

How, When and How Often: Counselling of Women as a 'health service' to Improve Breastfeeding and Infant and Young Child Feeding Practices

Despite the fact that 80% of women deliver in the health facilities (both public and private), only 2 out of 5 women in India are able to begin breastfeeding within one hour of birth. Similarly exclusive breastfeeding and complementary feeding practices are sub-optimal. Skilled counselling of the mother and family is one of the interventions, which has been proven to help in enhancing breastfeeding practices. The global and national guidance exist and evidence is overwhelming, however, there is a need to streamline this 'health service' to be available to all women who continue to face barriers, especially in the health system. India has an opportunity in the Mothers' Absolute Affection (MAA) programme launched in 2016 to implement the Ten Steps to Successful Breastfeeding in all hospitals to reach all mothers- rich or poor.



Photo credit: Neelima Thakur

INTRODUCTION

Despite the tremendous benefits of breastfeeding and infant and young child feeding (IYCF) practices, they lack programmatic priority. Key interventions to improve feeding practices in the health systems include implementing “Ten Steps” of the BFHI, skilled counselling of women, community mobilisation, maternity protection and protection from commercial tactics of baby food industry. Removing barriers that women face at home, hospitals or at work place is the key.

India's nationwide programme to promote breastfeeding, Mothers' Absolute Affection (MAA) in the health facilities

needs to organise skilled counselling for all women during pregnancy, at birth and later, including in disaster situations. The W.H.O. has recently provided an evidence- based guideline for this purpose.¹

This is a policy brief that focuses on counselling and will be useful to the policy makers and programme managers of the MOHFW, Government of India and the State Governments, managers of National Disaster Management Authority (NDMA), development agencies, institutions, private hospitals, professional bodies of doctors and nurses, midwives and all others concerned.

BACKGROUND

The Ministry of Health and Family Welfare, Government of India, the World Health Organization and UNICEF recommend optimal feeding of infants and young children to achieve optimal health and development outcomes. These include: breastfeeding initiation within an hour of birth along with skin to skin contact, exclusive breastfeeding for the first 6 months and continued breastfeeding along with adequate and quality complementary feeding after 6 months to two years or beyond.

Indian situation is far from adequate.

Only 41.6% women are able to begin breastfeeding within an hour of birth as against nearly 80% delivering in the health facilities as per the NFHS-4 (2015-

16)² and only 55% babies are exclusively breastfed during 0-6 months. At the same time 21% newborns receive pre-lacteal feeds, 18% of infants receive water, 11% receive other milks and 10% receive complementary foods during first six months. All this breaks the exclusivity. Only 42 % kids begin solid/semisolid foods at 6-8 months and only 9.6% kids of 6-23 months receive minimum acceptable diet with a variety of at least 4 food groups(e.g. fruits, vegetables, grains, pulses, oils, milk etc.). This is a fundamental deficit in nutrition inputs during first year alone and is one of the most critical factor determining the nutrition status of the child.

According to a new study, annually inadequate breastfeeding costs dearly to India³. It results in 100,000 preventable child deaths (mainly due to diarrhoea and pneumonia), 34.7 Million cases of diarrhoea, 2.4 Million cases of pneumonia, and 40,382 cases of obesity in India. Health impact on mothers is more than 7000 cases of breast cancer, 1700 of ovarian cancer and 87000 of type- 2 diabetes. Formula feeding of children aged 0-23 months results in more than INR 25393.77 Crores family costs to buy formula (which is 19.4% of nominal wages for individual family) and INR 727.18 Crores spending on health care due to illness as a result of inappropriate feeding practices⁴.

RESULTS OF INADEQUATE BREASTFEEDING: INDIA (ANNUALLY)

Preventable Child Deaths

100,000

Cases of Diarrhoea

34,791,524

Cases of Pneumonia

2,470,429

Cases of Obesity

40,382

Cases of Breast Cancer

7,976

Cases of Ovarian Cancer

1,748

Cases of Type II Diabetes

87,855



Health Care Costs

₹ 727.18 crores*

Household Costs of Formula Feeding

₹ 25393.77 crores*

* Extrapolated from the tool, 'The Cost of Not Breastfeeding Tool' (1 US\$ = INR 68.5672 as on 16 July 2019)

HOW TO PROVIDE COUNSELLING SERVICES

Skilled counselling is different from giving information; it is a process that helps women/families to make informed decisions on feeding their infants.

It is not simply giving a message on breastfeeding. Instead, it helps to build the confidence of mother and other family members to enable them to follow optimal breastfeeding and complementary feeding practices.



Photo credit: IndiaSpend/Swagata Yadavar

The WHO/UNICEF's Implementation Guidance (2018)⁵; the MOHFW, Government of India's MAA programme; the National Guidelines on Lactation Management Centers in Public Health Facilities; and "WHO's Guideline on Counselling of Women to Improve Breastfeeding Practices (2018)"⁶, all lend support for skilled counselling as a health service to enhance early and exclusive breastfeeding rates through the health systems and the community. The WHO's guideline makes evidence based recommendations for counselling: how often, when, how-face to face or other means, and who should provide counselling. Table 1 provides simplified information adapted from WHO guideline.

Table 1: Guidelines to provide counselling of women to improve breastfeeding and infant and young child feeding practices as a standard of care

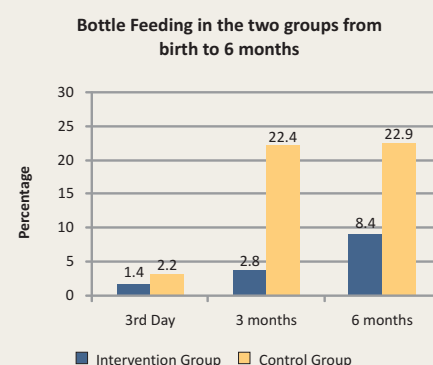
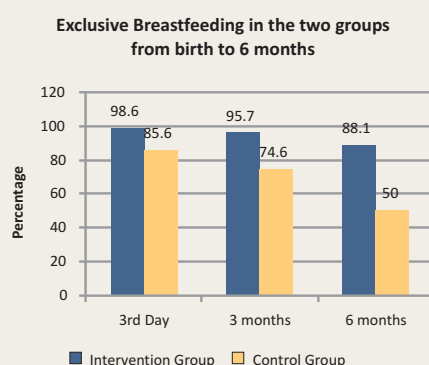
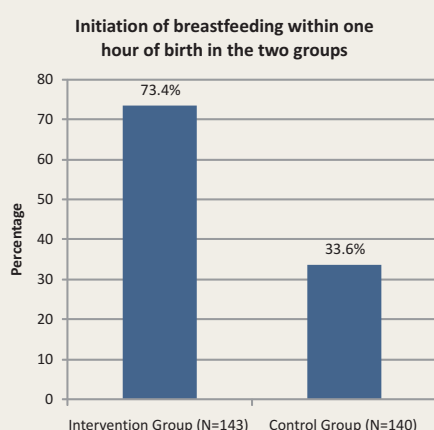
S.No.	Specifics	Recommendations
1.	Target audience	<ul style="list-style-type: none"> Breastfeeding counselling should be provided to all pregnant women and mothers with young children. It should also be a part of the disaster risk reduction strategies and should serve as a preparedness response during disasters.
2.	Anticipatory counselling	<ul style="list-style-type: none"> Breastfeeding counselling should anticipate and address important challenges and contexts for breastfeeding, especially in situations like return to work, first pregnancy, pregnancy with 2 or more babies, mental ill health, low birth weight, caesarian section delivery, humanitarian emergencies and breastfeeding in public.
3.	When	<ul style="list-style-type: none"> Breastfeeding counselling should be provided in both the antenatal and postnatal period and up to 24 months or longer. Counselling during pregnancy is very important to enable the mother to initiate breastfeeding within one hour of birth, stay together with the baby, and establish skin-to-skin contact, proper attachment and position to maintain breastfeeding. Counselling during the postnatal period helps in practicing and sustaining exclusive breastfeeding for the first six months, and continued breastfeeding along with complementary feeding after six months.
4.	Frequency	<ul style="list-style-type: none"> Breastfeeding counselling should be provided at least six times, and additionally as needed. The schedule may be, 1st-Antenatal, 2nd-immediately after birth within 2-3 days, 3rd- at 1-2 week after birth, 4th- at 3-4 month, 5th-at 6 months for CF and 6th-after 6 months. In addition, every 2-3 months from 6-24 months. The schedule may be aligned to the home visits in Home Based Newborn Care programme and Home Based Young Child Care programme.
5.	Mode	<ul style="list-style-type: none"> Breastfeeding counselling should be provided through face-to-face counselling. It may be complemented but NOT replaced by telephone counselling and /or other technologies.
6.	By whom	<ul style="list-style-type: none"> Appropriately trained health-care professionals and community-based lay and peer breastfeeding counsellors should provide Breastfeeding counselling as a continuum of care. A cascade training for skills and competence both in the health system and community along with supportive supervision is necessary. Lactation consultants or highly trained counsellors could play a role in supervision and helping mothers with heightened needs/intense counselling and support.

EVIDENCE SUPPORTS FOR THIS SERVICE

Evidence is available from India that supports counselling services. A recent study titled 'Skilled Counselling in Enhancing Early and Exclusive Breastfeeding Rates: An Experimental Study in an Urban Population in India', concluded that “..providing ante-natal and post-natal counseling support to

mothers by a dedicated breastfeeding counselor can significantly enhance rates of early initiation and helps mothers to sustain exclusive breastfeeding in hospital born infants” (see graph below).⁷ Another study from the Uttar Pradesh found that peer counselling by trained mother support

groups (MSGs) resulted in a sustained improvement infant and young child feeding (IYCF) practices in the community.⁸ Yet another study from Bihar concluded that counselling provided by the front-line health workers was associated with increased exclusive breastfeeding.⁹



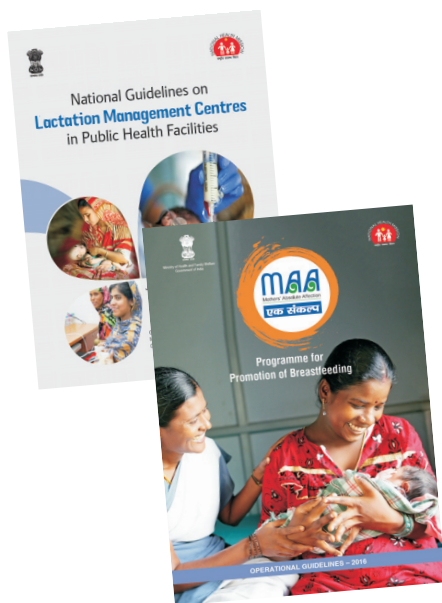
Adapted from reference 7.

BARRIERS TO SUCCESS

Breastfeeding rates are inadequate because of the fact that women continue to face barriers at several levels. These include lack of coordination and funding, inadequate human resources leading to overburdened health facilities, weak monitoring and evaluation mechanisms, private hospitals not involved, and ineffective implementation of the *Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003*. At the hospital level, babies are separated from mothers especially in cesarean section births, more so in private sector, weak capacity and competence of health staff, and unnecessary use of infant formula contributes to failures. Pre- and postnatal counselling and support

services are almost missing for early initiation and exclusive breastfeeding, probably because of the heavy workload of the health facility staff. Evidence^{10,11}, shows negative association between caesarean section delivery and early initiation of breastfeeding within an hour of birth and exclusive breastfeeding. Barriers to complementary feeding include traditional practices, time and knowledge of the parents and health workers, availability because of low income and aggressive marketing and availability of ready to eat foods.

OPPORTUNITIES



MAA programme recognizes skilled breastfeeding counselling as a vital intervention during pregnancy, at the time of birth and during the postnatal period in the health facilities and later in the community. The MOHFW, Government of India calls upon medical colleges and district hospitals to establish comprehensive lactation management centres; sub-district hospitals to establish lactation management units and all delivery points to establish lactation support units. The Home Based Young Child Care (HBYC) has a provision of 5 home visits by the health worker at 3, 6, 9, 12 and 15 months.

MAA programme recognizes counselling as a vital intervention to enhance breastfeeding practices.

CONCLUSIONS AND RECOMMENDATIONS

Breastfeeding counselling support is lacking in both public and private hospitals and women continue to face barriers to optimal breastfeeding. Use of formula during the hospital stay is common and known to be harmful for the health of the newborns and infants. Unsupportive environment at health facilities without any counselling during pregnancy, or support at the time of birth is not conducive to success of breastfeeding. Evidence shows that counselling works. MAA programme implementation lacks specific inputs in many of the steps.

It is, therefore, recommended that health workers, especially those working in maternity area are given the knowledge and skill to assist mothers. About 5-10 nurses in each hospital depending on its size should be competent enough to counsel the mothers. Dedicated counsellors in health facilities may help in bridging the gap of inadequate human resources. Same action is required at block level. Home visits must be ensured every

month till six months.

The Government of India and States should formally provide this health service and support to all women during antenatal, at birth and post-natal period through proper notifications to monitor these services. Adequate financial resources should be made available.



Photo credit: Nupur Bidla

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The Breastfeeding Promotion Network of India (BPNI) is a 28 years old registered, independent, non-profit, national organisation that works towards protecting, promoting and supporting breastfeeding and appropriate complementary feeding of infants and young children. BPNI works through policy analysis, advocacy, social mobilization, information sharing, education, research, training and monitoring the company compliance with the IMS Act. BPNI is the Regional Coordinating Office for International Baby Food Action Network (IBFAN), South Asia. BPNI also serves as the global secretariat for World Breastfeeding Trends Initiative (WBTi) programme, that analyses policy & programmes and galvanises action at country level.

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