Protecting, Promoting and Supporting Continued Breastfeeding from 6–24 + Months: *Issues, Politics, Policies & Action*

JOINT STATEMENT based on a workshop of the World Alliance for Breastfeeding Action (WABA) Global Breastfeeding Partners Meeting VII in Penang, Malaysia, October 2008

STATEMENT RATIONALE

Internationally agreed recommendations for optimal feeding of infants and young child advocate exclusive breastfeeding for the first six months of life, followed by complementary feeding and continued breastfeeding for up to two years or beyond. Feeding practices which are not in accord with these recommendations (sub-optimal breastfeeding)[1] may be responsible for 12% of deaths in children under 5 years[2]. Almost a quarter of these preventable deaths (23%) are due to lack of continued breastfeeding in the 6-24+ month age group.[2]

Improving breastfeeding practices has great potential for helping to achieve the Millennium Development Goals (MDGs). Participants at the WABA Workshop were concerned that actions to protect, promote or support 'continued breastfeeding' have been noticeably lacking; most activity on infant and young child feeding (IYCF) has been directed towards increasing rates of exclusive breastfeeding in the first 6 months, or improving the foods available for complementary feeding.

Action on exclusive breastfeeding from birth to 6 months has been an understandable priority because of the major health gains it can achieve. In many countries exclusive breastfeeding rates are low but breastfeeding into the second year of life is common, so there has been no obvious need for action to support breastfeeding beyond 6 months. However, while exclusive breastfeeding rates are rising, rates of continued breastfeeding are stagnating or are falling. Protection, promotion and support of continued breastfeeding needs to be put on IYCF agenda.

CONTEXT AND BACKGROUND TO STATEMENT

Importance of continued breastfeeding

Breastfeeding during the 6–24+ month period provides advantages for the child, the mother, the family, and the nation. These include improved child survival; benefits to child health, nutrition and cognitive development; benefits to maternal health and child spacing; benefits to family and national economies and to the environment. Human milk continues to provide living cells and immuno-protective factors which help to reduce both the rates and severity of infections during 6–24+ months. Breastmilk substitutes (including complementary foods) do not contain these protective factors. The act of breastfeeding is important psychologically in nurturing socialisation, trust and security for mother and child. Many of the health benefits for mothers are associated with breastfeeding which is sustained beyond 6 months, for example reducing the risk of breast and other cancers. Nutritionally, when the intake of breastmilk is sustained at a level similar to that before 6 months, it continues to meet a substantial proportion of the protein, energy and micronutrient requirements up to 12 months and beyond.

Complementing continued breastfeeding

From 6 months, infants need additional foods alongside continued breastfeeding. This is termed complementary feeding because the aim is to give other foods and drinks to 'complement', as in 'make complete', the nutrients provided by human milk. 'Complementary feeding' supersedes the term 'weaning' which implies weaning off breastmilk rather than adding to it.

How much complementary food is required is estimated by calculating the gap between the nutrients which can be provided by breastmilk and children's nutritional requirements. In 2001 energy requirements were revised downwards by around 20% in the 6-24 month age group.[3] This means that breastfeeding is able to meet a higher proportion of children's energy needs than had previously been thought. Furthermore, technical documents tend to assume that as soon as children begin taking other foods, they take less breastmilk, although there is evidence that this need not be the case.[4] How to complement continued breastfeeding is a challenge; providing too much food can reduce children's desire to breastfeed so that foods displace human milk intake rather than complement it.[5]

Continued breastfeeding in policy and programmes

Continued breastfeeding is a neglected aspect of IYCF.[6] Policy and practice guidance tends to refer to the need to support continued breastfeeding, but offers little insight into what practices define optimal 'continued breastfeeding' or how it can be supported. There is little data collection on breastfeeding practices beyond 6

1. World Health Organisation. Global Strategy for Infant and Young Child Feeding. WHO, Geneva, 2002. WHA55/2002/REC/1.
2. Black R E et al. Maternal and Child undernutrition. Global and regional exposures and health consequences. Lancet 2008; 371: 243-60
3. FAO. Human Energy Requirements. Report of a Joint FAO/WHO/UNU Expert Consultation, Rome Oct 2001. Food and Nutrition Technical Report Series 1. FAO, Rome,2004.
4. Butte N. Lopez-Alarcon MG, Garza C. Nutrient adequacy of exclusive breastfeeding for the term infant during the first six months of life. WHO, Geneva, 2002
5. Islam et al. Effects of energy density and feeding frequency of complementary foods on total daily energy intakes and consumption of breastmilk by healthy breastfed Bangladeshi children. Am J Clin Nut 2008:88; 84-94
6. Lauer JA et al.Deaths and years of life lost due to suboptimal breast-feeding among children in the developing world: a global ecological risk assessment. Public Health Nutrition, 2006; 9(6):673–685

months to inform a description of optimal continued breastfeeding and it has not been a key part of any research agenda on nutrition. Most infant feeding surveys, including Demographic Health Surveys using WHO's new IYCF indicators[7], simply record whether children 6–24+ months are breastfed or not, defining breastfed as having received at least one breastfeed in the past 24 hours. Without accepted indicators for defining and monitoring adequate and optimal continued breastfeeding practices, national targets and programme activity are likely to prioritise complementary feeding which now has defined indicators, and give less emphasis to adequate continued breastfeeding.

CHALLENGES TO CONTINUED BREASTFEEDING

Fortified complementary foods

The period from birth to two years is described as a 'critical window' for addressing malnutrition. International initiatives to improve growth and nutrition of children 6–24+ months tend to focus on improving complementary feeding through increasing the frequency of complementary feeds, and/or the nutrient density of feeds through the consumption of special (industrially produced) nutrient-rich foods targeted to the 6–24+ month age group. Workshop participants were concerned that these interventions do not sufficiently consider the impact of these foods and their promotion upon continued breastfeeding, nor include action to support continued breastfeeding as part of their strategy. With better continued breastfeeding the amounts of nutrients needed from complementary foods could be decreased.

Programmes promoting use of fortified complementary foods, including those from commercial, not-for-profit and charity sectors, have the potential to de-value continued breastfeeding and indigenous foods, further commercialise infant feeding, and delay the gradual transition to family foods and sustainable meal patterns. Furthermore, these foods raise serious questions about inequalities and access. Families who have the most to gain nutritionally from fortified foods, are the least likely to have the resources to use them and countries with the highest rates of malnutrition probably have the weakest capacity to implement effective checks and controls on quality, safety and promotion of these products. There are also concerns about the medicalisation of food by health programmes encouraging use of fortified food products, and the loss of the social and cultural experiences that are part of children progressing from mothers' milk to eating with the family.

Research studies into the effectiveness of these special foods tends to compare different formulations of the foodstuffs with controls, but fail to make comparisons with actions to improve continued breastfeeding combined with optimal use of customary family foods. The longer term acceptability, feasibility, affordability, sustainability and safety (AFASS) of the interventions are not sufficiently explored. In some cases, the research studies are funded or carried out in association with partners who have conflicts of interest due to commercial involvement in the products. Furthermore, it is necessary to determine and confirm that programmes using these foods fully comply with the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA Resolutions.

Follow-on formula, 'growing-up' milks and commercial complementary foods

Inappropriate marketing and labelling of follow-on formula, 'growing-up' milks and commercial complementary/'weaning' foods can undermine continued breastfeeding. The power of advertising and promotion increases with urbanisation and economic growth, which are often accompanied by increasing numbers of women moving into employment. The World Health Assembly considers that follow-on milks are unnecessary.[8] UNICEF and WHO[9] are clear that follow-on milks/formula ARE breastmilk substitutes (albeit for the older baby) and are covered by the Code and subsequent WHA Resolutions and should never be promoted. However, the infant feeding industry challenges this, and the promotion of these products is sometimes not prevented by national legislation intended to implement the Code. Consequently, follow-on milks/ formula are promoted in ways that not only undermine breastfeeding, but also promote the brand names of infant formula and facilitate direct contact between manufacturers and mothers and pregnant women.

Complementary foods and drinks are also covered by WHA Resolutions and should not be marketed for infants under 6 months or in ways which undermine continued breastfeeding for the older child. Codex guidelines prohibit health and nutrition claims on complementary foods unless they are specifically permitted in national legislation. This applies to claims made using text such as 'for a healthier baby', or claims which are implied by logos, brand names, or symbols.

SPECIAL SITUATIONS

Treatment of malnutrition

The success of programmes to treat severely malnourished children using 'Ready to use therapeutic foods' (RUTF) has led to campaigns for a wider promotion of such foods for prevention of malnutrition in children under two years of age.[10] This is worrying because existing protocols on the use of RUTF pay little attention to breastfeeding under 6 months and make no reference at all to human milk for the 6–24+ month old.[11] (Incorporation of breastfeeding support into Community-based Treatment of malnutrition training manuals is very recent.) There are concerns that wider use of these 'ready to use foods' (RUF) without proper

7. WHO. Indicators for Assessing Infant And Young Child Feeding Practices. Part 1: Definitions. WHO, November 2008
8. World Health Assembly Resolution 39.28,1986.
9. UNICEF/WHO. *Baby Friendly Hospital Initiative, revised, updated and expanded for integrated care, Section 1*, Background and Implementation, Preliminary Version, January 2006).
10. Medecins Sans Frontieres' Summary of Starved for Attention campaign: MSF accessed Oct 2008. http://www.doctorswithoutborders.org/publications/reports/2008/Starved-For-Attention.pdf
11. WHO/WFP/ UNSCN/UNICEF Community Based Management of Severe Acute Malnutrition. Joint Statement by WHO, WFP, UNSCN and UNICEF. May 2007

training, care and appropriate guidance may undermine and displace breastfeeding and use of customary family foods.

HIV infection

Strategies to limit post-natal transmission of HIV have also had a negative impact on continued breastfeeding, particularly in countries where HIV prevalence is high. The most recent guidance from WHO (2006) advises exclusive breastfeeding unless replacement feeding (feeding formula and not breastfeeding) is AFASS, and that HIV-infected mothers continue breastfeeding beyond 6 months of age if replacement feeding continues not to be AFASS.[12] This statement is not widely disseminated or implemented. Earlier guidance that breastfeeding be discontinued as soon as feasible is still considered valid and with it the potential for early cessation of breastfeeding to spill over into the wider population of women who are HIV-negative or of unknown status. The availability of RUTFs has enabled some HIV prevention programmes to encourage breastfeeding cessation at 6 months and use of RUTF as a breastmilk substitute thereafter.[13] However, more recent evidence suggests that in resource-poor communities, continued breastfeeding by HIV-infected mothers beyond 6 months improves HIV-free survival, further challenging current guidance.[14,15]

GLOBALISATION AND THE COMMERCIALISATION OF MALNUTRITION

The world of food, nutrition, health and commerce and social constructs, is becoming increasingly complex. Although on the surface there is unity towards achieving the Millennium Development Goals (MDGs), the network of relationships and financial interests involved in policy, research and implementation can be difficult to untangle. Amongst the many stakeholders in malnutrition, there is no well-resourced breastfeeding champion, let alone an advocate for continued breastfeeding beyond 6 months. Diminishing public sector funds have created a funding reliance on Public-Private Partnerships (PPPs) for research and programme implementation, but there are no clear private partners stepping forward to invest in breastfeeding. This is in contrast to the resources available through PPPs for research and investment in improved complementary foods, (often with partners who have vested interests.) The creation of public-private partnerships to improve complementary foods risks using government bodies and public resources to promote commercialisable products and creating monopolies, particularly where patenting is involved.

Support for continued breastfeeding and best use of indigenous[16] food may be a better long-term sustainable investment. Mother's milk is the ultimate indigenous food; locally made, sustainably available, untouched by fluctuations in prices and logistics, and requiring no foreign exchange for importation. Its quality and safety is assured even in countries where food standards are weak and fake or adulterated food products are a concern. Finally continued breastfeeding is an environmentally-friendly way to feed a child, giving the child and the world it has entered, a better start for life.

To address these concerns and issues presented above, more than fifty participants from 21 countries representing more than 25 Non-Governmental Organisations (NGOs) and academic researchers gathered at the World Alliance for Breastfeeding Action (WABA) Global Breastfeeding Partners Meeting VII in Penang, Malaysia, 7-8 October 2008 to discuss Protecting, Promoting and Supporting Continued Breastfeeding from 6–24 + months.

We, the participants of the WABA 'Workshop on Protecting, Promoting and Supporting Breastfeeding from 6–24+ months' reaffirm our commitment to the Global Strategy on Infant and Young Child Feeding, the Innocenti Declarations 1990 on the Protection, Promotion and Support of Breastfeeding, and 2005 on Infant and Young Child Feeding, and the International Code of Marketing of Breastmilk Substitutes and subsequent related WHA resolutions, **AND FURTHER RESOLVE TO BUILD ON THEIR PRINCIPLES IN ORDER TO**:

- Ensure that protection, promotion and support of continued breastfeeding 6–24+ months is prioritised on the policy, programme and research agenda.
- Advocate for consideration of the intrinsic value and normalcy of continued breastfeeding for the mother-baby dyad, households, communities, health systems, governments and the wider community seeking achievement of the Millennium Development Goals and health and well-being for all.
- Challenge existing ambivalence and tokenism towards continued breastfeeding which has resulted in its current programmatic neglect.

GIVEN THAT

1. There are established recommendations for optimal infant and young child feeding (IYCF) which include early and exclusive breastfeeding for 6 months, and continued breastfeeding for up to 2 years and beyond, with age-appropriate complementary feeding.

12. WHO 2007, HIV and infant feeding : new evidence and programmatic experience : report of a technical consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their infants, Geneva, Switzerland, 25-27 October, 2006.
13. Van der Horst C et al. Modifications of a large HIV prevention clinical trial to fit changing realities: A case study of the Breastfeeding, Antiretroviral, and Nutrition (BAN) protocol in Lilongwe, Malawi. Cont Clin Trials 2009;30: 24–33
14. Rollins N C et al. Infant Feeding, HIV transmission and mortality at 18 months: the need for appropriate choices by mothers and prioritization within programmes. AIDS 2008;22:2239-2357
15. Kuhn L et al. Effects of Early, Abrupt weaning on HIV-free survival of children in Zambia. N Eng J Med 2008;359:130-41.
16. In this statement we use the word indigenous to mean foods stuffs which are grown and produced in a country or area

2. Human milk is a human-specific food adapted over the course of evolution to meet the needs of human infants, and breastfeeding continues to provide valuable nurturing care, health protection and optimal development during childhood and beyond.

3. Breastfeeding at current levels is considered to be able to contribute on average at least 75% of the energy requirements for children 6–8 months, 50% for 9-11 months, 40% at 12–24 months. (When breastfeeding is well established and supported it can contribute an even larger percent to energy and nutrient requirements.)

4. There is insufficient awareness and understanding of the value of continued breastfeeding from 6-24+ months at all levels, from policy makers and health practitioners to mothers and societies, and across disciplines.

5. There is insufficient investment in research or programme evaluation for the articulation of clear evidence-based strategies to support continued breastfeeding, resulting in only token mention in policies, programmes and practice.

6. In many countries, the marketing of follow-on formulas, 'growing-up' milks and/or foods prepared or marketed for the 4-24+ month age group is not controlled by national legislation, or other measures, because they have no laws or do not implement the full scope of the Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions.

7. There is an increased promotion and availability of 'special foods' for infants from both commercial and not-for-profit sectors, particularly in urbanised and economically developed areas, which may threaten continued breastfeeding.

8. The focus and investment in improving complementary feeding tends to occur in isolation from consideration of breastfeeding support, so that complementary foods compete rather than complement breastfeeding.

9. There have been no research or programme trials to assess sustaining the frequency of breastfeeding as a method of improving nutrition of 6-24+ month olds during the complementary feeding period.

10. Use of foods designed for therapeutic management of severe acute malnutrition is expanding into 'preventive management' of more moderate levels of malnutrition in children under 2 years of age without consideration of continued breastfeeding.

11. There is no health outcome-related definition of optimal breastfeeding in the 6–24+ months period.

12. Indicators for monitoring feeding at this age emphasise complementary foods and pay no attention to the adequacy of breastfeeding, and hence are not sufficient or effective in informing programme and policy.

13. Data reveal that rates of breastfeeding at one and two years of age are stagnant or decreasing, and there are no data from which to assess adequacy of the breastfeeding at those points in time.

14. Women's employment is increasing with little improvement in maternity rights or development of working practices and strategies for employers to support, and mothers to continue breastfeeding while returning to work.

It is the position of the Workshop Participants that continued and sustained levels of breastfeeding of children 6-24+ months are under threat.

RECOMMENDATIONS

We call upon everyone involved in improving the health and development of infants and young children to ensure that continued breastfeeding 6-24+ months is defined based on scientific evidence, protected, promoted and supported as the precondition for and foundation of appropriate complementary feeding, by taking steps to ensure that:

Communication, education and promotion

1. The value of continued breastfeeding for the health and development of mother and child is clearly articulated and widely disseminated at policy, programme and practice levels so that each extra day of breastfeeding is **valued** by mothers, families, communities and the wider society.

2. Continued breastfeeding is promoted and **normalised** in education and communication activities throughout the community.

3. Continued breastfeeding is supported and valued throughout the health care system and **integrated** into service provision, e.g. immunisation, growth monitoring.

4. Continued breastfeeding is included in **training and orientation** of health, social service, early-childhood education, child care and all other staff working with mothers and young children.

Practical support

5. All parties work collaboratively, avoiding conflicts of interest, to develop a body of knowledge and experience on HOW to support continued breastfeeding, so that **core guidance** and locally appropriate practical strategies can be developed.

6. Consideration is given to exploring how the supportive role

of **fathers, family** members, and the **community** can be harnessed and where necessary, enhanced; endorsing and promoting the WABA Global Initiative on Mother Support,[17] as a strategy of involving all those who can support continued breastfeeding and the breastfeeding mother.

Breastfeeding as part of complementary feeding

7. Continued breastfeeding is included as a key component of all work (literature, programmes or research) on complementary feeding.

Definitions and monitoring

8. Clear definitions and indicators for adequate and optimal breastfeeding 6–24+ months are developed, possibly based on a series of funded studies and WHO technical consultations, and identification of further research needs.

9. There is development of agreed indicators and targets, as well as appropriate monitoring of adequate and optimal continued breastfeeding practices.

Addressing the misinformation through marketing

10. There are renewed efforts to monitor and report on the marketing and promotion of follow-on and growing-up formula and other special milks and foods marketed for children 6–24+ months which breach the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly (WHA) Resolutions, and threaten to undermine continued breastfeeding.

11. Advocacy is carried out to propose further WHA resolutions to strengthen and clarify the Code of Marketing of Breastmilk Substitutes with regard to the marketing of milks and foods for 6–24+ months. (Using evidence collected from Item 10 above)

12. By working collaboratively with those researching, using or supplying 'Ready to Use (Therapeutic) Foods' and other fortified food supplements, guidelines for their appropriate use are developed which include strong advice about the risks of undermining continued breastfeeding and how to support continued breastfeeding in emergency situations.

13. Guidelines on avoidance of conflict of interest situations are developed and supported with particular regard to Public-Private-Partnerships and highlighting concerns about any conflict of interest in research, policy development and programmes promoting use of fortified foods for children 6–24+ months.

14. The necessary research, trials and programmes on improving nutrition of 6–24+ month-olds are carried out, to give equal weight to strategies using increased support for continued breastfeeding and optimal use of customary family and indigenous foods rather than focussing solely on fortified foods.

Special circumstances

15. Blanket messages recommending that mothers with HIV avoid breastfeeding 6–24+ months, or assuming the safety of breastmilk substitutes, including RUTFs where these are intended to be used to justify early cessation of breastfeeding for mothers with HIV are rejected. Instead these mothers are empowered and provided with care and support to enable them to make fully informed decisions appropriate to their personal situation.

16. UN guidance on HIV and Infant Feeding is reviewed in the light of recent studies suggesting that continued breastfeeding may enhance HIV-free child survival. Further research into HIV-free child survival and malnutrition when breastfeeding by HIV-infected mothers is continued beyond 6 months is funded and carried out.

17. Practical guidance on how to support continued breastfeeding (or relactation as appropriate), during treatment of severe acute malnutrition is included in all training and protocols.

18. There is greater recognition that continued breastfeeding and complementary feeding in emergencies is a neglected area which needs to be addressed.

19. The widespread roll-out of use of Ready to Use Therapeutic Foods (RUTFs) and other fortified food supplements for the treatment or prevention of moderate malnutrition is halted until there is:

    a) concrete, independently funded, evidence of long term benefits and sustainability (meeting AFASS criteria),

    b) evidence from trials comparing benefits of RUTFs, with the benefits of improved breastfeeding and complementary feeding making best use of indigenous foods,

    c) clear guidance on the regulatory status of such foods, and

    d) a system that ensures effective regulation, checks and controls on food quality, safety and appropriate marketing of RUTFs and other fortified food supplements for children 6–24+ months. ■

17. World Alliance for Breastfeeding Action. Global Initiative for Mother Support (GIMS) +5. WABA 2007 www.waba.org.my/whatwedo/gims/gims+5.htm

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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 based on the Innocenti Declarations, the Ten Links for Nurturing the Future and the WHO/UNICEF Global Strategy for Infant and Young Child Feeding. Its core partners are International Baby Food Action Network (IBFAN), La Leche League International (LLLI), International Lactation Consultant Association (ILCA), Wellstart International and Academy of Breastfeeding Medicine (ABM). 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).

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