International Journal of Community Medicine and Public Health
Sasikala R et al. Int J Community Med Public Health. 2026 Mar;13(3):1474-1482
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20260710

Original Research Article

Knowledge, attitude and practices of breastfeeding among urban and rural mothers in the field practice area of a tertiary care centre: a cross-sectional analytical study

R. Sasikala[1]*, J. Arun Daniel[2], Govindaraj Rajendran[2], S. Andrew John Silvester[3]

[1]Master of Public Health, School of Allied Health Sciences, Vinayaka Mission's Puducherry Campus, Puducherry, India
[2]Department of Community Medicine, Aarupadai Veedu Medical College and Hospital, Puducherry, India
[3]School of Allied Health Sciences, Vinayaka Mission's Puducherry Campus, Vinayaka Mission's Research Foundation-DU, Salem, India

Received: 04 February 2026
Accepted: 23 February 2026

***Correspondence:**
R. Sasikala,
E-mail: sasikalarasu98@yahoo.com

ABSTRACT

Background: Breastfeeding is an important infant nutrition and maternal health factor. Although there are clear recommendations by the World Health Organization on the exclusive breastfeeding practice in the first six months, significant differences continue to be observed between the urban and rural population as a result of socio-cultural variations, education and access to health services.
Methods: A cross-sectional analysis study was done between February and July 2025 with a total number of mothers (n=278) with children under two years of age to be included in the study according to cluster and simple random sampling method. A structured questionnaire was used to collect data on socio-demographic variables, breastfeeding knowledge, attitudes and practices (WHO IYCF indicators). The data were analysed through descriptive statistics and chi-square tests.
Results: The general knowledge and attitude to breastfeeding was satisfactory among urban and rural mothers. The awareness of the prevention of breast cancer and the milk storage was higher among urban mothers compared to rural mothers and longer and more frequent time of breastfeeding was reported by rural mothers. Rural mothers were found to have pre-lacteal feeding more as compared to urban mothers who practiced early breastfeeding initiation. Attitude (p=0.032) and practice (p=0.003) had significant relationships with place of residence whereas knowledge did not.
Conclusions: Despite the fact that the knowledge and positive attitudes of both urban and rural mothers were sufficient, there were considerable differences in the patterns of breastfeeding and rural mothers were more acceptable. Intensifying antenatal and postnatal counselling, breastfeeding support at the workplace and family involvement is required to fill the knowledge-practice gap and enhance the outcomes of breastfeeding.

Keywords: Breastfeeding, Knowledge, Mothers, Practice

INTRODUCTION

Breastfeeding is an important infant nutrition that plays an important role in the health and development of children during their childhood. The World Health Organization recommends breast milk within the first six months of life and the rationale is based on the various health benefits, including reduction of infectious morbidity and infant mortality and also, the potential health benefits of the mother, such as reduced risk of breast and ovarian cancers.[1,2] Even in India, in spite of such guidelines, breast feeding practices are very different in urban and rural communities which depend on a plethora of factors such as socio-cultural beliefs,

maternal education and access to healthcare services.[3] The differences in the breastfeeding habits of various populations remark the necessity to explore the knowledge of breastfeeding among mothers in various socio-economic settings. In the past studies, it has been reported that urban mothers are more likely to be better exposed to healthcare and education, which is associated with increased rates of early initiation and exclusive breastfeeding.[4,5]

Studies revealed that 70.3 per cent of mothers initiating breastfeeding in urban areas in the first hour after birth did so, whereas a corresponding figure of rural mothers was only 50.8 per cent, which is a very substantial disparity in healthcare access and education levels on breastfeeding practices.[4] Additional research is also necessary especially with urbanization which alters traditional behaviors and maternal beliefs towards breast-feeding in more competitive worlds.

Additionally, knowledge, attitude and the practice framework plays a key role in the research of maternal behaviors and may result in specific interventions that could help to increase the outcomes of breastfeeding.[6] Health education and counseling on the same in the context of antenatal care have a significant impact on mothers breast feeding practices; but research indicates that most mothers particularly in rural regions complain that healthcare providers do not provide proper support.[7] It is important to note that such kind of knowledge can never contribute to positive practices and therefore it is important to dig into how such attitudes that are shaped by social norms and personal experiences affect the practices of breastfeeding among mothers.[8]

With this background, the research aims to conduct a detailed cross sectional analytical study to test knowledge, attitudes and practices of breastfeeding among urban and rural mothers in field practice area of a tertiary care unit in India. Such an investigation will add to the existing knowledge on the determinants of breastfeeding practices and inform policy development and health-related policies at the healthcare level to improve maternal and infant health outcomes.

METHODS

The study was a cross-sectional analysis study conducted between February 2025 and July 2025 in the urban and rural field practice setting of the Aarupadai Veedu Medical College (AVMC), Puducherry. A study population included mothers who live in the chosen urban and rural field practice areas and met the inclusion criteria and were ready to sign written informed consent.

The mothers who had medical conditions that contraindicated breast feeding like HIV infection or those undergoing chemotherapy as well as mothers who were not the main caregivers of their infants were not included in the study. The present cross-sectional analytical study was done based on the formula n=4pq/d2 to calculate the sample size. A previous Indian study that was carried among rural and urban mothers was used to take the prevalence of suboptimal breastfeeding practices at 21%.[9] With this prevalence, the sample size was calculated as 265.44 and it was rounded down to 265. The adjusted sample size was 291 after including 10 percent non-response allowance. But based on feasibility and availability of eligible participants throughout the study period, final sample size of 278 mothers was incorporated in the study which was deemed to be sufficient enough to achieve the study objectives.

The technique used to select the participants was a cluster sampling process. All of the urban and rural villages within the field practice area were viewed as clusters and eight clusters were identified. The proportion of these clusters as far as population size is concerned was used to divide the total sample size. In every chosen cluster, simple random sampling was used to select the eligible mothers until the required sample size was reached.

A pre-structured and pre-tested questionnaire in form of face-to-face interview was used to gather data. The questionnaire comprised of five parts that include the socio-demographic information, socio-economic status assessed on the basis of B.G. Prasad scale, knowledge on breastfeeding based on WHO and Indian national guidelines on infant and young child feeding, attitude towards breastfeeding measured with the help of IOWA infant feeding attitude scale and breastfeeding practices measured with the help of WHO infant and young child feeding indicators.

To determine the clarity, feasibility and reliability of the tool, a pilot study was done on 30 mothers. There was no need in any alterations and pilot study data were not involved in the analysis. The test-retest reliability coefficient indicated that the questionnaire had acceptable reliability over a test-retest reliability of more than 0.7 and good internal consistency.

The aim and significance of the study were well explained to the participants before data collection and informed consent was signed in writing. Their confidentiality and anonymity were ensured and no one was forced to take part in the study. The study received ethical approval of the Institutional Ethics Committee of AVMC, Puducherry (ECR/847/Inst/PY/2016/RR-20).

The data that was collected were typed into Microsoft Excel, cleaned, coded and analyzed through the Statistical Package of Social Sciences software. Socio-demographic characteristics, knowledge, attitude and practice variables were summarized using descriptive statistics. The chi-square test was used to do inferential analysis by determining relationships between place of residence (urban and rural) and breastfeeding-related knowledge, attitude and practices. P value below 0.05 was taken as statistically significant (two tailed).

RESULTS

The Table 1 reveals that the majority of the mothers consisted of the age 2630 (46.4%), then 1925 (28.8%). Most of them graduated at the graduate level (36.7%) and intermediate level (28.4%). The majority of mothers were housewives (60.8%) and they lived in cities (52.9%). There were more nuclear families (60.4%). Ninety-two-point eight percent of the mothers received prenatal care and 65.8 percent of them gave birth through the vagina. Over half of the mothers possessed one child (53.2%). In 42.8 percent, the youngest child was aged 13 or 24 months. Sixty-four-point four percent of mothers received breastfeeding counselling. The majority of the spouses were skilled laborers (40.6%). In the B.G. Prasad scale, 51.8 percent of the families fell in the category of 2729-4548 per-capita income.

Table 2 indicates that the level of information on breastfeeding was high among urban and rural mothers. Sixty-four-point three percent of urban and 61.1 percent of rural mothers mentioned knowledge on the need not to give water during the first six months. City mothers (77.6) had a greater understanding of the fact that breastfeeding prevents breast cancer than country mothers (67.2%). Only 83.0% of urban and 80.2% of rural mothers reported that she had the correct understanding of breastfeeding as the only first six months adequate strategy.

Breastfeeding was carried to two years and beyond was reported by 36.7% of urban mothers as compared to 69.3% rural mothers. The rate of frequent breastfeeding among urban and rural mothers was found to be 59.2 and 92.4 percent respectively. The percentage of mothers who reported to have traditional feeding beliefs was 16.3% in urban and 48.9% in rural areas whereas awareness of expressing and storing breast milk among working mothers was found to be high among urban mothers (34.0%) compared to rural mothers (9.2%). Table 3 shows that the attitudes to breastfeeding were rather favorable in both groups. Conception that formula feeding was contemporary was reported by 67.3% of urban and 42.7% of rural mothers. Sixty-one-point two percent of urban and 67.9 percent of the rural mothers indicated that they strongly agreed that the first six months of breastfeeding is beneficial. The need to use breastfeeding as a method of enhancing immunity was strongly accepted by 81.6 of urban and 84.0 of rural mothers. Forty-six-point three percent of urban and sixty-eight-point seven percent of the urban mothers and rural mothers respectively agreed to breastfeeding as a mother-infant bonding activity. Breast milk was the ideal food with 81.6% of urban mothers and 90.1% of the rural mothers supporting it. The rate of returning to work was a barrier to 58.5% of city and 61.1% of country mothers and formula feeding conveniently was agreed upon strongly by 51.0% of urban mothers and 32.1% of country mothers. The initial feed was colostrum that the 63.3 and 52.7 percent of the mothers in the urban and rural regions respectively accepted.

Table 4 characterizes the residence-based breastfeeding practices among mothers. Sixty-six-point seven percent of mothers in the urban and 92.4 percent rural reported breastfeeding on the previous day. Fifty-two-point four percent of urban and forty-eight-point one percent of rural mothers received advice given by health professionals. Mothers in the cities engaged in pre-lacteal feeding at 19.0% and country women at 44.3%. The rate of breast milk as the first feed attempted by urban and rural mothers was 88.8 and 80.2 respectively. Sixty-six- and forty-two-point seven percent of urban and rural mothers respectively were found to have initiated breastfeeding within one hour.

The practice of feeding at particular times was more prevalent in urban mothers (56.5%) but the rural mothers had higher chances of random feeding (42.7%). Sixty-nine-point two percent of urban and 81.7 percent rural mothers had breastfed on exclusive basis when the mother was not available. The urban mothers and the rural mothers omitted extra feeds during the first six months by 53.1% and 46.6% respectively. The chi-square test indicated that there was no significant correlation between information on breastfeeding and location of residence. A statistically significant correlation was however found between attitude and place of residence ($p<0.05$) and highly significant correlation was observed between breastfeeding practices and place of residence ($p<0.01$), which means that the rural mothers had better breastfeeding practices (Table 5).

Table 1: Distribution of socio-demographic variables of mothers (n=278).

Variable	Frequency (N)	(%)
Age (in years)		
19–25	80	28.8
26–30	129	46.4
31–35	61	21.9
36–40	8	2.9
Educational status		
Illiterate	6	2.2
Primary school	19	6.8
Middle school	24	8.6

Continued.

Variable	Frequency (N)	(%)
High school	36	12.9
Intermediate	79	28.4
Graduate	102	36.7
Professional	12	4.3
Occupation of mother		
Homemaker	169	60.8
Employed	109	39.2
Place of residence		
Urban	147	52.9
Rural	131	47.1
Type of family		
Nuclear	168	60.4
Joint	110	39.6
Antenatal care received		
Yes	258	92.8
No	20	7.2
Type of delivery		
Vaginal	183	65.8
Caesarean	95	34.2
Number of children		
1	148	53.2
2	109	39.2
3	21	7.6
Age of youngest child		
Less than 6 months	49	17.6
6–12 months	110	39.6
13–24 months	119	42.8
Counselling about breastfeeding		
Yes	179	64.4
No	99	35.6
Spouse's occupation		
Clerical	10	3.6
Factory worker	51	18.3
Handicraft	6	2.2
Professional	20	7.2
Skilled labour	113	40.6
Technician	37	13.3
Unskilled	41	14.7
Per-capita income (₹, B.G. Prasad scale)		
<1,364	10	3.6
1,364–2,728	88	31.7
2,729–4,548	144	51.8
4,549–9,097	26	9.4
≥9,098	10	3.6

Table 2: Knowledge level on breastfeeding among the place of residence.

Statement/response	Urban (N)	Rural (N)	Total (N)
Water should not be given to the baby for the first 6 months			
Yes	90 (64.3)	85 (61.1)	175 (62.9)
No	50 (35.7)	54 (38.9)	104 (38.9)
Breastfeeding prevents the mother from getting breast cancer			
Yes	114 (77.6)	88 (67.2)	202 (72.2)
No	33 (22.4)	43 (32.8)	76 (27.3)

Continued.

Statement/response	Urban (N)	Rural (N)	Total (N)
Breastfeeding delays the mother's next pregnancy			
Yes	14 (9.5)	3 (2.3)	17 (6.1)
No	133 (90.5)	128 (97.7)	261 (93.9)
Correct feeding practice for a newborn			
Breastfeeding only for 6 months	122 (83.0)	105 (80.2)	227 (81.7)
Give water with breastfeeding	22 (15.5)	26 (19.8)	48 (17.3)
Formula better than breast milk	3 (2.0)	0 (0.0)	3 (1.1)
Recommended duration of breastfeeding			
Up to 2 years & beyond	51 (36.7)	98 (69.3)	149 (53.6)
Up to 1 year	35 (23.8)	55 (42.0)	90 (32.4)
Up to 6 months	12 (8.2)	22 (16.8)	34 (12.2)
Up to 3 months	2 (1.4)	3 (2.3)	5 (1.8)
Frequent breastfeeding			
Yes	87 (59.2)	121 (92.4)	208 (74.8)
No	60 (40.8)	10 (7.6)	70 (25.2)
Breastfeeding is essential for baby's brain development			
Yes	133 (90.5)	114 (92.4)	247 (88.8)
No	14 (9.5)	17 (7.6)	31 (11.2)
Traditional feeds during first 6 months have positive outcomes			
Yes	24 (16.3)	64 (48.9)	88 (31.7)
No	123 (83.7)	67 (51.1)	190 (68.3)
Working mothers can express, store and give breast milk later			
Yes	50 (34.0)	12 (9.2)	62 (22.3)
No	97 (66.0)	119 (90.8)	216 (77.7)

Table 3: Attitude on breastfeeding among the place of residence.

Statement / Response	Urban N (%)	Rural N (%)	Total N (%)
Formula feeding is modern, breastfeeding is old			
Strongly agree	99 (67.3)	56 (42.7)	155 (55.8)
Agree	33 (22.4)	37 (28.2)	70 (25.5)
Neutral	11 (7.5)	32 (24.4)	43 (15.5)
Disagree	3 (2.0)	4 (3.1)	7 (2.5)
Strongly disagree	1 (0.7)	2 (1.5)	3 (1.1)
It is very good to give only breastfeeding exclusively for first 6 months			
Strongly agree	90 (61.2)	89 (67.9)	179 (64.4)
Agree	48 (32.7)	38 (29.0)	86 (30.9)
Neutral	8 (5.4)	48 (36.6)	56 (20.1)
Disagree	1 (0.7)	0 (0.0)	1 (0.4)
Breastfeeding improves immunity and reduces infections			
Strongly agree	120 (81.6)	110 (84.0)	230 (82.7)
Agree	20 (13.6)	15 (11.5)	35 (12.6)
Neutral	7 (4.8)	6 (4.6)	13 (4.7)
Breastfeeding improves mother–infant bonding			
Strongly agree	68 (46.3)	90 (68.7)	158 (56.8)
Agree	50 (34.0)	30 (22.9)	80 (28.4)
Neutral	25 (17.0)	11 (8.4)	36 (12.9)
Disagree	4 (2.7)	0 (0.0)	4 (1.4)
Breast milk as ideal food			
Strongly agree	120 (81.6)	118 (90.1)	238 (85.6)
Agree	20 (13.6)	10 (7.6)	30 (10.8)
Neutral	7 (4.8)	3 (2.3)	10 (3.6)
Breast milk more easily digested than formula			
Strongly agree	90 (61.2)	78 (59.2)	168 (60.4)

Continued.

Statement / Response	Urban N (%)	Rural N (%)	Total N (%)
Agree	41 (27.9)	30 (22.6)	78 (25.5)
Neutral	16 (10.9)	23 (17.6)	39 (14.1)
Getting back to work is a barrier to breastfeeding			
Strongly agree	86 (58.5)	80 (61.1)	166 (59.7)
Agree	48 (32.7)	33 (25.2)	81 (29.1)
Neutral	13 (8.8)	18 (13.7)	31 (11.2)
Formula feeding is convenient			
Strongly agree	75 (51.0)	42 (32.1)	117 (42.1)
Agree	45 (30.6)	21 (16.0)	66 (23.7)
Neutral			

Table 4: Practice on breastfeeding among the place of residence.

Statement/Response	Urban N (%)	Rural N (%)	Total N (%)
Breastfed the baby yesterday (day/night)			
Yes	98 (66.7)	121 (92.4)	219 (78.8)
No	49 (33.3)	10 (7.6)	59 (21.2)
Took advice from doctor / nurse / lactation counsellor			
Yes	77 (52.4)	63 (48.1)	140 (50.4)
No	70 (47.6)	68 (51.9)	138 (49.6)
Given prelacteal feeds			
Yes	28 (19.0)	58 (44.3)	86 (30.9)
No	119 (81.0)	73 (55.7)	192 (69.1)
Type of first feed given after birth			
Breast milk	130 (88.8)	105 (80.2)	235 (84.5)
Animal milk	4 (2.7)	10 (7.6)	14 (5.0)
Formula milk	7 (4.8)	4 (3.1)	11 (4.0)
Sugar water/honey	6 (4.1)	12 (9.2)	18 (6.5)
Initiation of breastfeeding after delivery			
Within 1 hour	98 (66.7)	56 (42.7)	154 (55.4)
1–6 hours	37 (25.2)	39 (29.8)	76 (27.3)
After 24 hours	12 (8.2)	36 (27.5)	48 (17.3)
Frequency of breastfeeding			
At random	10 (6.8)	48 (42.7)	58 (20.9)
Specific intervals	83 (56.5)	40 (29.8)	123 (44.2)
On demand	54 (36.7)	43 (27.5)	97 (34.9)
Type of food fed when mother was not available			
Exclusive breastfeeding	99 (69.2)	107 (81.7)	206 (76.6)
Animal milk	23 (16.1)	9 (6.9)	32 (11.9)
Infant formula	13 (9.1)	7 (5.3)	20 (7.4)
Complementary foods	3 (2.1)	3 (2.3)	6 (2.2)
Prelacteal feeds	2 (1.5)	5 (3.8)	7 (2.6)
Feeding during first 6 months			
Infant formula	46 (31.3)	22 (16.8)	68 (24.5)
Animal milk	9 (6.1)	19 (14.5)	28 (10.1)
Plain water	7 (4.8)	24 (18.3)	31 (11.2)
Any other liquids	7 (4.8)	24 (18.3)	31 (11.2)
None	78 (53.1)	61 (46.6)	139 (50.0)

Table 5: Association between knowledge, attitude and practice on breastfeeding and place of residence (N=278).

Variable	Category	Urban n (%)	Rural n (%)	Total n (%)	χ^2	df	P value
Knowledge	Adequate	92 (62.6)	76 (58.0)	168 (60.4)	2.14	2	0.343
	Moderate	41 (27.9)	39 (29.8)	80 (28.8)			
	Inadequate	14 (9.5)	16 (12.2)	30 (10.8)			

Continued.

Variable	Category	Urban n (%)	Rural n (%)	Total n (%)	χ^2	df	P value
Attitude	Favourable	89 (60.5)	94 (71.8)	183 (65.8)	6.87	2	0.032*
	Neutral	38 (25.9)	27 (20.6)	65 (23.4)			
	Unfavourable	20 (13.6)	10 (7.6)	30 (10.8)			
Practice	Good	76 (51.7)	92 (70.2)	168 (60.4)	11.94	2	0.003*
	Fair	45 (30.6)	29 (22.1)	74 (26.6)			
	Poor	26 (17.7)	10 (7.6)	36 (12.9)			
Total		147 (100)	131 (100)	278 (100)			

*Significant at p is 0.05.

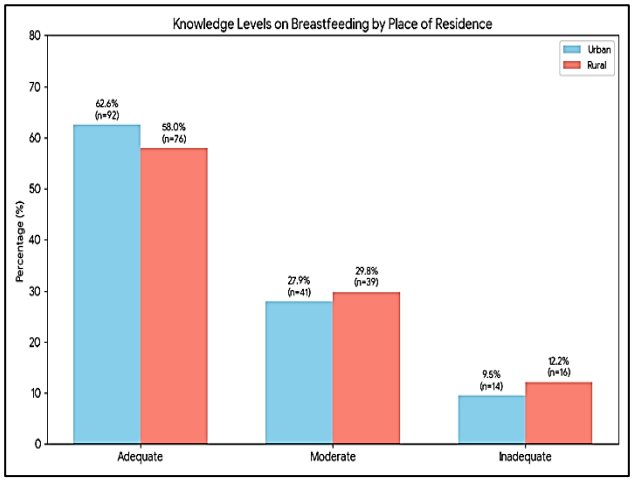

Figure 1: Knowledge level on breastfeeding.

DISCUSSION

The study findings indicate that urban and rural mothers have sufficient knowledge of breastfeeding and positive attitudes towards it, which can support the general aim of promoting infant well-being among various socio-demographic groups. In both groups, awareness on the benefits of exclusive breastfeeding in the first six months and its advantages was noted. Nevertheless, the urban mothers had higher knowledge regarding the prevention of breast cancer as well as the methods by which they could express and store breast milk, unlike the rural mothers who are likely to continue breastfeeding longer and more frequently. These results are in line with earlier researches, which indicate that urban mothers tend to be more educated as opposed to rural mothers who still adhere to the usual culture that promotes long term breast feeding.[10]

The difference in the conception of breastfeeding and especially how the urban mothers prefer to consider formula feeding as a modern and convenient way is a result of changing lifestyle patterns relating with urban dwelling. In comparison, rural mothers were more inclined to believe that breastfeeding is the optimal kind of infant nutrition and a vital part of the mother-infant relationship. The findings are consistent with previous research showing that urban mothers tend to face the pressures of modernization which might be against the traditional ways of breastfeeding.[11] Also, both settings found the work obligations to be a barrier to breastfeeding and it was evident in the complexity of maternal decision-making and the necessity of supportive workplace policies regarding breastfeeding. Concerning the breastfeeding behaviors, the research found that recent breastfeeding and exclusive breastfeeding were more prevalent amongst rural mothers especially in cases where the mother was unavailable which means that there is a high rate of breastfeeding practices even in the face of difficulties. Urban mothers, in turn, tended to start breastfeeding during the first hour of birth and adhered to the regular patterns of feeding. This finding is consistent with past studies indicating that maternal education has a positive effect on breastfeeding in the initial stages.[12] The fact that the pre-lacteal feeding is more prevalent in rural mothers is in line with previous research findings indicating that this has continued to be a popular cultural practice and, therefore, acts as a barrier to best practices in breastfeeding.[13] All these trends demonstrate the impact of common cultural norms on the decision to breastfeed.

The literature available promotes the effects of knowledge and attitude in determining the breastfeeding behavior. Research findings have indicated that mothers who show positive attitude towards breastfeeding have high chances of successfully practicing exclusive breastfeeding.[14] In this respect, breastfeeding outcomes are promising as the positive attitudes towards this practice were observed in the current study among urban and rural mothers. The same conclusions have been provided, pointing to the significance of the role of antenatal education in enhancing knowledge and consolidating beneficial attitudes toward breastfeeding.[12]

Although there is enough knowledge, the urban-rural disparities demonstrate complications in the actual practice of breastfeeding. The mothers in the urban areas are informed but they can choose to provide formula feeding or scheduled feeding as a result of the limitations they have at work. The trend is in line with previous reviews that suggest that urban settings have adopted a trend of convenience over the conventional breastfeeding practices.[15] The work hours and inadequate lactation services in urban areas may also deter exclusive breastfeeding as it has been recorded before.[16] Moreover, the burden of malnutrition should be taken into consideration and combined with the practice of breastfeeding. Breast milk substitutes and decreased community support in cities might adversely affect the

success of the breastfeeding process.[17] On the other hand, the rural mothers might have less exposure to such commercialization and they may be more inclined to use breastfeeding rather than commercial options.[18] The results highlight the importance of socioeconomic and environmental issues in determining the maternal education and breastfeeding behavior.

Lastly, although there is good knowledge and positive attitudes of mothers at both urban and rural components, there is still a gap in the knowledge and practice. Specific measures taken to enhance supportive conditions in support of breastfeeding, especially in an urban setting, are indispensable. Engaging family members, particularly grandmothers, who tend to have a major role in infant feeding decision-makers could be useful in closing the knowledge-practice gap.[19,20]

CONCLUSION

The study concludes that urban and rural mothers possessed adequate knowledge and positive attitude towards breastfeeding, though there were significant differences in actual practice. Rural mothers had a higher compliance to extended and high frequency of breastfeeding and the urban mothers were more influenced by work and life restrictions. Although there is high awareness on exclusive breastfeeding, knowledge and practice gaps are still found especially among urban dwellers. That is why, it is suggested to enhance the education given during antenatal and postnatal phases on breastfeeding, adoption of workplace interventions like lactating areas and working at home practices to discourage pre-lacteal feeding and engage family members (in particular grandmothers) in promoting breastfeeding in both contexts.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Rudrappa S, Raju H, Kavya M. To study the knowledge, attitude and practice of breastfeeding among postnatal mothers in a tertiary care center of South India. Indian J Child Health. 2020;7(3):113–6.
2. Mane S, Pawar S, Aghav P. Breastfeeding knowledge and practice among women in western Maharashtra: A cross-sectional study. Magna Scientia Adv Res Rev. 2019;8(2):193–200.
3. Kazmi S, Akparibo R, Ahmed D. Prevalence and predictors of exclusive breastfeeding in urban slums, Bihar. J Fam Med Prim Care. 2021;10(3):1301–7.
4. Senanayake P, O'Connor E, Ogbo F. National and rural–urban prevalence and determinants of early initiation of breastfeeding in India. BMC Public Health. 2019;19(1):234-7.
5. Shanmugam J, Kumar M, Jayaraj N. Maternal experiences during pregnancy, delivery and breastfeeding practices: A community-based analytical cross-sectional study. Indian J Comm Med. 2024;49(3):532–8.
6. Waits A, Guo C, Chien L. Evaluation of factors contributing to the decline in exclusive breastfeeding at 6 months postpartum: The 2011–2016 national surveys in Taiwan. Birth. 2017;45(2):184–92.
7. Benedict R, Craig H, Torlesse H. Trends and predictors of optimal breastfeeding among children 0–23 months, South Asia: Analysis of national survey data. Mat Child Nut. 2019;14(4):173-7.
8. Bheeman B, Hannula L, Pushpalatha K. Knowledge, attitudes and breastfeeding practices of postnatal mothers in a tertiary health center. Indian J Child Health. 2021;8(6):220–4.
9. Manjapallikkunnel SR, Nair K, Sujatha, C. Knowledge, attitude and practices among mothers of infants regarding breastfeeding: A cross-sectional study. J Fam Reprod Health. 2023;17(3):136–41.
10. Valappil H, Jayalakshmi R, Sewor C. Intersectional inequalities in exclusive breastfeeding practices in India: Analysis of National Family Health Survey-4. International Breastfeeding J. 2023;18(1):328.
11. Mohammed S, Yakubu I, Fuseini A. Systematic review and meta-analysis of the prevalence and determinants of exclusive breastfeeding in the first six months of life in Ghana. BMC Pub Health. 2023;23(1):23-9.
12. Shanmugam J, Kumar M, Jayaraj N. Maternal experiences during pregnancy, delivery and breastfeeding practices: A community-based analytical cross-sectional study. Indian J Comm Med. 2022;49(3):532–8.
13. Dadzie B, Bayor F, Doat A. Investigating factors that influence the practice of exclusive breastfeeding among mothers in a peri-urban general hospital in Ghana. 2022.
14. Gebretsadik G, Tadesse Z, Mamo L. Knowledge, attitude and determinants of exclusive breastfeeding during COVID-19 pandemic among lactating mothers. BMC Pregn Childbirth. 2022;22(1):864-8.
15. Patil D, Pundir P, Dhyani V. A mixed-methods systematic review on barriers to exclusive breastfeeding. Nutr Health. 2020;26(4):323–46.
16. Le Q, Lam P, Nguyen V. Factors associated with a low prevalence of exclusive breastfeeding during hospital stay in urban and semi-rural areas of southern Vietnam. Int Breastfeed J. 2018;13(1):56-9.
17. Amallia A, Pamungkasari E, Adriani R. Meta-analysis of the effects of maternal education, residence and birth delivery place on exclusive breastfeeding. J Mat Child Health. 2023;8(2):154–68.
18. Mohamed M, Ochola S, Owino V. Comparison of knowledge, attitudes and practices on exclusive breastfeeding between primiparous and multiparous

mothers in Kenya. Int Breastfeeding J. 2018;13(1):67-72.
19. Mundagowa P, Chadambuka E, Chimberengwa P. Determinants of exclusive breastfeeding among mothers in Zimbabwe. Int Breastfeed J. 2019;14(1):76-9.
20. Um S, Chan Y, Tol B. Determinants of exclusive breastfeeding of infants under six months among Cambodian mothers. J Pregn. 2020;3:1–7.

Cite this article as: Sasikala R, Daneil JA, Rajendran G, Silvester AJ. Knowledge, attitude and practices of breastfeeding among urban and rural mothers in the field practice area of a tertiary care centre: A cross-sectional analytical study. Int J Community Med Public Health 2026;13:1474-82.