WHO/NMH/NHD/14.7

Global Nutrition Targets 2025

Breastfeeding Policy Brief

TARGET:

Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%

WHAT'S AT STAKE

In 2012, the World Health Assembly Resolution 65.6 endorsed a *Comprehensive implementation plan on maternal, infant and young child nutrition (1)*, which specified six global nutrition targets for 2025 *(2)*. This policy brief covers the fifth target: **increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%**. The purpose of this policy brief is to increase attention to, investment in, and action for a set of cost-effective interventions and policies that can help Member States and their partners in improving exclusive breastfeeding rates among infants less than six months.

Exclusive breastfeeding – defined as the practice of only giving an infant breast-milk for the first 6 months of life (no other food or water) – has the single largest potential impact on child mortality of any preventive intervention *(3)*. It is part of optimal breastfeeding practices, which also include initiation within one hour of life and continued breastfeeding for up to 2 years of age or beyond.

Exclusive breastfeeding is a cornerstone of child survival and child health because it provides essential, irreplaceable nutrition for a child's growth and development. It serves as a child's first immunization – providing protection from respiratory infections *(4)*, diarrhoeal disease, and other potentially life-threatening ailments. Exclusive breastfeeding also has a protective effect against obesity and certain noncommunicable diseases later in life *(4)*.

Yet, much remains to be done to make exclusive breastfeeding during the first 6 months of life the norm for infant feeding (see Box 1). Globally, only 38% of infants aged 0 to 6 months are exclusively breastfed *(5, 6)*. Recent analyses indicate that suboptimal breastfeeding practices, including non-exclusive breastfeeding, contribute to 11.6% of mortality in children under 5 years of age. This was equivalent to about 804 000 child deaths in 2011*(5)*.

It is possible to increase levels of exclusive breastfeeding. Between 1985 and 1995, global rates of exclusive breastfeeding increased by 2.4% per year on average (increasing from 14% to 38% over 10 years) but decreased subsequently in most regions. However, 25 countries increased their rates of exclusive breastfeeding by 20 percentage points or more after 1995, a rate that is similar to what is needed to achieve the global target *(7, 8)*. Countries already at or near 50% exclusive breastfeeding should continue to strive for improvements because of the health and economic benefits of exclusive breastfeeding. In these cases, we suggest a minimum increase of 1.2% per year or more.

World Health Organization
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BOX 1: WHAT CONTRIBUTES TO LOW RATES OF EXCLUSIVE BREASTFEEDING GLOBALLY?

Inadequate rates of exclusive breastfeeding result from social and cultural, health-system and commercial factors, as well as poor knowledge about breastfeeding. These factors include:

- caregiver and societal beliefs favouring mixed feeding (i.e. believing an infant needs additional liquids or solids before 6 months because breast milk alone is not adequate);
- hospital and health-care practices and policies that are not supportive of breastfeeding;
- lack of adequate skilled support (in health facilities and in the community);
- aggressive promotion of infant formula, milk powder and other breast-milk substitutes;
- inadequate maternity and paternity leave legislation and other workplace policies that support a woman's ability to breastfeed when she returns to work;
- lack of knowledge on the dangers of not exclusively breastfeeding and of proper breastfeeding techniques among women, their partners, families, health-care providers and policy-makers.

Increasing rates of exclusive breastfeeding can help drive progress against other global nutrition targets (stunting, anaemia in women of reproductive age, low birth weight, childhood overweight and wasting) and is one of the most powerful tools policy-makers have at their disposal to improve the health of their people and their economies. Policy-makers should consider pioritizing the following actions, in order to **increase the rate of exclusive breastfeeding in the first 6 months of life up to at least 50%**:

- provide hospital- and health facilities-based capacity to support exclusive breastfeeding, including revitalizing, expanding and institutionalizing the Baby-friendly Hospital Initiative *(9)* in health systems;
- provide community-based strategies to support exclusive breastfeeding, including the implementation of communication campaigns tailored to the local context;
- significantly limit the aggressive and inappropriate marketing of breast-milk substitutes by strengthening the monitoring, enforcement and legislation related to the *International code of marketing of breast-milk substitutes (10)* and subsequent relevant World Health Assembly resolutions;
- empower women to exclusively breastfeed, by enacting 6 months' mandatory paid maternity leave, as well as policies that encourage women to breastfeed in the workplace and in public;
- invest in training and capacity-building in exclusive breastfeeding protection, promotion and support.

FRAMEWORK FOR ACTION

Scaling up efforts to increase rates of exclusive breastfeeding requires actions at the health-systems, community and policy levels *(8)*. Evidence shows that countries with policies and programmes most closely aligned with recommendations set out in the WHO/United Nations Children's Fund (UNICEF) *Global strategy for infant and young child feeding (11)* have the most success at raising levels of exclusive breastfeeding *(12)* (see additional resources). It is important to create an enabling environment through policy and legislation.

Health-systems level

At the health-system level, the 10 steps to successful breastfeeding *(13)* of the Baby-friendly Hospital Initiative *(9)* and its certification process significantly improve rates of exclusive breastfeeding *(8)* (see additional resources). Strengthening, revitalizing and institutionalizing baby-friendly practices in health facilities providing maternity care services is particularly important in countries where there is a high proportion of institutional deliveries. It is also important to establish standards for other health-service contacts such as antenatal care, immunizations and sick child visits throughout the first year of life, when infant feeding practices can deteriorate rapidly without adequate support.

In-service training, pre-service education and professional development of health-care providers in optimal infant and young child feeding practices, including protection, promotion and support for exclusive breastfeeding, are also essential. Owing to high turnover of health-care providers in many settings, continual investment in, and attention to, training is needed.

However, training investments need to be protected by ensuring follow-up through supportive supervision, monthly or quarterly meetings, and refresher training/orientations of frontline workers and their supervisors, while holding managers accountable through monitoring. Breastfeeding support should also be provided through the health-system, as part of an integrated package of nutrition actions encompassing infant and young child feeding, micronutrients and women's nutrition.

Community level

Support for breastfeeding at the community level is critical. Successful scale-up efforts for exclusive breastfeeding will not be possible in most cases if community-based support is not given adequate emphasis *(14)*. Counselling of mothers during pregnancy, immediately after childbirth and during the neonatal period has significant positive effects on rates of exclusive breastfeeding *(8)*. However, extending exclusive breastfeeding to 6 months requires going beyond the neonatal period, to mobilize continued family and community support through community leaders and other communication channels. In countries where the rate of deliveries occurring in a health-facility is low, community-based support through home visits, support groups, and prenatal and postpartum contact with the health system is particularly important.

Communication strategies to increase awareness and support for exclusive breastfeeding are important. Communication channels should be appropriately selected for the setting, taking into consideration literacy levels and access to media. Behaviour change messages should ideally be based on formative research to identify barriers and facilitators to exclusive breastfeeding. Mass media behaviour change campaigns can significantly improve exclusive breastfeeding during the first 6 months of life and are particularly effective for reaching mothers with infants between 1 and 4 months of age *(8)*.

Policy level

Countries need to enact policies that protect breastfeeding and support women in their efforts to breastfeed their children exclusively for the first 6 months. Evidence shows that longer maternity leave is associated with longer duration of exclusive breastfeeding *(15),* though effects may be limited in countries where women are largely employed in the informal sector. Six months of paid maternity leave allows women to continue to breastfeed for longer without having to choose between earning an income and providing the best nutrition for their infant.

Another critical policy action involves the enacting, enforcement and monitoring of legislation related to the *International code of marketing of breast-milk substitutes (10)* and subsequent relevant World Health Assembly resolutions (the Code) aim to protect breastfeeding by ensuring the proper use, marketing and distribution of breast-milk substitutes. This includes the prohibition of any promotion of breast-milk substitutes, feeding bottles and teats (see additional resources). Countries with strong legislation and enforcement protecting against the inappropriate marketing of breast-milk substitutes have higher rates of exclusive breastfeeding *(10)*. Therefore, legislating, monitoring and enforcement of the Code need to involve legislative bodies and government bodies that negotiate and defend trade agreements and regulate labelling and marketing.

Rates of exclusive breastfeeding tend to increase when effective policy and regulatory frameworks and guidelines exist and when comprehensive programming is implemented at scale *(16)*. Sri Lanka, Cambodia and Malawi (see Boxes 2–4) have all seen particularly dramatic increases in rates of exclusive breastfeeding. In addition to the implementation of interventions and policies designed to increase rates of exclusive breastfeeding, these countries share a number of other factors that helped drive up rates of exclusive breastfeeding, including:

- strong political commitment, particularly at the highest levels of government leadership *(16)*;
- recognized authorities that served as breastfeeding champions *(16)*;
- commitment and advocacy from the highest level of leadership at international organizations (e.g. UNICEF and WHO) *(7, 16)*;
- effective coordination of programme and policy strategies *(16)*;
- effective communication strategies tailored to the context, literacy levels, and access to media channels;
- dedicated and adequate human and financial resources and long-term financing;
- use of data to design contextualized interventions and to track progress continuously, in order to fill gaps in a timely manner.

BOX 2: INCREASED RATES OF EXCLUSIVE BREASTFEEDING IN SRI LANKA

Between 1995 and 2007, the average rate of exclusive breastfeeding among infants aged 0–6 months increased from 17% to 76%, an annual increase of roughly 6% per year. In Sri Lanka, more than 95% of births occur in health facilities, and extensive lactation management training of health workers allowed for skilled lactation assistance to reach the majority of women after childbirth. Public health midwives performed community outreach, including two home visits in the first 10 days after delivery, which extended breastfeeding support into the community. Community outreach, coupled with a culture that was supportive of breastfeeding and parents, helped to improve rates of exclusive breastfeeding in Sri Lanka. Finally, high political commitment, effective communication strategies and high literacy levels among women also contributed to progress *(16)*.

BOX 3: INCREASED RATES OF EXCLUSIVE BREASTFEEDING IN CAMBODIA

In 2000, only 11% of Cambodian infants aged 0–6 months were exclusively breastfed. This proportion increased to 60% by 2005 and to 74% by 2010. In Cambodia, 89% of births occur at home and antenatal/postnatal care for women is rare. Cambodia's strategy for increasing rates of exclusive breastfeeding included:

- identifying breastfeeding as the highest priority among child-survival interventions in Cambodia;
- aligning strategies of partners to include breastfeeding promotion in all initiatives and services for infants and young children;
- establishing a sub-decree on the marketing of infant and young child products, coupled with dissemination campaigns;
- launching a "Baby-friendly Child Initiative", involving both Baby-friendly Hospital Initiative *(9)* accreditation, and establishment of mothers' support groups for home visits, and counselling and support for breastfeeding women at the village level;
- a communication strategy that incorporated breastfeeding messages into popular TV and radio shows and trained journalists on key messages about breastfeeding, as well as national-level advocacy campaigns with high-level officials *(17)*.

BOX 4: INCREASED RATES OF EXCLUSIVE BREASTFEEDING IN MALAWI

Between 1992 and 2010, the average rate of exclusive breastfeeding among infants aged less than 6 months increased from 3% to 71% in Malawi, representing an annual increase of approximately 4% per year. Malawi's progress on raising rates of exclusive breastfeeding has been attributed to:

- strong leadership in support of infant and young child feeding at all levels of government;
- well-articulated policies and guidelines; integrated services at the community level; providing infant and young child feeding support through multiple channels;
- national advocacy and intensive mass education to increase support for and knowledge of breastfeeding;
- implementation of the Baby-friendly Hospital Initiative *(9)*, and links to programmes for prevention of mother-to-child transmission of HIV *(17)*.

ACTIONS TO DRIVE PROGRESS IN INCREASING EXCLUSIVE BREASTFEEDING

The following evidence-informed recommendations should be implemented at scale, in order to achieve progress on the global exclusive breastfeeding target for 2025 *(6)*.

1. **Provide hospital- and health facilities-based capacity to support exclusive breastfeeding, including revitalizing, expanding and institutionalizing the Baby-friendly Hospital Initiative in health systems.**

- Sustaining the effectiveness of the Baby-friendly Hospital Initiative *(9)* requires institutionalization within the health system, to allow for certification and recertification of hospitals, and continued investments in training, follow-up and supervision of health-care staff.

- Sustainability also requires monitoring to track progress and measure the number and proportion of hospital births in baby-friendly hospitals and other health-care facilities.

- Integrate breastfeeding promotion and support throughout the maternal and child health continuum, particularly in the prenatal and postpartum periods.

2. **Provide community-based strategies to support exclusive breastfeeding, including implementing communication campaigns tailored to the local context.**

- Ensure strong linkages between facility- and community-based strategies. The influence of facility-based programmes on exclusive breastfeeding such as the Baby-friendly Hospital Initiative *(9)* may wane after women return home from facilities and community support is needed.

- Provide continued family and community support through community leaders and a variety of other communication channels.

- In countries where the rate of health facility delivery is low, community-based support can be provided through home visits or support groups.

- Communication channels and messaging should be tailored to the context, based on literacy levels, use of and access to different media and contact with health-care providers among target audiences. Behaviour change messages should be tailored to specific barriers to, and motivators for, exclusive breastfeeding identified in each country, at the national or subnational level.

- One-on-one and peer-to-peer counselling are effective but group counselling also improves rates of exclusive breastfeeding, and a combination of both appears to be particularly effective *(18)*. Support to mothers can come from adequately/appropriately trained professionals or laypersons, and is most effective when consistent information and messages, practical support and referrals come from both health facilities and community members.

3. **Significantly limit the aggressive and inappropriate marketing of breast-milk substitutes by strengthening the monitoring, enforcement and legislation related to the *International code of marketing of breast-milk substitutes* and subsequent relevant World Health Assembly resolutions.**

- Countries are urged to enact legislation/regulations or other legally enforceable measures to give effect to the Code, and actively monitor, implement and enforce effective sanctions in case of violations *(14)*.

4. **Empower women to exclusively breastfeed, by enacting 6 months of mandatory paid maternity leave as well as policies that encourage women to breastfeed in the workplace and in public.**

- Workplace policies should support all working women – from both formal and informal sectors – to continue breastfeeding in the workplace (e.g. on-site child care, breaks for breastfeeding or milk expression, and private comfortable places for women to express and safely store breast milk).

5. **Invest in training and capacity-building in breastfeeding protection, promotion and support.**

- In addition to training in infant and young child feeding practices, training in problem-solving and counselling skills should be strengthened, and ways to provide follow-up and mentoring for staff after training should be identified.

- Recognizing the different skill sets and information needs of different types of health-care providers will also make training more efficient and effective. Health-care providers also need to be trained on their responsibilities under the Code.

ADDITIONAL RESOURCES

WHO/UNICEF	*Global strategy for infant and young child feeding (9, 10)*
WHO	*International code of marketing of breast-milk substitutes (10)*
Alive and Thrive	*Expanding Viet Nam's maternity leave policy to six months: an investment today in a stronger, healthier tomorrow (15)*
WHO Nutrition	Baby-friendly Hospital Initiative *(9)*
UNICEF	*Breastfeeding on the worldwide agenda: findings from a lanscape analysis on political committment to protect, promote and support breastfeeding (7)*
CORE GROUP	Essential nutrition actions trilogy (http://www.coregroup.org/component/content/article/413, accessed 8 October 2014)
Food and Nutrition Bulletin	Designing large-scale programs to improve infant and young child feeding in Asia and Africa: methods and lessons of Alive & Thrive Food Nutr Bull. 2013;34(Suppl. 2) (http://nsinf.publisher.ingentaconnect.com/content/nsinf/fnb/2013/00000034/a00203s2, accessed 9 October 2014)

WORLD HEALTH ORGANIZATION NUTRITION TRACKING TOOL

To assist countries in setting national targets to achieve the global goals – and tracking their progress toward them – WHO's Department of Nutrition for Health and Development and partners have developed a web-based tracking tool that allows users to explore different scenarios to achieve the rates of progress required to meet the 2025 targets. The tool can be accessed at www.who.int/nutrition/trackingtool *(19)*.

ACKNOWLEDGMENTS

WHO and UNICEF would like to acknowledge technical contributions from the following individuals (in alphabetical order): Dr France Begin, Dr Francesco Branca, Dr Carmen Casanovas, Dr Camila Chaparro, Ms Sarah Ann Cumberland, Ms Kaia Engesveen, Ms Olivia Lawe-Davis, Dr Chessa Lutter, Mr Jason Montez, Dr Chizuru Nishida, Dr Juan Pablo Peña-Rosas and Dr Lisa M Rogers. WHO would also like to thank 1,000 Days for their technical support, especially Rebecca Olson.

FINANCIAL SUPPORT

WHO would like to thank the Micronutrient Initiative and the Bill & Melinda Gates Foundation for providing financial support for this work.

SUGGESTED CITATION

WHO/UNICEF. Global nutrition targets 2025: breastfeeding policy brief (WHO/NMH/NHD/14.7). Geneva: World Health Organization; 2014.

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