CHAPTER - II

REVIEW OF LITERATURE
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Before deciding upon the plan and procedure to study, first a study of the related material was made. The review of literature helps the researcher to get herself more acquainted with the subject matter and channelise efforts in a desirable direction. Therefore the investigator collected relevant studies and presented under the following heads.

2.1 Information about hospitals.
2.2 Information of mothers.
2.3 Anthropometric measurements of newborns.
2.4 Socio-economic status of mother.
2.5 Caretakers of newborns.
2.6 Feeding practices of newborns.
2.7 Toilet practices of newborns.
2.8 Bathing and Dressing practices of newborns.
2.9 Clothing of newborns.
2.10 Sleeping of newborns.
2.11 Factors related to nursing practices of newborns.

2.1 Information about hospitals.

Guttmacher (1957) pointed out that in developed countries like United States of America, a baby has virtually 99% chance of being
formed perfectly after birth. But Devdas (1968) found that in developing countries, basic problems of maternal and child health are due to the absence of maternity centres or inadequate trained midwives and the delivery itself considered to be unclean phenomenon. WHO reported that the proportion of deliveries attended by trained health personnel ranges from 23.8% to 97% in the Latin American countries. But the presence of a trained person during delivery in other countries ranges from 13% to almost 100% in countries where data are available and that even within regions there is great variation. In developing countries, the trend has been largely towards increasing institutional deliveries. Therefore, a number of services and strengthening of services is necessary.

A study carried out in a general hospital of a district of Columbia reported that 41.5% infants had been separated from their mothers immediately after delivery. This early and prolonged neonatal hospitalization interfered with the development of natural maternal infant bonding, and upset early successful lactation (Fomufod et al, 1975) and Garbe and Martin (1983) studied on influence of hospital in the care of newborns and found that the immediate breast feeding after the delivery influenced by the rooming in-system of hospital. A research evidence has emerged that mother’s presence with baby in nursing home did not increase the risk of infection and proper care and immunization by well trained hospital staff (Chinn, 1979).

Dudani and Chandra (1979) conducted a study on the work output of paramedical workers of health training centre Naila, during 1971 to 1976, and concluded that there was improvement in the work output by sanitary inspector and health educator. It was observed in terms of increase number of wells; disinfected, construction of soakage pit and installation of sanitary latrine in health centre, which affect the health of mother and child.
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Falkner et al (1984) found that in hospital specially in public hospitals of California, 50% of the deliveries were performed by midwives and the rest by doctors. Biological, physical and social environment of hospital and lack of access of health care services were depend upon the risk factors of newborn child.

Bhatnagar (1988) studies on maternal and child health status and patterns of health care in urban slums of Delhi and indicated that low level of mother-child health services indicate the poor health of women and children in Urban Slums of Delhi.

In a recent survey conducted by the National Neonatology Forum, found that neonatal care facilities are rather dismal in most teaching institutions. It was indeed shocking to learn that several major hospitals were not equipped even with the basic tools of newcare. The neonate is not allocated the status of a ‘bed’ in the hospital and is merely considered as a byproduct of pregnancy (Singh, 1989).

Kain (1992) studied on care for the mother and child, during and after delivery and found that rooming in or the practice of keeping mother and child in separate rooms and permitting ‘visits’ only according to schedule in the hospital permits early breast feeding, feeding on demand allows for close contact with father and other family members and minimise the risk of neonatal infection.

A research study on primary health care of maternal and child in health care centre conducted by Tarimo (1991) reported that action of improvement in the health of children and mothers had a great impact on the health of the community. Khandekar et al (1993) study revealed that education of parents of newborns had influenced on the uses of service of trained medical personnel and to trust in hospital services.
Jani (1994) reported that government nursing and maternity homes in Bombay generally had no vacancy. Therefore most of the mothers have to rush in private hospital of poor status.

2.2 Information of mothers.

A study of Jepson et al (1976) found that there was a reason to increase the number of mother's breast feeding by education of the expectant mother in antenatal classes in clinic and improving help given to the mother by health personnel. Garbe and Martin (1983) indicated that the way of delivery had no influence on the breast feeding behavior.

A report of UNICEF in 1980 reported that an Indian women, undergo 6 to 7 pregnancies on an average, resulting in 5 to 6 live births of whom 4 to 5 survive. She thus spends the greater part of her reproductive years in pregnancy and lactation. The foetal wastages as in abortion, intra-uterine deaths and still births, occur in about 20% of conceptions among poor communities. These very groups tend to have low birth weights and a perinatal mortality rate ranging from 50-70% per 1000 live births (Devdas, 1993).

Falkner and Manciaux (1984) studied on Prevention of Perinatal Mortality and Morbidity and found that the age of mother, history of still births, abortions, chronic disease of mother, previous neonatal deaths and previous cesarean history were associated factors.

World Fertility Survey had shown that there is relationship between short birth intervals and infant mortality (Grant, 1984). Omran et al (1976) found that infant mortality is high, when the interval between the births was less than one year. A study on Nutrition, Fertility and Mortality conducted by National institute of
Nutrition (Anonymous, 1988) reported that lower number of parity, proper birth space, better feeding at right time and no exposure to infection through breast feeding could be help to reduced morbidity and mortality of child in early life. Survey observed that fertility rates observed was more in Muslim community. Diggavi et al (1990) Walia (1979) Mehta (1979) opined that the basic cause of excess mortality among infant are the excessive fertility rates, poor perinatal care, low birth weight of baby, lack of colostrum feeding, low maternal weight.

Gangotra and Das (1989) analysed the determinants of infant mortality in a community of Gujrat and noted that age of mother at birth does have an effect on neonatal mortality.

Ramankutty (1990) found in his study that several socio-economic factors under lie the biological linkages between women’s position and child survival.

Joshi et al (1990) studies the practices among women during pregnancy and their hospital stay after delivery. It was observed that in practices, mother observed many of the advices given, a notable exception to this was the time of first breast feeding in their antenatal visits. But study of Anand et al (1991) showed that antenatal and perinatal motivation on breast feeding is a great help towards successful breast feeding.

Gupta (1992) found that the health of baby depend upon the health of mother. Therefore, it is necessary to strengthen proper maternal service. According to Singh (1989), Grant (1984) age of mother, no. of antenatal visits of mothers, interval between birth, no of parity, and previous history of mother had adverse effect on both to mother and the baby.

Pendharkar (1994) noted that newborns get nutrition and security from mother, so mother ought to take care of her baby’s
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health from birth day. Breast feeding is best food for newborn, and it is scientifically proved that mother would be more physically fit if she give breast feeding to her newborn.

2.3 Anthropometric measurements of newborns.

In a survey of over 300 mothers belonging to the poor socio-economic group in South India, it was observed that the mean birth weight of infants of the low socio-economic group was about 2.8 kg, while that of infants of the high Socio-economic group was about 3.1 kg. (Gopalan, 1961).

John and Joseph (1970) conducted a study on the birth weight of infants born in a hospital in Bombay, and revealed that Christian children were heavier than children born of Hindu or Muslim parents and the average birth weight of males (2505.3 gm) was significantly higher than that of females (2434.5 gm).

Mukharjee and Biswas (1970) investigated the probable relationship between the birth weight and demographic factors of the family of child. It was found that there was tendency for the birth weight to increase with parity upto 4th para. And positive relationship upto the age of mother of 25, but after that it showed a tendency for the birth weight to decrease, with advancing age. And the average birth weight for male was found to be 6.01 lbs and for females 5.91 lbs. It further showed that birth weight was found higher in the economically better group.

Pachauri et al (1971) and Shrotriya et al (1981) observed definitive trend between the maternal weight and the birth weight, and between the per capita income and birth weight. Vijayaraghawan (1976) concluded that Indian infant starts life with a handicap even from birth because average birth weight of infants born to mothers of
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Low-income is 2800 gms as against 3200 gms in the high-income group.

Pachauri et al (1971) did a multifactorial approach to study the factors influencing birth weight in the urban community of New Delhi and in this study 31 factors which are determinants of birth weight were grouped into 5 categories. A direct co-relation was found between mother's age, her parity and weight to birth weight of child.

Vijayaraghawan (1976) concluded that Indian infant starts life with a handicap even from birth because average birth weight of infants born to mothers of low-income is 2800 gms. as against 3200 gms. in the high-income group.

National Institute of Nutrition (Anonymous, 1984) reported that infants born to poor Indian mothers had found low weight at birth 2.8 kg. or even 2.5 kg. upto the first six months, Indian infants grew at the same rate as western infants. That was because he obtained good nutrition only through breast milk during early infancy and later on weight of Indian infants declined.

2.4 Socio-economic status of mother.

A survey conducted in Andhra Pradesh, West Bengal and Gujrat in 1976 to 1977 by Ramnath (1980) observed that maternal education level had an influenced on the number of live births and childhood mortality. The average number of children even born to women, were found to be higher among those who had lost a child or more as compared to those who had not. The inverse relationship between maternal education level and child mortality was found in this study.

An Information of the World fertility surveys and the Demographic and health surveys in 1977-78 was presented by Irma,
et al (1986). It showed that economic circumstances are likely to have influenced behaviour among the poor and the uneducated like the more socio-economically advantaged women, these women were more likely to ever breast fed their children and to start in earlier period in the mid-1980's than a decade earlier, although the increases were of smaller magnitude. And Vijayalaxmi (1981) studied relation between lactation and socio-economic factors and concluded that income group did not influence the breast milk output. Cameron and Halvander (1983) pointed out that mothers from a lower socio-economic level generally deliver infants of lower birth weight, prematures infants and small-for-date infants are more likely to get infections and possibility to die. The newborn babies allowed to suckle at the breast within the first half hour, improve the health. A study in United States in 1974, found that race had a strong effect on the distribution of the infant mortality rates. (Admchak and Robinson, 1986). Mahadevan (1985) found that income showed very high negative association with infant mortality in Harijans, but not significantly correlation found in Muslims and Hindus.

Rao (1988) found that higher the female literacy rate, lower is the infant mortality ratio. The literacy of mother also improves the nutritional status of mother. Chances of full term baby and improved child rearing practices and reduces infant mortality rate.

Gangotra and Das (1980) found strong negative association between mother's education and neonatal mortality. Poverty has been seen to be an over prevalent condition among the Scheduled Caste population, the average level of mortality is consistently higher for Scheduled Caste children as compared to children from general population.
Velhal et al (1990) found that maternal literacy and economic status seem to have some influence on breast feeding and feeding of prelacteals. Women who were illiterate and economically poor were against colostrum feeding. In a study of growth pattern of early infancy showed that socio-economic status influenced on birth weight, and health of baby (Diggvi, et al 1990).

A study of Lonare (1990) in Nagpur city showed that employed and joint family women have more knowledge about child birth and child rearing practices and Muthayya (1994) found that relation between infection influence on physical growth in early infancy due to poor socio-economic & environmental condition.

2.5 Caretakers of newborns.

Cross (1971) pointed out that early hospital discharge depend largely on the skill of the nurse or caretaker of low birth baby and also, the normal mother - baby relationship. Jelliffe (1976) found out that the doula or female assistant or caretaker of newborns, provides physical and emotional support and generates confidence, but she must have knowledge of mother-craft.

Prince and Adams (1978) showed that lack of knowledge of breast feeding on the part of health or nurses or caretakers and ignorance of members of family about lactation and the management of breast feeding, discouraged early breast feeding. Self conscious or uneasy incompany has minimised the maternal role as a caretaker of newborns. The practice of isolating newborns from mother is a direct heritage of the western system of medicine, but it discouraged early breast feeding.

Davidson (1980), found that the infant mortality had fallen from 97 to 39 per 1000 over the five years of the Jamkhed Project’s
operation, include proper care taken by nurses or caretaker, motivation of early breast feeding and hospital management.

A study of Jayachandran, and Jarvis (1986) indicated that the presence of informally treated health care personnel i.e. midwives as caretaker are more significantly related to low rates of infant mortality than are the employment status of women and the presence of formally trained health care personnel such as physicians.

Miller et al (1995) showed that the training of birth attendants among refugee Afghan women in Pakistan, provides an effective route for educating the women. Education on hygiene and health, reduces neonatal mortality and morbidity. In this study, breast feeding was started within an hour after delivery by 22 of the mothers out of 61. All the trained birth attendants know that colostrum is good for the baby.

2.6 Feeding practices of newborn s.

2.6.1 Initiation of breast feeding.

Karkal (1968) studied on pattern of infant feeding in greater Bombay at Demographic Training and Research centre. Commencement of breast feeding was found that a high proportion (66%) of mothers started breast feeding on the third day of their deliveries.

Smart and Bomford (1976) found in their study that eight percent of mothers started to breast feed, but had stopped by the time of discharge and mostly for non-medical reason. It must be a cause for concern that these mothers were not sustained even while they were ‘Captive’ in hospital. Miles (1976) also found that over 80% of mothers stated their choice of feeding was the result of self advice rather than advice from doctor, nurse or even a relative.
Prince and Adams (1978) found correlation between successful breast feeding and the social class of the mother. In a group of mothers delivered at home, breast feeding was more successful than those mothers who delivered at hospital. The normal hospital routine of separation immediately after birth might interfere to the establishment and maintenance of breast feeding. When mother and baby are left alone with skin to skin contact for 45 minutes immediately after birth, breast feeding was successfully started early and for longer period.

Sharma (1981) studied on child rearing practices and child growth of Indian urban families. He conducted survey on sophisticated parents of upper middle class status, Gujarati Hindu families. Study found that 95% mothers breast fed their babies initially.

A study was carried out by Rao and associates (1981) on mothers selected on a systematic random basis from among 2000 families, living in subcentre area in Hayat nagar block, near Hyderabad City and found that the colostrum was not rejected in 88.6% of the sample. Small number of the mothers reported that they fed other milk since breast feeding started only on the third day.

An explorative study covering about 100 Bhil families in Jhabha district and 100 Gond households in Bastar district was conducted by National Nutrition Monitoring Bureau (Anonymous, 1983). Infant rearing practices are found to be conductive to good nutritional status of this group. Colostrum is not discarded and while breast feeding continues for as long as possible.

At the three centres, Bombay, Calcutta and Madras, a study was carried out and found that the variation at Bombay, were seen more among infants. Calcutta shows by far the best picture and
Madras too comes no where near it. The highest percentage of infants breast fed on the first day at Madras (31%) was lower than the lowest at Calcutta, and in Bombay, it was only 5% (Gopujkar, 1980).

Gnanasundaram and Santhanakrishnan (1986) conducted survey in urban slums in Madras in 1971, 84% of mothers started breast feeding their babies from the first day of their birth. And in a study of two entire slum centrally located in Coimbatore city with the total population 1224 with 280 household, it was seen that all the mothers given breast feeding except three percent, who had no breast milk (Ramisetty, 1988).

Study of Pant and Chuthia (1988) on the knowledge of mothers belonging to high income groups of urban area indicated that only half the mothers breast fed their babies on the first day. Rajashree et al (1988) studied infant feeding and child rearing practices in Trivendrum district found that breast feeding were universal having been initiated within 24 hours in above 75% of women in all areas.

A study of maternal knowledge and practices in relation to breast in urban slums of Bombay found that 50%, 29% and 21% mothers breast fed their children on the first, second and third day respectively. 25% women were inclined to give colostrum (Velhal et al, 1990).

Siali and Verma (1990) carried out a study in slums of Ludhiyana city and concluded that colostrum was discarded by all the mother, 72.2% of mothers started breast feeding on the third day after parturition. Jalil and Lindbland (1991) conducted a study in slum area of the city of Lahore and surrounding villages, and concluded that breast feeding was initiated for 10% at 24 hours after birth. Almost 90% were breast fed 4-6 days after birth. In a study of breast feeding in babies delivered by caesarean section, breast feeding is
initiated in 1-2 hrs, 2-12 hrs, 12-14 hrs, 24-48 hrs, 48-72 hrs by 3%, 6%, 11%, 19%, 23%, 21% and 17% mothers respectively (Mathur, 1993).

Khan (1993) observed that cultural practices which support the general practice of delaying the initiation of breast feeding thereby depriving the baby from getting valuable colostrum and breast feeding started often after 48 to 72 hours in most of part of our country.

Singh (1993) carried out study on traditional society of Mizos, Nicobarese, Nairs of Kerala and Kashmiri pandits. All above groups traditionally discarded colostrum, but were now changing and using the first flow being developed.

Shah et al (1993) carried survey on 818 children belonging to Scheduled caste communities, residing in 44 villages of two districts of Haryana, and found that predominant and timely first breast feeding suckling rate is very low and top feeding rate is high.

A study on ignorance about breast feeding and a survey on Tripura tribal women was conducted and reported that 66% mother fed colostrum in six hours after delivery. This showed that this good custom and natural thinking changed in middle of 20th century in non tribal communities (Nadkarni, 1994).

Report on the promotion of breast feeding through routines and attitudes at maternity hospitals was presented by Hofvander & Hillervik (1995). The baby - friendly hospitals initiative was launched by UNICEF with support from WHO in 1990. Growth monitoring, oral rehydration and immunization programme have been very successful in Sweden. But breast feeding initiative programme is much more difficult to implement as it involves a large number of determinants. These include psychological and emotional factors within the woman.
herself, her position and status, economic factors, and the attitudes of
the health service and the public.

2.6.2 Reasons for avoiding first day breast milk.

Akhatar and Shukla (1985) observed that 32% Kashmiri
mothers were not satisfied with first flow of breast feeding, others
thought that breast feeding to be out of fashion. The mothers were
quite aware of the advantages of breast feeding. Colostrum was
thought to be heavy and indigestable initially. Mothers did not know
about the benefits and nutritive value of colostrum. Said report of
international collaborative study that a large number of rich Indian
women do not breast feed because of insufficient secretion of milk.
Anand (1985) also reported that higher the educational status of the
Indian mother, lower was the incidence of successful lactation.

A study carried out on 430 infants in an urban area by Kaur
(1990) indicated that 99 percent infant were fed wholly on breast, but
colostrum was discarded by 60.5 percent mothers as it was
considered impure milk. Mothers in urban area were aware of the
advantages of breast feeding but were ignorant about the nutritive
value of the colostrum.

Study of Singh and Pothen (1982) studied on slum children in
India, found that 20% newborns were put to breast within 24 hours.
80.19% were put to breast within a period ranging from 2-7 days after
birth because of the beliefs that the colostrum is stored for nine
months and poisonous, it is bluish in colour, dirty and thick and
therefore can't digested by newborn baby and get deposited and can
cause gastro-intestinal tract problems. The - colostrum was fed by
only 15.38% of the mothers and this was most probably because they
were delivered in hospitals and were educated by medical and
paramedical staff to start early feeding.
Joshi et al (1990) conducted study on the attitudes of medical professional in various disciplines. Simultaneously, actual practices of elite women were also surveyed among women during pregnancy and their hospital staff after delivery. It was observed that generally health care personnel, but not all, were aware of recent recommendations made by apex health bodies. In practice, mother observed many of the advices given, a notable exception to this was the time of first breast feeding.

A study was conducted on Urban and Rural women in and around Bangalore city. Most of the beliefs, customs and taboos appear to restrict mothers from providing the benefits of breast feeding to their infants. It was common practice to deprive children of breast feeding during the first two or five days of their life. The belief is that the milk is either not matured, inadequate for the child's needs the 'dirt' (amniotic fluid) which is accumulated in the child's stomach while in the womb 'pus' and spoiled milk, it will stick to the infants intestine and making it difficult for them to digest food and that it may cause colic and diarrhoea (Shariff and Farsana, 1990).

Gopalan and Puri (1992) reported that women especially those belonging to poor communities in our country followed traditional practice of breast feeding. It is certainly not necessary for us to educate them or preach to them on the virtues of breast milk. And hard economic realities compel them to stick to breast feeding. And it is observed that under the impact of industrialization and urbanization the salutary practices of breast feeding is today being endangered and mothers are confusing about initiation of breast feeding.

Manjure (1992) found that mothers in urban area have misconception about breast feeding. They believe that it may affect their
physical beauty, mother does not secret sufficient milk, and animal milk has same nutritive value. Therefore, most of the mothers prefer artificial milk feeding. A study on breast feeding practices amongst mothers having undergone cesarean section, found that nearly two third (65%) of mothers complained of insufficient breast milk secretion until 4th day after delivery. (Kapil et al, 1992).

In India, the colostrum was discarded by most of the mothers because of the general belief that it is heavy or not good for the child and the colour of the initial milk is not pure white, it supported their perception that in the first two days, mother’s milk is not pure and hence, it could harm the child (Khan, 1993).

A study of Tripuram (1993) reported that in most parts of our country, colostrum was considered dirty, harmful, heavy for baby. Therefore it is neglected by mothers. Mathur et al (1993) studied on breast feeding in babies delivered by cesarean section only. The commonest reason given by mothers for delay in initiating breast feeding was sedation and pain in stitches (100%). Other reasons were administration of intravenous fluids (8.4%), no milk secretion (8.2%), traditional of not giving colostrum for 2-4 days after delivery (69%), delayed rooming in (12%) and essential complete bed rest (13%).

A survey carried out in various villages of Udaipur district, found that breast milk was never given to the baby instead they were propogating the idea of discarding the milk and to start breast feeding only after the second or third day (Gupta and Gupta, 1993).

Nadkarni (1994) pointed out that only 22% of women lived in city and 18% of women lived in village fed colostrum to their newborn. only 40 women out of 167, fed colostrum who were delivered at city hospitals. 35% mothers considered that it is pus and dirty, 32%
mothers said it is harmful to newborns & it is not secreted in first
three days and it is not advised by doctor.

National Nutrition Monitoring Bureau found that millions of
infants in India, are exposed illness. Poor growth and early death by
the decline in early breast feeding. The feeling was avoided by mothers
because colostrum contain puss and blood. Some communities donot
feed colostrum to babies. (Theophilus and Doniel, 1994).

2.6.3 Reasons for starting early breast milk.

Thimmayamma et al (1980) found that mothers prefer breast
feeding and they opined that it is a healthy, strength giving and
nutritious food and contains all vitamins (43.2%), it is easily digestible
(32.6%), it does not cause any infection or disease and imparts great
resistance to infection (19.9%). It is convenient labour and time
saving and no problem with preparation as in the case with other
types of milk (14.8%). It allows for better growth of children (3.3%). It
is economical (2.7%), it is natural food and develops good mother -
child relationship (25.1%).

Grant (1983) reported that the percentage of mothers who
breast fed fallen down in too many developing countries, but a
majority of educated women in the industrial world are returning
overwhelmingly to the merits of early breast feeding. In Lahore, 10%
poor mother breast fed, but after motivation 80-90% of mothers
initiated within 24 hours after birth. (Jalil and Lindblad, 1991).

Swaminathan (1993) pointed out that the perceived trend of
decline in breast feeding in India, though still probably confined to
certain groups, has generally been attributed to lack of awareness of
its importance and value. As a result, the conventional approach to
the empowerment of women to breast feed, has rested mainly on
eradicating the supposed ignorance of mothers, a task which is seen as the responsibility of health professionals.

### 2.6.4 Schedule of breast feeding.

Venkatachalam and Rebello (1978) carried out a study on feeding pattern of new babies in the hospital, found that during the first week, the baby is nursed about 10 minutes on breast at each feeding. Intervals of feeding were irregular.

A study of Sharma (1981), conducted survey on upper middle class family and found that 60% of mothers breast fed on demand and flexible 40%. The longest breast feeding periods was reported in case of 'first child' and amongst the least educated mothers. Mothers showed wide variety of patterns in breast and bottle feeding. Very few mothers strictly adhered to the scheduled feeding.

Nursing care of children with pneumonia by Mayimbo (1990) found that an exclusively breast fed baby requires an average about 150 ml of breast milk per kilo of baby weight per day divided into eight, three hourly feeds are necessary.

### 2.6.5 Prelactial or first liquid food for babies.

A study carried out on mother and child, found that the baby is usually given boiled water with sugar or dilute milk during 24 hours in the hospital (Venkatachalam and Rebello, 1978).

A study of nursing practices of newborn found that many mothers think colostrum is 'bad milk' and refuse to feed the child. In many areas of India, various customs are in vague regarding the first feed offered to the baby. They give boiled cooled water and sugar / honey / jaggery water often by forced feeding (Arya, 1990).

A study of Sing and Pothen (1982) on slum children in India had found that the different prelacteal feeds used by mothers instead
of first few day's, were ghutti (47%), honey (19.09%), goat's milk (9.69%), Tea (8.89%), cow's milk (3.42%) and cow's urine (1.14%). Ghutti and honey were given to loosen the meconium with the belief that they help in clearing the gut of unhealthy contents presumed to have been swallowed during fetal life and other feeds are nutritious till the breast milk is established. Cow's urine was given because they consider cow as a sacred animal.

Park and Park (1985) opined that in some part of the country, the child is not put to the breast during the first 3 days of birth because of the belief that colostrum might be harmful; instead the child is put on water, jaggery and sugar solution. Cow's urine and sugar solution is preferred to feed instead of colostrum feeding. This is a custom prevalent in Gwalior region and Madhya Pradesh.

Mahadevan (1985) concluded that a few dangerous customs that cause infant mortality were particularly starving the baby for one to two days, not giving colostrum, giving castor oil, sugar water etc., which were likely to cause infections.

A study carried out by Akhatar and Shukla (1985) on breast feeding patterns and practices of mothers in a maternity ward of a hospital in Srinagar, showed attitudes of mothers about feeding. 50% of mothers gave colostrum as the first feed, whereas 50% gave boiled water with sugar or Kashmiri tea known as 'Kahwao'.

Rajashree et al (1988) studied in Trivendrum district, found that colostrum was not discarded by the majority of mothers, but prelacteal feeds were given by about 98%, sugar water being the commonest. In survey on maternal attitudes and practice in initiation of newborn feeding by Kumari et al (1988) indicated that only 16% newborns were fed colostrum. The prelacteal feeds were used in 76.9% babies.
A study on breast feeding practices and its implication for promotional activities, indicated that prelacteals feeds were used in less than 25% babies. These feeds were given mostly by nursing staff in the nursing ward. (Kumar et al, 1989).

A study on feeding of newborn child and their relation with traditional beliefs practices in Karnataka showed that the practice of prelacteal feeding was prevalent. They were honey, jaggery, sugar and glucose water, animal milk and commercial powdered milk. Some of these feeds act as the rehydrating agents. Over three fourths of the urban respondents used commercial milk, and concoctions, including glucose and gripe water (Shariff and Farsona, 1990).

Velhal et al (1990) studied on Maternal knowledge and practices in relation to breast in urban slums of Bombay and found that 89-96% offered prelacteal feeds to their children.

Kaur (1990) indicated that the first feed of honey and sugar water was given one to two time after birth in urban area. Whereas Siali and Verma (1990) carried study on infant feeding in slums of Ludhiyana city, showed that ‘Janam ghutti’ was the main prelacteal feed.

Mathur et al (1993) studied on breast feeding in caesarean section and found out that only 5% mothers gave breast feeding as the first feed. Prelacteal feeds included powder milk (69.5%), cow’s milk (10.5%), glucose water (13.7%), plain water (25.3%) and honey (10.5%).

Khan (1993) found that lack of knowledge about cleanliness and hygiene, and prelactation practices could easily cause infection and thus number of cultural practices which contribute to the continued high infant mortality rate in India. Prelactation food includes beverages like tea, boiled water, honey, sugar/jaggery or
glucose with plain water, cow/buffalow milk etc. And it is fed to the baby with the help of a piece of cotton and fingers are used to feed honey.

Tripuram (1993) found that in India, prelacteal feeds were usually given in the form of honey, ghee, butter, jaggery, sugar water, milk or a combination of any of these were widely prevalent. These were given with finger, cottonwick, spoon, bottle, special devices like ‘paladey’, usually without any concern for hygiene. Reasons for giving prelacteal feed were found that breast milk output was presumed to be poor during the first few days. And babies were given janam ghutti either as pre-lacteals feed or even later after a variable period. Common ingredients are turmeric, ghee, saunf (Aniseed), hirda, ajwain (Parsley) etc. but a few contain opium derivatives also. It was considered to be of special value in prevention and treatment of abdominal problems of the newborn.

Gupta and Gupta (1993) studied on practices imparted to rural mothers in the care of newborn. Mothers were given ‘Janam ghutti’ as the first feed to be given to the child followed by liquid prepared from turmeric and neem leaves and other herbs.

2.6.6 Artificial milk feeding.

Davidson (1975) pointed out that taboo against suckling breast milk was coming from Europe to India and artificial feeding in a community encouraged when food industry was capable of producing commercial milk powder of high quality in large amount and mothers had equipment to prepare each feed in 19th century.

Thimmayamma et al (1980) carried survey on Infant feeding practices. It showed that most of the mother used commercial baby powder in earlier days of infants. They felt that the recommended proportion of baby food powder to water must be high for the infant to
digest easily. 8% of mothers did not choose to breast feed because of reasons such as their health problems or their previous knowledge regarding proper use of commercial baby milk powder.

Gopujkar and Gopalan (1984) found that delivery in hospitals, favours use of commercial infant foods was distressing. In some hospitals in Bombay, infants were introduced bottles of commercial milk immediately after birth, even before their mothers had a chance to put them to breast was shocking.

Akhatar and Shukla (1985) studied on feeding patterns and practices of mothers in a maternity ward. It was noted that in rating of the breast milk, powdered milk was not considered to be superior to breast milk by 74% of mothers, but 10% thought that tinned milk was superior than breast milk. This consciousness seems to be related to the advertisements and labels used by manufactures for milk formulas. It was found that although most of the mothers considered breast milk is better for growth of their babies. However, 30% of mothers also thought that combined feeding was also good, and 10% considered that bottle feeding equally good.

Kumar (1988) studied on breast feeding and bottle feeding of baby. The old Indian tradition of using a small spoon and glassi ( a special spoon made of sliver) as a present at the time of child birth than bottle feeding, had much safe, and found that bottle feeding disease can account for 5 to 10% of hospital admissions. Some maternity hospitals delay feeding the baby until 24 hours or even longer after birth.

Thimmayamma et al (1980) studied that large number of mothers were in favour of dilution of milk, which digest easily to newborn. And study of Shah (1993) conducted on breast feeding and
top feeding of scheduled caste communities and found that 92% of children received top milk in diluted form.

In terms of economy of the individual most of the families cannot afford artificial feeds in a country like India but in urban area, social forces are leading to the breakdown, old custom of breast feeding. (Javalikar, 1994).

2.7 Toilet practices of newborns.

A toilet practice of newborns in some part of country classified as bad by Park and Park (1985). A tradition practice of administration of opium and drastic purgatives to newborn child. The result of these customs is high infant morbidity.

A research report on breast feeding and your baby by Anand (1990) presented that some exclusively breast fed babies pass frequent watery motions - at times green or with mucous. But they are normal and active and pass urine frequently. No treatment is required and no need of traditional purgatives.

Shariff and Farzana (1990) carried survey on breast feeding practices, beliefs and taboos in Karnataka. It observed that castor oil was fed, as a laxative and cleansing agents to newborn child by their mothers. This is old-age house-hold remedy.

2.8 Bathing and dressing practices of newborns.

2.8.1 Bathing practices of newborns.

A study carried out on infant and child care by Arya (1990), found that various customs are vogue regarding bathing the baby immediately after birth. After birth baby being born, excessive blood and vermix is sponged away with cotton wool dipped in soxion and wiped off.
Mahadevan (1985) found that there were evidences of differences in nature of bath given among the three main cultural groups in India. Harmful practice of the reasons of increase in infant mortality.

A report of the National workshop on traditional practices of neonatal care in India presented by Tripuram (1993). Bathing of babies soon after birth is practised with considerable variation across the country. The newborn covered with vernix is not acceptable in many communities. It is considered dirty, foul smelling. Hence many forms of cleaning are advocated out of which an immediate bath is the most commonly practised. But the vernix covering of the baby is harmless. It reduces heat loss and it gets removed by itself. Immediate bath carries a definite risk of hypotherma.

A research conducted by Banaras University concluded that traditional Indian practices of bathing of baby on elbows of caretaker and bathing is done with neem leaves, added to lukewarm water. These practices are good and neem has anti infective factors against bacterial infection and used as sedative (Anonymus, 1994).

2.8.2 Care of skin, eyes, ears, nose and cord of newborns.

The various customs in the field of mothers-child health have been classified as good, bad, unimportant and uncertain by Park and Park (1985). Customs such as oil bath, massage and exposure to sun are good customs. Sometimes, it may be difficult to say whether certain customs are good or bad. The practice of applying Kajal or black soot mixed with oil or ghee is applied to the eyelids partly for beautification and partly for warding off the effects of “evil eye”. Often times, this customs has been blamed for transmitting trachoma and other eye infections. And there are certain customs which are
unimportant viz. punching the ear and nose, application of oil or a paste of turmeric on the anterior fontanelle.

In a study, very high mortality rate was found during the first week of infancy because of the unscientific methods used for caring the umbilical cord. It was found to dress the cord with ash, mud from earthen stove, nut powder, zeera (cumin seed), talcum powder etc. Mahadevan (1985). Arya (1990) studied on child care in India and found that some of the mothers in rural India apply home brews to the cord stump of their newborns child as a care of cord.

Singh (1990) studied on Role of technology in primary care of the newborn babies. It concluded that oil massage is culturally acceptable and provides insulation against heat loss and insensible water loss. Further it concludes that this can be readily provided in the community by appropriate and cheap technology.

A study in Karnataka observed that Castor oil was apply over the baby of newborn in order to keep him cool and make him strong. (Shariff and Farsona, 1990).

A study was carried out on traditional society of the Mizos Nicobarese, Nairs of Kerala and Kashmiri Pandits. Some traditional practices of child care were studied. Mizos reported use of lard (internal fat of abdomen of pigs specially when rendered) as a disinfectant. However, at present use of olive oil is popular. The Kashmiri pandits and nairs of Kerala didnot massage as a regular feature. It is a custom directly related to climatic conditions with Kashmir being a cold region and Kerala being close to the sea. In Mizo group, grand mother spends 30 to 40 minutes daily massaging baby with mustard oil. She checks every limb of the baby scrubbing oil in between every finger and toe. (Singh, 1994).
National workshop on traditional practices of neonatal care in India reported that material like turmeric, kumkum, ghee, oil, cowdung etc. applied on the cord. But it carries the risk of neonatal infection, and reported that custom of massaging, makes babies stronger and healthy, it improves circulation and exposing them to sunlight is practiced in various parts of country. In Maharashtra massage of the anterior fontanelle is practiced. And Kajal application was believed to improve eye sight and make the eyes bigger and beautiful. Surma is used mainly in North India. It is used even on the cut cord. In Maharashtra, oil is instilled in the nose and ears of babies along with the massage. This traditional practices is widely prevalent. Oil in the nose is known to cause lipid pneumonia (Tripuran, 1993).

According to a research report prepared by the consumers association talcum powder which is freely used for baby is not as refreshing as it is believed to be, but a source of numerous skin and lung diseases due to the presence of magnesium silicate in it and body tissue contaminated with talcum powder (Anonymous, 1994).

In a study, the investigator provided 40 preterm neonates 45 minutes of massage using gentle pressure per day (in doses of three 15 minute periods) for 10 days. The results of this study suggested that (a) the massaged infants gained 47% more weight even though the groups did not differ in calorie intake, (b) the massaged infants were awake and active a greater percentage of the observation time, (c) the massaged infants showed better performance on the habituation, orientation, motor activity and regulation of state behaviour and (d) the massaged infants were hospitalized six days less than the control infants yielding a hospital cost saving per infant (Field, 1995).
2.9 Clothing of newborns.

Cross (1971) carried research on preterm baby and discussed on clothing of baby. Soft, washable with simple designed loose in order to allow free movement of the chest and limbs, non-irritating and having water sucking capacity of clothing is used. Clothing and mattress used is easily adjusted so that it can be undressed and redressed with as little disturbance as possible.

Singh (1991) carried research on traditional health practices, which can be categorised into for main subgroups, useful, harmful, innocuous and of uncertain utility. Use of rags/dirty clothes for mothers, for clothing of newborns and for toilet practices of newborns, is a positively harmful custom and cultural practice, which is prevalent in our country.

2.10 Sleeping of newborns.

A study of Prince and Adam (1978) found that the total number of hours newborn babies sleeps, has probably over estimated. 4% and 37% of the total hours of a day baby remains alert perhaps the states which concern mothers and midwives most were sleeping and crying.

In a study of the traditional health practices for the care of newborn babies, Singh (1991) found that baby allowed to sleep on mother’s bed and later avoiding to turn her back towards the baby is one of the useful practice and based on sound scientific knowledge and logic.

A survey on breast feeding and Post-partum Amenorrhea in a traditional society in the rural area of Assam and Eastern Uttar
Pradesh with the mother’s bed. Therefore, it is easy to feed children on demand and at night as well. (Nath et al. 1993).

2.11 Factors related to nursing practices of newborns.

According to Chandrashekhar (1959), the knowledge about bearing and rearing infants is derived from a fund of folklore, traditionally handed down from mother to daughter and this knowledge is at glaring variance with the scientific verdict. These areas cover feeding, clothing and treatment of common ailments of newborn child.

Devdas (1968) opined that death rate of early life of infants is very high due to ignorance, superstition and faulty practices in the care of newborns.

Bhattacharya (1990) studied on community beliefs and recognition and concluded that health education based on local beliefs and the knowledge of the local custom is very effective for improving the health status of neonate.

Shariff and Farsona (1990) studied that there are certain ceremonies performed on the third or the fifth day after the delivery. Then they initiate breast feeding.

Sen (1990) reported that there were direct relationship between currently widespread beliefs and practices concerning the feeding of newborn child and the high levels of infant mortality.

Some innocuous or inconsequential traditional practices prevalent in India for mother craft and newborns rearing are found by Singh (1991). Ear prickling, talisman, a mulets, removing ‘Nazar’ by burning lahi, chillies and alum, and massage of anterior fontane, and feeding of prelactal are widely practised. Though most of these
practices are harmless due to lack of utility but they may lead to delay in seeking medical aid with resultant deterioration of the child health.

In India various surveys have shown that traditional beliefs and practices, food fads and taboos are widely prevalent, particularly in rural communities. Most of these are not only unscientific and unhealthy but are injurious to the health of the mother and their offspring. Moreover these beliefs, practices and taboos age old, are passed on from generation to generation. They act as an obstacle to the utilization of the existing maternal care services, which lack in themselves uniformity in various regions of the country. (Bharadwaj, 1991).

Saraswathy and Ananthakrishnan (1993) found that the Tamil Nadu and Kerala mothers were not interested in learning more about care of baby as they stick to their old traditional practices.

From above studies it is revealed that the proportion of delivery cases and trained health personnel was very low. Socio-economic condition, number of parity, maternal weight and age are associated with birth weight of newborns, but not on the nursing practices of newborns. It is associated with different types of community and healthy services. Some newborns who were in hospital had various problems, they had been separated from their mothers immediately after delivery. Therefore, this interfered with the development of natural maternal child bonding and starting breast feeding within few hours after delivery. In many studies, it is found that before 1980, duration of breast feeding was long, but initiation of breast feeding on first day, started slowly from 1980 by influence of different types of organization and it was mostly increasing by education of doctors and nurses, practical managements in hospital and education of mothers from different sources. In some situation, culture and customs may
act as risk factors by limiting the educational opportunities are by perpetuating unhygienic practices and most of the mothers did not following advice of health personnel.

Breast feeding initiative programme is much more difficult than immunization programme. It include psychological, emotional factors and the attitude of health services with the mother and her relatives or her caretaker. Many mothers had misbelief regarding colostrum but in Tribal families, it is not discarded. Most of the studies found that mothers fed traditional prelacteals instead of colostrum on first day and they had reasons about it. Very few studies focused on beliefs and traditional practices of newborns regarding toilet, bathing, clothing, sleeping practices and care of skin, eyes, ears, nose and cord and found that most of them are harmful than beneficial and such improper nursing practices of newborn could be result of infant mortality and morbidity.

Most of the studies are regarding only feeding of newborns, but none of studies focused on general nursing practices of newborns in different types of community. Therefore present study is a small attempt made to study the nursing practices of newborns and their mothers.