The World Alliance for Breastfeeding Action (WABA) recognises that the scope of the 2nd International Conference on Nutrition (ICN2) aims to respond to nutrition challenges especially in developing countries. The focus on all forms of malnutrition, the nutrition transition and the need to improve nutrition throughout the life cycle are timely. WABA believes that focusing on the poorest and most vulnerable households; and on women, infants and young children in deprived, vulnerable and emergency contexts is critical. In light of development of the Post 2015 agenda, WABA asserts that the Protection, Promotion and Support of Breastfeeding as a human right, is a vital component of any concrete response.

Yet in most countries breastfeeding is neglected, known supportive interventions are under-resourced and aggressive marketing of breastmilk substitutes in violation of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions continues unchecked. Most women want to breastfeed, but many find they cannot as social, cultural and economic barriers to the establishment of successful and sustained breastfeeding interfere.

ICN2 has an opportunity and a responsibility to ensure that the protection, promotion and support of breastfeeding become universally endorsed as public health policy, and implemented as the foundation of good nutrition and healthy child development in all populations.

**Not breastfeeding and decreasing breastfeeding rates worldwide can have hazardous outcomes:**

### Risks and Consequences of Artificial Feeding:

**Undernutrition and stunting; overnutrition and obesity.**
Prevention of stunting has been identified as a top nutrition priority, for which improved infant and young child feeding in the first 1000 days of life is essential\(^1\): A major component of this is optimal breastfeeding, which is initiated in the first hour of life, practised exclusively for six months, and continued with complementary feeding for 2 years or beyond. Yet only 42% of mothers achieve timely initiation of breastfeeding, and only 39% do so exclusively for 6 months\(^2\). With breastfeeding, the quantity of milk consumed adjusts naturally to the infant’s needs, but with artificial feeding the quantity is often too little or too much, resulting in undernutrition and stunting or overnutrition which contributes to the spreading obesity epidemic among young people\(^3\).

**Infection, impaired immunity, increased neonatal and infant mortality**
It is beyond question that feeding infants with breastmilk substitutes (BMS) can cause diarrhoea, pneumonia and other infections in all populations, impairing nutrition and growth. Worldwide over 800,000 children die as a result\(^4\). Not only are breastmilk substitutes readily contaminated, but they lack the numerous anti-infective properties of breastmilk which give immune protection for the first 2 years of life while the child’s own immune system is developing. Concentrated anti-infective factors in the first milk, colostrum, provide the infant’s first immunization, crucial for vulnerable newborns. Feeding breastmilk substitutes also increases the risk of allergies, and other chronic illnesses such as diabetes that may have an immunological basis\(^3\). A formula feeding infant is also more vulnerable under emergency conditions.

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\(^1\) This statement has been endorsed as of 10 November 2014 by WABA Core Partners, and Allies: Academy of Breastfeeding Medicine (ABM), International Baby Food Action Network (IBFAN), International Lactation Consultant Association (ILCA), La Leche League International (LLLI) and Wellstart International; and the Carolina Global Breastfeeding Institute (CGBI- University of North Carolina), the International Confederation of Midwives (ICM), the International Society of Social Pediatrics and Child Health (ISSOP), and the People’s Health Movement (PHM) – as well as other endorsers noted at the end of this document.
**Lower intelligence and mental health**  
Human milk contains nutrients and micronutrients, perfectly adapted for the human baby. The nutrients in breastmilk substitutes are biochemically different, and can affect the body adversely, for example development of the nervous system. Artificial feeding also interrupts the close contact between mother and child, interfering with their hormonal responses, emotional bonding, and the general sense of wellbeing and satisfaction that accompanies successful breastfeeding. For a combination of these reasons, artificially fed children have lower scores on tests of intelligence and behaviour, and their mothers have a two-fold risk of puerperal depression.

**Threats to Women’s Health and Nutrition**  
Women who do not breastfeed also have an increased risk of breast and ovarian cancer. Furthermore, there is a risk of earlier return of fertility, leading to shorter birth intervals which can undermine their nutrition and the increase the risk of premature birth in subsequent pregnancies.

**These hazardous outcomes are of public health importance:**  
**Effective interventions exist:**  
There is now substantial evidence of interventions that can increase optimal breastfeeding rates. Much of this evidence has been obtained at project level, but there is also evidence at country level where appropriate policies have been put in place.

Evidence of the effectiveness of breastfeeding promotion by itself, or of the protection of breastfeeding through implementation of the Code, or adequate maternity protection for working women in the absence of other measures is limited. There is more evidence of the effectiveness of support of mothers in health services and the community, by professional health workers and lay counsellors. What is most effective is the combination of protection, promotion and support of breastfeeding together, achieved by implementation of comprehensive policies covering all aspects of breastfeeding simultaneously, which has been achieved in some countries. UNICEF in 2010 found that 23 countries had over the course of 5-10 years achieved increases in exclusive breastfeeding rates of over 20% with national policies which included Code implementation, maternity protection, supportive delivery practices, increased health worker capacity for breastfeeding counselling, and communication strategies. This is what we must strive for everywhere.

These measures were set out in the *Innocenti Declaration* of 1990, and reaffirmed and elaborated in the WHO/UNICEF *Global Strategy for Infant and Young Child Feeding* in 2002. In turn, implementation of the Global Strategy was further emphasised by the WHO Comprehensive Implementation Plan on Maternal, Infant and young child nutrition in 2010. That comprehensive breastfeeding policies have not been widely adopted and implemented has been due to a lack of political will and a reluctance to make resources available combined with the continued interference of the infant food manufacturers on setting health policy.

**Breastfeeding as a human right:**  
Specifically addressed in the Convention on the Rights of the Child (Article 24 (2) e CRC) and included in the broad scope of the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women, breastfeeding constitutes a right of both the mother and the child. It forms an integral part of their right to health (Articles 12 CEDAW, Article 12 CESCRT), and is included in the child’s right to adequate food and nutrition (Article 24 (2) c CRC) as well as in the woman’s right to work (Article 11 CEDAW). In 2013, the CRC General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24) and General Comment No. 16 (2013) on State Obligations Regarding the Impact of the Business Sector on Children’s Rights included strengthening the legal basis of States’ obligations to implement and enforce the Code and the obligation of baby food companies to comply with the International Code in all contexts has been re-affirmed.

**Costs of action and inaction:**  
There is an undoubted cost of taking action to ensure that protection, promotion and support of breastfeeding reaches every woman and baby. Yet national estimates of the costs of suboptimal breastfeeding, for treating unnecessary illness (both short and long term), and purchase of breastmilk substitutes and other commodities, indicate that the cost of inaction may well be greater. Women’s own investment in breastfeeding, and of the many volunteers who help them, must be recognised as national assets. Breastfeeding is a nutrition system of unique value, contributing to food security for children, and irreplaceable in its role for the wellbeing of families and society.
**Call for Action**

World Alliance for Breastfeeding Action (WABA), its Core Partners and Allies, and the Endorsers of this Statement urge the Second International Conference on Nutrition (ICN2) to ensure that the protection, promotion and support of breastfeeding become universally endorsed as public health policy, and implemented as the foundation of good, gender-just, sustainable nutrition in all populations.

ICN2 aims to build upon existing global political processes and initiatives to contribute to the post-2015 UN development agenda. This includes identifying priority areas, nutrition development goals as well as the policies that are required to achieve measure and account for them.

Therefore we call upon all governments and relevant UN agencies to work towards:

- Ensuring that “At least 50% Exclusive Breastfeeding (EBF) in the first 6 months”\(^{(11)}\), is included as a target indicator in the post 2015 agenda, and in relevant national policy on nutrition and health.
- Ensuring that all facilities or hospitals where babies are born should implement Baby-friendly best practice standards.
- Ensuring that all mothers have access to skilled breastfeeding counselling and support, both at health facility level and community level.
- Implementing maternity protection legislation with the ILO Maternity Protection Convention C183 as a minimum standard.
- Enacting Legal provisions that fully implement the International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly resolutions.
- Strengthening of national emergency preparedness policies and plans to include Infant Feeding in Emergencies (IFE) with regulation of donations and of untargeted distribution of breast-milk substitutes, and of ready-to-use foods (RUFs).

**References:**

11. As per the WHO’s proposed Global targets 2025. See: http://www.who.int/nutrition/topics/nutrition_globaltargets2025/en/
Additional List of Endorsers to the WABA Statement to ICN2

1. Club Solo Mamá, San Lucas Maternidad, Argentina
2. ELACTA European Lactation Consultants Association, Austria
3. Körpergarten, Austria
4. La Leche Liga Österreich, Austria
5. Eminence, Bangladesh
6. La Leche League Belgium-Flanders asbl, Belgium
7. USP - Public Health-Nutrition, Brazil
8. Universite Brunei Darussalam, Brunei
9. Prime Lactation Center Cameroon, Cameroon
10. No Limit For Women Project, Cameroon
11. Alberta Breastfeeding Committee, Canada
12. Allaitement Quebec, Canada
13. Breastfeeding Community of Practice, Nova Scotia, Canada
14. Breastfeeding Action Committee of Edmonton (BACE), Edmonton, Canada
15. Calgary Breastfeeding Matters Group, Canada
16. Clark County Breastfeeding Coalition, Vancouver, Canada
17. From the Roots Holistic, Ontario, Canada
18. Nurtured Products for Parenting, Nova Scotia, Canada
19. Entraide Naturo-Lait, Quebec, Canada
20. Public Health Department, Quebec, Canada
21. Réseau Québécois d’Accompagnantes à la Naissance (ROAN), Quebec, Canada
22. Baby Friendly Hospital Initiative Hong Kong Association, HK, China
23. Catholic Messengers of Green Consciousness, HK, China
24. Hong Kong Breastfeeding Mothers’ Association, HK, China
25. Hong Kong Catholic Breastfeeding Association, HK, China
26. Peanuts’ Family, Hong Kong, China
27. Croatian Association of Lactation Consultants, Croatia
28. Sveti Duh Clinical Hospital, Croatia
29. Grupo de Promoción y Apoyo a la Lactancia Materna, Cuba
30. Marchalot, France
31. La Leche League France
32. La Leche League, Nice, France
33. Pediatricians and Family Physicians Association CLARITAS XXI, Georgia
34. German Midwives Association, Germany
35. Bapuji Child Health Institute, Karnataka State, India
36. Breastfeeding Promotion Network of India
37. DMC & Hospital, Ludhiana, India
38. D/O Community Medicine, Jawaharlal Nehru Medical College, India
39. Government District hospital, Andhra Pradesh, India
40. Indian Institute for Development Initiative, Rajasthan, India
41. Integrated Development in Education, Agriculture and Health, Andhra Pradesh, India
42. Krishna Institute of Medical, Maharashatra, India
43. M.S. Ramaiah Institute of Nursing Education and Research, Karnataka State, India
44. IBFAN Ireland
45. La Leche League of Ireland, Ireland
46. La Leche League Italia, Italy
47. Safe Healthcare Africa, Kenya
48. Initiativ Liewensfunk, Luxembourg
49. CSO Luika, Macedonia
50. The Breastfeeding Advocates Network, Malaysia
51. BIB Malaysia, Malaysia
52. Malaysian Breastfeeding Peer Counselor Association, Malaysia
53. NGO Azafady, Madagascar
54. Centro-re, Mexico D.F.
55. Un Kilo de Ayuda A.C., Mexico D. F.
56. Nepalgunj Medical College Teaching Hospital, Nepal
57. Borstvoedingorganisatie La LecheLeague, Netherlands
58. Maternity Services Consumer Council, New Zealand
59. New Zealand College of Midwives, New Zealand
60. The Nurture Centre, New Plymouth, New Zealand
61. Dieticians Association Of Nigeria, Nigeria
62. Blue Veins, Pakistan
63. National Integrated Development Association (NIDA-Pakistan), Pakistan
64. Society for Human & Environmental Development (SHED), Peshawar, Pakistan
65. PARHUPAR, Paraguay
66. Центр грудного вскармливания, Russia
67. Info centar’ (Info centre), Serbia
68. IHAN (BFI-SPAIN), Madrid, Spain
69. La Liga de la Leche de Navarra, Spain
70. La Leche League Spain
71. Natural Beginnings Society, Slovenia
72. National breastfeeding promotion committee, Slovenia
73. Human Milk Bank Association of South Africa
74. Breastfeeding committee in NGHA, Riyadh, Saudi Arabia
75. Swaziland Infant Nutrition Action Network, Swaziland
76. La Leche League Schweiz, Switzerland
77. COUNSENUTH, Tanzania
78. Baylor College of Medicine Children’s Foundation, Tanzania
79. Kavishe International Consultancy Services, Tanzania
80. Association of Breastfeeding Mothers, United Kingdom
81. Breastfeeding LENS Limited, Derbyshire, United Kingdom
82. Lactation Consultants of Great Britain, United Kingdom
83. La Leche League, of Great Britain, United Kingdom
84. Mammas, United Kingdom
85. Arizona Breastfeeding Action Committee, USA
86. Arizona Breastfeeding Center, USA
87. Arizona Breastfeeding Coalition, USA
88. Best for Babes Foundation, LLC, USA
89. Birth Network of Santa Cruz County, USA
90. Breastfeeding Coalition of Oregon, USA
91. Breastfeeding Coalition of Washington USA
92. California Breastfeeding Coalition, USA
93. Georgia Breastfeeding Coalition, Dalton, Georgia, USA
94. Healthy Children Project, Massachusetts, USA
95. Kindred Mother Care, Oregon, USA
96. Lamaze International, Washington USA
97. Luna Lactation and Wellness, Oregon, USA
98. Mid-Hudson Lactation Consortium, NY, USA
99. NICU Department MDMC, Texas, USA
100. North Carolina Breastfeeding Coalition, USA
101. Oregon Washington Lactation Assn, USA
102. Pratt Area Breastfeeding Coalition, Beautiful Bond Breastfeeding Services, Kansas, USA
103. Raphael Center for Integrative Education, NJ, USA
104. Southeastern Lactation Consultants Association, Cleveland, Georgia, USA
105. St. Mary’sMedical Center, Florida, USA
106. St. Louis Breastfeeding Coalition, St. Louis, USA
107. IBFAN-Sumy, Ukraine
108. VietWise JSC (Bethbuti), Vietnam
109. Breastfeeding Association of Zambia