Summary of Main Points

1. In low-resource, high-mortality settings where infection causes a large proportion of newborn deaths, early initiation of exclusive breastfeeding can substantially reduce child mortality.

2. Initiation of breastfeeding within the first hour can help prevent neonatal deaths caused by sepsis, pneumonia, and diarrhea and may also prevent hypothermia-related deaths, especially in preterm and low birthweight infants.

3. Early initiation of exclusive breastfeeding serves as the starting point for a continuum of care for mother and newborn that can have long-lasting effects on health and development.

The benefits of breastfeeding for infant nutrition, development, reduced morbidity and mortality, and prevention of long-term chronic diseases are now widely recognized. The lower risk of mortality is primarily due to reductions in deaths caused by infectious diseases and is most evident in infants who receive only breast milk (exclusive breastfeeding) during the first 6 months. Early initiation of breastfeeding provides additional benefits.

The World Health Organization (WHO) and UNICEF recommend initiation of breastfeeding within the first hour after birth and exclusive breastfeeding for the first 6 months followed by continued breastfeeding to age 2 years or beyond along with appropriate complementary feeding. As described below, recent evidence indicates that early initiation of breastfeeding and exclusive breastfeeding are both linked with substantially lower neonatal mortality. The data suggest a cause-effect relationship between early breastfeeding and reduction in infection-specific neonatal mortality.

WHO and other organizations recommend delaying for at least the first hour routine newborn care procedures that separate mother and baby such as bathing and weighing. This will allow mother and newborn uninterrupted skin-to-skin contact until the first breastfeed. Despite these recommendations, only 39 percent of newborns in the developing world are put to the breast within one hour of birth, and only 37 percent of infants under six months of age are exclusively breastfed.

Neonatal mortality: a global health priority

Each year approximately 4 million newborns die, most from preventable causes. Deaths in the neonatal period (the first 28 days of life) account for 41 percent of all deaths in children younger than 5 years (figure 1). Most neonatal deaths happen during the first 7 days after birth, known as the early neonatal period.

Millennium Development Goal (MDG) 4 calls for a two-thirds reduction in the death rate for children under five, from 95 per 1000 live births in 1990 to 31 per 1000 in 2015. By 2007 the world was less than half way toward achieving this goal, and death rates are not dropping fast enough to meet the 2015 target. None of the 46 sub-Saharan African countries is on track to reach the MDG target.

Most of the progress in reducing under-five mortality is attributable to lives saved after the first 4 weeks of life, with very slow reduction in the risk of death in the neonatal period. As a result, the proportion of child deaths occurring during the neonatal period has increased. This reflects the relative success of interventions targeting deaths after the neonatal period and the lack of progress in tackling neonatal mortality, particularly in the early neonatal period.

The burden of newborn death falls disproportionately on the world’s poorest communities within the poorest countries or regions: almost 99 percent of neonatal deaths take place in low- and
middle-income countries, with two-thirds occurring in just 10 countries (table 1). A strong focus on sub-Saharan Africa and South Asia is crucial for accelerating progress. These two regions represent three-fourths of all neonatal deaths: 33 percent in sub-Saharan Africa and 41 percent in South Asia.\(^\text{13}\)

**Recent evidence on the impact of early initiation of breastfeeding on neonatal mortality**

Two recently published studies evaluated the relationship between the timing of initiation of breastfeeding and neonatal death.\(^6,7\) The studies also assessed whether the exclusivity of breastfeeding played an additional protective role. Both studies were conducted in rural settings where most newborns are delivered at home, access to health services is limited, and infections cause many neonatal deaths.

One of the studies, a community-based prospective cohort study in rural Ghana, was nested within a large maternal vitamin A supplementation trial conducted by investigators at the London School of Hygiene and Tropical Medicine in collaboration with the Kintampo Health Research Centre (KHRC), Ghana.\(^6\) The other study, a similar community-based observational study in southern Nepal, was conducted jointly by investigators at the Johns Hopkins Bloomberg School of Public Health and the Nepal Nutrition Intervention Project, Sarlahi (NNIPS).\(^7\) Table 2 provides descriptive information for the two studies.

The studies found:

- **The later the initiation of breastfeeding, the greater the risk of neonatal death.** Initiation of breastfeeding after the first 24 hours was associated with a 2.4-fold increased risk\(^1\) of mortality in Ghana and a 1.4-fold increased risk in Nepal when compared to initiation before 24 hours. The authors of the Ghana study estimated that 16 percent of neonatal deaths could have been prevented if all newborns had been breastfed starting from day 1 and 22 percent if breastfed within the first hour of birth. The authors of the Nepal study estimated that initiation of breastfeeding within the first hour of birth could

### Table 1: Countries with the largest numbers of neonatal deaths

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of global neonatal deaths (n=3.99 million)</th>
<th>Neonatal Mortality Rate (per 1000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>28%</td>
<td>39</td>
</tr>
<tr>
<td>China</td>
<td>9%</td>
<td>18</td>
</tr>
<tr>
<td>Nigeria</td>
<td>7%</td>
<td>47</td>
</tr>
<tr>
<td>Pakistan</td>
<td>7%</td>
<td>53</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>4%</td>
<td>47</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>3%</td>
<td>41</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>3%</td>
<td>36</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2%</td>
<td>60</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2%</td>
<td>17</td>
</tr>
<tr>
<td>Tanzania</td>
<td>2%</td>
<td>35</td>
</tr>
</tbody>
</table>


\(^1\) Adjusted odds ratio
Studies in Nepal and Ghana suggest that initiation of breastfeeding within the first hour of birth could prevent about 20 percent of neonatal deaths.

have prevented 19 percent of neonatal deaths. The apparent beneficial effects of early breastfeeding remained significant after controlling for other factors known to be linked with mortality around the time of birth and during infancy.

- **Greatest impact on mortality through exclusive breastfeeding.** Exclusively breastfed infants were at lower risk of neonatal death than partially breastfed infants, regardless of the timing of initiation of breastfeeding. Partial breastfeeding means that an infant received breastmilk plus animal milk, infant formula, or solid foods.

- **Benefits in settings with high and low prevalence of low birthweight.** The beneficial effects of early and exclusive breastfeeding were found in both sites, with the prevalence of low birthweight at 7 percent in Ghana and 30 percent in Nepal.

The authors of the Ghana study also examined the association between early breastfeeding and infection-specific neonatal mortality. Of infants in the study who died between day 2 and day 28, two-thirds died from infections and one-third from non-infectious causes. Late (after 24 hours) initiation of breastfeeding was associated with a 2.6-fold increased risk of infection-related neonatal mortality, and partial breastfeeding was associated with a 5.7-fold increased risk of this outcome. No significant relationship was observed between early infant feeding practices and neonatal deaths related to non-infectious causes. These findings suggest a biologically plausible cause-effect relationship since breastfeeding would be expected to have an impact on infectious causes of neonatal deaths but little or no impact on non-infectious causes.

Both studies considered only deaths occurring after 48 hours, excluded high risk infants from the analysis, and adjusted for potential confounders, but the results might still be confounded by other, unmeasured differences between infants with early vs. late initiation of breastfeeding or exclusive vs. partial breastfeeding.

**Potential links between early initiation of exclusive breastfeeding and lower neonatal mortality**

Approximately 86 percent of global neonatal deaths are due to three main causes:

- Severe infections: sepsis/pneumonia, tetanus, and diarrhea (36 percent)
- Asphyxia (23 percent)
- Preterm birth (27 percent)
In very high mortality settings where the neonatal mortality rate is above 45 per 1000 live births, infection contributes to almost half of all neonatal deaths. Early initiation of exclusive breastfeeding may reduce neonatal mortality through the following biological pathways.

- **Provides immune factors present in colostrum.** Beginning breastfeeding immediately after birth ensures that the newborn receives the “first milk” (colostrum), the baby’s first “immunization”. Colostrum protects the newborn from illness by providing a number of immune factors, as well as anti-microbial and anti-inflammatory agents.

- **Protects against exposure to infectious pathogens.** Early introduction of breastmilk as the exclusive food prevents ingestion of infectious pathogens that can cause gastrointestinal damage.

- **Promotes optimal maturation of the gut and immune system.** Early ingestion of breastmilk provides nutrients that promote maturation of the intestines and immune system and protect against infectious pathogens. Early gut “priming” is particularly crucial for preterm infants. Research shows that early feeding with non-human milk proteins may severely disrupt this important gut priming.

- **Helps protect against hypothermia.** Early, frequent breastfeeding, especially if accompanied by skin-to-skin contact with the mother, helps to keep the baby warm and has the potential to prevent hypothermia-related morbidity and mortality. Newborn infants are particularly at risk for hypothermia during the first 12 hours after birth, mainly because of heat loss from the evaporation of amniotic fluid in the immediate post-birth period. Exposure to cold and hypothermia is a well-known risk factor for neonatal morbidity and mortality, including an increased risk of pneumonia and sepsis in newborns and young infants.

- **Facilitates sustained breastfeeding.** Early suckling is associated with successful establishment and maintenance of breastfeeding throughout infancy, which can contribute to a lower risk of mortality beyond the first few days of life.

In summary, initiation of breastfeeding within the first hour can help prevent neonatal deaths caused by infections such as sepsis, pneumonia, and diarrhea and may also prevent additional hypothermia-related deaths, especially in preterm and low birthweight infants in developing countries.

### Program and Policy Implications

The studies discussed above provide solid evidence that simple, inexpensive interventions have the potential to dramatically reduce neonatal mortality in low-income countries where most births take place at home and access to health services is poor. Facilitating early initiation of exclusive breastfeeding should be part of infant and young child feeding and nutrition programs, child survival initiatives, and the package of delivery care practices in both facility-based and home-based delivery care settings.

Table 3 shows that significant progress needs to be made to ensure that newborns get the best start in life.

### Table 3: Breastfeeding indicators and antenatal/delivery care coverage in six regions

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Eastern and Southern Africa</td>
<td>59%</td>
<td>42%</td>
<td>72%</td>
<td>41%</td>
</tr>
<tr>
<td>Central and Western Africa</td>
<td>36%</td>
<td>22%</td>
<td>71%</td>
<td>50%</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>47%</td>
<td>30%</td>
<td>78%</td>
<td>76%</td>
</tr>
<tr>
<td>South Asia</td>
<td>27%</td>
<td>45%</td>
<td>68%</td>
<td>42%</td>
</tr>
<tr>
<td>East Asia and the Pacific</td>
<td>46% (*)</td>
<td>(-)</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>48%</td>
<td>41%</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>World</td>
<td>39% (*)</td>
<td>37%</td>
<td>78%</td>
<td>64%</td>
</tr>
</tbody>
</table>

**Notes:** The percentages for the “World” category include industrialized countries and the Central Eastern Europe/Commonwealth of Independent States when information is available.

(*) Excludes China

(-) Data not available

Currently, the percentage of infants who are breastfed within the first hour of life and breastfed exclusively varies widely across countries and regions. Several actions can be taken to facilitate early and exclusive breastfeeding.

- **Identify barriers to early and exclusive breastfeeding and then develop appropriate messages, policies, and procedures.** Understanding socioeconomic and cultural barriers to early and exclusive breastfeeding, the attitudes and practices of health care providers and birth attendants, and procedures in health facilities is a critical first step. Messages need to be targeted to mothers, grandmothers, health professionals, and those who assist in home deliveries.

- **Prepare women for birth, breastfeeding, and newborn care.** Infant feeding plans should be made before delivery. The importance of immediate and exclusive breastfeeding can be reinforced in antenatal and postpartum care, child and nutrition counseling, and community mobilization. A recent study in Nigeria showed that women who received psychosocial support during childbirth from a birth companion initiated breastfeeding earlier than those without a birth companion.30

- **Equip frontline health workers to promote and support early and exclusive breastfeeding.** Even when there is adequate contact with skilled health professionals, breastfeeding practices are not optimal.11 This highlights the need for better in-service and pre-service training of frontline health workers, including birth attendants, with an emphasis on counseling skills and actions they can take to help the mother and baby establish and maintain good breastfeeding practices.10,31 Effective support and counseling in the first days after birth increases exclusive breastfeeding rates.32

Effective partnerships and coordination will allow research results to be translated into tangible actions that can have a global impact on child survival and well-being.

**Research Priorities**

Research is needed on how to reach women in different settings and how to encourage them to practice early and exclusive breastfeeding. Identifying the optimal type, content, and duration of communication programs to increase early initiation and care for mother and baby can also advance program efforts. Operations research on ways to overcome barriers to early initiation in both facility and home-based delivery care settings is also needed. Another priority is assessing strategies to ensure that mothers of preterm and low birthweight infants receive the extra support needed for breastfeeding and breastmilk expression.33

Alive & Thrive, launched with a grant from the Bill & Melinda Gates Foundation, is an initiative to improve infant and young child feeding in Bangladesh, Ethiopia, and Viet Nam and inform policies and programs around the world.

For more information visit our website: www.aliveandthrive.org
References


