and data collectors. Training includes class presentations, practice interviews, and tests. Data processing begins with data checking. Data editing is done to ensure that the data obtained is clean data, that is, the data has been filled in completely, is consistent, relevant, and can be read properly. This is done by analyzing or cleaning up missing data, so that they are not used in the analysis. The next stage is coding the data. Each data was recorded to facilitate the needs of statistical analysis in research. The final stage is cleaning the data by re-checking the data that has been entered, whether there are errors or not. This error may occur when we enter data into the computer.

Statistical Analysis

Data analysis used univariate analysis to describe the proportion of each variable. Bivariate analysis to test the homogeneity of variance of independent variables and variable selection for multivariate analysis. Multivariate analysis using multiple logistic regression test.

Ethics Statement

The 2017 IDHS has received ethics from the Institutional Review Board Findings Form ICF IRB FWA00000845. ICF Project Number: 132989.000.

RESULTS AND DISCUSSION

The results in table 1 show that the practice of giving EIBF to Indonesian newborns is still low, only 56.2% of babies are given EIBF. Likewise, the practice of exclusive breastfeeding for infants in Indonesia is still low, only 57,4% of infants receive exclusive breastfeeding.

The results in Table 1 show that more than half of mothers had EIBF. Early Initiation of Breastfeeding is the process of the baby suckling immediately after birth, the baby is placed on the mother's chest and left to find the mother's nipple on its own. Giving Early Initiation of Breastfeeding can also provide a large nutritional coverage for babies, because the content of milk in the mother's breast that first comes out is colostrum which is very beneficial for babies, especially as the formation of the baby's body immunity. This shows that it is still relatively low for mothers who do EIBF. Meanwhile, according to Damayanti's research (2016), the scope of EIBF practices in developed countries such as the United States and the Netherlands has reached 75%. In South Asia, only 41% of newborns are breastfed within 1 hour of birth. Several South Asian countries have some of the worst Early Initiation of Breastfeeding practices in the world, rates in Pakistan 29%, India 41%, Bangladesh 47% and Nepal 45%.[17] It is important to understand the factors associated with delayed Early Initiation of Breastfeeding and the existing barriers and facilitators to EIBF in order to design and deliver effective strategies to increase the success of EIBF for newborn survival.

Table 1. The Practice of Early Initiation of Breastfeeding and Exclusive Breastfeeding in Indonesia

Variable	Frequency (n = 5.458)	Percentage %
Practice of Early Initiation of Breastfeeding		
Early Initiation of Breastfeeding	3,067	56.2
No Early Initiation of Breastfeeding	2,391	43.8
Practice of exclusive breastfeeding		
Exclusive breastfeeding	3.131	57,4%
No exclusive breastfeeding	2.327	42,6%

The results of this study are in line with research in Nambia, EIBF decreased significantly from 82.5% in 2000 to 74.9% in 2013. Factors associated with EIBF in 2000 were urban residence, poorer household wealth, weight birth body. In 2013, factors related to EIBF were maternal age 15-19 years, birth delivery, married mothers, delivery assistance from health workers and birth order fourth or above.[18] The success of exclusive breastfeeding can be seen from the optimal implementation of EIBF. EIBF has many benefits for the mother, by touching, sucking, and licking the baby on the mother's nipple during the EIBF process, it will facilitate the release of the hormone oxytocin causing the uterus to contract, thereby helping the expulsion of the placenta and reducing bleeding in the mother.[5]

Table 2 shows that mothers who gave EIBF mostly gave exclusive breastfeeding (67.2%), mothers who did not give EIBF mostly did not exclusively breastfeed (58.6%). The results of the bivariate analysis showed that there was a relationship between Early Initiation of Breastfeedingand exclusive breastfeeding (P=0.000). Table 2 also shows that there is no difference in the proportion of exclusive breastfeeding based on place of residence (P>0.05). This study shows that the coverage of exclusive breastfeeding for infants aged 6-24 months in Indonesia in rural areas is higher than in urban areas, which is 49.8% in rural areas and 50.2% in urban areas. Based on socioeconomic status, the richer the less exclusive breastfeeding, the poorer giving exclusive breastfeeding. The higher the socioeconomic status, the lower the proportion of exclusive breastfeeding There is a socioeconomic relationship, education, birth

attendant and parity has something to do with exclusive breastfeeding. However, there was no difference in the proportion of exclusive breastfeeding between boys and girls (P=0.471), child's birth weight (P=0.111), according to mother's age (p=0.301) and mother's occupation (p=0.609).

Table 2. Relationship Family, Child, and Mother Characteristics with Exclusive Breastfeeding

Characteristics	Exclusive Breastfeeding				Total		*P-Value*
	Exclusive Breastfeeding		No Exclusive Breastfeeding				
	n	%	n	%	n	%	
Early Initiation of Breastfeeding							
Yes	2,104	67.2	963	41.4	3,067	56.2	0.000
No	1,027	32.8	1,364	58.6	2,391	43.8	
Residence							
Urban	1,582	50.5	1,136	48.8	2,718	49.8	0.212*
Rural	1,549	49.5	1,191	51.2	2,740	50.2	
Socioeconomic							
Status	543	28.6	401	23.6	944	26.5	
Very poor	554	19.1	435	21.0	989	19.9	
Poor	542	17.3	453	19.5	995	18.2	0.001*
Intermediate	597	17.7	488	18.7	1,085	18.1	
Rich	895	17.3	550	17.2	1,445	17.3	
Very Rich							
Gender							
Male	1,671	53.4	1,219	52.4	2,890	52.9	0.471
Female	1,460	46.6	1,108	47.6	2,568	47.1	
Child's birth weight							
Normal (≥2500 gr)	2,684	93.4	2,040	92.3	4,724	92.9	0.111*
LBW (<2500 gr)	189	6.6	171	7.7	360	7.1	
Mother Age							
15 – 20 Year	234	7.5	150	6.4	384	7.0	0.301
21 – 35 Year	2,264	72.3	1,714	73.7	3,978	72.9	
36 – 49 Year	633	20.2	463	19.9	1,096	20.1	
Mother's Education							
Higher education	571	18.2	499	21.4	1,070	19.6	
Middle education	1,772	56.6	1,336	57.4	3,108	56.9	0.000*
Basic education	737	23.5	474	20.4	1,211	22.2	
No school	51	1.6	18	0.8	69	1.3	
Birth attendant							
Health workers	2,819	90.2	2,150	92.4	4,969	91.2	0.004*
Non-health workers	306	9.8	176	7.6	482	8.8	
Parity							
Primiparaus	895	28.6	868	37.3	1,763	32.3	0.000*
Multipara	1,988	63.5	1,330	57.2	3,318	60.8	
Grandemultipara	248	7.9	129	5.5	377	6.8	
Mother's work							
Working	1,506	48.1	1,103	47.4	2,609	47.8	0.609
Doesn't work	1,625	51.9	1,224	52.6	2,849	52.2	

**Variable Candidate Multivariate (p≤0,25)*

Table 2 shows that in Indonesia, exclusive breastfeeding is still relatively low because milk production does not come out smoothly or milk secretion is having problems, because most mothers have given birth for the first time (primiparous parity). In primiparous mothers,

mothers had never previously received stimulation from the baby for the first time during breastfeeding for milk production. A primiparous mother is a woman who has had a live child for the first time and has just become a mother. mothers who have children for the first time (primiparas) have breastfeeding problems, in contrast to mothers who have had children and breastfeed before, problems in primiparous mothers are related to milk production, breast milk cannot be produced smoothly without stimulation to the breasts because the mother has not have received stimulation for milk production, especially from infants during breastfeeding.[19]

Table 3. Relationship between EIBF and Exclusive Breastfeeding in Children in Indonesia

Variable	B	p-value	OR (95% CI)
Early Initiation of Breastfeeding			
EIBF	-	0.000	1
No EIBF	1.049		2.855 (2.552 – 3.194)
Residence			
Urban	-	0.003	1
Rural	0.196		1.217 (1.070 – 1.383)
Socioeconomic Status			
Very poor	-	0.000	1
Poor	0.331	0.000	1.392 (1.175 – 1.648)
Intermediate	0.384	0.000	1.469 (1.226 – 1.759)
Rich	0.298	0.002	1.347 (1.120 – 1.621)
Very Rich	0.284	0.004	1.328 (1.093 – 1.614)
Parity			
Primiparaus	-	0.000	1
Multipara	0.291	0.000	1.338 (1.186 – 1.509)
Grandemultipara	-0.205	0.085	0.814 (0.645 – 1.029)
Constant	-1.195		

The results in Table 3 show that EIBF is associated with exclusive breastfeeding (P=0,000). Mothers who did not do EIBF had a 2.855 times risk of not exclusive breastfeeding compared to those who did EIBF (OR 95% CI: 2,552–3,194) after controlling for factors of residence, socioeconomic and parity. If the mother does not do EIBF, there will be 2.855 times the risk of not exclusive breastfeeding compared to mothers who do EIBF. Mothers who live in urban areas are at 1.217 times (OR 1.217; 95%CI: 1.070 – 1.383) risk of not exclusive breastfeeding compared to those who live in rural areas. Families who have middle social status are at risk of 1.469 times not exclusive breastfeeding compared to very poor families. Mothers who have given birth for the first time have 1.338 times the risk of not exclusive breastfeeding compared to mothers who have given birth more than once. Mothers who have more than 1 child are at risk of 1,338 times not giving exclusive breastfeeding compared to mothers with their first child (OR 1.338; 95%CI:1.186 – 1.509).

The results in Table 3 show that EIBF is associated with exclusive breastfeeding. The results of this study are in line with the findings in several countries, that early initiation of breastfeeding is associated with exclusive breastfeeding.[20][7][21]The results of this study are in line with research in India, which states that skin contact increases the success of EIBF and the competence of breastfeeding infants, there is an effect of EIBF on the success of exclusive breastfeeding. Sucking by the baby immediately after birth can accelerate the release of breast milk and can guarantee the continuity of milk production.[4] The success of exclusive breastfeeding does not come by itself, but through a process that must be taught. Health workers

such as midwives have the most role in being able to carry out EIBF because mothers cannot do EIBF without the assistance of health workers and facilitation from health workers. This study was a qualitative study of 6 months exclusive breastfeeding with a group of mothers who were exclusively breastfed and not exclusively breastfed. It was seen that most of the exclusive breastfeeding informants were facilitated by EIBF by health workers, one of which was a midwife, while most of the non-exclusive breastfeeding informants were not facilitated by EIBF. The reasons the informants did not provide EIBF include the mother being sick after caesarean section, separating the mother and baby, the baby entering the incubator, and the mother experiencing bleeding during childbirth, the baby is immediately cleaned and swaddled.[22]

Breast milk will come out after the baby is born, followed by a decrease in the level of the hormone estrogen which encourages increased levels of prolactin for milk production. On the first day of milk that comes out is still a little, the mother must continue to breastfeed. This is not only intended to provide nutrition to the baby, but so that the baby learns to suckle or gets used to sucking the mother's nipples and supports milk production. The success of the lactation process or breast milk production, one of which is the shape of the nipple. The shape of the protruding nipple will make it easier for the baby when breastfeeding, finally the baby has no difficulty sucking the nipple. This makes it easier for babies to breastfeed and increase milk production.[23] Breast milk (ASI) contains ideal nutrition for babies because it contains the most suitable nutrients for the baby's needs and also contains a set of nutrients to protect the baby against various diseases. The World Health Organization (WHO) recommends that infants be exclusively breastfed for the first 6 months.[24]

Table 3 shows a significant relationship between socioeconomic status, parity and residence was associated with exclusive breastfeeding. This study showed a statistically significant relationship between socioeconomic status and exclusive breastfeeding. The higher the socioeconomic status of the family, the lower the risk of non-exclusive breastfeeding. Mothers with Very Rich socioeconomic status are at risk of 1.328 times to give exclusive breastfeeding according to recommendations compared to mothers with very poor socioeconomic status. Mothers with Rich socioeconomic status are at risk of 1.347 times to give exclusive breastfeeding according to recommendations compared to mothers with very poor socioeconomic status. The results of this study are in line with the findings in Ethiopia that socioeconomic status and area of residence are associated with the success of exclusive breastfeeding.[25]The results of research in South Asia show that the social and economic conditions of a woman and household influence exclusive breastfeeding, then mother's education, mother's occupation, household wealth and family size and family type.[7]

Mothers who live in rural areas are at higher risk of non-exclusive breastfeeding. Table 2 shows that exclusive breastfeeding is better in urban areas than in rural areas, in line with the results of other studies which found that exclusive breastfeeding is more likely among urban capitals compared to rural mothers, which is consistent with previous studies.[18] Increased employment and higher education levels among mothers living in urban areas. Urban women may also have easier access to information, so they can understand the importance of exclusive breastfeeding. Other research findings show that the rate of not exclusive breastfeeding is lower in women from rural areas.[21] The area where the mother lives contributes to the process of exclusive breastfeeding. Mothers who live in urban areas have a smaller chance of being able to provide exclusive breastfeeding compared to mothers who live in rural areas. This is due to the easy access and availability of formula milk in areas of mothers who live in urban areas when compared to rural areas. Apart from that, the availability of formula milk can also encourage mothers to prefer giving formula milk. The results of this study prove that mothers who live in urban areas are more at risk of discontinuing exclusive breastfeeding than mothers

who live in rural areas. Residence in urban areas as a risk factor for the failure of exclusive breastfeeding. Mothers who live in urban areas tend to have higher education and better economic status, and generally work, so mothers prefer to replace breast milk with formula milk. This of course will have a negative impact on exclusive breastfeeding.[26]

The results of this study indicate a statistically significant relationship between parity and exclusive breastfeeding. Mothers with grandemultipara were likely not to give exclusive breastfeeding at 0.814 times risk for inappropriate exclusive breastfeeding compared to mothers with primiparous parity. Delayed exclusive breastfeeding was more common among women with no formal education in Bangladesh (29.30%), India (26%), Nepal (31%) and Pakistan (32%). In Bangladesh, delayed exclusive breastfeeding was associated with less educated husbands (29%). Working mothers in Pakistan are more likely not to exclusively breastfeed compared to non-working mothers.

The limitation of this study lies in the type of cross-sectional study by conducting a survey to ask about the history of giving early initiation of breastfeeding and exclusive breastfeeding for 5 years before the survey. The data depended on the mother's memory of events that occurred during the last 5 years from the time of initiation of breastfeeding to the time the survey was conducted. The main limitation is recall bias. Another weakness of this study is that several important factors that might influence the practice of exclusive breastfeeding were not investigated due to incomplete information.

CONCLUSION

The practice of EIBF in children aged 6 – 24 months in Indonesia has not yet reached the national target. The coverage of exclusive breastfeeding is also not optimal. Giving EIBF was significantly related to exclusive breastfeeding after controlling for socioeconomic factors and maternal parity.

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