When not one country in the world meets the “breastfeeding standards” set forth by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF), it might be time to question their value. Are they attainable—more importantly, should they be?

Or, are they a tool to push through an overarching agenda of changing maternal behavior and legislation on paid maternity or family leave? Among other political motives. Since they claim a mother’s decision to feed her child is “strongly influenced by economic, environmental, social and political factors” and “no country is highly compliant on all indicators, illustrating that substantial progress on all fronts is needed,” maybe the world disputes how pressing this “need” is and embraces a family deciding for itself how it will feed their child?

Breastfeeding at all costs as an idealized metric epically fails families. It perpetuates notions of inadequacy among women. It promotes fear and anxiety during a time that should be filled with joy. Though likely well-intended, the alarmist statements made throughout these newly released materials linking infant deaths and not breastfeeding are quite misguided and require significant unpacking.

There is no dispute that breastmilk is the optimal form of nutrition for a baby, but formula can be good enough and is not evil. There are pathological conditions (in mother or baby) where exclusive breastfeeding is not in the best interest of the infant and family. This, too, is valuable to convey as feelings of failure and worry are rampant in parents, especially new ones.

There is no room for this nuanced thinking in the new report and fact sheets generated by the WHO and UNICEF conglomerate referred to as The Global Breastfeeding Collective. For
example, they support even when “feeding in exceptionally difficult circumstances...Breastfeeding remains the preferred mode of infant feeding in almost all difficult situations” and they specifically cite doing so with “families suffering the consequences of complex emergencies.”

I would argue that there are many instances of complex emergencies where demanding breastfeeding of a mother who sustained a stroke in delivery, is suffering post-partum depression or psychosis, is on chemotherapy for breast cancer or endured other catastrophic family scenarios misses the point. A mentally and physically healthy mother best contributes to a healthy baby, more so than the benefits of breastmilk in these and similar situations.

The guidelines also include malnourished infants in this mix. A well-nourished mother provides high quality breast milk for her baby. If mom is dehydrated and profoundly calorie-deficient for any number of reasons, then her breast milk might not have the requisite fat composition an infant needs. Again, this is why the choice to breastfeed must be an informed one individualized to that baby and that family in consultation with their doctors and caregivers.

This recent work is based on a narrow lens in a vacuum. For one, the countries of comparison are so vastly different that a unifying policy seems quite myopic, ignoring the unique challenges and barriers between disparate nations. It paints with a wide brush — that is clearly not realistic for families across the world. It utilizes sub-standard data points without a clinical picture and vital information about very real matters that impact feeding and correlate directly with weight gain and infant development.

This global call to action is being deemed “urgent” for policy makers worldwide to increase public funding for breastfeeding and prompt countries to alter their policies.

One such initiative they actively champion to “expand and institutionalize” is the baby-friendly hospital designation. This label always drives me bananas because it implies there are hospitals that are anti-baby. The measures put in place by hospitals desiring this distinction often are a veiled effort to reduce staff numbers while under the guise of “baby-friendly initiatives.” Among the efforts to do so are avoiding placing the baby in the nursery and instead rooming in with the mother at all times — this can serve a facility the opportunity to truncate their nursing staff and nurseries.

Childbirth can be wrought with unexpected issues for mom and baby. Where one mother prefers the infant to room in with them at all times in the hospital, many do not and require focused recovery from their surgical or complicated births. In over a decade of medical practice in Manhattan, it is hard for me to think of an occasion when a mother hasn’t cried to me having felt pressured to breastfeed.

It was recently reported [4] that an Oregon woman is suing a hospital where she gave birth to her son who she accidentally smothered to death. She is claiming she was heavily medicated with Ambien and Vicodin when a nurse put the baby in bed with her in the middle of the night to breastfeed and left the room. When more information is released about the policies and practices in the delivery unit, this woman’s case might actually prove compelling.

Women are routinely on medications in the perinatal period (and at other times). Some are
incompatible with breastfeeding. These absolute commandments by the Global Breastfeeding Collective do not support women and families, for example (with my commentary):

- **Babies who are fed nothing but breast milk from birth through their first 6 months of life get the best start**

Breastmilk is wonderful. It encourages bonding between mom and baby. It has immune-protective and cognitive benefits etc. But, a baby who receives alternative nutrition can also have a great start to life.

- **Exclusive breastfeeding provides babies: the perfect nutrition & everything they need for healthy growth and brain development**

Don’t let the perfect be the enemy of the good. Many circumstances exist that make this exclusive breastfeeding not possible. The baby can still lead a healthy, wonderful life when that is the case.

- **Protection against obesity & non-communicable diseases such as asthma and diabetes**

Breastfeeding is the absolute gold standard. It provides a lot of positive health benefits that increase an individual’s likelihood of good outcomes. But, it does not guarantee that complex disease states like obesity and other diseases can’t occur in the future.

**In conclusion…**

Women have consistently been getting messages of a breastfeeding at all costs mentality. This does families a disservice.

How to feed an infant is routinely and repeatedly addressed in the United States from newborn nursery to pediatric office to communities and parenting groups etc. What is best for an infant is up to the parents in discussion with the child’s healthcare provider who is fully aware of the comprehensive clinical picture and medical history.

The WHO and UNICEF recommendations need to be tailored to the specific needs of the region. What works in the United States won’t necessarily work elsewhere and vice versa. The barriers to breastfeeding can be very different. Asking for hefty sums to mandate societal shifts might be a solution to a problem that may not even be uniformly in need of solving.

Advocating for workplace breastfeeding areas is certainly helpful to the cause and worthwhile. As is educating populations about the many positives about breastfeeding. Finding that balance where “standards” don’t cross over to coercive or create more harm than good is a delicate dance. Unfortunately, the tone and language of this just released position statement did not produce a measured, supportive approach for change. Until it does, the message will not be a nurturing one.

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