Breastfeeding: investing in our children’s future is everyone’s business

Breast milk is a unique nutritional source that cannot adequately be replaced by any other food, including infant formula. The promotion of universal exclusive breastfeeding (EBF) in the first 6 months of life and continued breastfeeding until of two years of age is widely recognised as the single most effective intervention for improving child health and development.

Breastfeeding has been shown to have substantial benefits for women and children in rich and poor countries alike, and it is estimated that increasing breastfeeding worldwide could prevent over 800,000 child deaths and 20,000 deaths from breast cancer every year according to the recent Lancet series on breastfeeding. Keith Hansen, Vice President for Human Development at the World Bank, argues that if breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in both medicine and economics. Breastfeeding is the best for lifelong health and also an excellent intervention for improving economic growth and reducing poverty. Breastfeeding represents not only a child’s first inoculation against death, disease, and poverty, but also the most enduring investment in their physical, intellectual, and social well-being. Breastfeeding reduces infant morbidity and mortality, increases Intelligence Quotient (IQ) score, improves school achievement, and boosts adult earnings – all essential elements of reducing poverty and re-dressing inequality.

Yet many children are not receiving this investment, and worldwide rates of breastfeeding are low. For example, just 1 in 5 children in high-income countries are breastfed to 12 months, whilst only 1 in 3 children in low and middle-income countries are exclusively breastfed for the first 6 months. As a result, millions of children are failing to receive the full benefits provided by breastfeeding.

A recent series published in the Lancet argues that low- and middle-income countries are at a crossroads. Proactive steps are needed now to prevent further declines that could lead to the extremely low levels of breastfeeding that are found in many high-income countries (such as the United Kingdom and Ireland where fewer than one in fifty children are breastfed at 12 months of age). Countries can significantly improve breastfeeding practices by scaling up known interventions, policies, and programmes. For example, Bangladesh increased exclusive breastfeeding rates by 13 percent, through introduction of a number of key interventions including six months of maternity leave, comprehensive health-worker training, community mobilisation, and media campaigns. In Brazil, the length of breastfeeding increased from 2.5 months in 1974-75 (one of the shortest in any low- or middle-income country) to 14 months in 2006-07 due to sustained action over a thirty year period by policy-makers, health workers, civil society and the media.

In August 2011, South Africa declared its commitment to the protection, promotion and support of exclusive breastfeeding as the infant feeding option of choice for all children, irrespective of the mother’s HIV status. However many mothers continue to encounter challenges that prevent them from exclusively breastfeeding, and exclusive breastfeeding rates in South Africa remain low.
But what are the barriers, and what can be done to address them? For a start, mothers may not be adequately informed about the benefits of exclusive breastfeeding, and may not receive the correct advice, counselling and support from health professionals. This is particularly true for HIV-positive women who may receive incorrect or outdated advice. All HIV-positive women who are breastfeeding or pregnant are eligible to receive anti-retrovirals (ARVs) and should be taking these for their own health as well as the health of their baby. Provided the mothers take their ARVs regularly there is a negligible chance that her baby will be infected with HIV through breastmilk. This means that the baby receives all the benefits of being breastfed, whilst remaining HIV-free.

Health professionals are certainly not the only sources of information about breastfeeding and for breastfeeding to thrive it needs support from families, communities and other stakeholders as well. For example well-meaning household and community members often influence mothers to stop breastfeeding or to introduce foods and liquids other than breastmilk before six months of age. Society as a whole is also not geared towards supporting breastfeeding. Many members of the public feel that women should not breastfeed in public; at the same time adequate space is not provided and mothers are often expected to feed their babies in public toilets or other unsuitable places. This negative attitude undermines the notion that breastfeeding is normal and natural.

Mothers must also contend with aggressive or inappropriate marketing of breastmilk substitutes such as infant formula milk, and other milk-like drinks and teas specifically marketed for young children. Regulations are now in place to remove commercial pressures from the infant feeding arena and to ensure that all parents receive independent and objective information. However ongoing civil society advocacy and awareness-raising is needed to ensure that members of the public are able to identify and report non-compliance with the regulations.

Returning to paid employment is another significant barrier to breastfeeding for many women, particularly for low income families. Although women should be given four months’ maternity leave, this may be unpaid leave or there may be delays in the mother receiving payment through the unemployment insurance fund (UIF). As a result, many women end up going back to work early to environments that do not support them to continue breastfeeding.

However, increasingly mothers are receiving the support that they need to successfully breastfeed. Seventy percent of health facilities are implementing the Mother Baby Friendly Initiative which ensures that mothers are supported to initiate breastfeeding and human milk banks have been established to provide breastmilk to high-risk infants. Use of local youth peer educators to support teenage breastfeeding mothers is another initiative that is showing promising results. The KZN Initiative for Breastfeeding Support (KIBS) has improved EBF from under 25% to almost 50%. In Limpopo, initiatives have included enhanced training for community-health workers, seizing opportunities to involve men and grandparents in breastfeeding promotion, and using social media and traditional media such as local radio shows to promote breastfeeding.

To protect, promote and support breastfeeding is everyone’s business. Government is working to provide an enabling and conducive legislative and policy environment. However action is also required from many other role-players including mothers, fathers, grandparents, siblings, healthcare workers, employers, the business community, public figures, schools and media. Everyone’s efforts will be required to invest in a brighter future for children through protecting, promoting and supporting breastfeeding!