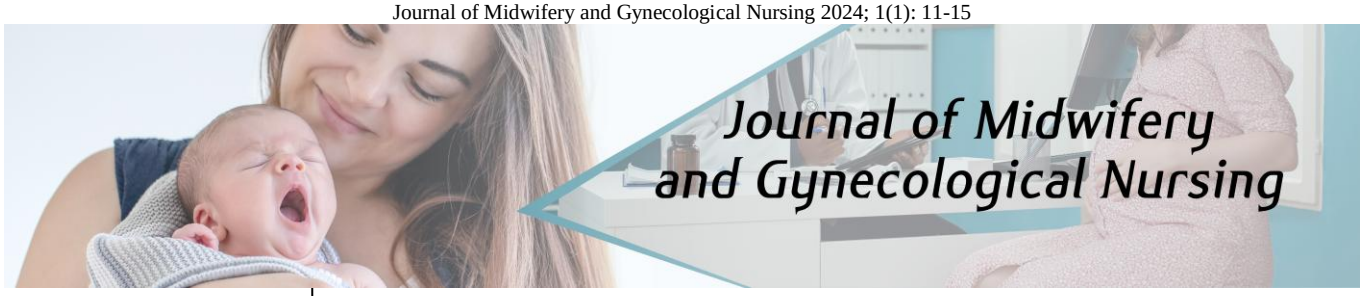

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Role of midwives in early initiation of breastfeeding and exclusive breastfeeding adherence

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Abstract
Breastfeeding is universally acknowledged as the optimal method of infant feeding, significantly contributing to the survival, health, and development of children. Despite global campaigns, early initiation of breastfeeding within the first hour after birth and adherence to exclusive breastfeeding (EBF) for the first six months remain suboptimal in many settings. Midwives play a crucial role in promoting these practices through direct support, counseling, and advocacy. This paper explores the multifaceted role of midwives in facilitating early initiation and sustaining exclusive breastfeeding, examining current practices, challenges, and opportunities for strengthening maternal and neonatal care. Drawing on evidence-based studies and global health recommendations, this study emphasizes the need for midwifery-led interventions to improve breastfeeding outcomes and maternal-child health indicators.

Keywords: Breastfeeding adherence, maternal-child health indicators, breastfeeding outcomes, midwifery-led interventions

Introduction
Breastfeeding is more than a feeding method; it is a cornerstone of infant survival and a fundamental aspect of maternal and new-born health. The World Health Organization (WHO) and UNICEF recommend that all new-borns initiate breastfeeding within the first hour of life and be exclusively breastfed for the first six months. Despite these recommendations, global statistics remain far from ideal. According to UNICEF's 2023 report, only 43% of new-borns are breastfed within the first hour, and just 44% are exclusively breastfed during the first six months.

The early hours post-birth are critical for the mother and the baby, both physiologically and emotionally. The skin-to-skin contact and immediate suckling stimulate the release of oxytocin, which facilitates uterine contraction and milk let-down. Initiating breastfeeding early not only ensures better nutrition but also significantly reduces neonatal mortality. Conversely, delayed initiation has been associated with increased risks of infection and neonatal death.

Midwives, often the primary healthcare providers during childbirth, are in a unique position to influence breastfeeding practices. They bridge the gap between clinical care and emotional support. Their responsibilities extend beyond assisting childbirth to educating mothers, initiating breastfeeding, and promoting adherence to exclusive breastfeeding. Through prenatal counseling, labor room support, and postnatal follow-ups, midwives can profoundly shape breastfeeding trajectories.

Globally, numerous studies have highlighted that women who receive midwife-led breastfeeding support are more likely to initiate breastfeeding early and maintain exclusivity. For instance, a study conducted in Ghana (Amorim Adegboye *et al*., 2021) [1] revealed that mothers who received postnatal guidance from midwives had a 50% higher likelihood of maintaining EBF for six months. In India, frontline midwives trained under the LaQshya program showed significantly improved support for lactating mothers in public health facilities.

Despite their potential, midwives often face structural challenges such as inadequate staffing, lack of training, cultural resistance, and institutional constraints. Moreover, there is a widespread inconsistency in breastfeeding support practices across various healthcare facilities. Addressing these gaps is crucial to harnessing the full potential of midwives as advocates and facilitators of optimal breastfeeding.

This paper aims to explore the role of midwives in early initiation and exclusive breastfeeding adherence, analyzing global and regional evidence, identifying barriers, and proposing strategies for capacity building and policy alignment. It argues that empowering midwives through training, institutional support, and recognition can significantly improve breastfeeding rates and overall maternal-child health outcomes.

Early initiation of breastfeeding: A window of opportunity

Early initiation of breastfeeding, defined as placing the newborn to the mother's breast within the first hour after birth, is a simple yet powerful intervention with profound implications for both neonatal and maternal health. This golden hour post-delivery is a critical window of opportunity, not just for establishing the foundation of nutrition but also for enhancing survival, immunity, and maternal-infant bonding. Global health organizations such as UNICEF and the American Academy of Pediatrics advocate for this practice based on overwhelming scientific evidence that early initiation significantly reduces neonatal morbidity and mortality, particularly in resource-constrained settings. The first hour of life is often referred to as a "magical hour" due to the baby's instinctual behaviors. New-borns exhibit a sequence of behaviors during this period, including rooting, crawling towards the breast, and suckling, all of which are innate and critical for the successful establishment of breastfeeding. This physiological readiness, when appropriately supported, facilitates optimal latching, increases maternal milk production, and reduces the risk of breastfeeding complications such as engorgement or mastitis. Moreover, the colostrum-commonly called "liquid gold"-is packed with immunoglobulins, growth factors, and anti-inflammatory agents that are irreplaceable for a new-born's immune defense system. A delay in initiating breastfeeding means depriving the infant of these life-saving components. From a survival perspective, early initiation of breastfeeding has been shown to reduce neonatal mortality by up to 22%, as reported in studies published in *The Lancet*. This reduction is attributed to multiple biological mechanisms. Colostrum acts as the infant's first immunization by providing passive immunity, while early suckling stimulates uterine contractions in the mother, reducing postpartum hemorrhage, one of the leading causes of maternal death. Skin-to-skin contact during breastfeeding further stabilizes the baby's body temperature, heart rate, and glucose levels, thereby minimizing the risks of hypothermia and hypoglycemia, especially in preterm or low-birth-weight infants. The hormonal and emotional exchange during early breastfeeding has long-term benefits for both mother and child. The act of suckling stimulates the release of oxytocin-a hormone responsible for the let-down reflex and for fostering emotional bonding. Mothers who initiate breastfeeding early are more likely to continue exclusive breastfeeding for the recommended six months, which in turn is associated with lower risks of gastrointestinal infections, respiratory illnesses, and sudden infant death syndrome (SIDS). On the maternal side, early and exclusive breastfeeding delays the return of fertility, facilitates postpartum weight loss, and has been linked to a reduced risk of breast and ovarian cancers. However, despite its proven benefits, early initiation of breastfeeding remains suboptimal in many parts of the world. According to data from the National Family Health Survey (NFHS) and World Bank reports, less than 45% of new-borns globally are breastfed within the first hour of birth. Cultural practices, lack of awareness, inadequate support from healthcare providers, and the high rate of cesarean deliveries are among the leading barriers. In some communities, pre-lacteal feeds such as sugar water, honey, or formula are given, delaying the initiation of breastfeeding. Moreover, in hospital settings, the separation of the mother and infant for observation or procedural routines frequently disrupts the initiation process.

A shift in healthcare policies and delivery practices is essential to address these gaps. Baby-Friendly Hospital Initiatives (BFHI), endorsed by WHO and UNICEF, advocate for immediate skin-to-skin contact and rooming-in as standard care practices. In facilities where these protocols are strictly implemented, early initiation rates are substantially higher. Trained midwives and nurses play a crucial role in these settings by educating mothers during antenatal visits, assisting with positioning and latching post-delivery, and ensuring that cultural misconceptions are respectfully addressed. The role of midwives, in particular, is pivotal. Their presence during labor and delivery enables real-time encouragement and support for early initiation. In both high-resource and low-resource settings, studies have shown that when midwives are empowered with proper training in breastfeeding counseling, initiation rates dramatically improve. Their holistic approach to maternal and neonatal care helps bridge the gap between knowledge and practice. Moreover, midwives often act as cultural mediators, helping families understand the physiological and emotional importance of immediate breastfeeding while being sensitive to traditional beliefs. Furthermore, public health messaging and community-based programs must emphasize the life-saving nature of early initiation. Mobile health platforms, mother support groups, and peer counseling models have emerged as effective channels for disseminating this knowledge. Programs that involve grandmothers and elder women-who are often the gatekeepers of infant feeding practices-can help dismantle deeply rooted myths about colostrum or breastfeeding delays. Research also underscores the significance of maternal education in improving early initiation rates. Mothers with higher levels of education are more likely to be informed about breastfeeding benefits and are more confident in initiating it. Thus, integrating breastfeeding education into school health programs and adult literacy initiatives may have a ripple effect on public health outcomes over time. While vaginal deliveries generally favor early initiation, cesarean births present unique challenges. Mothers recovering from anesthesia, restricted movement, and postoperative pain often delay breastfeeding. Hence, institutional protocols must be adapted to provide additional support in such scenarios. Trained staff can assist with positioning and pain management while ensuring the new-born is placed skin-to-skin with the mother at the earliest opportunity. Recent interventions have included the use of "breastfeeding trolleys" or sidecar bassinets to facilitate early contact post-cesarean, showing promising results. In humanitarian settings or during health emergencies, the practice of early initiation becomes even more critical. When health services are disrupted, breastfeeding remains the safest and most

accessible means of infant nutrition. During crises like pandemics or natural disasters, misinformation and fear may lead to a decline in breastfeeding practices. Therefore, health workers must be equipped not only with clinical skills but also with culturally competent communication tools to reassure and guide mothers during these times.

The long-term public health benefits of promoting early breastfeeding initiation also tie into broader development goals. Improved infant nutrition contributes to better cognitive development, school performance, and productivity in adulthood. Economically, increasing breastfeeding rates can reduce healthcare costs by preventing common childhood illnesses and decreasing the burden on health systems. The World Health Organization estimates that scaling up breastfeeding to near-universal levels could save over 820,000 child lives annually and generate billions of dollars in economic gains.

In conclusion, early initiation of breastfeeding represents a unique window of opportunity-biologically, emotionally, and socially. It sets the stage for lifelong health and development while reinforcing the intimate bond between mother and child. Yet, to translate evidence into widespread practice, a coordinated effort involving policy makers, healthcare providers, families, and communities is required. By embedding this simple yet powerful practice into the framework of maternal and newborn care, we can make significant strides toward improving survival, reducing inequality, and fostering healthier future generations.

Midwives and Exclusive breastfeeding adherence

Midwives play an indispensable role in promoting, establishing, and sustaining exclusive breastfeeding practices among new mothers. Exclusive breastfeeding, defined as feeding infants only breast milk for the first six months of life without any additional food or drink-not even water-is a cornerstone of early childhood nutrition and health. Despite its critical benefits, adherence to this practice is often challenged by cultural beliefs, misinformation, maternal fatigue, and inadequate support systems. In this context, midwives serve as both clinical guides and empathetic educators, helping mothers overcome these obstacles with evidence-based knowledge and compassionate care. The postpartum period is a time of profound physical and emotional transition for mothers. In many cases, mothers may doubt their milk supply or feel overwhelmed by the demands of newborn care. Midwives are uniquely positioned to address these concerns, especially during the immediate hours and days after birth, when breastfeeding practices are most vulnerable to disruption. By offering hands-on support, reassurance, and guidance, midwives help mothers develop confidence in their ability to nourish their babies solely through breastfeeding. This early intervention is crucial, as studies have shown that mothers who receive lactation support from skilled providers are significantly more likely to maintain exclusive breastfeeding for the recommended six-month duration.

Midwives also play a proactive role during antenatal care by initiating discussions around the benefits of exclusive breastfeeding, setting expectations, and debunking prevailing myths. Topics such as the nutritional adequacy of breast milk, the risks associated with formula feeding, the importance of night feeding, and techniques for managing sore nipples or engorgement are addressed comprehensively. This prenatal counseling ensures that mothers are informed and prepared even before labor begins.

Moreover, midwives facilitate the physiological and emotional environment necessary for successful breastfeeding. Practices such as immediate skin-to-skin contact, delayed cord clamping, and rooming-in are encouraged and supported by midwives, all of which contribute to the early establishment and continuation of exclusive breastfeeding. In settings where midwives are the primary birth attendants, these baby-friendly practices are more consistently applied, leading to improved breastfeeding rates.

Postnatal follow-up is another key domain where midwives contribute to adherence. Through regular home visits or clinic appointments, midwives monitor infant weight gain, assess latch quality, and address any breastfeeding difficulties that may arise. They also educate mothers on recognizing hunger cues, feeding on demand, and maintaining hydration and nutrition, which are vital for sustaining lactation. Importantly, midwives often extend their influence beyond the mother by involving family members-especially grandmothers and partners-who may impact feeding decisions. By creating a supportive and informed home environment, they increase the likelihood of continued exclusive breastfeeding.

In low- and middle-income countries, where access to pediatricians or lactation consultants may be limited, midwives often represent the primary or only source of breastfeeding support.

Their culturally sensitive approach, grounded in local languages and traditions, enhances the credibility and acceptance of health messages. Community-based midwifery programs, in particular, have demonstrated high effectiveness in improving exclusive breastfeeding rates through sustained engagement and trust-building. Midwives also contribute to public health by participating in campaigns and education programs aimed at normalizing breastfeeding in communities where bottle feeding is prevalent due to marketing pressure or urban lifestyle changes. By serving as advocates for breastfeeding-friendly policies in hospitals and workplaces, they help dismantle structural barriers that undermine exclusive breastfeeding adherence. In conclusion, midwives are central to promoting and sustaining exclusive breastfeeding. Through a combination of technical expertise, empathetic communication, and continuous care, they empower mothers to adhere to this life-saving practice. As frontline healthcare providers, their role extends beyond the clinical setting to influence broader community behaviors and health outcomes. Investing in midwifery training, staffing, and integration into maternal health policies is not just a health system priority-it is a societal imperative to ensure that every child receives the best possible start in life through exclusive breastfeeding.

Challenges faced by midwives

Midwives are essential frontline providers in maternal and new-born care, offering a range of services that include antenatal counseling, skilled birth attendance, postnatal support, and promotion of breastfeeding. Despite their critical role, midwives around the world face numerous challenges that hinder their ability to deliver optimal care, particularly in resource-limited settings. These challenges are multifaceted-spanning structural, professional, cultural,

and psychological dimensions-and often contribute to burnout, reduced job satisfaction, and compromised care delivery. One of the most significant challenges midwives face is the shortage of human resources. Many healthcare systems, especially in developing nations, are grappling with inadequate staffing, leading to excessive workloads for midwives. A single midwife may be responsible for attending to several laboring women simultaneously, conducting postnatal visits, maintaining documentation, and educating families-all within a single shift. This overload not only affects the quality of care but also limits the time midwives can dedicate to counseling on exclusive breastfeeding, emotional support, and monitoring maternal-infant bonding.

Another pressing issue is the lack of infrastructural support. In many facilities, essential supplies such as clean delivery kits, medications, sterilization equipment, and even private delivery spaces may be limited or unavailable. The absence of dedicated breastfeeding support rooms, reclining beds, and safe postnatal care areas further restricts the midwife's ability to create a conducive environment for early and exclusive breastfeeding practices. Midwives working in rural or remote areas often struggle with poor transportation and communication networks, making it difficult to reach mothers for follow-up visits or emergency care.

Professional development and training pose additional barriers. Inadequate opportunities for continuing education, limited access to updated clinical guidelines, and a lack of structured mentorship programs can leave midwives underprepared to handle complex deliveries or manage breastfeeding complications. The evolving nature of maternal care-including the integration of mental health support, gender-sensitive communication, and respectful maternity care-requires regular upskilling, which is often overlooked or underfunded.

Social and cultural barriers also pose substantial difficulties. In many communities, traditional beliefs and familial influences heavily dictate maternal choices, including feeding practices. Midwives may encounter resistance when advising against harmful customs such as discarding colostrum, introducing pre-lacteal feeds, or early weaning. Without community engagement or support from local leaders, midwives often work in isolation, attempting to reconcile medical recommendations with deep-rooted customs, which can lead to mistrust or non-compliance.

Legal and policy-related constraints further complicate midwifery practice. In some regions, midwives operate with limited autonomy or are not fully recognized within the healthcare hierarchy, leading to underutilization of their skills and diminished decision-making power. Additionally, inconsistent enforcement of maternal health policies, such as maternity leave, baby-friendly hospital initiatives, and breastfeeding promotion campaigns, hampers the broader impact of midwives on maternal-child outcomes.

Emotional and psychological stress is another overlooked challenge. The demanding nature of midwifery-dealing with life-and-death situations, experiencing traumatic births, working night shifts, and witnessing maternal or neonatal loss-can lead to compassion fatigue, burnout, and even post-traumatic stress disorder. Without proper mental health support, peer networks, or counseling services, many midwives continue to work in emotionally taxing environments with little respite.

Strategies for strengthening midwifery role in breastfeeding support

To enhance breastfeeding outcomes and ensure exclusive breastfeeding adherence, strengthening the role of midwives is a crucial strategic intervention. Midwives, when fully supported and integrated into maternal healthcare systems, have the potential to act as primary agents of breastfeeding promotion, guidance, and problem-solving. However, to realize their full potential in this capacity, comprehensive strategies must be adopted at institutional, community, and policy levels. One of the most impactful strategies is enhanced training and continuing education. Midwives must be equipped with up-to-date knowledge and practical skills in lactation counseling, identification of breastfeeding complications (such as poor latch, nipple trauma, or low milk supply), and interventions for special cases such as preterm infants or cesarean deliveries. Regular workshops, simulation-based training, and access to updated clinical protocols can significantly boost midwives' confidence and competency in delivering breastfeeding support. Another essential strategy involves institutional support through Baby-Friendly Hospital Initiatives (BFHI). Facilities that implement BFHI's "Ten Steps to Successful Breastfeeding" create an enabling environment for midwives to promote and practice breastfeeding-friendly care. This includes immediate skin-to-skin contact, rooming-in policies, avoidance of formula supplementation unless medically indicated, and comprehensive breastfeeding education for all new mothers. Ensuring that midwives lead or co-lead BFHI implementation in maternity settings strengthens their visibility and authority in this domain. Integration of midwives in antenatal and postnatal education programs is also critical. Midwives can serve as primary educators during antenatal classes, offering pregnant women a detailed understanding of breastfeeding physiology, techniques, and benefits. During the postpartum period, structured follow-up visits led by midwives should include individualized breastfeeding assessments, latch checks, and emotional support. These touch points help detect problems early and reinforce mothers' confidence, thereby improving adherence. Supportive supervision and mentorship structures further strengthen midwifery roles. When experienced midwives mentor junior colleagues or community health workers, they not only transfer skills but also build a culture of continuous learning. Supervision must be constructive, emphasizing problem-solving rather than fault-finding, and should provide a platform for midwives to share challenges and innovative practices. At the policy level, formal recognition of midwives as key breastfeeding stakeholders is necessary. National maternal and child health policies must clearly articulate the role of midwives in breastfeeding promotion and allocate specific resources to support their work. This includes fair remuneration, workload regulation, access to breastfeeding aids (e.g., breast pumps, pillows, lactation charts), and time for patient education. Community-level engagement also plays a powerful role. Midwives should be connected to community networks, including women's groups, local leaders, and traditional birth attendants, to extend breastfeeding messages beyond the clinical setting. When community members view midwives as accessible and trustworthy, the likelihood of behavioral change in feeding practices increases. Finally, digital and telehealth solutions can be leveraged to enhance midwifery-led breastfeeding

support. Through mobile apps, video consultations, or helplines, midwives can continue guiding mothers who are unable to return to clinics. This continuity of care helps address issues like engorgement, feeding positions, or infant fussiness in real-time, reducing dropout from exclusive breastfeeding.

Conclusion

Midwives serve as pivotal agents in promoting, initiating, and sustaining exclusive breastfeeding, particularly during the critical early postpartum period. Their role extends far beyond clinical support, encompassing education, emotional reassurance, and advocacy for evidence-based practices. Despite numerous challenges such as inadequate training, limited infrastructure, and cultural barriers, midwives consistently demonstrate their capacity to influence positive maternal and neonatal outcomes. Strengthening their position through strategic interventions-such as continued education, supportive health policies, community engagement, and integration into Baby-Friendly Hospital Initiatives-can significantly enhance breastfeeding adherence and maternal-infant well-being. As global efforts aim to improve child survival and maternal health, empowering midwives must be recognized as a foundational step. Investing in midwifery is not only an investment in women's health but a long-term strategy for nurturing healthier societies through the promotion of optimal infant nutrition and care.

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