

WABA Research Task Force (RTF) e-newsletter

August 2010 issue

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From the Editors

We are pleased to share with you the inaugural issue of the WABA Research Task Force (RTF) E-newsletter. There is an abundance of research and much of this can be accessed through journals and databases such as Medline. This newsletter aims to present some of this emerging research in a comprehensive and easy-to-read format. For each issue, we will choose a few current topics where we ask key researchers/programme experts to summarise the latest research and explain how these findings can be applied in the real world.

You will also find abstracts and commentaries on a few research studies and the links to the full text articles for further reading. We hope that this newsletter will enhance your work, whether programme, clinical or advocacy, as well as stimulate discussion about research findings, methodologies and ethics.

Your comments on the current topics and articles are most welcome! If you have any suggestions for future topics, please let us know. The newsletter will be issued three times a year.
Enjoy reading!

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Exploring the impact of the Baby-Friendly Hospital Initiative on trends in exclusive breastfeeding

By Sheryl W Abrahams and Miriam H Labbok
International Breastfeeding Journal 2009, 4:11

The Baby-Friendly Hospital Initiative (BFHI) seeks to support breastfeeding initiation in maternity services. This study uses country-level data to examine the relationship between BFHI programming and trends in exclusive breastfeeding (EBF) in 14 developing countries. Demographic and Health Surveys and UNICEF BFHI Reports provided EBF and BFHI data.

BFHI implementation was associated with average annual increases of 1.54 percentage points in the rate of EBF of infants under two months ($p < 0.001$) and 1.11 percentage points in the rate of EBF of infants under six months ($p < 0.001$), however these rates were not statistically different from pre-BFHI trends.

BFHI implementation was associated with a statistically significant annual increase in rates of EBF in the countries under study; however, small sample

Peer counselling and breastfeeding

By Barni Nor¹

sizes may have contributed to the fact that results do not demonstrate a significant difference from pre-BFHI trends. Further research is needed to consider trends according to the percentages of Baby-Friendly facilities, percent of all births occurring in these facilities, and continued compliance with the program.

URL: <http://www.internationalbreastfeedingjournal.com/content/pdf/1746-4358-4-11.pdf>

Editors comment: *Although the BFHI programme is definitely a tool for positive changes in exclusive breastfeeding, measuring the true impact of BFHI is quite complex. The increase in exclusive breastfeeding at national level depends on multiple factors. The BFHI programme needs to be enforced with other national promotional efforts and community support programmes in order to increase exclusive breastfeeding rates. In Oman where all public hospitals were certified Baby-Friendly the exclusive breastfeeding rate actually dropped to <30% at 3 months of age!*

Exclusive breastfeeding (EBF) is recognised to make an important contribution in improving infant health and survival and is further associated with decreased risks of HIV transmission compared to mixed-feeding (breast milk in addition to other liquids or solids). Despite this knowledge EBF remains rarely practiced in most countries, especially in low-income settings where infants could benefit most from this feeding mode. Two strategies have been reported to increase EBF rates. The Baby Friendly Hospital Initiative (BFHI) within health care facilities and the use of community-based lay health workers such as peer supporters.

While the BFHI has been an important milestone in establishing EBF initiation at the hospital, the development of peer support has been recognised to be critical in sustaining EBF beyond the first weeks of birth. Further, the use of peer support has additional significance in low-income settings, where most babies are delivered at home or where access to health care services is limited.

The impact of peer support as an approach to increase EBF rates is however not totally conclusive. Several randomised controlled trials in Asia, Latin America and in North America report a significant increase in EBF initiation and duration, while trials in UK have failed to show much impact. Considering the diversity of communities it is possible that the success of peer support programs has much to do with the specific nature of the context in which they are implemented.

Main elements of peer support

Currently, there is little or no precise and agreed definition of “community or lay health workers”. Complex and confusing terminology is often used to describe various types of non-professional health workers. In a Cochrane review based on 43 trials where the effects of lay health worker

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interventions were assessed, community or lay health workers were defined as *“any health worker carrying out functions related to health care delivery; trained in some way in the context of intervention; and having no formal professional or paraprofessional certified or degree tertiary education”*. A number of conditions should be met before implementing peer support (1).

Peer supporters should be **part of the communities** they serve and should be selected by the community members for the task.

Peer supporters should be **“equal”** to mothers, have similar characteristics such as age, social status and educational background and have limited or no previous health background.

Peer supporters must have **an experience** in child care and feeding.

In principle, peer support is considered effective when these requirements' are present. This creates the expectations that the relationship between peer supporters and mothers is mutual, and thus the gap separating professional caregivers and mothers is minimised. This way, mothers will be more confident to accept and take up key messages on EBF. Peer supporters are further believed to have the capacity to reach mothers in their real life situation which enables them to better conceptualise mothers actual problems in sustaining EBF in comparison to nurses and doctors.

Peer support as such is a tool which seeks to serve three main purposes:

- **Informative Counselling** – It strives to give mothers adequate information of different facts in order for them to make a sound judgment.
- **Supportive Counselling** – It aims to help mothers safeguard their choices.
- **Preventive Counselling** – It aims to develop awareness for and confidence of sustaining exclusive breastfeeding.

In terms of recruitment and accountability of these workers, a statement from a WHO Study Group suggests that *“Community health workers should be members of the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organisation and have shorter training than professional health workers”*. Community participation is foundation of peer support programs.

Application for practice

Peer support is a complex and dynamic concept and encompasses a wide range of activities depending on the purpose for which it is being used. As such, the operational effectiveness of peer support programs is not without problems (2) and may vary depending on the context in which it occurs. **It is therefore necessary to conceptualise the specific socio-cultural and economic context in which peer support programs are being implemented.** Numerous programs have failed in the past because of unrealistic expectations. Some of the operational factors

Implications of the new WHO guidelines on HIV and infant feeding for South Africa

By Tanya Doherty² and Debra Jackson³

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worth investigating before, during and after implementing peer support programs include:

- **The concept of community** – i.e. how do different communities organise themselves (rural versus urban conditions)?, what constitutes a community?, who speaks for the community?, and what is women's status, role and involvement within a specific community?
- **The process of selecting** women for the task? – i.e. what motivates women to volunteer?
- **The process of training** peer supporters for the task – i.e. what type of training of should these workers have? and for how long?
- **The process of managing and supervising** peer support programs? – i.e. what are the essential characteristics of peer support supervisors?, how are they trained, managed and in turned supported with regards to salary and work hours?

Since primary health care – in its 30th year after the declaration of Alma-Ata – is currently being revised, we should take the opportunity to rethink the role of lay health workers in health promotion programs such as EBF. Our responsibility as researchers and public health providers is to find ways to utilise the “good will” of local women volunteering in an effective manner.

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2. Nor, B., et al., “Peer but not peer”: Considering the Context of Infant Feeding Peer Counseling in a High HIV Prevalence Area. J Hum Lact, 2009: p. 0890334409341050.

In November 2009, WHO released a rapid advice outlining revised principles and recommendations for HIV and infant feeding (1). These recommendations are based on programmatic evidence and research studies that have accumulated over the past few years within African countries. There is now greater emphasis placed on ensuring the optimal health of the mother. The first recommendation states that mothers receive the care that they need through anti-retroviral treatment or prophylaxis in line with the new WHO recommendations on anti-retroviral drugs for pregnant women and infants (2). Furthermore there is a recommendation that either the infant or the mother receive antiretroviral prophylaxis for the duration of breastfeeding to reduce postnatal transmission.

The second recommendation is perhaps the most welcomed in the child health community. Evidence to support exclusive breastfeeding for all HIV infected women for a period of six months is highlighted from South Africa, Zimbabwe and Zambia. Translation of this recommendation into operational settings requires policies to change towards one recommended option for HIV positive mothers at national

or sub-national levels based on local circumstances (Key Principle 3) rather than the current, often confusing choices.

There is also guidance on when and how to safely stop breastfeeding (Recommendation 3), what to feed infants when breastfeeding is stopped (Recommendation 4) and heat treatment as an interim feeding strategy (Recommendation 6). A final strong recommendation (7) is that infants infected with HIV should be breastfed exclusively for six months with continued breastfeeding for two years as for the general population. This is based on evidence from Botswana and Zambia showing the extreme mortality risk to HIV infected infants from not being breastfed.

Recommendation 5 of the new guideline sets out six clear requirements for safe formula feeding including reliability of supplies. This is particularly relevant for countries such as South Africa and Botswana where the governments provide free formula milk to HIV positive women choosing not to breastfeed. There is currently discussion in South Africa of the need to review the policy of provision of free formula since evidence (3) has shown that it has not been chosen appropriately and that women's home circumstances are not being taken into account in counselling.

In South Africa the WHO Rapid Advice on HIV was embraced by the Presidency on World AIDS Day. In South Africa, however, in addition to the policy changes required there is also a major challenge to improve exclusive breastfeeding practices, where the Demographic and Health Survey (DHS) cites an overall EBF rate of only 7%, amongst the lowest in Africa. The reasons for this low rate are complex and involve longstanding support of formula milk through the government protein-energy malnutrition (PEM) scheme and the lack of support for breastfeeding as a consequence of the high HIV prevalence. **Increased investment in advocacy and regeneration of programmes such as the Baby Friendly Hospital Initiative (BFHI) as well as World Breastfeeding Week are urgently needed to ensure that these new recommendations are translated into improved breastfeeding rates overall and improved infant feeding practices in the context of HIV.**

These revised recommendations provide an opportunity for policy makers and health workers to utilise the accumulated evidence to initiate a period of rapid reductions in postnatal HIV transmission through access to antiretrovirals and optimal infant feeding.

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Commentary on impact of maternity benefits on successful breastfeeding

By Dr. JP Dadhich⁴

The global recommendation for optimal breastfeeding requires women to practice exclusive breastfeeding for the first six months of her child's life. This requires a woman to be with her infant 24 hours a day during this period. However, with increasing number of women adopting work outside their home in the postnatal period, the task is becoming increasingly difficult. **To practice exclusive breastfeeding mothers require support from their employers, co-workers, governments and their communities in the form of sufficient maternity benefits.**

Maternity benefits are legislative and executive measures to protect the breastfeeding rights of working women. These benefits encompass maternity leave along with other provisions such as nursing breaks, facilities for nursing infants, support for pregnant and lactating women regarding duty hours and type of work, and job protection and payment etc.

Research evidence

It has been documented that mothers who intend to work full time post partum, often do not even initiate breastfeeding, and those who initiate stop breastfeeding, citing early breastfeeding problems. **On the other hand, duration of maternity leave, which ensures delayed return to work for varying period of time, is positively associated with a prolonged duration of breastfeeding. Studies have shown that short postpartum maternity leave among full-time working mothers is associated with higher risk of early breastfeeding cessation.** A case control research study conducted in California, USA and published in the Journal *Pediatrics* (5), analysed the effects of maternity leave and occupational characteristics (e.g. job autonomy) on breastfeeding initiation and duration (1). Salient results reported by the study were:

The length of postpartum maternity leave was associated with breastfeeding establishment in the early weeks after birth. Mothers who returned to work within 12 weeks after delivery, and especially within six weeks, were less likely to establish breastfeeding than those who took longer leaves.

Women who described their jobs as managerial, fulfilling, or high in autonomy were more likely to establish breastfeeding.

Returning to work and short postpartum leave were related to earlier breastfeeding cessation, and having a manager position, autonomous position, or flexible work schedule was associated with longer breastfeeding duration. In a multivariate model including occupational factors, returning to work within six weeks was the strongest predictor of breastfeeding cessation.

Existing situation of maternity benefits in India

The government of India has given some limited facilities to the working women regarding maternity benefits:

4. Dr J.P. Dadhich is a Pediatrician and infant feeding specialist. He is the coordinator of the Breastfeeding Promotion Network of India, Delhi, India.

- **Maternity Leave** – Twelve weeks paid leave to all working mothers (2) Six months maternity leave to the female employees of Central Government. (3)
- **Paternity Leave** – A male central government servant gets 15 days of paternity leave during the confinement of his wife (3) Nursing Breaks – Two breaks of the prescribed duration for nursing the child until the child attains the age of fifteen months. (2)
- **Child Care Leave** – Women employees of central government having minor children may get child care leave for a maximum period of two years (i.e. 730 days) during the entire service for taking care of up to two children whether for rearing or to look after any of their needs like examination, sickness etc. (3)

Status of global maternity benefits

An analysis of the status of national policies and programmes on maternity benefits in 31 countries of Africa, Asia and Latin and Central America, **using the World Breastfeeding Trends Initiative (WBTi), has revealed a very dismal picture (4)**. The assessment included parameters like the duration of breastfeeding, breastfeeding breaks after resuming work, worksite accommodation for breastfeeding or expression and storage of breast milk, scope of coverage of the national programmes to include women in the unorganised sector and private sector, dissemination of the information about maternity benefits, paternity leave, and ratification and enactment of the ILO MPC 183.

The average score received for this indicator was 4.5, with Brazil and Sri Lanka having the highest score at 7.5, and Bangladesh and Uganda having the lowest at 1 and 1.5 respectively. In 20 of the 30 countries assessed, women working in the formal sector are given up to 14 weeks of paid maternity leave. Only three countries offer leave for up to six months or more: Sri Lanka and Mongolia offer leave more than 26 weeks, while Bolivia offers leave up to 25 weeks. In India, there is dichotomy in the maternity leave offered to women. Women working for the Central Government and some state governments are given paid maternity leave, along with an additional paid 18 months of leave that can be taken for child care any time up till the child is 18 years old. However, the maternity legislation itself provides for less than 14 weeks leave for those employed by the private sector.

Application for practice

It is amply clear from the discussion above that governments and societies need to come forward to support lactating women who are engaged in full time work outside the home to provide maternity benefits including breastfeeding leave for six months post partum. Along with the leave, access to adequate information and skilled counselling for breastfeeding should be ensured. Work site facilities like Crèches, accommodation for breastfeeding or breast milk handling and breastfeeding breaks should be universalised. Governments and society should understand that this is an investment for a healthy childhood and motherhood for a nation.

Exclusive breastfeeding in Sri Lanka: problems of interpretation of reported rates

By Suneth B Agampodi,
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and Avanthi de Silva
International Breastfeeding
Journal 2009, 4:14

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3. The Government of India. Sixth Central Pay Commission. Available at: <http://india.gov.in/govt/paycommission.php>.
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Accurate interpretation of reported breastfeeding rates is essential in understanding the true picture of a country's breastfeeding status. This paper discusses the problems of definitions, measurements and interpretation of EBF rates in the Demographic and Health Surveys (DHS) using the example of Sri Lanka. WHO recommends estimating EBF rates based on the 24 recall method, for cross-sectional studies. Information is gathered about the feeding practices during the preceding 24 hours. Another method is that of "recall since birth". In this method, an infant is categorised as being EBF only if they have not received any food or drink apart from breastmilk since birth. **The 24 hr recall method tends to overestimate the EBF rates compared to the recall from birth method.** According to the 2007 DHS, Sri Lanka has an exclusive breastfeeding (EBF) rate among infants aged from 0 to 5 months of 75%. The authors emphasise the fact that this is figure does NOT represent the proportion of infants that are exclusively breastfed until just under six months. It is a calculated average of all the EBF rates in ALL the age categories below six months. The problem lies in the misinterpretation of the EBF rate to mean that 75% of all Sri Lankan infants are exclusively breastfed since birth until the completion of 6 months. Sri Lanka has thus achieved a high EBF rate and health workers begin to believe that no further effort should be made in this area. This is very dangerous as the potential to further improve rates of EBF will not be addressed. We discuss the interpretation of survey data and various definitions used in the relevant literature. We strongly recommend that interpretation of EBF rates should be done only after careful evaluation of the definitions and survey methods used.

URL: <http://www.internationalbreastfeedingjournal.com/content/pdf/1746-4358-4-14.pdf>

Editors comment: *This commentary highlights how important it is to look carefully at the definitions and methodology used when interpreting surveyed EBF rates in a given country. Although it may seem encouraging for a country to have a high EBF rate, this may be misleading and undermine efforts to protect, promote and support breastfeeding. In the Sri Lankan case described above, the authors speculate that the EBF rate may be as low as 20%!*

Physician mothers: an unlikely high risk group – call for action

By Maryam Satari, David Levine
and Janet R Serwint
BREASTFEEDING MEDICINE
Volume 5, Number 1, 2010

Breastfeeding rates have been improving in the United States. However, current rates, especially those of exclusive breastfeeding and breastfeeding duration, are still below the Healthy People 2010 objectives. Furthermore, gaps in breastfeeding rates continue to exist among different racial and socioeconomic groups. Physician mothers' breastfeeding behavior has been studied because it impacts their anticipatory guidance to their patients, which in turn influences patients' breastfeeding initiation and continuation. In this paper, we review available literature regarding breastfeeding among female physicians in the United States. The current data suggest that female physicians are initiating breastfeeding more often than the general population but their continuation rates are lower. In other words, **working as a physician might be a newly identified maternal characteristic associated with low breastfeeding maintenance rates.** We also review possible factors that might affect breastfeeding decisions and behaviors of physician mothers. Once modifiable factors are further identified, programs can be suggested and implemented to improve breastfeeding continuation in this newly identified high-risk group.

URL: <http://www.liebertonline.com/doi/pdfplus/10.1089/bfm.2008.0132>

Editors comment: *This review article is unique in that it identifies a “new” target group for breastfeeding promotion, protection and support work. Although the studies reported in this article were conducted in the US, it is likely that similar patterns may be found amongst physicians (and other health workers for that matter) elsewhere in the world. Further qualitative research is needed to understand the obstacles and enabling factors, such as the existence of maternity leave and other workplace support systems. It is high time that breastfeeding advocacy and programs also address the situation for health professionals, the very same persons whom we expect to deliver supportive health services to the general public.*

“No sister, the breast alone is not enough for my baby” a qualitative assessment of potentials and barriers in the promotion of exclusive breastfeeding in southern Zambia

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Journal 2008, 3:26

Appropriate feeding practices are of fundamental importance for the survival, growth, development and health of infants and young children. The aim of the present study was to collect baseline information on current infant and young child feeding practices, attitudes and knowledge in Mazabuka, Zambia, using a qualitative approach. Nine focus group discussions with mothers and a total of 18 in-depth interviews with fathers, grandmothers, health staff and traditional birth attendants were performed in both rural and urban areas. Breastfeeding was reported to be universal, the use of pre-lacteal feeds appeared to be low, colostrum was rarely discarded, and attitudes to and knowledge about exclusive breastfeeding were generally good. However, few practised exclusive breastfeeding. The barriers revealed were: (1) the perception of insufficient milk, (2) the fear of dying or becoming too sick to be able to breastfeed, (3) convention, (4) the perception of ‘bad milk’ and (5) lack of knowledge on the subject. The health staff and traditional birth attendants were the most important actors in transmitting knowledge about infant feeding to the

mothers. Both categories appeared to have updated knowledge on child health and were well respected in the society. Fathers and grandmothers tended to be less knowledgeable on novel subjects such as exclusive breastfeeding and often showed a negative attitude towards it. At the same time they had considerable authority over mothers and children and infant feeding decisions. The rural population was in general less educated and more prone to conventional non-exclusive feeding practices. The message that exclusive breastfeeding (EBF) is beneficial for child health had reached the health workers and was taught to mothers. However, conventions and expectations from family members in this Zambian community were important barriers in preventing the message of EBF from being translated into practice. The deep-rooted beliefs that prohibit EBF need to be addressed in projects and campaigns promoting EBF.

URL: <http://www.internationalbreastfeedingjournal.com/content/pdf/1746-4358-3-26.pdf>

Editors comment: *Qualitative research can shed light on some of the underlying beliefs, attitudes, misconceptions and knowledge gaps not brought out in a classic quantitative study. An example of this is presented in the above-mentioned research study which aimed at using the information gathered to design an intervention to improve IYCF practices. The study also highlights the lack of autonomy in decision-making especially amongst young mothers which reinforces the need to empower women through education and income generation. At the same time men/spouses and grandmothers need to be targeted in health/breastfeeding education programmes for exclusive breastfeeding rates to increase, how do we meet this need?*



The World Alliance for Breastfeeding Action (WABA) is a global network of individuals and organisations concerned with the protection, promotion and support of breastfeeding worldwide based on the Innocenti Declaration, the Ten Links for Nurturing the Future and the WHO/UNICEF Global Strategy for Infant and Young Child Feeding. Its core partners are International Baby Food Action Network (IBFAN), La Leche League International (LLL), International Lactation Consultant Association (ILCA), Wellstart International, and the Academy of Breastfeeding Medicine (ABM). WABA is in consultative status with UNICEF and an NGO in Special Consultative Status with the Economic and Social Council of the United Nations (ECOSOC).

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