# SECTION 5

5

# How to support women living with HIV



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## KEY MESSAGES

- Mothers living with HIV should receive infant feeding recommendations rather than just a neutral presentation of options;
- Stigmatisation, discrimination and other human rights violations hinder and prevent women from seeking HIV testing and treatment, which in turn significantly compromise access and adherence to, as well as retention of available ARVs, thus negatively impacting prevention of vertical HIV transmission;
- National or sub-national health authorities should decide whether health services will principally counsel and support mothers living with HIV to either breastfeed with ARVs or avoid all breastfeeding as the strategy most likely to give infants the greatest chance of HIV-free survival;
- Global, national and community leaders have an opportunity to act in concert to support prevention of vertical transmission of HIV to infants and to save the lives of their mothers;
- Mothers living with HIV need consistent, up to date information and close practical assistance to feed their babies in the safest way. In most settings this means breastfeeding exclusively for the first 6 months, and continued breastfeeding with appropriate nutrient-dense complementary foods and other liquids for up to 24 months, or until safe replacements for breastfeeding can be provided. Compared to exclusive breastfeeding, mixed feeding in the first six months after birth can increase the risk of HIV transmission, and therefore should be avoided.

# 5.1 RIGHTS AND CHOICES OF THE MOTHER

## Breastfeeding is possible for almost all mothers

Virtually all mothers can breastfeed provided they have accurate information and support from their families, healthcare providers and within the wider community. International Board Certified Lactation Consultants (IBCLCs) and breastfeeding counsellors find that, with the exception of a very few medical conditions (WHO & UNICEF, 2009), exclusive breastfeeding from birth to 6 months is possible for the large majority of mothers. Unrestricted, exclusive breastfeeding with thorough breast emptying results in ample milk production.

Mothers may need access to skilled practical help from trained health workers, lay and peer counsellors, and IBCLCs when available. This includes specific measures to prevent or resolve breastfeeding problems, and more general support to build confidence in mothers.

## Gender inequality is a root cause of women's vulnerability

Women and girls affected by HIV represent 52% of all adults affected by HIV globally and 57% in Sub-Saharan Africa (UN, 2015).

Human rights are central to the AIDS response. Today, 89% of countries explicitly acknowledge or address human rights in their national AIDS strategies. Most report that they have programmes in place to reduce HIV-related stigma, and accept that women require special protection from gender-based violence and greater economic independence (UNAIDS, 2010c). Yet, translating these programmes into action remains challenging.

Due to gender inequality, which reflects the disadvantaged position of women in society, issues which affect their lives are less likely to be monitored and recorded in their developmental, physical, behavioural and sexual indicators, such as the following:

- Women bear the main burden for care of the ill, elderly and young, AIDS patients and orphans;
- Their knowledge about HIV may be limited;
- Although women living with HIV are more motivated to use contraception, there is still a knowledge gap, and possible lack of empowerment of women for decision-making in the area of family planning (UNAIDS, 2016c);
- The economic vulnerability of women, especially younger women, increases high-risk behaviour, e.g. drug use, sex work, transactional or non-consensual sex, and low condom use;
- Women often suffer stigma, including sexual violence by intimate partners, and discrimination.

Health sector policies and programmes should empower women and girls to reduce their vulnerability to HIV,

challenge harmful gender norms, and contribute to gender equality. Gender-based access to health interventions, such as ARVs, should be addressed in HIV programming. Boys and men need to be included in behavioural and structural interventions aimed at reducing gender inequality (WHO, 2009e; Johnson et al., 2012).

### Breastfeeding: a public health approach to infant feeding

The decision about the optimal feeding method for an HIV-exposed infant was thus shifted away from a promotion of options from which a woman should choose, and replaced by a public health approach. The rationale was the consideration that if there is a medical consensus in favour of a particular option, patients prefer a recommendation rather than simply a neutral presentation of options, as was previously recommended (WHO et al., 2010). Thus, mothers known to be HIV-infected would want to be offered interventions;

- that can be strongly recommended,
- are based on high quality evidence,
- are free from bias among counsellors, and
- do not represent a conflict with interests of the individual patient, either the infant or the mother.

A more directive approach to counselling about infant feeding–in which practitioners make a clear recommendation for or against breastfeeding, rather than simply presenting different options without expressing an opinion–is fully consistent with an individual rights framework. There is no single approach to counselling and consent that is appropriate in all situations. Rather, with all medical interventions, there is a continuum of options available, with the choice among options dependent on various contextual factors (See Figure 1).

Most importantly, the change in recommendations in 2009/2010 describes the effectiveness of ARVs to reduce HIV transmission through breastfeeding as "transformational". In conjunction with the known benefits of breastfeeding to reduce mortality from other causes, this finding justifies an approach that strongly recommends a single option as the standard of care. Information about options should be made available, but services should principally promote and support one approach.

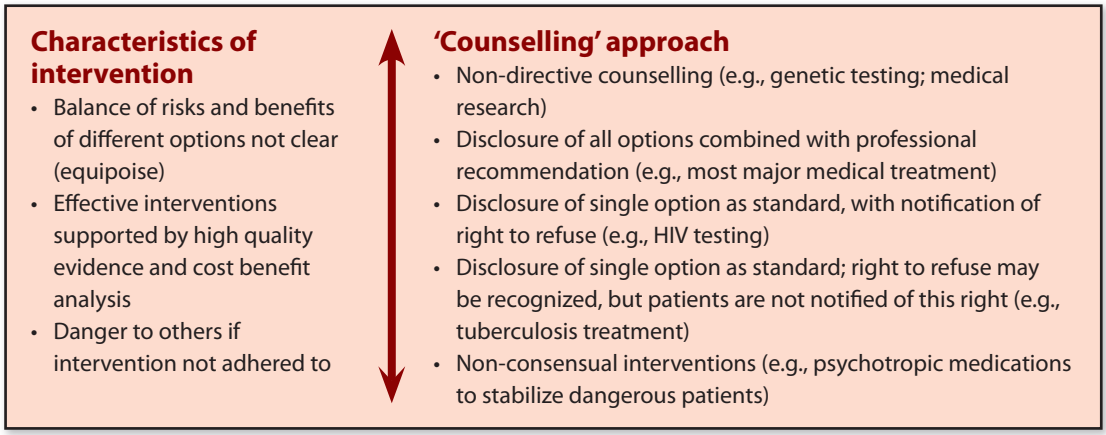
## 5.2 CHALLENGES OF WOMEN LIVING WITH HIV

### Different challenges in the high HIV prevalence context for engaging and keeping pregnant and breastfeeding women in care based on when they were diagnosed with HIV

In most low-income countries women's health is shaped by poverty, ill health, multiple burdens, insecure jobs with poor working conditions, migration for work, lack of shelter, abuse and domestic violence, combined with a lack of basic resources, including food (Menon & Amin, 2005). However, all those issues escalate when girls and women become infected with HIV (Holla-Bhar, 2006). For instance, in India there is enormous gender discrimination, such as (Menon & Amin, 2005; Holla-Bhar, 2006):

- Girls and women living with HIV are viewed as immoral and suffer verbal and physical abuse from their family;
- Even utensils are kept separate, as the family thinks HIV is also contagious through shared use;

FIGURE 1: Characteristics of intervention and 'counselling' approach, 2010




Source: WHO (2010d)

- Normally, men's multi-partner sexual behavior is accepted, but if women have extra-marital relationships they are condemned and punished;
- Men living with HIV are accepted, but women living with HIV are treated with contempt;
- Males living with HIV do not disclose their HIV status to their wives/partners and also do not want them to receive testing;
- When a woman is infected with HIV, male relatives do not support her care and treatment.

Also, it is not uncommon for a male living with HIV not to give consent for his pregnant sexual partner/wife to attend antenatal care, as he knows that pregnant women normally get tested during antenatal visits. In addition, as a result of gender discrimination and women's disempowerment, pregnant women can be prevented from giving birth at a health facility, contributing to maternal and neonatal morbidity and mortality. This risk is increased for women who have undergone female genital mutilation.

Nevertheless, in countries with high HIV incidence and prevalence, pregnant girls, adolescents and women especially the ones exposed to HIV can face several challenges in accessing antenatal testing counselling and early initiation of ART. Apart the lack of consent from their partners, girls, adolescents and women may be prevented from attending antenatal care due to distance, lack of transport, shortage of money and inability to pay health service costs/fees. If exposed to HIV during late pregnancy, women are at high risk of opportunistic infections and can also face discrimination from unskilled healthcare providers at health facilities. These issues can negatively influence adherence to ART and retention in care by girls, adolescents and women which in turn will have a negative impact on vertical transmission, including HIV transmission through breastfeeding in the absence of ART.

### Challenges of women living with HIV in low-income settings

- In order to breastfeed exclusively, women may have to go against cultural norms for early introduction of fluids and mixed feeding (Marinda et al., 2017);
- Furthermore, as a result of conflicting breastfeeding information carried over from the AFASS era, it is still common for women with full adherence to ART to fear infecting their babies through prolonged breastfeeding;
- Moreover, inadequate ART supply and shortage of continued and strengthened counseling support at health facilities are part of today's challenges for breastfeeding women living with HIV;
- According to a study in Zambia, women are not totally convinced that even when they receive ART, their babies will not be infected through breastfeeding. Thus, it seems clear that women would give infant formula to their babies if they could afford to buy it. The same study shows that women, even under option B+, had little confidence related to breastfeeding management, for instance, they were afraid of infecting their babies through breastfeeding if they had sore nipples or any breast problem (Hazemba et al., 2016);
- Women living with HIV also have doubts about when to interrupt breastfeeding (Hazemba et al., 2016).

### Challenges of women living with HIV in high-income settings

In high-income countries a major challenge for HIV+ women wanting to breastfeed:

- lack up-to-date information amongst healthcare providers who may not have had many HIV+ patients before;
- receive infant feeding recommendations based on the belief that breastfeeding with HIV is too risky and/or that formula-feeding is safe (Morrison & Faulkner, 2015);
- only consider breastfeeding for HIV+ woman in exceptional situations, some national guidelines still recommend formula.

## 5.3 COUNSELLING PROCESS

Mothers should be counselled to breastfeed exclusively in the first six months of life and continue breastfeeding thereafter unless environmental and social circumstances are safe for, and supportive of replacement feeding. Correct and effective communication of the new policy is essential (UNICEF, 2011; WHO & UNICEF, 2016).

## Counselling the HIV infected woman and her family

Counselling is a helping relationship specific to the needs of the individual. Most women benefit from a respectful, empathetic discussion of their situation. Counselling a woman and her partner together as a couple, or including other key family members, is especially helpful. Counselling is particularly important at certain times:

- during family planning visits to prevent unintended pregnancy;
- before pregnancy, to discuss the question and risks of becoming pregnant;
- during pregnancy for guidance about breastfeeding.
- shortly after the birth;
- during routine follow-up visits for care of the mother and child.

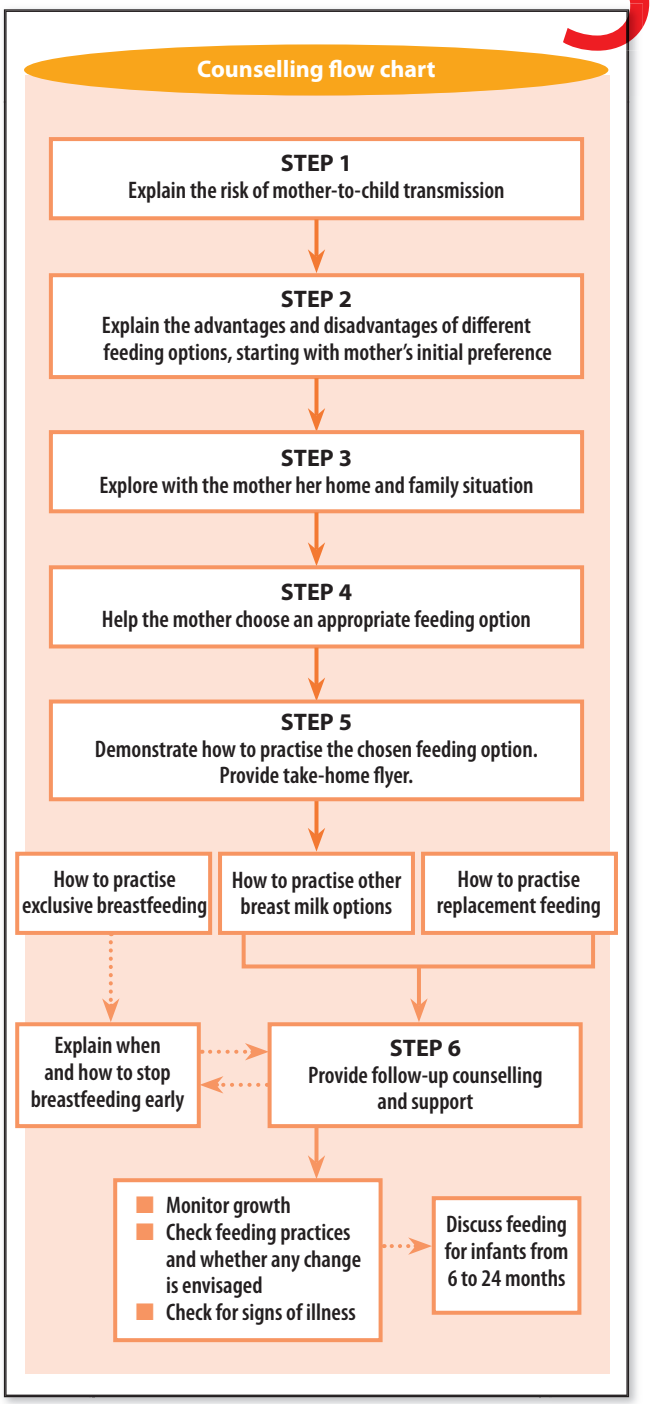
A 2012 pilot study from South Africa found that an infant feeding buddy system amongst mothers living with HIV, to provide support for exclusive breastfeeding could be successfully integrated into routine PMTCT visits. Study participants confirmed that having a buddy was a helpful support (Kramer & Kakuma, 2002; Andreson et al., 2013).

### Challenges and solutions to counselling women living with HIV

Infant feeding counselling of mothers living with HIV has posed particular challenges related to choice. Some counsellors expressed trust in advice given to practice exclusive breastfeeding, but experienced great uncertainty and confusion about alternatives to breastfeeding (Våga et al., 2014). In 2010 WHO began recommending a universal and unambiguous message on infant feeding to all mothers in PMTCT programmes designed to create more confidence, less confusion and better results in terms of HIV-free survival of the baby (WHO et al., 2010).

The following flow chart from the 'WHO 2005 Counselling Tools' (Figure 2) illustrates the difficulties inherent in the steps which a counsellor should take during an infant feeding counselling session, 2005 (WHO et al., 2005).

FIGURE 2: WHO 2005 Counselling Tools




Source: WHO et al. (2005)

## New focus of infant feeding counselling

New guidance issued by WHO in 2016 (WHO & UNICEF, 2016) contains an important amended recommendation for duration of breastfeeding compared to previous guidance from 2010 (WHO et al., 2010). Advocacy and recommendations about the duration of exclusive and continued breastfeeding, while important, are often insufficient on their own (Israel-Ballard et al., 2014).

Even when access to ARV regimens is universal, mothers and healthcare workers must continue to receive the education and support they need to ensure safe infant feeding and ultimately optimal levels of HIV-free survival in each setting (USAID et al., 2012).

To prevent and resolve common breastfeeding difficulties, and overcome pressure to follow inappropriate traditional infant feeding practices, e.g. premature mixed feeding, mothers need:

- Accurate, consistent information, guidance and skilled assistance from knowledgeable and sympathetic healthcare personnel and community workers who have all received up-to-date training (USAID et al., 2010b);
- Regular counselling and support provided in their homes and in the community close to where mothers live (Bland et al., 2008);
- Dissemination of accurate and up-to-date information to key family members (USAID et al., 2010a; USAID et al., 2010c; Israel-Ballard et al., 2014).

Based on the findings that infant HIV-free survival is increased in most settings by not interrupting breastfeeding, the 2010 recommendations contain several important changes in infant feeding recommendations (WHO et al., 2010) compared to previous guidance (WHO & UNICEF, 2007). Some of the recommendations from 2010 have been carried forward to be included in the 2016 WHO recommendations (WHO & UNICEF, 2016), such as:

- The principle of HIV-free survival of HIV-exposed babies and young children should be stated before all else to highlight the need to consider all the risks to the infant's life and not solely prevention of HIV infection or maintaining growth;
- Decision-making about infant feeding is shifted away from counsellors (who were previously expected to individually counsel women about various feeding options so that they could choose between them) and instead placed on national authorities in each country (to decide which infant feeding practice will be primarily promoted and supported by Maternal and Child Health Services) (WHO & UNICEF, 2007);
- Counselling will focus on informing mothers about the practice which is recommended, and how to feed the baby accordingly. Information about options should be made available, but services would principally support one approach.

Recommending a single option within a national health framework still requires the need for skilled counselling and support to be available to pregnant women and mothers regardless of country context and recommended national policy.

#### Key information on counselling for a country which recommends replacement feeding

A country which chooses replacement feeding should still provide information and counselling on breastfeeding plus ARVs and support women who wish to breastfeed.

#### Key information on counselling for a country which recommends breastfeeding

A country which principally recommends breastfeeding should still provide information about safe replacement feeding for mothers who request it. Counsellors should be able to provide additional information on the alternative options (Key Principle 5 of the WHO guidelines) (WHO et al., 2010). This may be particularly relevant in countries where mothers have already been exposed to PMTCT counselling and information directed towards choice (UNICEF, 2011).

## 5.4 NATIONAL POLICY, TRAINING, COMMUNITY SUPPORT AND CODE

### Dissemination and implementation of current recommendations

The current recommendations (WHO et al., 2010; WHO & UNICEF, 2016) pose a particular communication challenge: how to ensure that the public understands that breastfeeding has been made significantly safer with the new protocols on antiretroviral (ARV) regimes, but at the same time even when ARVs are not available, breastfeeding may still provide infants born to mothers living with HIV with a greater chance of HIV-free survival.

#### Main provisions of current recommendations (WHO et al., 2010)

National or sub-national health authorities are advised to decide whether their health services will principally counsel and support mothers known to be HIV-infected:

- to breastfeed and receive lifelong ARV interventions, or
- to avoid all breastfeeding.

In settings where national authorities have decided that maternal, newborn and child health services will

principally promote and support breastfeeding and lifelong ARVs, recommending a single option within a national health framework does not remove the need for skilled counselling and support to be available to pregnant women and mothers. However, counselling services should be directed primarily at supporting mothers in their feeding practices, rather than focussed on a process of decision-making.

### Exclusive breastfeeding for the first six months

Repeated emphasis needs to be placed on the importance and feasibility of exclusive breastfeeding. In both developed and developing countries, many health workers, family members, and mothers believe incorrectly that "just breastmilk" contains inadequate fluids and food to sustain a baby for the first six months of life. This belief is a common reason for supplementing the breastfed baby and many believe that mixed feeding with early introduction of solids and other liquids is inevitable.

### Optimal infant feeding method recommendation

Exclusive breastfeeding for the first 6 months of life is accepted as the optimal infant feeding method (Kramer & Kakuma, 2002).

## Revised training needs

It is important for health workers to be fully trained to teach breastfeeding women how to breastfeed exclusively and continue breastfeeding for the first two years or longer. A mother living with HIV will require both:

- anticipatory care to provide accurate information on preventable difficulties and prepare for any changes in feeding method, starting other foods, weaning, or mother-baby separation, e.g. to continue exclusive breastfeeding until 6 months while working outside the home;
- remedial care to overcome any breastfeeding or breast problems, e.g. latching difficulty, breast refusal, painful/damaged nipples, breast engorgement, mastitis, insufficient milk.

HIV and infant feeding counselling has proven to be extremely challenging in many countries. Clinical officers and nurses play an important role in provision of primary healthcare to antenatal and postnatal women. A study aiming to assess and evaluate knowledge of staff in various hospitals in Kenya found that there is a need to promote training programmes on breastfeeding and transmission of postpartum HIV (Murila et al., 2015). This can be done as in-service training, continuous medical education, community-based training and workshops, and as part of the formal training within medical institutions (Murila et al., 2015). It is important to highlight that training on HIV and infant feeding needs to be updated very often as new research is revealed. In addition, health professionals, health workers and activists may need refresher training from time to time on up-to-date guidance on HIV in both community and hospital settings.

All workers who are in contact with pregnant women and mothers, e.g. those in PMTCT sites, and all MCH and community workers, should be well trained in guidelines, training materials, counselling tools, job aids, communication messages and materials from national and sub-national health authorities which address the updated WHO guidance (Yezingane Network & UNICEF, 2011; UNICEF, 2017). Current training materials are listed in Section 6.

Several studies show that skilled support of mothers can be very effective in achieving exclusive breastfeeding and delaying the premature introduction of complementary foods (Morrow et al., 1999; Haider et al., 2002). A priority for counsellors and women is a clear understanding of how the breasts produce milk, and of factors which interfere with that process.

Training for providers and good communication at all levels is important to ensure that health workers in richer and poorer districts within a particular country give clear and consistent recommendations based on current evidence. We call on the international community to fund and support dissemination of current 2016 WHO HIV and Infant Feeding Guidelines (WHO et al., 2010; WHO & UNICEF, 2016) and assist decision-makers at national, regional and district levels to implement them.

The Zambia study (Hazemba et al., 2016) shows that healthcare providers at health facilities request up-to-date refreshment training and mentoring to improve staff attitudes and give further support to breastfeeding women living with HIV, according to current recommendations on HIV, ART adherence and retention in care, and breastfeeding management in the HIV context.

## The role of the community in low income settings

The needs and priorities of mothers living with HIV and their babies should be identified by the whole of the community. Politicians, local leaders and support groups should be involved, and men and other decision-makers should be specifically targeted (USAID et al., 2012). The World Breastfeeding Week (WBW) campaign is an important opportunity for breastfeeding advocacy among the general population and health professionals in the community and hospital settings. Every year WABA indicates a relevant theme to adopt during the World Breastfeeding Week celebration from 1st to 7th August or during the whole month of August. In fact, independent of the WBW theme of each year, the subject of HIV and breastfeeding can be undoubtedly, supported during the campaign celebrating the WBW at the work place, and at community and hospitals/ maternities. Also, the World AIDS Day campaign (celebrated every year on 1st December) is an opportunity to raise awareness and improve knowledge on safe breastfeeding as the gold standard of infant nutrition including in the context of HIV and to maximise infant survival through full maternal adherence to ARVs and retention in care. Priority should be given to developing the knowledge and skills of resource persons such as community educators, counsellors, and health and development workers, in supporting mothers to feed their babies in the safest way (Israel-Ballard et al., 2014). Mother support close to where mothers live, through peer counselling support, has proved to be the most effective intervention in helping mothers to breastfeed successfully after discharge from the maternity unit. A gender-sensitive, community development approach is required, to build on and strengthen existing community structures. Activities can include:

- National social marketing, helping women living with HIV and their families towards acceptance of HIV testing and understanding of PMTCT;
- Mother-to-mother support group meetings and peer counselling, leaflets and items on public media as useful ways to provide information and educate a whole community;
- Supporting mothers in national infant feeding recommendations and ensuring that families are protected from inappropriate interventions, to prevent spill over of inappropriate feeding methods;
- Promoting exclusive and continued breastfeeding as the safest feeding method for the population in general, as well as for mothers who are HIV-positive;
- Facilitating formation of breastfeeding support groups for all mothers, including those who are living with HIV (USAID et al., 2011b; USAID et al., 2011a; USAID et al., 2012);
- Preventing and overcoming stigma, since exclusive breastfeeding should be promoted for all mothers, not just for those who are living with HIV;
- Educating grandmothers, men, community workers and volunteers about the importance of exclusive breastfeeding in the first six months of life;
- Continued breastfeeding for 24 months or beyond by both the general population as well as for mothers living with HIV.

## Reducing spill-over of artificial feeding to unexposed infants

In some communities many mothers living with HIV feed their infants artificially due to unfounded fears that breastfeeding is risky and better avoided. The consequent spread of artificial feeding is called 'spill-over'. Spill-over is often aggravated by:

- lack of breastfeeding promotion;
- misinformation about the risk of HIV transmission through breastfeeding;
- free supplies of formula provided by PMTCT sites;
- inappropriate efforts to normalise replacement feeding;
- persistence of recommendation of formula feeding for infant exposed to HIV;
- lack of up-to-date training programmes and refresh training (e.g. in-service training) on HIV and breastfeeding for health professionals.(Israel-Ballard et al., 2014; Murila et al., 2015).

### The consequences of spill-over

- Uninfected mothers may breastfeed for a very short time, or not at all, or they may mix-feed;
- When the community accepts artificial feeding, it may reduce stigma, but places the health of greater numbers of infants at risk for infant morbidity and mortality;
- Free supplies make replacement feeding easier for mothers who are living with HIV, but the formula may be sold or otherwise reach the wider community, thereby increasing the risk of artificial feeding among infants who are not exposed to HIV and creating a conflict of interest between the health professional and the infant formula company.

When funders, directors, and policy makers also lose confidence in breastfeeding it can result in:

- Displacement of funding and support for breastfeeding programmes, e.g. the Baby Friendly Hospital Initiative, breastfeeding support groups, capacity building, training of health workers on breastfeeding, implementation of the International Code of Marketing of Breastmilk Substitutes (the Code) (WHO, 1981; WHO, 2008). Code monitoring and implementation, and promotion of World Breastfeeding Week;
- Lack and/or poor planning and support for the Global Strategy on Infant and Young Child Feeding (IYCF) (WHO & UNICEF, 2003);
- Public information campaigns focussing on the risks of breastfeeding in the context of HIV rather than on the risks of artificial feeding;
- An overall decrease in breastfeeding rates and an increase in morbidity/mortality.

### Key actions to reduce spill-over

- Strengthening public information, action to support breastfeeding and monitoring feeding practices;
- Training of breastfeeding counsellors in up to date evidence-based research on transmission of HIV through breastfeeding and to help mothers to initiate, establish and sustain effective breastfeeding;
- Teaching only those mothers who need to know about replacement feeding. If other women receive such information, this may encourage formula use;
- Phasing out distribution of free supplies of infant formula (Tudor-Williams, 2010);
- Planning, implementing, supporting and awareness of the Global Strategy for Infant and Young Child Feeding (WHO & UNICEF, 2003);
- Compliance with the provisions of the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly Resolutions (WHO, 1981; WHO, 2016a);

## Protection from marketing of breastmilk substitutes 'The Code and HIV'

In 1981 the World Health Assembly adopted the International Code of Marketing of Breastmilk Substitutes (the Code) (WHO, 1981; WHO, 2008; WHO, 2016a). The aim of the Code is to contribute to the provision of safe and adequate nutrition of infants by:

- protecting and promoting breastfeeding;
- ensuring proper use of breastmilk substitutes when necessary, on the basis of adequate information and through appropriate marketing and distribution;
- controlling incorrect marketing practices used to sell products for artificial feeding (IOCU & IBFAN, 1990).

Breastfeeding, even in settings where HIV is not highly prevalent, has been complicated by messaging from the food industry and other groups so that mothers, who otherwise might breastfeed, choose not to do so base on unfounded fears (WHO et al., 2010). In settings where HIV-prevalence among women is high, application of the International Code of Marketing of Breastmilk Substitutes (Israel-Ballard et al., 2014) and subsequent relevant Health Assembly Resolutions (WHO, 1981; WHO, 2008) has particular importance. Implementation protects the babies whose mothers may inappropriately opt for artificial feeding.

While the status of the Code varies by country in terms of drafting, voluntary application, few or many provisions enacted into law, or a combination of both voluntary and regulatory provisions, most transnational infant food companies have pledged to abide by the international Code at least in all low-income countries and should be held up to criticism any time they do not (ICDC, 2011).

### Recommendation and guidance on HIV and donation of formula according to The Code

Donations of infant formula should only be provided to infants who are identified to be in need of them, according to specific criteria, and must be assured of a full ongoing supply as long as the infants need it, to prevent increased morbidity and malnutrition.

The Code does not prevent infant formula or other products from being manufactured, available, sold or used. It also does not prevent governments or aid agencies from making breastmilk substitutes available to HIV-infected mothers, for free or at a subsidised price, if health institutions purchase them at normal market prices. It does, however, aim to prevent manufacturers from donating supplies of breastmilk substitutes or providing them at reduced cost to any part of the healthcare system. It is also designed to prevent marketing and advertising to the general public, including pregnant women and mothers. It requires that donations of formula in emergency situations should be continued for as long as the infants concerned need

them. This has been understood to mean that free supplies are only provided to infants who are identified to be in need of them, according to specific criteria, and must be provided for the full period of need, which is usually for at least one year, to prevent increased morbidity and malnutrition (IOCU & IBFAN, 1990; ICDC, 2007; ICDC, 2011; WHO, 2016a).

It is the responsibility of governments to ensure that the international Code is implemented in their country and that manufacturers comply with it. Several countries have enacted legislation which limits the marketing of infant formula and related products even more stringently than the international Code. Members of the public also have an important role to play in noticing advertisements in the media, or promotion in shops, and reporting what they see to the responsible national authority and to the local Code monitoring groups in their countries.

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The World Alliance for Breastfeeding Action (WABA) is a global network of individuals and organisations concerned with the protection, promotion and support of breastfeeding worldwide. WABA action is based on the Innocenti Declaration, the Ten Links for Nurturing the Future and the Global Strategy for Infant & Young Child Feeding. WABA is in consultative status with UNICEF and an NGO in Special Consultative Status with the Economic and Social Council of the United Nations (ECOSOC).