Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

World Breastfeeding Week 2013

Breastfeeding Support: Close to Mothers

Introduction

Despite the recognition of the benefits of breastfeeding within the first hour of life, exclusive breastfeeding until 6 months of age, and breastfeeding for 2 years or more, there is a large gap between current breastfeeding practices in Latin America and the Caribbean and those recommended by the Pan American Health Organization/World Health Organization. As a result, neither young children nor their mothers fully enjoy its short- and long-term benefits.

In Latin America only 38% of infants are exclusively breastfed in their first 6 months of life (Table). In some countries, exclusive breastfeeding has been particularly resistant to change. For example, over the past 20 years exclusive breastfeeding in the Dominican Republic, already the lowest in the region (8%), has stagnated and in Mexico, it declined from 20% to 14.5%. However, over the same period, other countries have shown tremendous progress, such as Colombia where exclusive breastfeeding increased from 15% to 43%.

On average, children in Latin America and the Caribbean are breastfed for 14 months. However, as with other breastfeeding practices, there is great variability in breastfeeding duration. It ranges from only 7 months in the Dominican Republic and Uruguay to 18 months or more in Bolivia, El Salvador, Guatemala, Honduras and Peru. In some countries it has increased dramatically, like in Brazil, where it increased from 6 months in 1986 to 14 months in 2006 (PAHO/WHO, 2013). In others, like Mexico, it has remained stagnant at 10 months for more than 20 years.

Initiation of breastfeeding in the first hour of life reduces neonatal mortality, yet in the Americas only half of newborns receive this benefit, with countries presenting rates as low as 26.4%.

Table. Breastfeeding practices in 21 countries in Latin America and the Caribbean

Country	Indicator		
	Early initiation (%)	Exclusive breastfeeding < 6 months (%)	Median duration of breastfeeding (months)
Argentina, 2010	80.9	55.0	NA[1]
Bolivia, 2008	63.8	60.4	18.8
Brazil, 2006	42.9	38.6	14.0
Chile, 2008-10	NA	43.5	NA
Colombia, 2010	56.6	42.8	14.9
Costa Rica, 2006-08	NA	53.1	14.0
Cuba, 2006	70.2	26.4	NA
Dominican Republic, 2007	65.2	7.7 (E)[2]	7.1
Ecuador, 2004	26.4	39.6	14.7
El Salvador, 2008	32.8	31.5	18.7
Guatemala, 2008-09	55.5	49.6	21.0
Guyana, 2009	63.9	33.2	19.1
Haiti, 2005-06	44.3	40.7	18.8
Honduras, 2005-06	78.6	29.7	19.2
Mexico, 2012	NA	14.5	10.4
Nicaragua, 2006-07	54.0	30.6 (E)	18.4
Panama, 2009	NA	27.5	6.3
Paraguay, 2008	47.1	24.4	11.0
Peru, 2010	51.3	68.3	21.7
Uruguay, 2006-07	60.0	57.1	7.1
Venezuela, 2006-08	NA	27.9	7.5
Average (weighted for total number of births per country)	48.8	37.9	13.4

1 Not available.
2 Estimated.
Source: OPS/OMS. Situación actual y tendencia de la lactancia materna en América Latina y el Caribe: Implicaciones políticas programáticas. To be published, 2013.

Breastfeeding support: why and how

The focus of the 2013 World Breastfeeding Week is on the support needed to ensure optimal breastfeeding practices (http://worldbreastfeedingweek.org/).

Specifically, the goals are to:

- Draw attention to the importance of peer support in helping mothers to establish and sustain breastfeeding.
- Inform people of the highly effective benefits of peer counseling and unite efforts to expand programs.
- Encourage breastfeeding supporters, regardless of their ethnic, socioeconomic, or educational background, to step forward and be trained to support mothers and babies.
- Identify local community support contacts for breastfeeding mothers, whom they can go to for help and support.
- Call on governments, maternity facilities, and health centers to actively implement the 10 Steps to Successful Breastfeeding, in particular Step 10, to improve duration and rates of exclusive breastfeeding by providing support to breastfeeding mothers.

Traditionally breastfeeding has been a cultural norm and support provided by families and the community. However, as a consequence of global demographic transitions, especially urbanization and formal employment, which most Latin American and Caribbean countries have experienced, the source of breastfeeding support needs to be greatly expanded to encompass all members of society, including trained *peer counselors*.

Peer counselors are either women who have experience with breastfeeding or counselors of similar ethnic, socioeconomic and cultural background to the mothers they are supporting. They provide the necessary support to mothers to overcome breastfeeding barriers, including:

- Cultural barriers: such as perceived "insufficient milk", which continues to be the main reason for breastfeeding cessation.
- Health service barriers: so that women are empowered to question advice from health professionals when counseled to use breast-milk substitutes or stop breastfeeding and to advocate to give birth in Baby Friendly Hospitals.
- Work place barriers: so that women know how to ask for a private, comfortable, and hygienic place to express and store breast-milk for a family member or caregiver to give to their child.
- Legislative and policy barriers: so that women are supported in their demand for breastfeeding legislation and policies and their enforcement.
- Commercial barriers: so that mothers' self-confidence is reinforced when inappropriate marketing of breast-milk substitutes creates doubts about their ability to adequately nourish their infants through breastfeeding.

Peer support and counseling is recognized by WHO and UNICEF as an important component of policies and programs to support breastfeeding. One of the 10 Steps of the Baby Friendly Hospital Initiative recommends hospitals and maternity facilities to "Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic." This step has been the most difficult one to implement and illustrates the continued challenge of providing comprehensive support to mothers in a systematic and long term basis.

Effectiveness of peer support and counseling

Peer support has a positive impact on early initiation of breastfeeding, exclusive breastfeeding, and breastfeeding duration. In low- and middle-income countries, peer support reduced the risk of discontinuing exclusive breastfeeding by 30% (Sudfeld et al., 2012). Chapman and colleagues in their systematic review showed that "peer counselors effectively improve rates of breastfeeding initiation, duration and exclusivity" (Chapman et al., 2010). It also decreases infant diarrhea and increases the duration of lactational amenorrhea, thereby extending the birth interval in the absence of modern contraception.

Peer counseling programs are also effective when scaled-up through networks of well trained *peer counselors* and strong support from national and local authorities (Worobec, 2009). In South Africa, the most cost effective model for improving exclusive breastfeeding occurred entirely through clinic-based contacts (Desmond et al., 2008). The most effective programs also provided some compensation *to peer counselors.*

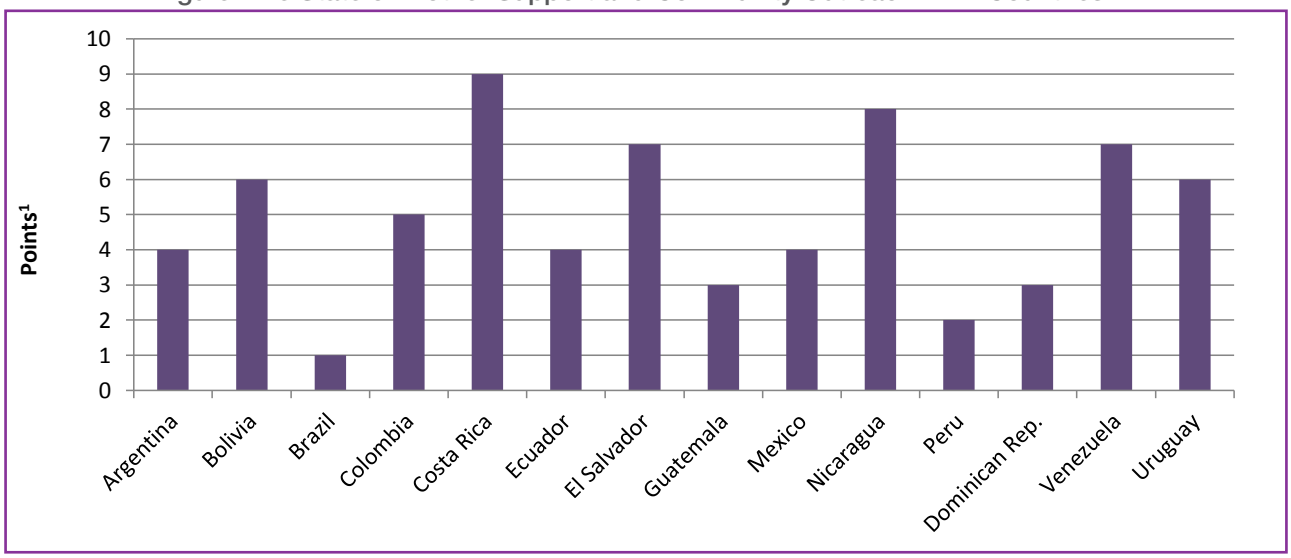
Challenges remain for scale up of *peer counseling* programs (Chapman et al., 2010). These include defining:

- The most effective peer counselor training programs.
- Salary ranges and supervisory structures.
- Prenatal, perinatal, and postnatal service delivery modes, such as phone, hospital/clinic-based, or home visits.
- Support and educational approaches, including individual counseling and support groups.
- Number of contacts or visits, and time per contact or visit.

Assessing peer support in the Americas

Despite the well-demonstrated benefits of *peer counseling*, more needs to be done to provide this support to women during the critical days after delivery and beyond. One of the indicators of the World Breastfeeding Trends Initiative (WBT*i*) tool is "mother support and community outreach", or community-based support for the pregnant and breastfeeding mother (Gupta et al., 2012). The purpose is to verify if the country is protecting, promoting and supporting optimal infant and young child feeding practices by providing support to the breastfeeding mother in the community. How well countries in Latin America and the Caribbean fare on this indicator is illustrated in the Figure.

Figure. The State of Mother Support and Community Outreach in 14 Countries



1 The score for this indicator, which ranges from 0 to 10, is based on: women have access to community-based support systems and services on infant and young child feeding during pregnancy and after birth; these services have national coverage and are integrated into an overall infant and young child health and development strategy; and volunteers and health workers possess correct information and are trained in counseling.

Source: Graph created from data from the World Breastfeeding Trends Initiative (http://worldbreastfeedingtrends.org/)

Breastfeeding support provided by Brazil: a model to replicate!

A cost effective way to provide breastfeeding support is to incorporate it into routine care provided at primary health care centers. In countries with high coverage, it provides the opportunity to reach pregnant women and mothers in a large scale, more so than home visits, since in many countries primary care is offered to women at no cost.

In Brazil, a strategy called Breastfeeding Friendly Primary Care Initiative (IUBAAM, in Portuguese) was developed in 2001 and 2002 to be implemented at a national level. It was based on the Baby Friendly Hospital Initiative, and aimed at addressing steps 3 ("Inform all pregnant women about the benefits and management of breastfeeding") and 10 ("Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic"). This initiative has been implemented successfully in the state of Rio de Janeiro.

Health workers undergo a 24-hour training course to learn to provide information about breastfeeding techniques, such as correctly positioning the baby at the breast, support when problems arise, such as engorgement or cracked and sore nipples, and also to discuss with mothers ways to deal with conflicting roles, such as being a wife and a working mother. They are also trained to discourage mothers to use bottles, pacifiers and breast milk substitutes.

The initiative has been successful in increasing not only the duration of exclusive breastfeeding and overall breastfeeding but also the satisfaction of mothers with the support provided. A study that measured the impact of the initiative showed that the rates of exclusive breastfeeding in units with better quality breastfeeding support were 38.6% compared to 23.6% in units with lower levels of breastfeeding support, while the rates of satisfaction with the support was 61.9% for the former and 31.4% for the latter (Oliveira et al, 2005).

As part of a qualitative study, mothers were interviewed about their view of the support received in PHC units in the state of Rio (Oliveira et al, 2010). One mother said that she thought she would have to stop breastfeeding her baby when she went back to work as a domestic employee. At the health clinic, she was advised to take her baby with her to work. She discussed it with her boss, who accepted it. Another said she learned that putting the baby correctly at the breast might help to heal cracked nipples. As for the type of support they would like to have, mothers stressed that they need motivation, even persuasion, and support provided in the form of a dialogue.

Other types of support needed

In addition to *peer counseling and support,* mothers need other types of support to successfully breastfeed.

These include:

- Support by health systems: there are many ways to support mothers through health services, such as information provided on prenatal care; labor and delivery practices that facilitate bonding and early breastfeeding initiation; and health workers trained in counseling skills to support mothers in the first months after birth (see Box for the example of an initiative).
- Work and employment legislation: laws that ensure opportunities for mother-baby contact, and expression and storage of breast-milk.
- Government policies and legislation: establishment of national breastfeeding commissions, and legislation that regulates marketing of breast-milk substitutes and enacts paid maternity leave.
- Support in emergencies: special planning and support is needed in situations of natural disasters, refugee camps, critical illness of mother or baby, or high HIV/AIDS prevalence.

Mothers also need supportive environments that foster breastfeeding and that reflect a culture in which breastfeeding is seen as the best food for babies and mothers feel empowered by their ability to provide nourishment to their children.

Next steps

Therefore, we all need to work together to promote and support legislation, policies and programs that:

- Scale up *peer counseling*.
- Link *peer counseling* to other breastfeeding protection, promotion and support activities, such as the Baby Friendly Hospital Initiative.
- Provide supportive environments in workplaces, schools, markets and other places where breastfeeding women carry out their daily lives.
- Systematically monitor and evaluate *peer counseling* programs to improve their effectiveness and impact.

More needs to be done to ensure that all pregnant women and mothers get the support they deserve!

Let's use this year's World Breastfeeding Week, whose slogan is "Breastfeeding Support: Close to Mothers", to call attention to the need to revitalize and redouble our efforts so that all mothers have access to *peer counseling and support* and also to our obligation to create supportive breastfeeding environments so that all women are empowered to breastfeed their children.

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This brief and other materials on infant and young child feeding and nutrition are available at www.paho.org/childfeeding.

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