

## Antenatal and Postnatal Counseling Support for Improving Breastfeeding Practices

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The importance of exclusive breastfeeding in providing the vital nutrients from birth to 6 months of age is undisputed. Its contribution to infant's growth and development is unparalleled; therefore, there is an urgent need to strengthen policies, and support interventions that enable initiation of breastfeeding within an hour of birth and continued exclusive breastfeeding until the infant is 6 months of age. In India, there has been an improvement of early initiation of breastfeeding from 24.5% in 2006 to 44.6% in 2014 (*i.e.*, a 1.8-fold increase) due to strengthening of policies, effective capacity building initiatives, community-based actions and strategic mass media communication [1]. Similarly, the disaggregated district-level data from the NFHS-4 highlights that about one-third of all the districts have exclusive breastfeeding levels that are higher than 60 percent [2]. Despite these improvements, further progress is needed to achieve the recommended standards endorsed by the World Health Organization (WHO) [3]. Though, majority of new mothers begin breastfeeding, the exclusive breastfeeding rates decline steeply over next 6 months [4].

It is well established that the decision to initiate and continue breastfeeding depends upon the personal and professional support offered to the pregnant woman beginning in her pregnancy till she is discharged from the hospital [5]. This is also supported by a systematic review, which concluded that experiencing support extends the duration of breastfeeding significantly [6]. In this issue of *Indian Paediatrics*, Gupta, *et al.* [7] report findings from a randomized controlled trial of person-to-person counseling provided by trained lactational counselors to women attending the antenatal clinic of a teaching hospital. The counseling on breastfeeding practices was provided during the antenatal period at health facility and postnatal period at home during the first six months of life. The women were recruited during the antenatal period (20-22 weeks) and randomized weekly after recruitment. The counselors provided two antenatal sessions and eight postnatal home visits after discharge to 150 women who were randomized to receive

the intervention, in addition to routine care. The women in the control arm (150) received routine care like diet in pregnancy, delivery-related precautions and breastfeeding counseling – care that is usually offered to women in the hospital by the health professionals, and did not receive the additional sessions of counseling by trained lactational counselors. The rates of early initiation were 89.2% in intervention vs 55.4% in control group amongst normal deliveries, and 34.1% vs 9.1% in caesarean deliveries. The exclusive breastfeeding rates were also significantly high throughout the study period in the intervention group declining from 98.6% on 3 day of birth to 88% at 6 months compared to the control group which declined from 85.6% to 50% at 6 months. At the age of six months, mothers in the intervention group (8.4%) were less likely to practice bottle-feeding than the mothers in the control group (22.9%).

These results are consistent with many studies that emphasize the importance of antenatal and sustained postnatal counseling [8,9]. The strength of the study was that it recruited trained lactational counselors and separate data collectors for assessment of outcomes. However, there are several limitations. The women were assessed for eligibility around 20-22 weeks. They were randomized if they fulfilled the inclusion criteria, but exclusion criteria were applied at a different time point after randomization. The women were excluded if they experienced any complications around delivery or delivered a preterm baby or a baby that was sick soon after birth. They failed to describe these exclusions, which help to inform the optimum conditions of a successful intervention. Allocation concealment in this open labelled trial was also not reported. Also, the authors did not describe the reasons for delayed initiation (mode of delivery, prematurity, sick neonate) and lack of exclusive breastfeeding in the two groups. This description would have helped to understand which women are most likely to benefit from such counselling strategy. Finally, they did not describe how a desirable response from counseled women could have been mitigated. Despite these limitations, the study

unequivocally establishes and endorses the critical role of antenatal counseling and sustained postnatal support for breastfeeding.

Though, one-to-one counseling is the gold standard for achieving the intended breastfeeding goals, providing frequent postnatal home visits by counselor may not be pragmatically feasible. We conducted a trial of using cell phones for antenatal counseling and breastfeeding support after delivery for women from the urban areas. It showed an unprecedented improvement (95% adherence at all visits) in the exclusive breastfeeding rates in the intervention group as compared to control group that received only standard care [10]. This experiment showed that alternative methods like tele-counseling also aid in improving exclusive breastfeeding rates. Therefore, there is a need for healthcare systems to guarantee continuity of skilled support for lactation between hospitals and community. Though, a positive effect has been observed in the study by Gupta, *et al.* [7], the practical feasibility of the intervention needs to be assessed, considering the requirement of additional manpower or burdening the existing manpower with additional postnatal visits.

*Funding:* None; *Conflict of interest:* None stated.

#### REFERENCES

1. Aguayo VM, Gupta G, Singh G, Kumar R. Early initiation of breast feeding on the rise in India. *BMJ Global Health*. 2016;1:e000043.
2. POSHAN Report 2017. Exclusive Breastfeeding in India: Trends and Data Gaps August 4, 2017 by IFPRI. Available from: <http://poshan.ifpri.info/2017/08/04/exclusive-breastfeeding-in-india-trends-and-data-gaps/>. Accessed January 20, 2019.
3. World Health Organisation. UNICEF. Available from: Global strategy for infant and young child feeding. Available from: <http://apps.who.int/iris/bitstream/handle/10665/425909241562218.pdf;jsessionid=C9D5D606B90A000C3E32FC762B1A8B07?sequence=1>. Accessed January 23, 2019.
4. Victora CG, Bahl R, Barros AJ, França GV, Horton S, Krasevec J, *et al.* Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet*. 2016;387:475-90.
5. Brand E, Kothari C, Stark MA. Factors related to breastfeeding discontinuation between hospital discharge and 2 weeks postpartum. *J Perinat Educ*. 2011;20:36-44.
6. Britton C, McCormick FM, Renfrew MJ, Wade A, King SE. Support for breastfeeding mothers. *Cochrane Database Syst Rev*. 2017;24:CD001141.
7. Gupta A, Dadhich JP, Ali SM, Thakur N. Skilled counseling in enhancing early and exclusive breastfeeding rates: an experimental study in an urban population in India. *Indian Pediatr*. 2019;56:114-8.
8. McInnes RJ, Chambers JA. Supporting breastfeeding mothers: Qualitative synthesis. *J Adv Nurs*. 2008;62:407-27.
9. Regassa N. Infant and child feeding practices among farming communities in southern Ethiopia. *Kontakt*. 2014;16:e215-22.
10. Patel A, Kuhite P, Puranik A, Khan SS, Borkar J, Dhande L. Effectiveness of weekly cell phone counselling calls and daily text messages to improve breastfeeding indicators. *BMC Pediatr*. 2018;18:337.