

Factors Associated with Choice of Infant Feeding Practices among HIV-1 Positive Post-natal Clinic Attendees in Tharaka Nithi County

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Abstract

Background: Feeding practices for HIV-exposed infants plays a key role in determining the risk of morbidity and mortality. Infected mothers' choice of infant feeding is influenced by many factors within the community hence challenging their decisions. We sought to determine factors associated with choice of HIV exposed infant feeding practices in the region. **Methods:** Two hundred and forty nine HIV infected mothers were systematically recruited. Data on infant HIV status was obtained from facility records. Respondents were interviewed using a semi-structured questionnaire. Focus group discussions and key informant interviews were carried out to support primary data. Analysis was done using SPSS version 16.0. Logistic regression was used to determine association of factors that influenced choice of infant feeding practice. **Results:** Of the 249 respondents, 98% chose exclusively breastfeeding during prenatal counseling but majority did not sustain beyond 2 months, while replacement feeding was least practiced (2%) postnatal. Major factors that influenced feeding practices were mother's education (OR 2.637; CI: 1.088-6.388), non-health care workers advise (OR 3.053; CI: 1.706-5.463), not belonging to support groups (OR 2.804; CI: 1.620-4.854) rejection of health care workers support (OR 3.386; CI: 1.937-5.919). **Conclusion:** Although exclusive breastfeeding was the preferred feeding choice among the respondents immediately after birth, it was not sustained beyond the second month of the infant's life. Increased contact of HIV positive women with health care workers and professionals through promotion of trust in community health workers, attendance of ANC and delivery in hospital should be promoted. Education efforts should also target non health care persons who influence feeding practices to reduce stigma among HIV positive mothers.

Keywords: Infant feeding practices; Stigma

Background

Over 95% of new HIV infections occur in the developing countries where there is limited access to treatments that prolong life. The risk of mother to child transmission of HIV remains high in poor-resource settings where childbirth with professional guidance and complete avoidance of breast-feeding are not universally available (Helene D, 2001). HIV-infected pregnant women struggle with the decision of feeding practices to adopt for their unborn infants since commonly practiced feeding options differ from community to community. World Health Organization (WHO) recommendations stipulate that more than one option be discussed during infant feeding counseling, based on individual situation so that the feeding option's advantages and disadvantages are well understood. Guidelines recommending exclusive breastfeeding for HIV exposed infants in conjunction with maternal ART in low resource settings for first 6 months and EBF combined with complementary feeding from age 6 to 12 months (WHO 2005, 2010) are currently in place. Replacement feeding, though expensive and unavailable in developing countries, has been shown to decrease HIV transmission to infants (Nduati et al., 2000). Furthermore, it has been found that HIV positive mothers are more likely to feed their babies with modified animal milks compared to their HIV negative counterparts during the first week of birth, which is also related to mothers' morbidity (Anita et al, 2005). Stigmatization of mothers who choose alternative feeding in some communities makes it hard for many women to fully adhere to recommended infant feeding practices. This leads to mixed feeding hence compromising Prevention of Mother to Child Transmission (PMTCT) objectives (Chopra M & Rolins N, 2008).

The HIV pandemic has brought a lot of changes in policy guidelines and information flow. At the community level, mothers experience information pass-over through advice from mostly relatives and peers. Despite this, efforts to promote exclusive breastfeeding for optimal nutrition during the first six months of an infant have been universally emphasized amidst all the challenges. In Kenya, breastfeeding is nearly universal with about 97% of children being breastfed in the first two years. However, it's noted that complementary feeding among newborns in developing countries begins as early as one month old (UNAIDS/WHO, 2011; KNBS, 2010). At the same time, due to regular updates, health care systems continuously disseminate different information. Thus, there is need to assess the extent of professional postpartum support for infected mothers to

correctly guide them on infant-feeding practices. It is clear that the effort to promote this is hampered by the diverse environments that HIV positive mothers reside in. Therefore, this study set out to evaluate the factors that are associated with choice of infant feeding practices among HIV-1 positive post-natal clinic attendees with the county.

Materials and methods

This was a cross-sectional study. The study population comprised HIV positive post-natal clinic attendees bringing their infants to the clinics within three division healthcare facilities of Tharaka Nithi County. The infants were aged between six weeks and 12 months. Health care workers assisted in identification of the study subjects. Primary data was obtained from the sampled respondents using open and closed ended structured questionnaires. Secondary data for the infants' HIV status (based on PCR results) was abstracted from the infant's hospital records. Focus Group Discussions and Key Informant Interviews were carried out to support the primary data from the respondents.

Data analysis

Statistical analysis was done using Statistical Package for Social Sciences software (SPSS) version 16. Quantitative data from interview schedules were coded and entered into the database. Descriptive analysis was done to determine percentages and proportions of the quantitative variables. A bivariate analysis was used to determine differences in feeding practices at the time of data collection. Qualitative data from key informant and focus group discussions were analyzed based on themes and presented as direct quotes from the respondents.

Ethical consideration

Research and ethical clearance to conduct the study were obtained from the institutional review boards of Maseno University and Kenya Medical Research Institute (KEMRI). Approval was also sought from the Medical Officer of Health (MOH) in the district who facilitated the study through the District AIDs and Sexually Transmitted Infections Coordinators (DASCO). An informed consent was sought from the respondents where confidentiality and anonymity was assured to them.

Results

Demographic Characteristics of Respondents

Two hundred and forty nine HIV-positive mothers were recruited. No male partners accompanied the mothers to the clinics. Majority of the mothers delivered in a health facility 206(82.7%) while 43(17.3%) delivered at home. Most of the women first learnt of their HIV status while attending the ANC, 178 (71.5%). Fifty nine mothers (23.7%) had known their status before pregnancy. Twelve mothers (4.8%) first learnt of their status at delivery. The other demographic characteristics are summarized in **Table 1**.

Feeding practices

At delivery, 244(98%) mothers reported to be exclusively breastfeeding. Five mothers (2%) opted to practice replacement feeding. During the focus group discussion, most respondents affirmed that replacement feeding was not a common practice in the region:

“ I chose to breast feed since it will be affordable comparing to replacement feeding.” views from a 30 year old mother;

Figure 1 shows infant feeding practices among mothers whose infants were aged six months and below at the time of interview (n=184). It was observed that exclusive breast feeding practice decreased and mixed feeding practice increased, especially after the second month of age. Replacement feeding remained constant from birth through six months as no more infants were introduced to the practice.

An assessment of practices in relation to the demographic characteristics showed that feeding practices were associated with the age of respondents ($p<0.001$), age of infants ($p<0.003$), education level of mother ($p<0.002$) and source of income ($p<0.003$) but not with marital status. Mothers aged between 26 and 30 years had the highest frequency in the group of mixed feeding 32(12.9%), while a majority of those between 31 and 35 years 39(15.7%) (n=39) practiced EBF and 17(6.8%) practiced mixed feeding. The frequency of mixed feeding among respondents with a lower education level (Informal/primary) was 21.7%, compared to only 12.4% or 3.2%, among those who had some secondary or tertiary education respectively. A summary of these variables are indicated on **Table 2**.

Infant feeding challenges and health seeking behavior

These were obtained from the themes of key informant and focus group discussions. Respondents reported that they always had to be close to their infants before they were 6 months because of the risk of introduction of other foods by other caregivers:

“When practicing exclusive breast feeding and one leaves the baby under someone else’s care, the child is likely to be given foods other than the breast milk” Focus group discussants.

Others echoed that it was also expensive to sustain both exclusive and replacement feeding practices:

“... . Besides having the infants to take care of, we also have to live positively with our current health status.” a 20-year-old focus group discussant.

Key informants reported that a major challenge in adherence to recommended feeding practices leading to early weaning was mothers’ lack of moral and social support in trying to explain their situations to curious persons who may be wondering why the baby may cry and not get weaned. This is so because crying of an infant is associated with starvation due to lack of enough breast milk:

“We give them the right information on available options and leave the mothers to make their choices but cannot verify if they practice the right thing since there is no home setting follow-up to evaluate compliance.” key informant.

On the nutritional front key informants affirmed that mothers were not willing to disclose their HIV status and lack of knowledge on the benefits of practicing the right choices contributed to their situation.

Stigma influenced how the mothers behaved in terms of infant feeding practice as majority of respondents indicated that they made decisions by themselves. However, a nutritionist key informant indicated that stigma played a role in having mothers’ breastfeed for at least six months; thereafter they stopped and maintained that this was advice from clinics.

Major factors influencing choice of feeding practice

Logistic regression model was constructed for bivariate analysis exclusive breastfeeding as the dependent variable as indicated in **Table 3**. Factors contributing significantly to the early cessation of exclusive breast feeding were included on as independent variables where $P < 0.05$ was considered significant. Five of the ten assessed factors were significantly associated with influencing the mother’s decisions in the choice of infant feeding practices. Respondents who had some primary school or incomplete secondary school education were 2.6 times unlikely to practice exclusive breast feeding for the first six months compared to those respondents who had completed secondary school or tertiary level of education (p value 0.05).

Respondents who were influenced by a non health care worker were 3.05 times unlikely to practice exclusive breast feeding for the first six months (p value 0.001) compared to those who consulted the health care workers. Other significant factors included the role of community health workers support acceptance (p value 0.001) and either or not belonging to a support group (p value 0.001). The other considered factors are indicated on table 3.

Discussion

Adherence to the recommended infant feeding is known to reduce infant morbidity and mortality even though recommendations are not widely practiced in resource limited regions. Our study demonstrates that Exclusive breastfeeding was the favorable choice of infant feeding practice for majority of the respondents immediately after delivery with few opting for replacement. These findings concur with similar findings reported elsewhere (Victor Mogre, 2016; Sethuramank, 2011).

However, weaning of infants occurred as early as 2 months of the infant’s life.

In Kenya, it has been shown that supplementation of breast milk starts early with 60% of children aged 4-5 months being given complementary food. Only 32% of children less than six months of age are exclusively breastfed (KNBS, 2008-9; Lars et al 2009).

Common reasons given for early weaning included the ill health of the mother and the crying of the baby as indicators of a hungry baby. This may have led to the perception that the women do not have enough milk due to their health status hence the babies are not well fed (Obermeyer et al., 1996; Levy et al., 2010).

Coping with other health related issues in practicing exclusive breastfeeding or replacement feeding translated to high costs hence the believe that in order to sustain exclusive breastfeeding, there was need to be close to their infants (Leshabari et al., 2007; Maryam Al-Mujtaba et al, 2016). There was little moral and social support to the mothers as they implemented their choices. This might be due to stigma associated with HIV status disclosure; though some studies have shown that disclosure brings about family support and improves adherence to infant feeding options (Medley et al., 2004; Doherty et al., 2006).

Most women made decisions on infant feeding practices without consulting. Family members were least likely to be consulted due to fear of stigmatization. Culturally, there were no beliefs that presented a barrier to the utilization of antenatal clinics hence almost all respondents reported having attended (Mohammed et al., 2010). However, although majority of the women attended antenatal clinics, there were home deliveries. It has been reported that mothers who give birth at home may have less contact with trained health care personnel and have less awareness of appropriate feeding practices since they may not be aware of their HIV status (Edmond et al., 2005; Katushabe 2006; Mucheto et al., 2011). Similar to the findings of the current study where majority of

mothers first tested for HIV during antenatal clinic visits, it has been found that despite knowledge of sources of HIV testing in Kenya, only a small percentage of women still had ever tested for HIV (KNBS 2008-9) while KDHS, 2014 reported an overall 67 percent of pregnant women receiving HIV counseling, an HIV test, and the results during ANC for their most recent births.

for their most recent birth in the two years preceding the survey. In Kenya, most HIV-infected persons did not know their status (NASCO, 2007). In this study it was found that few respondents had joined support groups while health workers in the district reported that time pressure and workload hindered them from gaining adequate insight into the mother's personal circumstances to support them in practicing appropriate feeding choices. This led to lack of follow-up. Most mothers rejected Community health workers due to lack of confidentiality. As such adherence was a problem (Nkonki and Daniel 2010). Lack of Postnatal support and influence by non-healthcare providers were major factors influencing choice of feeding mode. In spite of some mothers preferring not to belong to a support group, or to accept services of community health workers, other sources of support influenced feeding options (Fadnes et al., 2010).

In this study respondents with low education were more likely to wean the infant before six months as observed by Joan et al 2008 in a study which showed that HIV-infected woman who were more educated had better infant feeding decisions. In the effort of making crucial clinical advances in reducing risk of transmission WHO has frequently revised PMTCT guidelines hence sharing of crucial information by peers who are non-health care providers may pass wrong information hence the need for health care workers to play a key role in providing correct information on PMTCT and supporting women's infant feeding choices to adhere to guidelines (Maman et al., 2012). Only few respondents felt the importance of joining support groups within their community and similarly felt the usefulness of community health care worker in supporting them as they implement their chosen feeding practices even though other studies have reported that encouraging HIV positive mothers to join HIV mother support groups helped them to gain confidence to overcome external pressures to practice inappropriate infant feeding (Maryam Al-Mujtaba et al, 2016).

Conclusions

Despite choosing exclusive breastfeeding immediately after birth, most mothers did not sustain it beyond the second month of some infants' life. Only one third of met the WHO guidelines beyond the second month. Among the challenges leading to this included the feeling that they had to be with their infants most of the time to sustain exclusive breast feeding, coping with their health related issues and presence of stigma. The health seeking behavior of mothers was dependent on what they perceived to be good for their infants. Hence the major factors that influenced choice of infant feeding practices were education level, non-healthcare workers advice, support by CHWs and membership to support groups. These factors should be targets in attempts to improve choice of recommended breast feeding options in developing countries like Kenya.

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REFERENCES

- Chopra, M., & Rollins, N.,(2008). Infant feeding in the time of HIV: rapid assessment of infant feeding policy and programmes in four African countries scaling up prevention of mother to child transmission programmes. *Archives of Disease in Childhood* 93:288-291.
- Doherty, T., Chopra, M., Nkonki, L., Jackson, D., Persson, L.A., (2006). A Longitudinal Qualitative Study of Infant-Feeding Decision Making and Practices among HIV-Positive Women in South Africa. *Journal of Nutrition*. 136 (9):2421-2426.
- Edmond, K.M., Zandoh, C., Quigley, M.A., Amenga-Etego, S., Owusu-Agyei, S., Kirkwood, B.R., (2005). Delayed breastfeeding initiation increases risk of neonatal mortality. *Pediatrics*. 117:e381
- Fadnes, L., Engebretsen, I., Moland K,Nankunda, J., Tumwine, J., and Tylleskär, T., (2010). Infant feeding counseling in Uganda in a changing environment with focus on the general population and HIV-positive mothers. A mixed method approach. *BMC Health Services Research*,10: 260.
- Gayle, H.D., Hill, G.L., (2001). Global Impact of Human Immunodeficiency Virus and AIDS. *Clin Microbiol Rev*. 14(2): 327–335.
- Joan, N. M., Dankwart, F.W., Jennifer, D.M., Bridget, J., Una, E.M., Brian, W.C., (2008). Psychosocial and economic determinants of infant feeding intent by pregnant HIV-infected women in Tshwane/Pretoria.

- South African Journal of Child Health, 2:3
- Katushabe, J., (2006). Knowledge and attitude pregnant women have on the use of prevention of mother –to-child transmission of HIV (PMTCT) services in Mbale regional hospital – antenatal clinic. Dissertation, Makerere University
- Kenya National Bureau of Statistics (KNBS) and ICF Macro. Kenya Demographic and Health Survey (KDHS) 2014. Calverton, Maryland: KNBS and ICF Macro.
- Kenya National Bureau of statistics (KNBS) and ICF Micro, (2010): Kenya Demographic and Health Survey 2008-9. Calverton, Maryland: KNBS and ICF Macro.
- Lars, T., Ingunn, M.S., Henry, W., Nulu, B. S., Thorkild, T., and James, K. T., (2009) Infant feeding among HIV-positive mothers and the general population mothers: comparison of two cross-sectional surveys in Eastern Uganda BMC Public Health. 9:124).
- Leshabari, S. C., Blystad, A., Moland, K.M., (2007). Difficult choices: infant feeding experiences of HIV-positive mothers in northern Tanzania. Journal of social aspects of HIV/AIDS research alliance,4(1):544-555
- Levy, J., Webb, L., Sellen, W., (2010). "On our own, we can't manage": Experiences with infant feeding recommendations among Malawian mothers living with HIV. Int Breastfeed J. 5:15
- Maman, S., Cathcart, R., Burkhardt, G., Omba, S., Thompson, D., Behets, F., (2012). The infant feeding choices and experiences of women living with HIV in Kinshasa, Democratic Republic of Congo. AIDS Care, 24:2, 259-265
- Maryam Al-Mujtaba., Nadia, A., Sam-Agudu., and Rose Khatri. Barriers to the practice of exclusive breastfeeding among HIV-positive mothers in sub-Saharan Africa: A scoping review of counseling, socioeconomic and cultural factors; Journal of AIDS and HIV Research, vol 8(6), pp. 70-79, 2016
- Medley, A., Garcia-Moreno, C., McGill, S., Maman, S., (2004). Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother to child transmission. Bull World Health Organ. 82:299-307.
- Mohammed, A., Shehu, U., Aliyu, A., Zoaka, I., (2010). Infant feeding options, practices and determinants of feeding practices among HIV seropositive mothers in Abuja, Nigeria. Niger Med J . 51:14-7
- Mucheto. P., Chadambuka, A., Shambira, G., Tshimanga, M., Gombe, N., and Nyamayaro, W.,(2011). Determinants of nondisclosure of HIV status among women attending the prevention of mother to child transmission programme. Pan African Medical Journal. 8: 51
- National AIDS and STI Control Programme (NASCOP), Ministry of Health, Kenya. Kenya AIDS Indicator Survey (KAIS) 2007:
- Nduati, R., John, G., Mbori-Ngacha, D., (2000). Effects of breast feeding and formula feeding on transmission of hiv-1: A randomized clinical trial. Journal of the American medical association 94: 1167-1174.
- Nkonki, L., Daniels, K., PROMISE-EB Study Group., (2010). Selling a service: experiences of peer supporters while promoting exclusive infant feeding in three sites in South Africa. International Breastfeeding Journal, 5:17.
- Obermeyer, C., and Castle, S., (1996). Back to nature? Historical and crosscultural perspectives on barriers to optimal breastfeeding. Med Anthropol. 17:39–63.
- Sethuraman, K., Hammond, W., Hoang., Dearden, K., Nguyen, M., Phan, H, Nguyen N., (2011). Challenges for Safe Replacement Feeding among HIV-Positive Mothers in Vietnam: A Qualitative Study of Mothers, Fathers, Health Care Providers, and Other Experts. Boston university school of public health
- Shankar, A.V., Sastry, J., Erande. A., Joshi, A., Suryawanshi, N., Phadke, M.A., Bollinger RC. (2005). Making the choice: the translation of global HIV and infant feeding policy to local practice among mothers in Pune, India. Journal of Nutrition. 135: 960-5
- UNAIDS/WHO (2011): AIDS epidemic update. www.UNAIDS.org
- Victor Mogre., Michael Dery., and Patience, K.G. Knowledge, attitudes and determinants of exclusive breastfeeding practice among Ghanaian rural lactating mothers, international Breastfeed Journal. 2016; 11: 12.
- WHO (2005). Infant feeding patterns and risks of death and hospitalization in the first half of infancy: multicentre cohort study. Bulletin of the World Health Organization. 83(6): 418-426
- WHO (2010). New guidance on prevention of mother-to-child transmission of HIV and infant feeding in the context of HIV.

Table 1 Demographic characteristics and Health seeking behavioral factors that influence choice of infant feeding among postnatal clinic attendees in Meru South district, Kenya

Characteristic	Category	Frequency (n, %) N = 249
Age of respondents (Years)	20 - 25	55 (22.1)
	26 - 30	68 (27.3)
	31 - 35	77 (30.9)
	36 - 40	33 (13.3)
	41 - 45	16 (6.4)
Infants age (Months)	≤ 1	24 (9.6)
	2 - 4	75 (30.2)
	5 - 6	85 (34.1)
	7 - 8	15 (6.0)
	9 - 10	15 (6.0)
	11-12	35 (14.1)
Infant HIV status	Positive	71 (28.5)
	Negative	178 (71.5)
Marital status	Single	61 (24.5)
	Married	188 (75.5)
Level of education	None/primary	96 (38.6)
	Secondary	131 (52.6)
	Tertiary	22 (8.8)
Who influenced choice of feeding practice	Nurse(clinic)	67 (26.9)
	Friends	29 (11.6)
	Family	38 (15.3)
	Self	115 (46.2)
	Yes	244 (98.0)
ANC attendance	No	5 (2.0)
	Home	43 (17.3)
Place of delivery	Hospital	206 (82.7)
	ANC profile	178 (71.5)
First HIV status diagnosis	At delivery	12 (4.8)
	Before pregnancy	59 (23.7)

Table 2 Feeding practices among postnatal clinic attendees in Meru South district, Kenya

Variable	EBF n (%)	RF n (%)	MF n (%)	p value
Age of the respondents				
21-25	22(8.8)	15(6)	17(6.8)	p<0.001
26-30	18(7.2)	19(7.6)	32(12.9)	
31-35	39(15.7)	21(8.4)	17(6.8)	
36-40	7(2.8)	5(2.2)	21(8.4)	
41-45	0	10(4)	6(2.4)	
Age of infant				
0-1 months	12(4.8)	6(2.4)	13(5.2)	p<0.003
2-4 months	45(18.1)	7(2.8)	31(12.4)	
5-6 months	27(10.8)	11(4.4)	23(9.2)	
> 7 months	2(0.8)	46(18.5)	26(10.4)	
Marital Status				
Single	16(6.4)	18(7.2)	27(10.8)	p<0.259
Married	70(28.1)	52(20.9)	66(26.5)	
Education level				
None/primary	29(11.6)	13(5.2)	54(21.7)	p<0.002
Secondary	46(18.5)	54(21.7)	31(12.4)	
Tertiary	11(4.4)	3(1.2)	8(3.2)	
Source of income				
Employment	6(2.4)	7(2.8)	3(1.2)	p<0.003
Farming	51(20.5)	22(8.8)	39(15.7)	
Casual	29(11.6)	41(16.5)	51(20.5)	

Table 3 Factors influencing choice of feeding practice among postnatal clinic attendees in Meru South district, Kenya: Bivariate analysis

Variable	Non-EBF n=166(%)	EBF n=83(%)	Odds Ratio	95% CI	p value
Marital status					
Married	121(48.6)	67(26.9)	0.642	0.337-1.222	0.212
Single	45(18.1)	16(6.4)			
Education					
Primary/2 ^o Incomplete	156(62.7)	71(28.5)	2.637	1.088-6.388	0.050
2 ^o /Tertiary	10(4.0)	12(4.8)			
Income					
Not employed	157(63.1)	76(30.5)	1.607	0.576-4.478	0.414
Employed	9(3.6)	7(2.8)			
Influence to change by:					
Non health care worker	134(53.8)	48(19.3)	3.053	1.706-5.463	0.001
Health care worker	32(12.9)	35(14.1)			
Monthly Income					
< Ksh 3000	159(63.9)	71(28.5)	3.839	1.451-10.160	0.006
> Ksh 3001	7(2.8)	12(4.8)			
Delivery					
Hospital	139(55.8)	67(26.9)	1.229	0.621-2.436	0.595
Home	27(10.8)	16(6.4)			
Residence					
Rural	109(43.8)	57(22.9)	0.872	0.496-1.533	0.671
Urban	57(22.9)	26(10.4)			
Support by CHWs					
No	126(50.6)	40(16.1)	3.386	1.937-5.919	0.002
Yes	40(16.1)	43(17.3)			
Support group membership					
No	120(48.2)	40(16.1)	2.804	1.620-4.854	0.001
Yes	46(18.5)	43(17.3)			
HIV status knowledge					
During pregnancy	129(51.8)	61(24.5)	1.257	0.684-2.312	0.528
Before pregnancy	37(14.9)	22(8.8)			

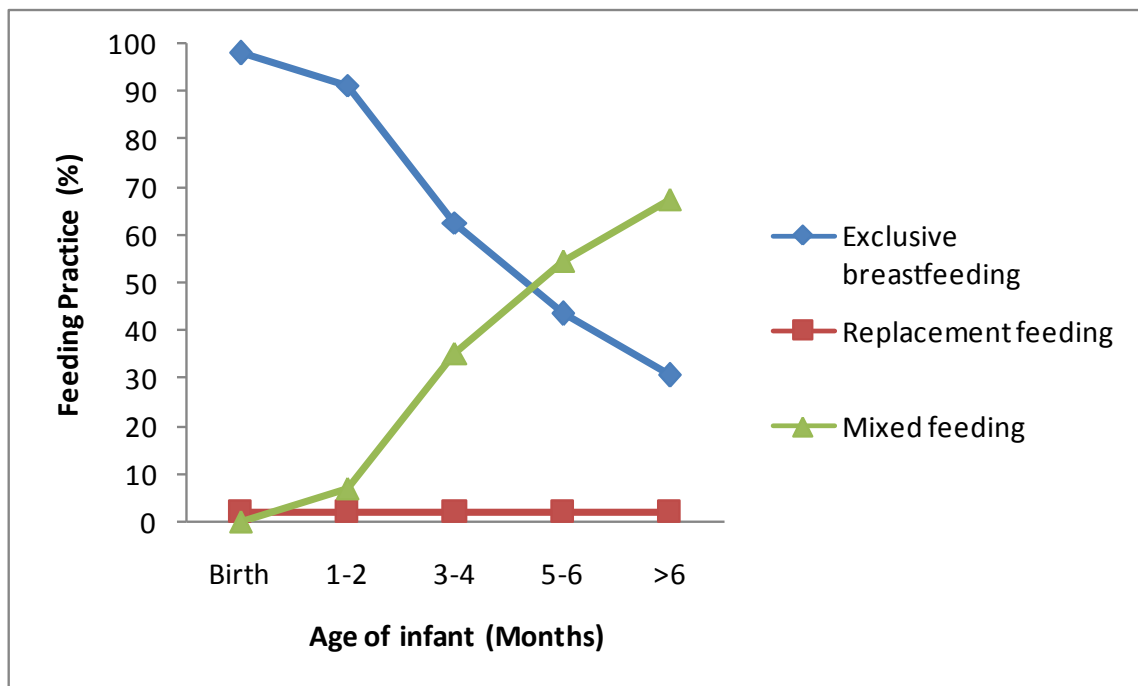


Figure 1. Feeding practices for children aged below six months (n=184)