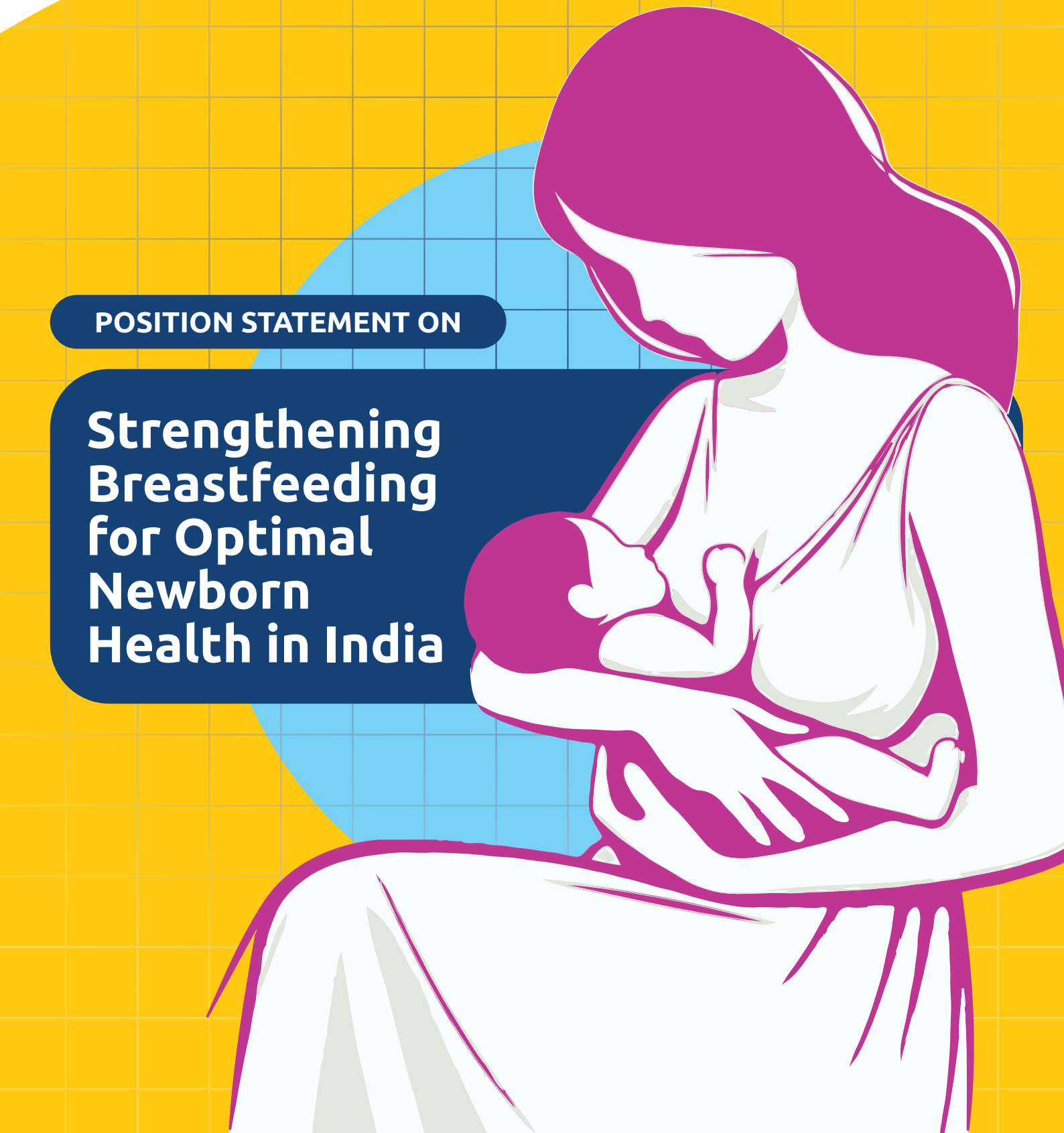
Indian Academy of Pediatrics

Global Health Strategies

POSITION STATEMENT ON

Strengthening Breastfeeding for Optimal Newborn Health in India



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We, the Indian Academy of Pediatrics (IAP), the Federation of Obstetric and Gynaecological Societies of India (FOGSI), the National Neonatology Forum (NNF), the Indian Association of Preventive and Social Medicine (IAPSM), AIIMS Delhi (Division of Neonatology), the Trained Nurses' Association of India (TNAI) and the Indian Association of Neonatal Nurses (IANN) **issue this joint statement to reaffirm our shared commitment to optimal breastfeeding practices across India**. We do so at a critical juncture: while institutional deliveries have become near-universal, exclusive breastfeeding has declined over the same period – a divergence that signals an urgent need to translate access to care into meaningful breastfeeding support.

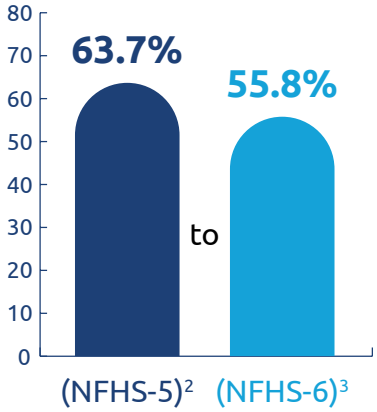
This statement is addressed to policymakers, healthcare institutions, providers, and the professional community whose collective action shapes breastfeeding outcomes. Its purpose is to set out, with a unified clinical voice, the specific gaps in current practice and the concrete measures needed to close them across all institutional settings. Breastfeeding is a fundamental right[1] and a cornerstone of newborn health. **Ensuring every mother is supported to breastfeed successfully, is a shared responsibility that this statement seeks to advance.**

BACKGROUND

A widening paradox

90.6% of births now occur in institutional settings and early initiation within the first hour has improved from **41.8%** to **50.1%**,

yet exclusive breastfeeding has fallen sharply from:

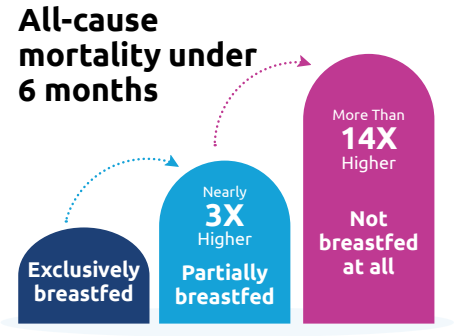


Access to institutional care is not yet translating into sustained breastfeeding support.

Preventable deaths

Compared with infants exclusively breastfed under six months **all-cause mortality is nearly three times higher among those partially breastfed, and more than fourteen times higher among those not breastfed at all**[4,5].

These deaths are preventable through practices already within institutional reach.



The caesarean gap

Caesarean deliveries have risen to **27.2% of all births in NHFS-6** (over half of births in private facilities), up from ↑ **21.5%** in NFHS-5.

The barrier is not caesarean birth itself but the absence of clear operating theatre and recovery-room protocols, which delays skin-to-skin contact and early breastfeeding.

Guidance already exists

National and global frameworks provide clear direction, including the Government of India's Infant and Young Child Feeding guidelines (MoHFW), National Neonatology Forum's Clinical Practice Guidelines on Breastmilk for Preterm Neonates, Maternal, Infant and Young Child Nutrition in Mother and Baby Friendly Services (IAPSM, FOGSI & IAP), National Guidelines on Lactation Management Centres in Public Health Facilities (MoHFW), Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992, and World Health Organization Guideline: Protecting, Promoting, and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services. These and other guidelines* collectively provide clear direction; the challenge is their consistent implementation.

*Other relevant guidance includes the WHO International Code of Marketing of Breast-milk Substitutes, the Mothers' Absolute Affection (MAA) programme (MoHFW), and the WHO Global Strategy for Infant and Young Child Feeding.

Institutional practice gaps

Facilities routinely lack trained lactation counsellors, breastfeeding protocols, structured follow-up support after discharge, and providers often respond to early feeding difficulties with formula supplementation rather than hands-on lactational support.[6] Furthermore, newborns are separated from mothers for routine postnatal procedures and after caesarean delivery, disrupting the critical window for early initiation, while a persistent misconception that colostrum is inadequate encourages early formula and can disrupt the establishment of a mother's milk supply.[7]

Preterm and LBW infants at highest risk

LBW infants account for **17-18%** of births in India;[2] infants who are not breastfed are nearly 15 times more likely to die of pneumonia than those exclusively breastfed.[4] 45% of all neonatal deaths occur on the first day of life and 80% within the first week, yet Kangaroo Mother Care (KMC) – continuous skin-to-skin contact combined with exclusive breastfeeding:

Reduces neonatal mortality by
↓32%

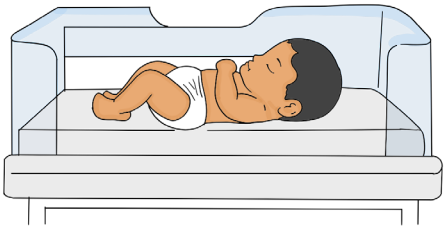
Typically initiated only **3 to 24 days** after birth[8]

Given for **just 3-5 hours per day against the WHO-recommended minimum of 8 hours**[9];

Most private facilities lack a dedicated Mother-Newborn Care Unit (MNCU) or standardised feeding protocols for these infants.

Maternal mental health – the cross-cutting gap

Mental health disorders are the leading cause of disability worldwide;[10] in developing countries an estimated 15.6% of pregnant women and 19.8% of women who have recently given birth experience a mental disorder,[11] yet India has no dedicated perinatal mental health policy. The relationship is bidirectional: successful breastfeeding is associated with lower rates of postpartum depression, while perinatal depression and anxiety impair the milk ejection reflex and are among the strongest predictors of early cessation.[12,13]



Postpartum depression affects up to 29% **of mothers of preterm and NICU-admitted infants,**[14] compromising maternal-infant bonding[15] and sustained caregiving at home.[16]

Routine screening is not integrated into maternity care, referral routes are lacking, and a widespread misconception persists that managing maternal mental illness requires stopping breastfeeding, despite most psychotropic medications being compatible with continued nursing.[17]

RECOMMENDATIONS

Our recommendations address **FOUR** critical points along the breastfeeding continuum:

Early initiation and exclusive breastfeeding in institutional settings, breastfeeding following caesarean delivery, kangaroo mother care for preterm and low birth weight infants, and maternal mental health.

Recommendation 1:

Strengthen Institutional Infrastructure to Facilitate Early and Exclusive Breastfeeding

1.1

Every institution to provide mandatory, competency-based lactation management training / refresher training for nurses, midwives, and clinical staff involved in maternal and newborn care, and to designate dedicated personnel for lactation support with defined minimum competencies to address latch issues, milk supply challenges, and breastfeeding counselling needs, including breastfeeding techniques, early initiation, recognition of infant feeding cues, and management of common breastfeeding challenges.[18,19]

Since exclusive breastfeeding is sustained at home, this support must extend beyond discharge through structured facility-to-community linkages with frontline workers such as ASHAs in the public sector, and regular follow-up by private sector providers to ensure ongoing guidance and assistance. IAPSM members to collaborate with local health authorities to improve the HBNC and HBYC implementation. Digital health platforms, teleconsultation, and mobile-based counselling may complement existing facility and community based services, particularly in underserved and remote settings.[20] A continuum of care spanning intranatal and postnatal support has been shown to approximately double the likelihood of exclusive breastfeeding at six months.[21]

In the Indian context, skilled counselling delivered antenatally and continued through postnatal home visits has been shown to enhance both early initiation and exclusive breastfeeding.[22]

1.2

Breastfeeding support to be made a mandatory institutional quality metric within the accreditation criteria of the National Accreditation Board for Hospitals and Healthcare Providers (NABH) for all healthcare facilities, and within the reporting requirements of the National Health Mission Health Management Information System (NHM/HMIS) for public facilities. Core indicators should include early breastfeeding initiation within one hour of birth, exclusive breastfeeding at discharge and at six months, coverage and average duration of Kangaroo Mother Care for eligible preterm and low birth weight infants, the proportion of mothers receiving antenatal and postnatal breastfeeding counselling, and the availability of trained personnel for lactation support[23] and as per KPIs defined under NQAS standards.

Outcome

Lactational support from trained professionals at the hospital and continued at home, with breastfeeding outcomes included in institutional quality-of-care parameters.

Recommendation 2:

Early Breastfeeding Initiation Following Caesarean Delivery

2.1

All institutions performing caesarean deliveries must develop and implement mandatory written protocols for breastfeeding initiation, encompassing skin-to-skin contact, feeding cue observation, and nursing staff responsibilities in the operating theatre and during recovery period. Skin-to-skin contact after caesarean section has been shown to reduce the time to first breastfeeding attachment by nearly 52 minutes and to increase breastfeeding rates nearly fivefold in the first two hours after birth.[24]

Outcome

Standardize breastfeeding initiation as a key component for all deliveries, with a special focus on post-caesarean care; by implementing institutional protocols for the operating theatre and recovery period to ensure maximum adherence.

Recommendation 3:

Ensure Immediate and Sustained KMC for Preterm and Low Birth Weight Infants

3.1

All institutions caring for preterm and LBW infants must implement family-integrated KMC protocols, actively training and involving fathers and family members to provide rotational skin-to-skin care, ensuring continuous coverage beyond the mother's capacity. KMC has been shown to lower the risk of severe infection by 15% and increase exclusive breastfeeding rates at discharge by 48%.[8]

3.2 Where preterm or LBW infants cannot feed directly at the breast, institutions to support mothers in expressing and maintaining their milk supply, so that infants receive their mother's own milk until direct breastfeeding becomes possible.[25]

3.3 Institutions caring for preterm and LBW infants to make provision for mothers to be roomed in alongside their newborns, enabling round-the-clock kangaroo mother care and breastfeeding.[26] Where infrastructure allows, this may be supported through certification or quality-recognition mechanisms, such as FOGSI's Manyata programme and the NNF's facility accreditation for newborn care units, that incentivise mother-newborn co-location. A multicenter trial conducted by WHO immediate study group showed that the initiation of continuous kangaroo mother care soon after **birth in infants with a birth weight between 1.0 and 1.799 kg improved neonatal survival by 25% as compared with kangaroo mother care initiated after stabilization, the approach that is currently recommended.**[27]

Outcome

Achieve a measurable increase in the average duration and continuity of uninterrupted kangaroo mother care, by actively involving families and redesigning facilities to ensure sustained, close mother-newborn contact.

Recommendation 4:

Integrate Maternal Mental Health Support into Breastfeeding Care Frameworks

4.1

Care for mothers experiencing perinatal mental health conditions to be coordinated across obstetricians, paediatricians, lactation counsellors, and mental health professionals, with family members actively involved in sharing caregiving responsibilities to ensure adequate maternal rest and sleep.[28]

4.2

Routine screening for perinatal depression and anxiety using a validated tool, such as the Edinburgh Postnatal Depression Scale, to be integrated into antenatal and postnatal care alongside breastfeeding support, enabling early identification at the points of routine maternal contact.[29]

4.3

Breastfeeding to be preserved where it supports maternal wellbeing, and supplementation or formula feeding actively destigmatised where breastfeeding is a source of distress, with priority being given to maternal mental health rather than the method of feeding.[30] Psychotropic medication not to be treated as a default reason to discontinue breastfeeding.[17]

Outcome

Perinatal mental health is effectively identified and managed within routine maternity care, ensuring uninterrupted breastfeeding.

These recommendations reflect our collective conviction that breastfeeding is a shared responsibility: Clinical, institutional and societal.

While comprehensive guidelines already exist, the challenge lies in sustained commitment to their consistent implementation at every point of care. As representatives of India's paediatricians, obstetricians, neonatologists, public health practitioners and nurses, we commit to champion these measures within our own networks and advocate for their adoption across all levels of the healthcare system. We call on policymakers, healthcare institutions, and providers to act with the urgency and resolve that is necessary to normalize and support breastfeeding. Every mother deserves unwavering support to breastfeed successfully, and every newborn deserves the vital foundation that breastfeeding provides. It is our collective responsibility to ensure that this support becomes a reality for ALL in India.

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