BREASTFEEDING INITIATION AT BIRTH CAN HELP REDUCE HEALTH INEQUALITIES

Introduction

WHO recommends that colostrum, produced at the end of pregnancy, is the newborn´s perfect food and it provides immune protection while the newborn's own immune system is developing. Breastfeeding should be initiated within the first hour after birth and be exclusive for six months. Benefits for infants include: reduction in diarrhoea and respiratory infections; protection against risk of obesity; improved I.Q.; and reduced risk of allergies as well as chronic diseases, such as diabetes, which have an immunological basis (1). Benefits for mothers include reduced risks of breast/ovarian cancer and obesity (1).

Breastfeeding Initiation by socioeconomic status (SES)

Mothers with lower SES (less income, education and employment) are much less likely to initiate breastfeeding than those with higher SES (up to 10 fold difference) and this is transmitted through generations (2). Moreover mothers with low SES may be adolescents and/or be obese and their infants are at risk of growth retardation as well as poor I.Q. development. Unfortunately data on breastfeeding initiation rates at birth, disaggregated by SES and age, are often lacking although these data could provide vital information to help reduce current differences.

KEY MESSAGES

- Don't assume what works for most, works for all – investigate reasons for lack of attendance by mothers from low socioeconomic groups (SEGs) at ante/perinatal services.
- Mothers from low SEG tend not to participate or drop-out and so our services may inadvertently contribute to exacerbating inequities.
- BFHI implementation, paid maternity leave and enforcement of International Code can improve breastfeeding initiation and duration.
- Pregnancy presents a window of opportunity to reduce health inequities:
  - Use participatory approaches to improve antenatal attendance of mothers from low SEGs and help remove barriers to breastfeeding and raise self-esteem;
  - Ensure skilled breastfeeding support, specialized for low SEG mothers, adolescents and their families;
  - Provide social benefits for fresh food purchases during lactation e.g. vouchers for vegetables; and
  - Protect breastfeeding in public places as the norm.
- Monitor breastfeeding initiation rates by SES along with the determinants of initiation.

Table 1. Examples of effective interventions to reduce inequity and improve breastfeeding initiation rates.

Drivers of inequity in mothers of low socioeconomic status	Examples of interventions to reduce inequity
Poverty	• Raise incomes through social protection; minimum wage and paid maternity leave. • Provide welfare vouchers for purchase of fresh food during lactation e.g. France. • Offer life-long education and skills training.
Barriers to accessing health services	• Implement BFHI throughout all birthing facilities and services. • Recruit professionals with diverse socioeconomic backgrounds. • Screen services to reduce marginalization and train staff how to avoid being judgemental. • Deliver breastfeeding counseling in community e.g. churches. • Recruit peer community workers or create mother-to-mother support groups.
Social marginalization	• Strengthen collaboration between health sector and sectors dealing with social protection and unemployment. • Empower adolescents to aspire to breastfeed. • Provide affordable and acceptable childcare, pre-school and schools that include breastfeeding as a "norm".
Marketing of infant formula	• Implement fully the Code in national law and enforce it.
Obesity	• Provide skilled professional assistance to support obese mothers to overcome the physiological and mechanical barriers to breastfeeding initiation.

What can be done?

1. In 1991 the Baby-friendly hospital initiative (BFHI) was launched. The original BFHI "Ten Steps" are now augmented to support both mother and baby in a wider range of settings and new community components include: leadership; counseling via local services; and training for all who assist in home deliveries. Implementation and regular updating of national plans should be monitored by a national breastfeeding coordinator along with a multi-sectoral breastfeeding committee.
2. The International Code of Marketing of Breastmilk Substitutes (BMS) and subsequent relevant World Health Assembly resolutions (the Code) regulate the marketing of BMS to protect the provision of nutrition for infants by regulating practices which can discourage breastfeeding. The Code ensures access to unbiased information and so enables parents to make decisions about infant feeding free from commercial pressures. Countries are recommended to: translate the Code into national law; enforce it; monitor violations; and act on violations through sanctions. The Code includes 10 important provisions that are summarized in the *Guide for Health Workers* (3). Even though the European Union (EU) Directive (2006/141) does not

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encompass the Code in its entirety, because it is adopted as a minimum requirement within the EU, national monitoring can, in addition to the Directive´s provisions, cover the Code provisions too.

3. Paid maternity leave, funded by social insurance or public funds, is a core requirement for the health and socioeconomic protection of mothers and their infants. Most countries have adopted statutory provisions for paid maternity leave however some protect *exclusive breastfeeding for 6 months* better than others. For example, a draft EU maternity leave Directive, adopted in its first reading by the European Parliament in 2010, has been stalled by the EU Council of Ministers. The Directive´s aim was to ensure a minimum of 20 weeks fully paid maternity leave across the EU and women were protected upon return to work. Fortunately many countries in the WHO European Region have adopted maternity leave that supports *6 months of exclusive breastfeeding* and research shows this improves initiation rates and breastfeeding maintenance (4). In addition no negative impact on productivity is observed and substantial benefits for businesses, including small and medium sized, are also indicated (5).

Use a step-wise approach and "First do no harm"

We must ensure current services do not make inequities worse. Unfortunately, though not our intent, health services may inadvertently make inequities worse. Our "usual" approach may have a negative impact on mothers most in need. For example information campaigns delivered without structural support and protection policies may have a negative impact because low income groups may be unable to act on the information due to lack of money, education, or employment rights. Community workers or mother-to-mother support groups may have more success compared with health professionals. For example, Roma Health Mediators, RHM, members of the Roma community, are trained to liaise between the community and health system. Health service utilization, especially for pregnant women among the Roma, has improved. The project works to advance the health and human rights of Roma by building the capacity of civil society leaders and organizations, as well as providing employment for, mostly female, RHMs. For more case studies related to improved breastfeeding initiation rates please see: http://www.unicef.org.uk/BabyFriendly/Commissioners/Case-studies/.

Interventions to reduce health inequities related to breastfeeding initiation

Interventions to reduce inequities in breastfeeding initiation demands a combination of innovative antenatal care and parenting support for mothers in low SEGs, incorporating BFHI criteria, along with paid maternity leave and acting on violations against International Code. Example of effective interventions are outlined in Table 1. Text box 1 provides a useful checklist for organizations, facilitities, policy makers and individuals to assess how they are doing when it comes to decreasing health inequities and improving rates of breastfeeding.

Conclusion

The most socially isolated mothers may feel marginalized by our health services so that they feel excluded from the health care system and are not willing to seek support. They require different approaches to help them feel empowered and to increase their self-esteem. We have to learn how health services can better improve breastfeeding initiation rates by mothers in all socioeconomic groups in order to reduce health inequalities from birth.

Aileen Robertson, PhD,
WHO Collaborating Centre in Global Nutrition and Health,
Metropolitan University College,
Copenhagen, Denmark,
airo@phmetropol.dk

Text Box 1.

CHECKLIST: ARE YOU ON TRACK TO IMPROVING BREASTFEEDING INITIATION RATES AND DECREASING HEALTH INEQUALITIES

- Do you routinely measure breastfeeding initiation rates at birth by SES?
- Have you identified which socioeconomic groups of mothers have the lowest breastfeeding initiation rates?
- Have you set targets for increasing the number of mothers, by SES, who initiate breastfeeding?
- Do you assess the impact of a range of ante/perinatal BFHI services on breastfeeding initiation at birth?
- Do you try to reduce marginalization of vulnerable mothers by inviting them to participate in discussions on how ante/perinatal services could better empower them to breastfeed?
- Do policies exist that:
  - Implement BFHI criteria and monitor violations of the Code?
  - Provide skilled breastfeeding initiation and parenting support and early infancy services for adolescents, obese mothers and mothers of low SES?
  - Provide skilled breastfeeding support for mothers who have to return to work soon after birth?
- Does paid maternity leave support exclusive breastfeeding for 6 months and paid breastfeeding breaks on return to work?
- Is there clear leadership and accountability for improving breastfeeding initiation rates in adolescents, obese mothers and mothers of low SES?

References

1. Horta B et al. *Evidence on the long term effects of breastfeeding. Systematic Review and Meta-analyses.* Geneva: WHO, 2007.
2. Robertson A, Lobstein T, Knai C. *Obesity and socioeconomic groups in Europe: evidence review and implications for action.* European Comission, 2007.
3. http://www.unicef.org/nutrition/training/5.2/16.html
4. *Maternity and paternity at work: law and practice across the world.* Geneva: ILO, 2014.
5. Lewis S, Stumbitz B, Miles L et al. *Maternity protection in SMEs: An international review.* Geneva: ILO, 2014.