INVITED COMMENTARY

Breastfeeding Support in Health Facilities: A Challenge Less Recognized?

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Optimal breastfeeding is one of the most effective ways to ensure child health and survival [1]. The World Health Organization (WHO) recommends initiation of breastfeeding within first hour of birth and exclusive breastfeeding for the first six months of life [1]. Early initiation of breastfeeding is an important intervention that ensures that the baby receives colostrum and also increases likelihood of successful exclusive breastfeeding [2]. Harmful breastfeeding practices include discarding of colostrum and providing prelacteal feeding. The attitude and practices towards breastfeeding in India is not only determined by awareness of appropriate breastfeeding practices but also heavily influenced by traditional practices and other context-specific factors [3]. Hence, prevalence of optimal breastfeeding practices may vary from community to community and is evident from the regional difference of breastfeeding indices [4].

In this issue of *Indian Pediatrics*, Rasailly and colleagues [5] have studied and compared the practices of timely initiation of breastfeeding, colostrum feeding and use of prelacteal in the tea garden community of Assam (a marginalized community) and native villages of Assam. It is encouraging to find that more than three-fourth of mothers initiated breastfeeding within one hour of birth of their newborn in both tea gardens and villages (76.4% vs 82.6%), which is much better compared to previous reports from the area and even compared to other Indian data [4-6]. However, it is concerning that the practice of discarding colostrum is still highly prevalent in both the settings (39.2% in tea-gardens vs 28.8% in villages), which is worse than the previously reported prevalence from this area [5]. High rate of discarding colostrum, especially in tea gardens, could be attributed to local cultural factor such as negative perception towards use of first milk (colostrum) [6]. One of the striking findings of this study is the near disappearance of harmful practices of providing prelacteal feeding to newborn [5]. This could be an impact of greater institutional deliveries achieved in both the study groups as birthing in health facilities is known to have positive impact on breastfeeding practices including reducing prelacteal feeding [6]. The authors have also demonstrated that institutional delivery was positively associated with early initiation of breastfeeding and giving colostrum [5]. It is a public health success story that both study populations are on verge of achieving universal institutional deliveries with overall 97.5% children being delivered at medical facilities. However, it is observed that a significant proportion of babies did not have timely initiation of breastfeeding despite being born in health facilities and delivery being conducted by trained health care staff. Similarly, nearly 39.2% babies in tea garden and 28.8% in villages were not fed on colostrum despite being delivered at health facilities [5]. Multitude of factors such as cesarean deliveries, obstetric complications, breast-related problems, low birthweight, prematurity or other neonatal factors, lack of knowledge regarding correct technique or positioning of breastfeeding particularly among primigravida, and work overload of existing nursing staff to tackle ever increasing numbers of institutional deliveries may pose a barrier in early initiation of breastfeeding for babies delivered in health facilities [3,6,7].

Findings from this study also suggest that not initiating breastfeeding within one hour was associated with low birthweight and assisted/cesarean section delivery [5]. Prevalence of low birthweight is very high in this population, especially in tea gardens. On the other hand, numbers of delivery by cesarean section mode is also significant in numbers [5]. Hence, these two factors may act as important barrier in the early initiation of breastfeeding in this area. However, there is need to conduct more in-depth research, especially qualitative, to precisely know why such a large chunk of children were not breastfed within one hour of birth or deprived of colostrum despite the fact that 97.5% delivery took place in health facilities. Due to the shift of place of delivery from home to health facilities in India, there is also a shift in the responsibilities of timely initiation of breastfeeding from peripheral health workers and families to the nursing care providers of health facilities where the births take

place, hence identifying these institution level barriers will help in effectively mitigating those factors [7,8].

The institute level barriers might differ in different health care settings depending on adoption and implementation of program in health facilities for promoting, protecting and supporting breastfeeding as defined in BFHI (Baby Friendly Hospital Initiative) target [9]. The findings of the study warrant greater health system efforts for promoting optimal breastfeeding for the children born in health facilities, especially in tea gardens.There should be more sensitization in tea company's hospitals for promoting breastfeeding where deliveries of tea garden women are likely to be conducted. Optimal breastfeeding could be a cost-effective public health intervention for improving health and nutritional status of tea garden children among whom under-nutrition is highly prevalent [10].

Authors also explored the relationship between breast-feeding practices and some important individual and family level variables where they observed some differential relationship in both the settings [5]. This study found that breastfeeding practices were better in homemakers than working women in tea garden, where a substantial number of women work in tea garden as laborer. On the other hand, timely initiation of breastfeeding was associated with nuclear family in villages and joint family in tea gardens [5]. One important limitation of this study is that it did not take into account other potentially important variables associated with breastfeeding such as local cultural and social norms, and individual level enabling variables (e.g., knowledge regarding benefit of optimal breastfeeding, education and counselling on breastfeeding, breastfeeding skill etc.). Therefore, more comprehensive research is needed to better understand the complex relationship between these variables in relation to breastfeeding practices to plan effective context-specific interventions.

Overall, the silver lining is the near disappearance of the harmful practice of prelacteal feeding, and high rate of institutional delivery in the study population. However, significant proportion of women still delay breastfeeding and discard colostrum despite high institutional birth rate. Given a high rate of institutional deliveries in both the study settings, there is a missed opportunity for health care providers to counsel and support appropriate breastfeeding practices [8,9]. Quality improvement measures to optimize breastfeeding recommendations to reality on ground seem crucial.

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