BREASTFEEDING – A VITAL EMERGENCY RESPONSE

Are You Ready?

BREASTFEEDING
A VITAL EMERGENCY RESPONSE

WABA World Breastfeeding Week ★ 1-7 August 2009

Breastfeeding after earthquake in Peru.

WABA 2009

www.worldbreastfeedingweek.org

Objectives of WBW 2009

- To reinforce the vital role that breastfeeding plays in emergency response worldwide.
- To advocate for active protection and support of breastfeeding before and during emergencies.
- To inform mothers, breastfeeding advocates, communities, health professionals, governments, aid agencies, donors, and the media, about how they can actively support breastfeeding before and during an emergency.
- To mobilise action and promote networking and collaboration between those with breastfeeding management skills and those involved in emergency response.

INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES (IFE)

An emergency is an extraordinary and extreme situation that immediately puts the health and survival of a population at risk. IFE focuses on the protection and support of safe and appropriate feeding for infants and young children in emergencies. It addresses both emergency preparedness and a timely and appropriate humanitarian response in the event of an emergency, to safeguard the survival, health, growth and development of infants and young children.

Why breastfeeding is a lifeline in emergencies?

Nowhere is 'immune' to an emergency. Emergencies can happen anywhere in the world. Whatever the emergency – from earthquake to conflict, from flood to flu pandemic – the story is the same: breastfeeding saves lives.

In emergencies, infants and young children are especially vulnerable to malnutrition, illness and death[1]. Here are just a few facts from emergency experiences:

- Published total mortality rates for infants under one year of age in emergencies are much higher than at ordinary times, ranging from 12% to 53%.
- In a large-scale therapeutic feeding programme in Niger in 2005, 95% of the 43,529 malnourished cases admitted for therapeutic care were children less than two years of age[2].
- In a therapeutic feeding programme in Afghanistan, the mortality rate was 17.2% amongst infants under 6 months of age admitted for therapeutic care[3].
- During the first three months of conflict in Guinea-Bissau in 1998, the death rate amongst 9–20 month old non-breastfed children was six times higher than amongst the children of the same age-group who were breastfed[4].

1. World Health Organisation and UNICEF. *Global Strategy for Infant and Young Child Feeding*. 2003, Geneva: World Health Organisation.
2. Isabelle Defourny, Emmanuel Drouhin, Mego Terzian, Mercedes Tatay, Johanne Sekkenes and Milton Tectonidis. *Scaling up the treatment of acute childhood malnutrition in Niger.* Field Exchange. 2006. 28:3. http://fex.ennonline.net/28/scalingup.aspx
3. Golden M. Comment on *including infants in nutrition surveys: experiences of ACF in Kabul* City. Field Exchange. 2000. 9:16-17.
4. Jacobsen. M et al. *Breastfeeding status as a predictor of mortality among refugee children in an emergency situation in Guinea-Bissau.* Tropical Medicine and International Health, 2003. volume 8, no 11, pp 992-996.

IFE CORE GROUP
An inter-agency collaboration concerned with the protection and support of safe and appropriate infant and young child feeding in emergencies

IFE Core Group full and associate members: WHO, UNICEF, UNHCR, WFP, IBFAN-GIFA, CARE USA, Save the Children US, Save the Children UK Action Contre la Faim International Network, Emergency Nutrition Network (ENN), Fondation Terre des hommes. ENN is the coordinating agency. The ENN and the IBFAN-GIFA are the lead contributors within the IFE Core Group to the WBW 2009 resource development. Visit www.ennonline.net/ife

Even in non-emergency situations, optimal infant feeding practices can mean the difference between life and death. The benefits are universal – with greatest effects in the most vulnerable contexts:

- Sub-optimal breastfeeding practices are responsible for 1.4 million deaths of children under five years in low-income countries and settings worldwide[5]. For these children, breastfeeding support tops the table of life-saving interventions: 13% of under–5 deaths could be saved through exclusive and continued breastfeeding until one year of age[6].
- One-fifth of neonatal deaths could be prevented by early initiation of exclusive breastfeeding (breastfeeding within the first hour)[7].

Can you imagine the difference that optimal breastfeeding could make in an emergency? Let's take, as an example, the most vulnerable: a newborn infant, born into a situation of insecurity and poor sanitation, with dirty water, scant food and no shelter. Extreme weather conditions, lack of skilled birth attendance and medical care, and premature birth increase risks even further. Skin-to skin contact from immediately after birth and initiation of breastfeeding within one hour reduces deaths by nourishing and actively protecting the infant, and helping to stabilise his/her body temperature. It also reduces the risk of post-partum haemorrhage in the mother – a leading cause of maternal mortality worldwide.

Breastfeeding is a shield that protects infants in an emergency

Breastmilk is the one safe and secure source of food for babies, instantly available, providing active protection against illness and keeping an infant warm and close to his/her mother. Protecting, promoting and supporting early initiation and exclusive breastfeeding for six months, followed by continued breastfeeding with the introduction of appropriate and safe complementary foods, until two years or beyond, will provide optimum protection in this risk-laden environment.

Three important international documents guide IFE policy responses in emergencies:

The Global Strategy for Infant and Young Child Feeding, produced in 2003[8], states:

> *"Infants and children are among the most vulnerable victims of natural or human-induced emergencies. Interrupted breastfeeding and inappropriate complementary feeding heighten the risk of malnutrition, illness and mortality. Uncontrolled distribution of breastmilk substitutes (BMS), for example in refugee settings, can lead to early and unnecessary cessation of breastfeeding. For the vast majority of infants, emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding."*

The International Code of Marketing of Breastmilk Substitutes, adopted by the World Health Assembly (WHA) in 1981, and all subsequent relevant WHA Resolutions (collectively known as 'the *Code*'), aim to protect mothers/carers of both breastfed and non-breastfed infants and young children from commercial influence on their infant feeding choices. All provisions of the *Code* apply in emergencies. Resolution 47.5 (1994) specifically highlights the issue of donations of breastmilk substitutes (BMS), bottles and teats in emergencies.

The ***Operational Guidance on Infant and Young Child Feeding in Emergencies (v2.1, Feb 2007)*** provides key policy guidance for emergency preparedness and response. The *Operational Guidance on IFE* reflects the WHO Guiding Principles[9] *for feeding infants and young children during emergencies* and has integrated and built upon the *Code* to respond to the particular challenges that emergencies pose to *Code* implementation.

Challenges to protecting and supporting breastfeeding in an emergency

We know why breastfeeding is important in emergencies and we have policy guidance to direct us. But the challenge is to 'make it happen', i.e. to put measures in place to protect and support breastfeeding in actual emergency situations.

The impact of an emergency on children will be influenced by prevailing feeding practices, women's and children's health and nutritional status, the resources available and the nature of the humanitarian response. Operational challenges to realising safe and appropriate infant feeding in emergencies, and to putting policy into practice, include common misconceptions, the risks of artificial feeding, and donations.

Artificial feeding – high risk for all infants

The risks of artificial feeding – and the vulnerability of HIV-affected infants – were exposed in Botswana in 2005/06[10]. Replacement feeding with infant formula had been offered to all HIV-infected mothers as part of a national programme to prevent transmission of HIV from mother to child. Flooding led to contaminated water supplies and a severe outbreak of diarrhoea and malnutrition in young children. National under five mortality increased by at least 18% compared to previous years. Non-breastfed infants were *50 times* more likely to need hospital treatment than breastfed infants, and much more likely to die. Use of infant formula 'spilled over' to 15% of HIV-uninfected women, exposing their infants, who would have been breastfed, to unnecessary risk.

Infants who are artificially fed need specialised support and close monitoring. In any context where artificial feeding is practised, strong breastfeeding support is needed to protect breastfed infants.

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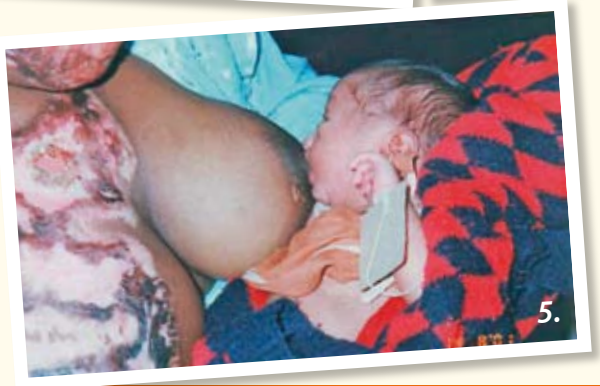
6. Jones et al. *How many child deaths can we prevent this year?* Lancet 2003; 362: 65–71.
7. Edmond, K.M., et al. *Delayed Breastfeeding Initiation Increases Risk of Neonatal Mortality.* Pediatrics, 2006. 117(3): p. e380-386.
8. Adopted at the World Health Assembly in 2002.
9. World Health Organisation. *Guiding principles for feeding infants and young children during emergencies.* Geneva, 2004. http://whqlibdoc.who.int/hq/2004/9241546069.pdf
10. Creek T, Arvelo W, Kim A, Lu L, Bowen A, Finkbeiner T, Zaks L, Masunge J, Shaffer N and Davis M. *Role of infant feeding and HIV in a severe outbreak of diarrhea and malnutrition among young children, Botswana,* 2006. Session 137 Poster Abstracts, Conference on Retroviruses and Opportunistic Infections, Los Angeles, 25-28 February, 2007. http://www.retroconference.org/2007/Abstracts/29305.htm
11. WHO. Relactation. *A review of experience and recommendations for practice.* 1998. WHO/CHS/CAH/98.14 http://whqlibdoc.who.int/hq/1998/who_chs_cah_98.14.pdf
12. World Health Organization, et al. *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* 2007, World Health Organization: Geneva.


2.


3.


4.


5.

6.

COMMON MISCONCEPTIONS AFFECTING BREASTFEEDING IN EMERGENCIES

MYTH: "Malnourished mothers cannot breastfeed."
FACT: Malnourished mothers can breastfeed. Moderate maternal malnutrition has little or no effect on milk production. In fact, the mother will continue to produce milk, at the expense of her own body stores. Extra food and fluids are needed to replenish the mother's own reserves, and micronutrient supplementation may be needed. She also needs encouragement and support to breastfeed frequently.
SOLUTION: Feed, nurture and support the mother and let her feed the baby.'

MYTH: "Stress prevents mothers from producing milk."
FACT: Stress does not prevent production of milk, but may temporarily interfere with its flow. Breastfeeding mothers have lower stress hormone levels than non-breastfeeding mothers.
SOLUTION: Create conditions for mothers that lessen stress as far as possible – a protected area, a mother-baby tent, reassurance from other women, keeping mothers and babies together, listening to mothers' special needs – and making sure the child keeps suckling so that milk flow continues.

MYTH: "Once a mother stops breastfeeding, she can't restart."
FACT: A mother can restart breastfeeding (relactate) – there is no time limit. In some contexts, grandmothers have breastfed their grandchildren[11].
SOLUTION: Offer support for breastfeeding and relactation.

MYTH: "When a woman has been raped, she cannot breastfeed."
FACT: Experience of violence does not spoil breastmilk or the ability to breastfeed.
SOLUTION: All traumatised women need special attention and support. There may be traditional practices that restore a woman's readiness to breastfeed after sexual trauma. Breastfeeding can sometimes help women to heal after sexual trauma but respecting and supporting their decisions and needs is a priority.

MYTH: "HIV positive mothers should never breastfeed."
FACT: Exclusive breastfeeding for six months is the safest option and gives the best chance of HIV-free child survival, unless total replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) – most unlikely in emergencies. After 6 months, if replacement feeding is still not AFASS, then continued breastfeeding with adequate complementary foods is the safest option[12]. The risk of postnatal transmission can be lowered with mother and/or infant receiving anti-retroviral (ARV) drugs.

Mixed feeding in the first six months (combining breastfeeding and formula feeding and/or too-early introduction of complementary foods) is the most risky feeding option, since it increases the risk of both HIV transmission and infections due to other causes, such as diarrhoea.

Where the HIV status of individual mothers is unknown, then recommended feeding practices are the same optimal feeding practices as for the general population, *irrespective of the prevalence of HIV in the population.*
SOLUTION: For guidance on programming for HIV and infant feeding in emergencies, see www.ennonline.net and/or www.waba.org.my

Cover and left photos were winners of WABA World Breastfeeding Week 2009 Photo Competition:

2. *Breastfeeding, the First Right to food – after 300 families were forcefully evicted and living under plastic canvasses.*
3. *Code Monitoring in Emergencies.*
4. *Breastfeeding in relief camp in India.*
5. *Stella is a victim of domestic violence where her husband had poured boiling water on her. With right support and counselling her baby was able to successfully breastfeed on both breasts.*
6. *Everyone needs to be ready and prepared for emergencies.*

'Generous' donations: more harm than good!

During the earthquake response in Indonesia in 2006, distribution of donated infant formula to children under two years led to its increased use among breastfeeding infants. Diarrhoea prevalence doubled in those who received donations of infant formula (25%) as compared to those who did not (12%)[13].

The infant feeding industry may view emergencies as an 'opportunity' to enter into or strengthen markets or as a public relations exercise. Individuals and non-governmental organisations (NGOs) unaware of the risks, may donate, out of a genuine desire to help, infant formula, other BMS and infant feeding items. Aid agencies and others may receive and distribute donations without any awareness of the increased risks to child health and survival.

Many violations of the Code, associated with donations of BMS and infant feeding items, have been recorded in emergencies. These violations were perpetrated by international and national NGOs, governments, the military and individuals.

The Operational Guidance on IFE states that donated or subsidised supplies of BMS, bottles and teats should not be sought or accepted in emergencies.
– Operational Guidance on IFE, v2.1, Feb 2007.

What can you do? Are you ready?

First and foremost, recognise that you have a role, think of how you can act, prepare yourself and take action. Wherever you are in the world, make sure that a story like this one never happens again . . .

"A mother had been stuck on a rooftop with many family members and her two week old baby who was bottle fed. They had no access to safe water for five days. Her baby was immediately hospitalised when they arrived in Austin, but she died several days later.

The nutritionist of a relief organisation supplying food aid asked the mother if there was anything else she could help her with. The mother asked for help drying up her breastmilk as her breasts were still sore. The nutritionist asked the mother why she hadn't breastfed her baby while she was stuck on the rooftop. But the mother had felt quite unable to do this.

What amazes me is that no one with the mother in New Orleans knew to have the mother put her baby to her breast. So many generations had not considered breastfeeding as a way to feed babies that the memory was lost. The baby was lost, also."
– Experience of a peer counsellor, Hurricane Katrina, USA, 2005

Emergency preparedness is the key to quick, appropriate actions. Development of protective policy, strong *Code* legislation, capacity building of staff and strengthening of the Baby-Friendly Initiative (BFI) are necessary at all times, not just in crisis.

Advocate with policy-makers and managers to make effective infant feeding support a part of normal health care and of collaborative emergency preparedness plans.

Formulate plans to prevent donations of BMS, bottles and teats and have a plan of action ready to handle any donations that do arrive during an emergency. **Network** and **collaborate** across sectors.

The best preparation for a mother facing an emergency is well established breastfeeding. A mother who practises and is confident in her own capacity to breastfeed her infant in any circumstance will be best placed to do just that, and to help other mothers to do the same.

Once an emergency strikes, simple measures can make all the difference in the world to a mother caught up in it. Ensure that mothers are secure, have priority access to **food** for the family, **water**, shelter, and when necessary, **safe places** to breastfeed (with privacy, where culturally required).

From water and sanitation, to health, to nutrition, to child protection, to food security and livelihoods response – see how you can integrate basic frontline protection and support for breastfeeding in your line of work.

Listen to the needs of the women and communities – they often know best how to create supportive environments for themselves and their families. Mother support groups can play an important role.

Protection and support also need to come 'from afar' – from donors, the media, and the general public who, through their actions, funding, donations, and press articles, affect emergency response.

Be alert to plans or reports of donations of infant formula, milk products, other BMS, baby bottles/teats. Monitoring and reporting Code violations in emergencies is an important step towards protecting breastfeeding.

Be proactive – an Interagency Joint Statement (see Model Joint Statement) and press releases can be used to prevent donations.

Work on communication. Use the Media Guide on IFE to develop press release messages that strengthen – not undermine – breastfeeding in emergencies.

Apply your knowledge – reinforce optimal feeding practices in the context of whatever emergency is happening in your setting, sharing links to key resources and materials.

Trained breastfeeding counsellors who can offer skilled breastfeeding assistance are of great help during an emergency. Breastfeeding counsellors may need extra training with specialised skills related to the emergency situation – for example, how to help mothers who are traumatised, infants/mothers who are malnourished, mothers who need relactation support, women who need support to wet-nurse.

Key Contacts

ACTION	CONTACT/CONTACT SOURCE	
Report Code violations	The IFE Coordinator during an emergency	Ask UNICEF at nutrition@unicef.org
	World Health Organisation (WHO)	cah@who.int nutrition@who.int
	UNICEF	dclark@unicef.org
	IBFAN International Code Documentation Centre (IBFAN-ICDC), Malaysia	ibfanpg@tm.net.my
Coordination on IFE	UNICEF at country/regional level	nutrition@unicef.org
Share experiences on implementing the Operational Guidance on IFE	IFE Core Group c/o Emergency Nutrition Network or IBFAN-GIFA	marie@ennonline.net info@gifa.org

13. Assefa F et al. *Increased diarrhoea following infant formula distribution in 2006 earthquake response in Indonesia: evidence and actions.* Field Exchange, 2006. 34:30-35

BREASTFEEDING – A VITAL EMERGENCY RESPONSE. ARE YOU READY?

Guide for Action on Infant and Young Child Feeding in Emergencies (IFE)

Everyone can play a positive and important role in emergency preparedness and /or response. It will be the synergy of our efforts that will help more children survive and strengthen women's capacity to cope in emergencies. Don't limit yourself to actions under one category –some actions are applicable to many different groups. These are just a selection to get you thinking . . .

	EMERGENCY PREPAREDNESS	EMERGENCY RESPONSE	
		ON THE GROUND	SUPPORT FROM AFAR
Government/ National policy makers	• Develop/strengthen national infant and young child feeding policy and emergency preparedness plans/policies to include IFE. • Enact strong national *Code* legislation. • Translate key resources. • Orient and train key staff on IFE. • Coordinate/link to networks of expertise. Make plans to prevent and handle donations of BMS, bottles and teats in emergencies. • Give the media clear guidelines on IFE. • Include breastfeeding promotion, protection and support in emergencies for the general public.	• Ensure that basic support for breastfeeding mothers is integrated across all sectors of emergency response. • Prevent/handle donations of BMS, bottles and teats. • Monitor and report Code violations.	• Watch out for appeals for donations of BMS, bottles and teats, and act to stop them.
(National) breast-feeding advocates/ counsellors/ trainers	• Undertake orientation and further training on infant feeding in emergencies. • Identify and network with agencies, local emergency committees, and communities, involved in emergency response. • Organise a seminar on 'helping mothers and babies in emergencies' for emergency workers. • Create a network of experienced staff available for training and/or deployment in emergencies. • Organise, with government and NGO allies, a press conference or media event on IFE. • Update your website with key links to resources.	• Get involved in early protection and support of breastfeeding. For example. training community counsellors and emergency relief staff, individual counselling, mother to mother support, phone line support. • Adapt materials and key messages to the context of the emergency.	• Identify agencies that support breastfeeding in emergencies and offer them your help. • Respond to negative stories and/or appeals for donations in the media.
Aid agencies/ NGO and UN staff	• Integrate Operational Guidance on IFE into agency guidance and policies. • Orientate all emergency response staff on IFE. • Identify networks of expertise, e.g. breastfeeding counselling, in countries/regions of operation. • Enrol health/nutrition staff in IFE training. • Communicate a clear plan to all staff on preventing/handling donations of BMS, bottles and teats. • Lobby the government and donors to include breastfeeding support in emergency action plans.	• Integrate IFE into minimum response across sectors – nutrition, health, shelter, protection, etc. • Implement skilled programmes to protect support and promote breastfeeding. • Act to prevent/handle donations of BMS, bottles and teats.	• Support 'on the ground' staff by not soliciting or accepting donations of BMS. • Support fund raising and send money instead of BMS.
Health professionals	• Increase your breastfeeding support skills and follow a breastfeeding counselling training course, or at minimum, an IFE training course for health/nutrition workers in emergencies *(see Module 2 on IFE)*. • Implement the BFI (in hospitals and in community health services). • Advocate for updated training on Breastfeeding Counselling and HIV and Infant Feeding Counselling at national /local level. • Gather information on what support is available for breastfeeding at national /local level (lactation consultants, peer counsellors, mother to mother support groups). • Organise training/a seminar for colleagues on IFE.	• Ensure that mothers and their children are kept together. • Implement the 10 Steps to Successful Breastfeeding in appropriate reproductive, maternal newborn and child health programmes in emergencies. • Ensure that skilled breastfeeding and infant feeding support is available for mothers ante-natally, at delivery, and post-natally for 2 years. • Ensure that skilled childbirth attendance is available for pregnant women. • Ensure that breastfeeding is fully supported for HIV-infected mothers unless AFASS conditions for replacement feeding are all in place.	• Be vigilant for local appeals of donations of infant formula, other BMS, and bottles/teats to emergencies, and act to stop them.
Mothers / caregivers	• Exclusively breastfeed your baby until s/he is 6 months of age. Continue to breastfeed your baby to 2 years or beyond. • Encourage your local mother support group(s) to discuss emergency preparedness. For example, plan ways that the group could staff a safe place for mothers and provide mother-to-mother support to breastfeeding if large numbers of people are made homeless. • Make contact with local emergency authorities and community groups and tell them about IFE.	• Continue to practice optimal breastfeeding. • Offer support to other mothers who are having difficulties or to mothers of newborns in an emergency. • Consider wet nursing if needs are identified, e.g. orphans, very ill mothers. • Help organise safe places for mothers with mother-to-mother support for breastfeeding.	• Identify agencies that support breastfeeding in emergencies and fundraise for them.

... continue on page 6

Communities	• Be prepared to face emergencies and raise awareness about IFE among community groups (e.g faith groups, youth groups, service organisations). • Emphasise the need to provide safe spaces for mothers and young children. • Make links with mother support organisations. • Lobby government to include breastfeeding support in emergency action plans.	• Help to counteract the disruption of family and support networks in an emergency. • Create safe spaces for mothers/babies. • Anyone involved in any part of an emergency response can help – from firefighters to supply drivers to security staff.	• Are you part of a community that fundraises or adopts 'causes'? Why not opt for breastfeeding in emergencies and fundraise/advocate?
Media & Communication	• Make links with nutrition and health personnel to develop key messages on IFE in an emergency. • Educate the public on how to protect and support breastfeeding in emergencies, and on how generous donations of BMS can do more harm than good. • Publish positive stories illustrating the importance of breastfeeding as life-saving in emergencies. *(See Media guide on IFE and Protecting babies in emergencies: the role of the public).*		
Donors	• Integrate key provisions of the Operational Guidance on IFE into guidance material.	• Do not donate BMS and bottles/teats to emergencies. • Support programmes which provide skilled support for breastfeeding. • Check whether implementing agencies have a policy on IFE that reflects provisions of the Operational Guidance on IFE.	

Key Resources

These and many more resources, including training materials, courses and translated versions, are available at www.ennonline.net select WABA 2009 and at www.waba.org.my

- *Operational Guidance on Infant and Young Child Feeding in Emergencies.* v2.1, Feb 2007. IFE Core Group. (11 languages)
- *Guidance on Infant feeding and HIV in the context of refugees and displaced populations.* UNHCR April 2008.
- *Training Module 1 on IFE (for all emergency relief workers) and Module 2 on IFE (for health/nutrition workers).* IFE Core Group.
- *Media Guide on IFE.* IFE Core Group.
- *Protecting babies in emergencies: the role of the public.* IFE Core Group.
- *Guiding principles for feeding infants and young children during emergencies.* Geneva, World Health Organisation, 2004.
- *The International Code of Marketing of Breast-milk Substitutes and relevant subsequent WHA Resolutions.*
- *Code Monitoring Form.* IBFAN.
- *Focus on the Code in emergencies.* 2009. IBFAN-ICDC.
- *Toolkit for Nutrition in Emergencies.* 2008. Global Nutrition Cluster.
- *Module 17 Infant and young child feeding. Harmonised training materials package.* Global Nutrition Cluster.
- *ILCA statement on breastfeeding in emergencies.* 2009.
- *Resources for breastfeeding during Emergencies.* 2007. La Leche League International.
- *Infant and young child feeding in emergency situations.* 2005. Wellstart International.
- *Acceptable medical reasons for use of breast-milk substitutes.* 2009. World Health Organisation, UNICEF.

Your local contact:

WABA does not accept sponsorship of any kind from companies producing breastmilk substitutes, related equipment and complementary foods. WABA encourages all participants of World Breastfeeding Week to respect and follow this ethical position.

ACKNOWLEDGEMENTS

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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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