



Anchor

breastfeeding as an equaliser to close gaps within society



Inform

people about inequalities that exist in breastfeeding support and prevalence



Galvanise

action on reducing inequalities in breastfeeding support by focusing on vulnerable groups



Engage

with individuals and organisations to enhance collaboration and support for breastfeeding





We live in a world where the great majority, and in many countries the vast majority, of women are choosing to breastfeed.

Yet very few can breastfeed for as long as they want and the poorer the women are the less likely they are to meet their breastfeeding goals. This huge inequity, that violates the right that women have to breastfeed their infants for as long as they wish, is clearly driven by **structural, organisational, interpersonal and community determinants** of infant feeding choices. These include aggressive and deceptive marketing from the commercial milk formula industry, lack of maternity/parental leave, workplace and community support. This action folder outlines the main causes of inequalities at different levels and provides some suggested actions to help close the gaps.

INEQUALITIES IN BREASTFEEDING: UNDERLYING FACTORS AND POSSIBLE SOLUTIONS/ACTIONS



STRUCTURAL LEVEL

Factors impacting on inequalities at the structural level include a lack of effective national policy on infant and young child feeding, urban- rural divide, socioeconomic status. During times of emergency, the influx of breastmilk substitutes (BMS) aggravated by a lack of a comprehensive infant feeding policy in emergencies disrupts breastfeeding.

Urban-rural Divide

There is often a gap in breastfeeding rates between the urban and rural population. However, the trend between in the urban-rural is not similar in all countries and regions. Some countries have higher breastfeeding rates amongst the urban population whereas in others the reverse is true. Reasons for lower breastfeeding rates in rural areas could be due to lack of access to information and breastfeeding support from the health system, technology. Other challenges include the marketing by the BMS industry targeting the different demographics with their advertising. Higher exposure to BMS marketing in the urban areas which are usually more densely populated can partially explain why breastfeeding rates could be lower in the urban areas.



In Japan, BMS marketing is prevalent in most delivery facilities other than BFHs, because there are no legal measures in place to implement provisions in the International Code.



In Australia, staff training for breastfeeding of Child & family Health (CFHN) and hospital Midwives and breastfeeding education are not standardised or a priority for the local health districts (LHD). Differences between disciplines are significant. Midwives are now case managing mothers and their babies for the first two weeks postnatal with no extra formal training of caring for an infant at this age or breastfeeding issues that present in the early weeks. Referral process to CFHN is delayed. Baby friendly accreditation is not a priority for LHD's as it is expensive and not a high priority to achieve in any strategic planning across the local health areas. Complementary feeding with formula is often the first option to be offered as opposed to supporting the mother to increase her milk production, breastfeed or use her expressed breastmilk.



In Kuwait citizens will receive better professional services if they are living in a community with healthcare services that include a breastfeeding counselling clinic or a Well-baby clinic run by a properly trained staff who can offer professional support to breastfeeding mothers and their infants, this situation has created a gap in the equity of service delivery.



In Zimbabwe, nutritionists are only found at district level and most clinics are run by health workers that do not have adequate knowledge to offer breastfeeding counselling and support. The village health workers get IYCF training and are not fully trained on breastfeeding so they are not fully capacitated to give breastfeeding counselling.





Socioeconomic Status

Women's income and education level affects breastfeeding rates significantly in different ways. Education level is more [predictive](#) of breastfeeding than income level. Women with low education and income may face challenges in accessing proper nutrition, healthcare, information and support during pregnancy and postpartum, including breastfeeding. On the other hand, they lack the resources to buy breastmilk substitutes. However, higher education and income can also mean higher exposure to inaccurate information on social media and through influencers which affect the social norms around breastfeeding.



In Argentina, the women who "breastfeed the least" are the poorest and least educated, and have inadequate prenatal control during their pregnancies. Only 88% of pregnant women have 5 prenatal control check-ups, thus reducing the opportunities to communicate their rights to enable them to make an informed decision.



In China, maternal and infant families are accustomed to using smart phones and WeChat to obtain parenting information; However, these information from different sources are mixed, and some of them mislead mothers. Hospital delivery is usually 2-3 days, but many families still have the custom of "confinement". When mothers stay at home, they may give up breastfeeding if they are not given the correct guidance when they encounter illness or other challenges of breastfeeding.



In Sweden as in many other countries the advertising messages from the baby food industry in social media equate breastmilk to infant formula which is misleading to parents.

Solutions/Actions

- 1 Ensure parents have access to free [comprehensive and accurate information about breastfeeding](#) through different channels throughout the antenatal, perinatal and postnatal period.
- 2 Include [breastfeeding education in school curricula](#).
- 3 Advocate for [coordination of breastfeeding](#) on a national level.
- 4 [Monitor and identify gaps in IYCF policies](#) and programmes at national level using existing tools.



By identifying gaps in the implementation of the Global Strategy for Infant and Young Child Feeding, India strengthened the Maternity Benefit Act of the country. Several other countries have constituted National Breastfeeding Committees while others have developed new breastfeeding policies. Government commitment to infant and young child feeding has been found to be a strong enabler for optimal breastfeeding policies, programmes and practices.



The Becoming Breastfeeding Friendly (BBF) initiative offers countries an empowering policy decision toolbox to self-assess their breastfeeding environments and make breastfeeding protection, promotion, and support policy decisions accordingly. BBF is based on the Breastfeeding Gear Model and gets implemented through an intersectoral committee that includes representation from government ministries and agencies, civil society organisations, academic institutions, and international agencies. BBF has been implemented successfully in countries across five world regions.

5.

- Implement and [monitor national Codes of marketing of breastmilk substitutes](#) with sanctions when violations occur.



The UAE National Code includes very good provisions for sponsorship and healthcare professional roles but the lack of a monitoring system and sanctions to ensure compliance makes it ineffective. Oman, Bahrain and Saudi Arabia also have their National Codes but without any sanctions or monitoring systems, leading to poor compliance.



6

Advocate for national [Baby-Friendly Hospital Initiative \(BFHI\)](#) policy to be implemented in each country.



Breastfeeding rates vary depending on where you give birth in Japan. The national average for breastfeeding rates is less than 50% while breastfeeding rates at certified Baby-Friendly Hospitals (BFHs) are more than 75% at one month. According to BFHI Network report (2022), only 4% of all babies are born at BFHs in Japan. Where breastfeeding is promoted and multiple BFHs exist, such as Toyama, Ishikawa and Miyagi districts, breastfeeding rates are higher than districts where no BFH exists and breastfeeding is not officially promoted.



7

Implement national policies that promote flexible and [family-friendly workplaces](#) to support breastfeeding.



Implementing and strengthening workplace breastfeeding support programmes to ensure mothers have adequate facilities and time for breastfeeding or expressing milk during working hours. In a study of working mothers in Selangor, Malaysia not having adequate lactation space at the workplace was associated with increased odds of breastfeeding discontinuation.



8

Create [emergency policies](#) that are supportive of breastfeeding and sound IYCF practices.



In Japan, the Noto Peninsula Earthquake happened in Ishikawa district in January 2024. The prefecture had five BFHs and a policy to create a breastfeeding-friendly environment in their health promotion plan. After the earthquake, realising donations of ready-to-use infant formula (RUIF) had been sent to the affected area, members from the Emergency Response team at JALC and from the Infant and Young Child Feeding (IYCF) Support Network in Japan contacted a Paediatric Perinatal liaison and shared information on IFE. Ishikawa prefecture's quick response to support infant feeding in emergencies (IFE) was remarkable after the earthquake. Prefectures where breastfeeding is supported may have higher resilience in emergencies.



ORGANISATIONAL LEVEL



Health systems

Within health systems there are several areas where inequities exist. These include gaps in implementation of BFHI, lack of human milk banks for premature and sick babies and additional support for women with physical and mental illnesses and disabilities.

Gaps in implementation of BFHI

There is a large gap in compliance with the practice of breastfeeding that is reflected in low rates of skin-to-skin contact, rooming-in and breastfeeding on demand. Babies predominantly receive breastmilk substitutes, the schedules for mothers to go to the neonatal units and the lactation room are restricted and the institutions that have institutional lactation rooms, breastfeeding rooms cannot meet the demand in the areas of neonatal care. A high percentage of babies get formula at the maternity wards with no medical reasons and it is not possible to make informed choices for parents to breastfeed their baby or not. Women who had Caesarean birth are associated with earlier breastfeeding cessation and higher breastfeeding difficulties. Delayed skin-to-skin contact and early breastfeeding may be a reason for this.

“



In Kuwait, only one of the four public hospitals managed to fulfil the criteria to become Baby friendly since 2014. The other hospitals are still in process and are not offering the expected breastfeeding support to the residents of their coverage areas. While the ever-breastfed rate in Kuwait is showing progressive improvement over the past two decades, the exclusive breastfeeding rate is extremely low without improvement. The inequality in delivering high standards services for all breastfeeding mothers is one of the major underlying factors that affect exclusive breastfeeding rate.

”

Milk Banks for premature and sick babies

[Human milk](#) banks cannot meet the demand globally to fulfil the need for donor human milk. The current supply of donor human milk is constrained by the limited number of human milk banks and the geographic locations where they exist. This leads to inequitable access to those babies who need it the most.

Support for women with physical and mental illnesses and disabilities

Lactating women may require hospitalisation for medical or surgical reasons. Unfortunately, hospitalisation of a breastfeeding woman or child can result in disruption of breastfeeding and unintended weaning, as well as other complications such as mastitis. HIV Positive mothers may not receive accurate information and proper guidance. [Guidelines surrounding HIV and breastfeeding](#) exist but are poorly implemented in some areas leaving women living with HIV vulnerable in their breastfeeding decisions. Similarly, women with [physical](#) and [mental challenges](#) will need more support appropriate to their needs.



Solutions/Actions

1

[Implement BFHI](#) to provide a supportive hospital environment and professional practices in the health facilities that improve the care of pregnant women (antenatal counselling), supporting new mothers, resolving breastfeeding difficulties and promoting breastfeeding that will ultimately help in healthy growth and development of babies with exclusive breastfeeding.



There is a sub-optimal implementation of the Ten Steps to Successful Breastfeeding especially Step 10. Nigeria is revitalising its implementation and expanding the BFI scope to include BFHI, BFWI and BFCI.



2

Advocate for [zero-separation after](#) birth and immediate and uninterrupted skin-to-skin practices.

3

Implement a [kangaroo mother care programme](#) for premature and sick babies.

4

[Train and educate health staff](#) in breastfeeding management and patient-centred treatment, to create an environment more conducive to the development of breastfeeding.



In Japan, The Japanese Association of Lactation Consultants (JALC) has offered breastfeeding support seminars since 1999, additionally physician's seminars since 2005. Members from JALC offer a basic breastfeeding course, based on WHO/ UNICEF BFHI training materials. La Leche League (LLL) Japan offers communication skills training not only for accredited LLL Leaders (breastfeeding counselors) but also for healthcare providers. The Breastfeeding Support Network of Japan (BSN Japan) translated IBFAN's A health workers' guide to the International Code of Marketing of Breastmilk Substitutes and distributed it to medical libraries.



Regional investments for instance in Stockholm with courses in breastfeeding for staff working antenatal, at delivery and maternity wards and in the child health sector. In other words, work for the Warm Chain of Support for Breastfeeding.



5

Use [language](#) that is consistent with gender identity preferences when offering breastfeeding support to be inclusive.

6

Provide continuous support post discharge through effective coordination with mother support groups and breastfeeding hotlines.



In China, The Baby-Friendly Hospital Development Fund of Chinese Red Cross Foundation has set up a WeChat official account, which contains 3 important functions of “Health Education - Discharge Investigation - Quality Improvement”. It contains more than 100 health education videos on breastfeeding, including common breastfeeding difficulties and solutions. Each short video is 1-3 minutes and easy to understand. No matter in urban or rural areas, mothers can learn it for free. During the period of hospital delivery, mothers can scan the QR code of the WeChat official account of the Baby-Friendly Hospital Development Fund attached to the bedside to learn the video at any time. The videos also can be used as an aid for medical staff.



7

Create breastfeeding support centres for [multiracial](#) and immigrant women with qualified and culturally competent personnel.



In Kuwait, Al-Adan hospital, a public baby friendly hospital with around 6000 deliveries annually, has established a Lactation Unit that offers support and counselling services to mothers living at Al-Ahmadi health region, with a walk-in breastfeeding clinic, that is implementing equality and justice to all citizens, even those who are not living in the same catchment area are allowed to use the services offered by this hospital aiming to close the gap of inequity in professional service delivery to those in need of their help. Other hospital-based services established and coordinated by the Lactation Unit staff include; antenatal education programme, successful practice of skin-to-skin contact and early initiation of breastfeeding for both vaginal and CS deliveries. All mothers post-discharge are assigned for follow-up soon, and offered a help-line phone number. Innovative system for the use of donated human milk at the NICU is well established.



8

Implement model [policies](#) to manage lactation of hospitalised mothers and breastfeeding children.

9

[Establish human milk banks](#) to cater for premature and sick infants.



Workplace and Employment

Within the workplace and employment sector there are several inequities mainly between the formal and informal sector and breastfeeding friendly workplaces. The duration of maternity leave available in different countries is another inequity.

Duration of Maternity leave availability among countries

According to the International Labour Organization (ILO), more than 830 million women workers do not have adequate maternity protection. Paternity and parental leave are available in only 78 and 66 countries respectively. Most countries offer at least some paid maternity leave. However, progress is slow in meeting the World Health Organization (WHO) recommendation for the provision of at least 6 months paid leave to support exclusive breastfeeding. Absence of paternity leave makes it more difficult for fathers to be able to fully support their partners to breastfeed.

Workplace support vs no workplace support

Maternal employment, particularly in demanding and inflexible roles, might make it challenging for mothers to maintain exclusive breastfeeding especially in the private sector. Working mothers may find it difficult to continue breastfeeding if their company does

not have supportive policies in place, such as limited breastfeeding breaks, inadequate facilities for breastfeeding or expressing milk and crèches at or near the workplace.



Informal employment in Peru, according to the Ministry of Labour and Employment Promotion as of September 2023 was 71.9%, which affects women's right to breastfeed. One explanation is that in areas with better living conditions, generally urban, mothers must return to their workplaces and do not always have the conditions to be able to continue providing breast milk to their children (breastfeeding facilities at workplaces, among other factors).



In Zimbabwe, only two lactation rooms are available at Lafarge and Harare hospital. Most of the workplaces do not have lactation rooms. Establishment of lactation rooms can encourage breastfeeding in workplaces.



Formal vs informal workers (leave and benefits)

More than half of the global workforce make a living in the informal economy, and are not covered by maternity protection policies. Workers in the informal economy face many barriers to breastfeeding such as living far from work, long working hours without breaks, and dangerous work environments. Furthermore, there is also a general lack of knowledge on how supporting breastfeeding is beneficial for businesses, workers and their families.



In Costa Rica, we have seen that there is a great gap between women who must re-enter the formal or informal labour system, even though it has a strong law that provides them protection.

Solutions/Actions

- 1 Develop a public-funded maternity and parental leave funding model that does not require employers to carry the full burden of leave payments.
- 2 Ratify and implement the [ILO C183 - Maternity Protection Convention](#), 2000 and R191 as the minimum standards.
- 3 Monitor relevant policies, develop and implement action plans to include [informal workers](#) in maternity protection policies that support breastfeeding.
- 4 Provide [parental leave](#) that enables mothers to exclusively breastfeed for six months and promotes involvement of fathers/partners in childcare and domestic work.
- 5 Support working mothers by implementing [breastfeeding-friendly workplaces](#) with support facilities such as crèches, breastfeeding rooms, and flexible work hours.
- 6 Work with colleagues and [trade unions](#) to advocate for [maternity, parental and breastfeeding rights](#) at the workplace.

INTERPERSONAL AND COMMUNITY LEVEL

At the interpersonal and community level, there are several inequities such as cultural practices towards breastfeeding, immigration status, and community support.



Cultural practices

Cultural practices can sometimes pose a negative impact on breastfeeding success and may discourage women from continuing breastfeeding. Some cultural practices may discourage exclusive breastfeeding or promote early introduction of other foods or liquids. Sociocultural norms and misconceptions in the community regarding breastfeeding can impede acceptance and cause uneasiness for mothers who want to breastfeed in public or continue breastfeeding for an extended period.

Local population vs immigrants

Lack of breastfeeding support to immigrants or discrimination in some communities to provide maternity rights to locals only can cause a breastfeeding gap in countries with high immigrant populations.

Heteronormative vs LGBTQ+

Lack of knowledge of LGBTQ+ reproductive care and a heavily-gendered approach to breastfeeding will discriminate against the parents within the community to provide human milk for their babies.

Community support

Gaps in community breastfeeding support structures also contribute to lower breastfeeding rates. In some communities there are peer counsellor or mother support groups that can provide breastfeeding support which can complement that of healthcare services.

Solutions/Actions

1

Create [community-based peer support groups](#) possibly utilising existing networks or launch new initiatives to connect experienced mothers with first-time breastfeeding mothers.



Community support programmes can help the mothers with lactation problems to continue breastfeeding successfully. This was observed in Oman where all Government hospitals are baby friendly but still exclusive breastfeeding rate dropped from almost 90% at birth to 12% only at 6 months of age. This drop is definitely due to lack of mothers' support at community level.



2

Create a [training programme](#) for perinatal peer counsellors, who would accompany mothers in the first weeks postpartum, and help them to resolve any difficulties they may have with breastfeeding.



One such successful initiative was implemented in India's Lalitpur district, in which village level trained mother support groups comprising local health and nutrition care workers and elderly women from the community provided skilled support to lactating women close to their habitat.



3

Reach out to [immigrants](#) (depending on the immigration circumstances, they may need access to trauma informed breastfeeding care) with information in their languages and create [culturally sensitive breastfeeding support systems](#).

4

Reach out to [fathers/ partners](#) and explain their role in supporting the breastfeeding mother. Equip both parents with the same information.



5

Organise social media campaigns for [normalising breastfeeding](#) and breastfeeding supports.



Kuwait breastfeeding promotion programme believed that combined health systems and community interventions will increase the exclusive breastfeeding rate and close the inequality gap, has established Community-based interventions including social mobilisation, with effective mass media campaigns and breastfeeding clinics run by well-trained breastfeeding counsellors and lactation consultants at the primary healthcare level, to support breastfeeding mothers, offering individual counselling or group education, immediate breastfeeding support, and lactation management.



6

Provide access to [breastfeeding services](#), particularly for low-income [families](#).

7

Develop tailored [breastfeeding/chestfeeding support](#) for [LGBTQ+ families](#).

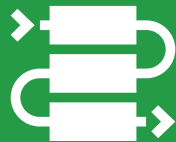


KEY MESSAGES

All actors along the Warm Chain need to work together to close the gaps in breastfeeding.



A comprehensive national policy on infant and young child feeding together with a plan of action will help ensure that breastfeeding support is available for all.



Universal implementation of BFHI along with access to donor human milk is essential to supporting early and continued breastfeeding for all babies.



Ensuring adequate maternity/paternity/parental leave, inclusion of the informal sector in maternity protection and workplace support is essential to supporting breastfeeding among working parents.



Working with community members to develop tailored breastfeeding support for vulnerable populations will help close the gap in breastfeeding rates.



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