International Journal of Midwifery and Nursing Practice

E-ISSN: 2663-0435
P-ISSN: 2663-0427
www.nursingpractice.net
IJMNP 2025; 8(1): 42-48
Received: 21-01-2025
Accepted: 25-02-2025

Ashish Tamang
Department of Community Medicine and Public Health, Patan Academy of Health Sciences, Lalitpur, Nepal

Corresponding Author:
Ashish Tamang
Department of Community Medicine and Public Health, Patan Academy of Health Sciences, Lalitpur, Nepal

Impact of Midwifery counseling on exclusive breastfeeding practices: A community-based study

Ashish Tamang

DOI: https://www.doi.org/10.33545/26630427.2025.v8.i1a.187

Abstract
Background: Exclusive breastfeeding (EBF) for the first six months of life is a cornerstone of optimal infant nutrition and survival, endorsed globally by health authorities including the World Health Organization and UNICEF. However, EBF rates remain suboptimal in many regions due to a combination of sociocultural, informational, and systemic barriers. Midwifery counseling, rooted in trust, continuity of care, and community-based support, has emerged as a vital intervention to improve breastfeeding practices.
Objective: This review explores the impact of midwifery counseling on exclusive breastfeeding practices, with a focus on community-level implementation, global evidence, and culturally responsive approaches.
Methods: The paper synthesizes data from randomized controlled trials, cohort studies, and systematic reviews conducted across multiple countries including Ethiopia, India, Indonesia, the UK, and Brazil. It analyzes counseling strategies such as antenatal education, postnatal follow-up, home visits, family involvement, and psychosocial support, highlighting their role in enhancing EBF rates and maternal confidence.
Results: Evidence indicates that midwifery-led counseling significantly improves EBF initiation and continuation rates, reduces breastfeeding complications, and fosters maternal self-efficacy. Context-sensitive counseling also addresses sociocultural myths, emotional challenges, and family dynamics. Programs that combine midwifery counseling with systemic support—such as adequate training, protected time, and policy backing—demonstrate the highest effectiveness.
Conclusion: Midwifery counseling is a cost-effective, scalable, and empathetic strategy to promote exclusive breastfeeding. It empowers mothers, reshapes community norms, and integrates seamlessly into maternal-child health frameworks. For sustainable impact, midwifery counseling must be institutionalized through policy, workforce development, and community engagement.

Keywords: Midwifery counseling, exclusive breastfeeding, maternal health, community-based intervention, antenatal education, postnatal care

1. Introduction

Exclusive breastfeeding (EBF), defined as feeding infants only breast milk for the first six months of life without any additional food or drink, not even water, is recognized globally as the cornerstone of child survival, growth, and development. Endorsed by the World Health Organization (WHO), the United Nations International Children's Emergency Fund (UNICEF), and most national health policies, EBF has been demonstrated to reduce infant morbidity and mortality by providing essential nutrients, bolstering the immune system, and preventing life-threatening infections such as diarrhea and pneumonia. For mothers, it contributes to reduced postpartum bleeding, promotes uterine involution, delays fertility, and offers long-term protection against breast and ovarian cancers. Despite these well-documented advantages, the rates of EBF continue to fall short of global targets in many regions, especially in low- and middle-income countries, where maternal and child health programs face numerous operational and sociocultural challenges.

In recent years, there has been growing interest in the role of midwifery counseling as a community-based approach to improving breastfeeding outcomes. Midwives, due to their trusted role and continuous presence in both antenatal and postnatal care, are uniquely positioned to provide tailored, culturally sensitive, and practical support to breastfeeding mothers. Their role extends beyond clinical delivery assistance to encompass emotional support, education, and behavior change communication aimed at empowering mothers with accurate information and skills to initiate and sustain EBF. The concept of midwifery

counseling goes beyond mere information delivery; it is a comprehensive process that builds confidence, encourages dialogue, and supports the psychological and physical readiness of women to breastfeed successfully.

Many barriers to EBF are not medical but are rather deeply rooted in cultural beliefs, social norms, misinformation, and a lack of support at the household or community level. Mothers often discontinue breastfeeding early due to perceived insufficient milk supply, pain, return to work, lack of knowledge about breastfeeding techniques, or the influence of older family members who favor prelacteal feeding or early weaning practices. These challenges are particularly pronounced in rural and underserved communities where access to healthcare facilities is limited, and traditional practices dominate maternal care.

Against this backdrop, community-based interventions, particularly those driven by midwives, are becoming essential. Midwives often serve as the first—and sometimes only—point of contact between the healthcare system and expectant mothers, particularly in resource-limited settings. Their role in facilitating early initiation of breastfeeding within the first hour of birth, promoting exclusive breastfeeding for the first six months, and supporting continued breastfeeding up to two years and beyond, is now increasingly emphasized in public health policy. Studies from diverse settings suggest that midwifery counseling, when integrated into routine maternal care services, can significantly enhance EBF rates by addressing knowledge gaps, improving maternal self-efficacy, and fostering positive attitudes toward breastfeeding.

Community-based midwifery counseling programs have taken various forms depending on regional and cultural contexts. These include home visits by trained midwives or community health workers, group counseling sessions at maternal clinics or community centers, breastfeeding education embedded within antenatal care visits, and peer-support mechanisms led or moderated by midwives. The effectiveness of these programs lies in their adaptability to local contexts and their ability to reach mothers who might otherwise be excluded from institutional health services.

In exploring the impact of midwifery counseling on exclusive breastfeeding practices, this review draws on evidence from global and regional studies, program evaluations, and meta-analyses to identify key themes, success factors, and challenges in implementing midwifery-led interventions. It also aims to provide insight into how midwifery counseling contributes to the overall framework of maternal and child health promotion and how it can be scaled through policy, training, and system integration.

To anchor the review in practical understanding, the analysis will consider case studies and data from community-based breastfeeding interventions in countries like Ethiopia, Nepal, India, and Indonesia, as well as highlight lessons from developed healthcare systems that have adopted midwifery-led continuity of care models. These experiences will help elucidate the mechanisms through which midwives influence breastfeeding behaviors, the barriers they encounter, and the conditions necessary for their success.

In conclusion, this paper posits that midwifery counseling is not just a supplemental service but a critical component of comprehensive maternal healthcare that can significantly influence breastfeeding behavior and outcomes. Understanding its impact within community settings will not only inform policy and practice but will also reinforce the importance of investing in midwifery as a cornerstone of public health infrastructure. By empowering midwives with the necessary tools, training, and institutional support, health systems can foster environments in which exclusive breastfeeding is more likely to be initiated, continued, and normalized across diverse populations.

2. Background and Challenges of Exclusive Breastfeeding in Community Settings

Breastfeeding is a natural process with immense health benefits, but it is not always a spontaneous or straightforward experience for new mothers. Particularly in community settings, a multitude of interconnected factors influences a mother's decision to initiate and sustain exclusive breastfeeding (EBF). These include educational attainment, socio-economic status, health literacy, cultural norms, healthcare access, and the availability of skilled support. Although global campaigns have amplified the message around EBF, the practical realities of its implementation reveal persistent gaps and challenges—especially among marginalized populations in both rural and urban areas.

One of the most significant barriers to EBF is the lack of maternal knowledge about the process of lactation and its nutritional importance. Misinformation about breast milk sufficiency, the need for water supplementation in hot climates, and misinterpretations about infant cues contribute to early cessation of EBF. These misunderstandings are often perpetuated by older generations or traditional birth attendants, whose influence over new mothers remains strong in many communities. Without authoritative and supportive counseling from trained midwives, many mothers adopt suboptimal feeding practices that compromise infant health.

Another pervasive challenge is the cultural stigma or embarrassment associated with breastfeeding in public or communal spaces. In certain societies, breastfeeding is viewed as a private act that should be hidden, which creates discomfort for mothers when they are outside the home or away from family support. This can discourage feeding on demand and may lead to early introduction of formula or cow’s milk. In such cases, midwifery counseling can be instrumental in reframing these attitudes through education, normalization of public breastfeeding, and advocacy.

Workplace constraints further exacerbate the situation. In many communities, especially where formal maternity leave policies are lacking or poorly enforced, mothers return to work within weeks of childbirth. This premature separation from the infant often disrupts the breastfeeding routine. The absence of breastfeeding-friendly workplaces—such as the lack of private nursing rooms or flexible break times—adds another layer of complexity to sustaining EBF. While this is a systemic issue requiring broader policy reform, midwifery-led community education can prepare mothers for these challenges by offering practical guidance on expression and storage of breast milk, and facilitating support networks among working mothers.

Economic status also plays a critical role in shaping feeding practices. In low-income settings, families might perceive formula feeding as a sign of modernity or better nutrition, even when they lack the financial capacity to sustain it safely. Improper dilution of formula to extend usage, use of contaminated water, and lack of sterilization of feeding

bottles increase the risk of infections and malnutrition. Conversely, some low-income mothers may practice EBF out of necessity but without understanding its proper techniques or duration. This paradox highlights the need for knowledge-based behavioral change, rather than practice driven by financial limitations alone. Midwives, through regular and relatable interactions, can bridge this knowledge-practice gap effectively.

Health system-related factors also contribute to the problem. In many community clinics, the postpartum period receives far less attention than pregnancy and childbirth. Once the mother is discharged from a health facility, follow-up services are sporadic or unavailable. This discontinuity leaves a vacuum in support precisely when breastfeeding challenges—such as latching issues, nipple pain, and perceived low milk supply—begin to emerge. Midwifery counseling services that extend into the postnatal period through home visits or community health meetings are essential to address these early barriers.

Compounding these issues is the pervasive marketing of breastmilk substitutes. Aggressive advertising strategies by formula companies often mislead mothers into believing that infant formula is equivalent or superior to breast milk. These companies exploit the absence of strong regulatory enforcement, particularly in developing countries, and often target vulnerable populations with free samples and promotional gifts. In communities where midwives are empowered to provide evidence-based information and debunk marketing myths, mothers are better positioned to make informed decisions favoring EBF.

The psychological state of the mother cannot be overlooked in this context. Postpartum depression, anxiety, and fatigue may contribute to reduced confidence in breastfeeding abilities. Women experiencing emotional distress are less likely to seek help or persist through common breastfeeding difficulties. In such cases, midwives who are trained to recognize the signs of maternal mental health issues can provide critical support, offer referrals, and act as non-judgmental allies during this sensitive period.

An additional challenge lies in the lack of male involvement in breastfeeding promotion. In many cultures, infant care is seen as exclusively a woman's responsibility, resulting in fathers being under-informed and under-engaged. This dynamic place immense pressure on the mother and limits the supportive environment required for successful breastfeeding. Midwifery counseling programs that include family members—particularly spouses—can contribute to shared understanding and encourage supportive behaviors at home.

It is clear that the promotion of exclusive breastfeeding is not merely a matter of health education. It requires a comprehensive understanding of the sociocultural, economic, psychological, and systemic factors that influence maternal behavior. While policies and public health campaigns provide a broad framework for breastfeeding promotion, community-level engagement through midwifery counseling serves as the linchpin in translating these ideals into action. In community settings where resources are limited, traditions are strong, and health literacy is low, the personal connection and guidance provided by midwives can make a transformative difference.

In summary, exclusive breastfeeding in community settings is a multidimensional issue influenced by individual, familial, and structural elements. Addressing the challenges faced by breastfeeding mothers requires more than one-off messages or leaflets—it requires persistent, personalized, and culturally sensitive interventions led by professionals who are trusted and accessible. Midwives, through their unique positioning and holistic approach, fulfill this role effectively. By situating EBF promotion within the lived realities of mothers and addressing the obstacles that hinder their ability to breastfeed exclusively, midwifery counseling proves to be not only impactful but indispensable in achieving optimal child nutrition and maternal well-being.

3. Methodological Framework and Global Evidence of Midwifery Counseling Effectiveness

To critically analyze the impact of midwifery counseling on exclusive breastfeeding practices, a comprehensive methodological framework is necessary to capture the multidimensional aspects of counseling interventions, maternal responses, and infant health outcomes. In this context, both quantitative and qualitative research designs have been employed globally, with particular emphasis on randomized controlled trials (RCTs), longitudinal cohort studies, mixed-method community surveys, and ethnographic evaluations.

Midwifery counseling, as an intervention, typically comprises a series of educational and emotional support activities provided during antenatal and postnatal periods. These interventions are delivered either at health facilities, during home visits, or through community group sessions. Key parameters measured in most studies include the rate of exclusive breastfeeding at various intervals (e.g., 1 month, 3 months, and 6 months postpartum), early initiation of breastfeeding within the first hour of birth, maternal knowledge and confidence levels, frequency of breastfeeding complications, and overall infant health indicators such as weight gain and morbidity incidence.

A well-known randomized trial conducted in Ethiopia (2020) examined the effect of community-based midwifery counseling on exclusive breastfeeding rates among 400 postpartum women. The intervention group received three antenatal counseling sessions and two postnatal home visits by trained midwives. At six months postpartum, 72.5% of women in the intervention group maintained EBF compared to 52.1% in the control group, showing a statistically significant improvement ($p<0.01$). Mothers reported better understanding of infant feeding cues and increased confidence in milk sufficiency. Importantly, they also experienced fewer episodes of nipple pain and breastfeeding-associated anxiety.

In a similar study carried out in southern India, researchers investigated the role of antenatal education and immediate postnatal counseling provided by midwives. The intervention was implemented in rural primary health centers, targeting low-income women with low formal education. The results indicated a significant increase in EBF rates at both 3 and 6 months postpartum among women who received the midwifery support. Furthermore, qualitative interviews revealed that women appreciated the emotional reassurance and culturally sensitive advice provided by the midwives, which was often lacking in interactions with general physicians or hospital staff.

One of the most comprehensive global reviews on this topic was conducted through a Cochrane systematic review in 2017, which analyzed 73 studies involving more than

56,000 mothers. The findings confirmed that breastfeeding support, especially when provided by trained midwives or peer counselors, significantly improved the duration and exclusivity of breastfeeding. The review emphasized that interventions were most effective when initiated during pregnancy and continued into the postpartum period, and when delivered face-to-face rather than through written or digital communication alone.

In Indonesia, a pilot program launched in 2021 focused on integrating midwifery counseling into routine maternal care across 12 public health centers in urban and peri-urban zones. The program employed a combination of individual counseling, group classes, and community awareness sessions that included family members. The EBF rate at 6 months rose from 38% to 65% in participating regions, demonstrating how culturally tailored, midwife-led approaches could effectively shift practices. Additionally, midwives were trained in motivational interviewing and active listening techniques, enabling them to address individual concerns more effectively than conventional didactic models.

In high-income settings, midwifery counseling has also shown positive outcomes, although the challenges in such contexts differ. In the United Kingdom, for instance, the "Continuity of Midwifery Care" model was introduced, which ensured that women received antenatal, intrapartum, and postnatal care from the same midwife or team. Evaluations of this model showed that women who experienced continuity of care were more likely to initiate and sustain breastfeeding, and felt more supported in their decisions. This finding underscores the importance of relational continuity, trust-building, and consistent messaging in shaping breastfeeding outcomes.

Studies from Latin America further illustrate the value of community health strategies that combine midwifery counseling with peer support groups. In Brazil, midwives facilitated breastfeeding support circles within neighbourhoods, offering mothers a space to share experiences, troubleshoot common problems, and foster a sense of solidarity. These peer-driven spaces, led by a midwife, contributed to higher EBF rates, lower maternal stress, and improved maternal mental health scores.

Evidence from these diverse settings highlights several recurring themes. First, the timing and continuity of midwifery counseling matter immensely. Interventions that begin during the antenatal period and extend at least through the first three months postpartum yield better outcomes than those confined to a single point in time. Second, cultural tailoring of messages and delivery styles plays a pivotal role in community acceptance and maternal behavior change. Midwives who understand local customs, language, and social dynamics are more effective in establishing trust and influencing attitudes.

Third, the emotional and psychological dimension of breastfeeding is often underappreciated but vitally important. Mothers are more likely to persevere through the difficulties of breastfeeding when they feel emotionally supported, validated, and understood. Midwifery counseling, through its personalized approach, addresses not only knowledge deficits but also feelings of self-doubt and isolation that frequently accompany new motherhood.

Finally, successful interventions are those that engage the broader family and community context. Breastfeeding is not solely a maternal choice—it is influenced by partners, grandparents, social networks, and community norms. Midwifery counseling that includes sessions with husbands, elder women, or community influencers can shift collective attitudes and build a supportive environment for EBF.

As demonstrated across various regions, midwifery counseling is not a one-size-fits-all solution but a flexible, adaptable strategy that responds to the unique needs of mothers and communities. By integrating global best practices with local realities, midwives can serve as catalysts for sustainable breastfeeding behaviors.

To consolidate this evidence and encourage broader adoption of effective practices, it is imperative that future programs and policies support the standardization of midwifery training in breastfeeding counseling. This includes practical instruction in communication techniques, mental health screening, cultural competence, and use of tools such as visual aids or infant feeding dolls. Equally important is the institutional recognition of midwives not only as birth attendants but as primary agents of maternal education and community health promotion.

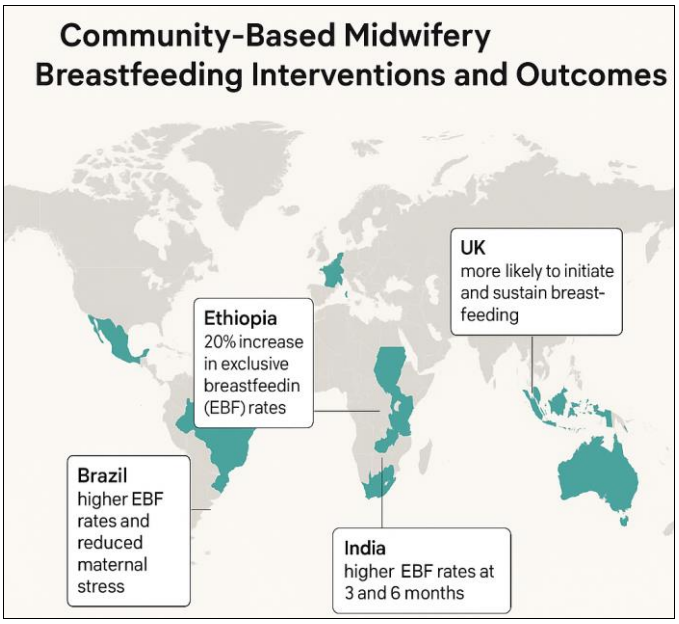

Fig1: Global Map Highlighting Community-Based Midwifery Breastfeeding Interventions and Outcomes]

4. Discussion and Analysis

The evidence collected from various international and community-based studies consistently demonstrates that midwifery counseling plays a pivotal role in enhancing exclusive breastfeeding (EBF) rates. While the benefits of breastfeeding are universal, the socio-cultural, economic, and infrastructural contexts in which mothers make infant feeding decisions vary significantly across regions. Therefore, the role of midwifery counseling must be analyzed through a lens that considers both global applicability and local specificity. This discussion explores how midwives' function as agents of change in diverse maternal care ecosystems and examines the mechanisms through which counseling contributes to improved breastfeeding outcomes.

One of the most crucial insights emerging from global interventions is the relational trust between midwives and mothers. Unlike physicians or hospital staff who often rotate shifts and lack consistent follow-up with patients, midwives typically provide ongoing care during pregnancy, delivery, and the postnatal period. This continuity fosters familiarity and psychological comfort, which encourages open dialogue. When mothers feel heard and understood, they are more likely to express doubts, share anxieties, and accept guidance. This relational foundation, while intangible, forms the backbone of effective counseling. Midwives use it not only to transmit information but to affirm the mother's ability to breastfeed, helping build self-efficacy—a central predictor of successful breastfeeding behavior.

The counseling process itself is multifaceted. It involves verbal education, demonstration of techniques, problem-solving for common breastfeeding issues, and emotional support. Counseling is most impactful when interactive, allowing for personalized feedback and clarification. The integration of culturally appropriate narratives, visual aids, and experiential sharing within sessions increases knowledge retention and resonance. For instance, using real-life scenarios or peer testimonials in local languages makes the counseling session feel more relevant and relatable. In community settings where formal literacy may be limited, midwives often act as translators of scientific knowledge into culturally comprehensible messages. Their ability to bridge the gap between biomedical and traditional beliefs enables mothers to reconcile conflicting advice and make informed choices.

In areas with deeply entrenched cultural practices around infant feeding—such as giving honey, water, or herbal concoctions to newborns—midwifery counseling is particularly valuable. It allows for respectful engagement with tradition while gently correcting misinformation. Rather than dismissing community customs outright, skilled midwives validate the concerns behind these practices and provide safer, evidence-based alternatives. This culturally sensitive communication, often absent in standard health promotion campaigns, is a hallmark of effective midwifery care.

Another significant dimension of midwifery counseling lies in its influence on the psychosocial wellbeing of the mother. The early postpartum period is fraught with challenges, including hormonal fluctuations, sleep deprivation, anxiety about newborn care, and in some cases, postpartum depression. These psychological factors can severely affect a mother's motivation and capability to breastfeed. Counseling serves as a therapeutic encounter where emotional burdens are acknowledged and managed. Midwives trained in basic mental health assessment can identify mothers at risk and either address mild symptoms through encouragement or refer them for specialized care. Such integrated attention to emotional and physical health is rare in maternal services but essential for sustaining EBF.

From a behavioral standpoint, midwifery counseling often acts as a catalyst for habit formation. Breastfeeding, like any new behavior, requires time and support to become routine. By providing scheduled touchpoints—whether through home visits, group sessions, or phone check-ins—midwives help reinforce breastfeeding behaviors at critical junctures. These interventions provide practical solutions to day-to-day obstacles such as poor latch, nipple pain, or concerns over milk sufficiency. They also address more complex issues such as maternal guilt, pressure to formula-feed, or fear of public breastfeeding. The repetitive and responsive nature of counseling helps mothers' transition from initial uncertainty to confident, autonomous feeding practices.

One area that has emerged as particularly influential is the involvement of family members in the counseling process. In many societies, the decision to breastfeed exclusively is not made by the mother alone. Husbands, mothers-in-law, and elders often exert significant influence. Midwives who include these family members in education sessions effectively build a supportive network around the mother. They clarify myths, create shared understanding, and reduce resistance to EBF. Studies have shown that when husbands are educated about the benefits and logistics of breastfeeding, they are more likely to encourage their partners and help with household responsibilities, indirectly boosting the likelihood of breastfeeding success.

In analyzing the broader public health context, midwifery counseling should not be viewed as a stand-alone intervention but rather as part of a continuum of maternal and child health services. Its impact is magnified when integrated with antenatal classes, postnatal care, immunization drives, and growth monitoring programs. In community health systems where resources are scarce, midwives often multitask across services, and their capacity to deliver quality counseling depends on adequate training, supervision, and institutional support. Programs that provide refresher courses, access to updated materials, and opportunities for peer learning ensure that midwives stay competent and motivated. Moreover, the provision of basic tools—such as flipcharts, breast models, and privacy during sessions—enhances the quality of engagement.

Another critical observation from global practice is the adaptability of midwifery counseling across digital platforms. In response to challenges such as travel distance, workforce shortages, or pandemics, many programs have piloted telephonic or mobile-based counseling. While in-person contact remains the gold standard, digital solutions have shown promise, especially in sustaining contact during follow-up phases. Applications that allow mothers to chat with midwives, access instructional videos, or log feeding patterns provide supplementary support. However, these tools must be tailored to user literacy levels and supported by digital infrastructure—a limitation in many rural settings.

While the benefits of midwifery counseling are evident, it is important to acknowledge the systemic barriers that hinder its widespread implementation. In many regions, midwives are underpaid, overburdened, or lack formal recognition within the healthcare hierarchy. Their workloads often

include administrative tasks, delivery services, and immunization duties, leaving little time for one-on-one counseling. Without adequate staffing or incentives, midwifery counseling risks being deprioritized or delivered perfunctorily. Policymakers must recognize that improving breastfeeding outcomes through counseling requires investments not only in training but in work conditions, logistics, and career development.

Additionally, there is a need for better monitoring and evaluation of counseling programs. Many interventions do not collect data systematically, making it difficult to assess impact or refine strategies. Implementing standardized indicators for counseling frequency, maternal satisfaction, knowledge retention, and breastfeeding rates can provide actionable insights. Community health information systems should integrate these indicators to inform planning and resource allocation.

Finally, the issue of gender-sensitive policy cannot be overlooked. Midwifery counseling interventions must be aligned with policies that support women's rights to maternity leave, workplace lactation support, and protection from exploitative formula marketing. Midwives alone cannot overcome systemic inequities, but their work can be leveraged to advocate for structural reforms. Engaging midwives in policy dialogues and including their perspectives in maternal-child health frameworks will enhance the credibility and effectiveness of breastfeeding promotion strategies.

In summary, midwifery counseling is an evidence-backed, context-sensitive, and highly adaptable approach to promoting exclusive breastfeeding. Its strength lies not only in providing accurate information but in empowering mothers, addressing emotional needs, and reshaping community norms. As a relational and educational intervention grounded in trust, empathy, and continuity of care, it offers a model of maternal support that can be scaled across diverse settings. However, to realize its full potential, governments and health systems must commit to long-term investment in midwifery education, workforce expansion, infrastructure, and policy integration. Only then can midwifery counseling fulfill its promise as a cornerstone of breastfeeding success and maternal-child wellbeing.

5. Conclusion and Policy Recommendations

Exclusive breastfeeding remains one of the most effective interventions for improving child survival, reducing infant morbidity, and promoting maternal well-being. Despite overwhelming scientific evidence and global endorsement, its practice continues to fall short of public health targets, especially in communities challenged by socio-cultural barriers, misinformation, and lack of systemic support. Within this complex landscape, midwifery counseling emerges as a powerful, context-sensitive, and evidence-based tool for improving exclusive breastfeeding practices.

This review has demonstrated that midwifery counseling significantly enhances both the initiation and continuation of exclusive breastfeeding. By combining clinical knowledge with empathetic communication, midwives act as both educators and advocates for breastfeeding mothers. Their continuous presence throughout the perinatal period fosters a relationship of trust that is often absent in conventional healthcare delivery systems. Counseling provided by midwives helps mothers navigate the emotional and physical challenges of early motherhood, address common breastfeeding difficulties, and overcome cultural or familial resistance to exclusive breastfeeding.

What distinguishes midwifery counseling from generic health promotion is its holistic approach. It attends not only to the biological aspects of breastfeeding but also to the psychological, cultural, and social contexts within which mothers operate. Midwives, especially those embedded in the community, are well-positioned to understand and respect local beliefs while guiding behavior change. Their ability to provide individualized care, engage with families, and integrate breastfeeding education into routine maternal services makes them indispensable to community health systems.

The impact of midwifery counseling is magnified when supported by a conducive environment—one that values midwives not merely as auxiliary workers but as core agents of maternal and child health. In communities where midwives are trained, equipped, and given time to counsel mothers effectively, breastfeeding outcomes improve substantially. Furthermore, when midwives are included in health system planning, they contribute valuable insights into grassroots realities that often escape top-down policy approaches.

However, despite its proven benefits, midwifery counseling faces multiple operational challenges. These include shortages of trained midwives, high workloads, lack of institutional recognition, and limited access to counseling resources. In some settings, midwives are expected to perform multiple tasks without adequate compensation or support, which undermines the quality and consistency of counseling. In others, health systems are so narrowly focused on clinical outcomes that they neglect the educational and emotional dimensions of maternal care.

To address these gaps and institutionalize the positive impact of midwifery counseling, a set of policy recommendations must be adopted at local, national, and international levels.

First, midwifery education and training programs must include a comprehensive module on breastfeeding counseling, communication skills, and cultural competence. This training should go beyond theory to include practical simulations, role-play, and field exposure. Midwives must be equipped with tools such as flipcharts, anatomical models, and access to digital content to enhance their counseling sessions.

Second, healthcare systems should provide structural support for midwifery counseling by ensuring manageable workloads, clear guidelines, and adequate staffing. Facilities must allocate protected time for midwives to conduct antenatal and postnatal counseling, recognizing it as an essential service rather than an optional add-on. Community outreach services, especially in rural and underserved areas, should prioritize home visits and peer-group education led by midwives.

Third, policymakers must integrate midwifery counseling into national breastfeeding strategies. This includes setting measurable targets for counseling coverage, monitoring outcomes through health information systems, and linking midwifery performance to breastfeeding indicators. Incentives such as recognition awards, continuing education credits, or career advancement opportunities should be made available to midwives who demonstrate exemplary performance in breastfeeding promotion.

Fourth, family and community engagement must be institutionalized as part of counseling initiatives. Breastfeeding decisions are rarely made in isolation. Midwifery counseling programs must deliberately include fathers, mothers-in-law, and other family influencers in education efforts. This not only strengthens the mother's

support system but also helps normalize exclusive breastfeeding across generations and social strata.

Fifth, the integration of technology can extend the reach of midwifery counseling, particularly in settings where travel is difficult or midwife-to-mother ratios are low. Mobile-based applications, video demonstrations, and helplines moderated by trained midwives can supplement in-person sessions. However, these tools should be adapted to the literacy levels and technological access of the target population, and never replace the relational essence of human counseling.

Sixth, governments and NGOs must collaborate to strengthen advocacy and community awareness regarding the importance of exclusive breastfeeding and the role of midwives. Public campaigns, school curricula, workplace policies, and media engagement should reinforce positive messages around breastfeeding and midwifery care. This broader societal shift is essential to sustain individual behavior change.

Finally, international agencies and donors must recognize midwifery counseling as a critical intervention in maternal and child health funding frameworks. Investments should be directed toward building midwifery capacity, improving working conditions, and evaluating best practices across diverse settings. Research should continue to explore innovative models of midwifery-led interventions and document their long-term impacts on maternal-child health outcomes.

In conclusion, midwifery counseling represents a high-impact, low-cost strategy to enhance exclusive breastfeeding practices at the community level. It aligns with global health priorities, respects cultural diversity, and empowers mothers through education and support. As the world seeks sustainable solutions to improve infant nutrition and reduce maternal and child mortality, strengthening the role of midwives through structured counseling programs must be placed at the forefront of public health agendas. Only by institutionalizing and investing in this vital service can we move closer to achieving universal breastfeeding targets and ensuring healthier beginnings for generations to come.

Conflict of Interest
Not available

Financial Support
Not available

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How to Cite This Article
Ashish Tamang. Impact of Midwifery counseling on exclusive breastfeeding practices: A community-based study. International Journal of Midwifery and Nursing Practice. 2025;8(1):42-48.