REPORT OF A TECHNICAL CONSULTATION
ON INFANT AND YOUNG CHILD FEEDING

Themes, discussion and recommendations
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Introduction

Nutrition for infants and young children is not only a vital health issue, but it is also central to poverty reduction and sustainable development. Inappropriate feeding is responsible for at least a third of the malnutrition associated with almost half the 10 million deaths of under-five year olds each year. WHO and UNICEF, along with their partners, have long supported governments in efforts to improve infant feeding practices. Many initiatives have been launched – some successful and others less so – but much more needs to be done, with a renewed sense of commitment, to accelerate progress in optimizing infant feeding for the highest possible level of health for all children.

To this end, WHO hosted and organized jointly with UNICEF, a Technical Consultation on Infant and Young Child Feeding (IYCF). As first announced to the Executive Board and World Health Assembly in 1998, the objectives of the consultation were to:

(i) assess the strengths and weaknesses of current infant and young child feeding policies and practices;
(ii) review barriers to policy implementation;
(iii) review key interventions as a first step towards identifying feasible and effective ways forward; and
(iv) contribute to the development of a comprehensive draft strategy which, when adopted, will guide Member States and the international community on policies and actions for infant and young child feeding in the years to come.

Organizational matters

The meeting was organized by the Department of Nutrition for Health and Development (NHD) in collaboration with a cross-cluster steering committee of staff from the other WHO programmes concerned with child feeding issues, namely the departments of Child and Adolescent Health and Development, and Reproductive Health and Research. The preparations, including selection of participants and the commissioning of nine background papers, were undertaken jointly with UNICEF. Altogether, 54 participants attended – 27 experts, 12 UNICEF staff members and 15 from WHO (see annex II for list of participants). They were invited in their individual capacity on the basis of their technical expertise in strategy and programme development. They included WHO regional advisers in nutrition, UNICEF headquarters and regional staff and representatives from the International Labour Organization (ILO), UNAIDS, the Office of the United Nations High Commissioner for Refugees (UNHCR) and the Subcommittee on Nutrition of the United Nations Administrative Committee on Coordination (ACC/SCN). Dr Alireza Marandi (Islamic Republic of Iran) chaired the meeting.
The process

Key issues on infant and young child feeding were presented in plenary sessions, followed by discussions (see annex I for agenda). Participants were then divided into working groups to discuss these issues in terms of obstacles and challenges, successes and lessons learned, and possible ways forward for a new strategy. They were also invited to consider cross-cutting issues such as indicators and targets, education and training, HIV and infant feeding, emergencies, status of women and human rights, early childhood care, cost-effectiveness of interventions, information and communication, and health promotion. Working groups focused on the following themes:

- Increasing rates of exclusive breastfeeding
- Improving complementary feeding practices and sustained breastfeeding
- Effective models for supporting breastfeeding women
- Integrating support of breastfeeding and complementary feeding into the health care system
- Strengthening the Baby-friendly Hospital Initiative (BFHI)
- Policies and practices to support breastfeeding in the workplace

The working groups presented their recommendations to the full plenary for discussion and input into a preliminary draft strategy (see Annex IV for a summary of the working group presentations). Further working groups then examined this draft in terms of strategic approaches at the national and institutional/organizational levels with regard to: exclusive breastfeeding; complementary feeding; feeding in exceptionally difficult circumstances; and obligations, responsibilities and resource mobilization. Their recommendations were taken into account during further revisions to the draft strategy.
SECTION I

Setting the scene

In her message to the meeting, Dr Gro Harlem Brundtland, Director-General of WHO, stressed the need to identify the way forward to fulfil the fundamental right to adequate food and nutrition, and ensure freedom from hunger and malnutrition. Malnutrition, she said, not only kills, maims, cripples and blinds on a massive scale, it is also a major cause and effect of poverty and underdevelopment that needs to be effectively addressed to achieve equitable human and national development.

A successful strategy is one that benefits from coalition and consensus building. Governments and their citizens should develop a sense of ownership through participation in the development of a strategy that can be adapted to specific needs of countries and their citizens. This should result in coherent national policies that deal with infant and young child feeding across sectors. At the same time, WHO and UNICEF should provide international advocacy and support, grounded in the best available scientific and epidemiological evidence, based on their complementary mandates.

The Director-General said she would inform the World Health Assembly in May 2000 of the outcome of the meeting and, the following year, would provide the Assembly and the WHO Executive Board with feedback from Member States on progress in developing a global strategy. In 2002, she would submit the proposed global strategy to the Executive Board and then to the Assembly for discussion, endorsement and decision.

Dr Brundtland urged participants to give free rein to their imagination in devising new initiatives for raising awareness, for communicating better, for building on earlier successful initiatives – such as the Baby-friendly Hospital Initiative – and in finding new ways to ensure that all concerned parties fulfil their responsibilities, including those involved in marketing foods in ways that could interfere with breastfeeding. She also drew attention to the need for refining knowledge about the threat of HIV/AIDS in infant feeding.

Mr André Robertfroid, Deputy Executive Director, UNICEF, referred to the complexities and challenges of feeding infants and young children. He recalled major international commitments which acknowledge the importance of breastfeeding to children’s health and survival such as the World Summit for Children and the Convention on the Rights of the Child (CRC). Societies should live up to their duty to ensure that all children receive adequate nutritious food, and that all members of society have a basic understanding of good nutrition, including the advantages of breastfeeding. He stressed that the progress made towards achieving the goals of the Innocenti Declaration of 1990 (which was adopted by the governing bodies of both WHO and UNICEF as a strategy to guide their work in infant feeding) now needs to be accelerated.

Over the last 10 years, he said, a new development paradigm has emerged with greater emphasis on human development and dignity and less emphasis on economic growth. However, the reality of development does not reflect this new vision. While globalization is applauded as generating wealth, it is also increasing disparities and inequities because
of the uneven distribution of its risks and benefits. This trend is hitting children very hard; by allowing it to continue, the international community is violating their most basic rights. It is also very short-sighted, as economic development depends on the energy and skills of people, and early childhood provides the best opportunity for breaking intergenerational cycles of chronic poor health, nutrition and sub-optimal human development. For optimal feeding of their children, mothers and families need skilled emotional and practical support, particularly against growing economic pressures.

Mr Robertfroid reaffirmed UNICEF’s commitment to working with governments, other agencies and civil society to ensure that children are given the best possible start in life.

Dr Tomris Türmen, Senior Policy Adviser to the Director-General, said that requests from several professional organizations, NGOs and even governments to attend the meeting had had to be turned down in order to keep the consultation to manageable proportions for debate and consensus on a first draft global strategy, and to ensure diversity of expertise and geographical balance. However, others would be able to take part in follow-up meetings and in the ongoing debate as part of the consensus-building process. She reminded participants that they had been invited in their personal capacities for their relevant technical expertise and called on them to exercise their best judgement independently of any influences. Dr Türmen said the technical consultation had an important role to play in establishing the strategy’s early orientation and its main elements at the start to a necessarily lengthy and complex process. By helping to focus on fundamental infant feeding issues and on new ways of dealing with them, she said, the meeting would be performing an invaluable service, helping to lay the foundations for a new strategy that governments, civil society and mothers everywhere would be willing to accept.

Dr Graeme Clugston, Director, Nutrition for Health and Development, WHO, explained the fundamental role of infant and young child feeding in child growth and development. He described the critical periods of growth and development of various body systems that occur between birth and 2 to 4 years. The three main factors contributing to infant and young child malnutrition, he said, are infection and ill health, food shortage and faulty feeding practices. He outlined the current dimensions of the major forms of malnutrition: 

- **intrauterine growth retardation** affects 30 million newborns a year or 23.8% of all births, resulting in low birth weight and brain damage; 
- **protein-energy malnutrition**, which affects 149 million children under five years, contributes to increased morbidity and mortality; 
- **iodine deficiency disorders** lead to goitre in 740 million and to retardation in 40 million; 
- **vitamin A deficiency** affects 140 million under-five year olds with subclinical deficiency leading to increased morbidity and mortality, and 3 million with xerophthalmia, which causes blindness; 
- **iron deficiency anaemia** in 198 million under-fives causes increased morbidity and mortality and impaired psychomotor development; and 
- **obesity** affects 22 million children contributing to increased incidence of diabetes and cardiovascular disease. The major causes of the 10.4 million infant deaths in all developing countries in 1995 were neonatal infection (32%), acute respiratory infections (24%), diarrrhoea (19%), measles (6%), malaria (7%), and other infections (12%). Malnutrition is associated with 49% of these deaths.

Dr Roger Shrimpton, Director, UNICEF Nutrition Programme, focused on the human rights aspect of infant and young child feeding as embodied in the Convention on the
Rights of the Child. A human rights perspective, which differs from a basic needs approach, has programme implications for governments in that it requires them to legislate in order to fulfil their obligations to respect, protect and facilitate peoples’ rights. He explained the shift in development thinking from one based on economics to one based on human development norms. The UNDP’s Human Development Report and various global conferences of the 1990s – the World Summit for Children (1990), the International Conference on Population and Development (1994), the Fourth World Conference on Women (1995) and the World Summit for Social Development – all reflect this paradigm shift. Viewed from this perspective, infant and young child feeding is particularly important. It is also the foundation for adult capability.

Dr José Martínez, Child and Adolescent Health, WHO, presented the key elements of a preliminary draft strategy. Although malnutrition is associated with almost half of all childhood deaths, it has received relatively little attention in the past two decades, with limited improvements in feeding practices during this period. However, while new knowledge has accumulated of how to improve feeding, there is also increasing recognition of new needs resulting from HIV and other emergencies. Dr Martínez outlined progress in the knowledge base and some important actions taken to improve infant and young child feeding in the past 20 years, all of which should be built upon. In developing a strategy framework, he said, the Innocenti Declaration’s goals should be reaffirmed and new goals asserted to protect promote and support adequate, safe and timely complementary feeding and the feeding of children in exceptionally difficult circumstances. Actions should include policies and legislation, information, the creation of conducive environments and social norms, and active assistance programmes such as counselling and “baby-friendly” hospitals. All these require commitment, national and international policies and actions, funding and priority setting. The meeting’s recommendations about these, he said, would contribute towards revising the current draft strategy.
SECTION II

This section reports on the presentations of the main themes with a bearing on infant and young child feeding. To avoid duplication many similar recommendations have been consolidated and included in Section III along with the major recommendations emerging from the discussions.

Measuring progress in breastfeeding and complementary feeding
presented by Dr Elisabeth Sommerfelt

An overview of the trends in measuring breastfeeding and complementary feeding shows that, according to findings from the Demographic Health Surveys (DHS), the percentage of infants under 4 months exclusively breastfed is very low, with wide variations within four regions (sub-Saharan Africa, North Africa, Asia and Latin America/Caribbean). A large proportion of infants are not put to the breast immediately, thus depriving them of colostrum and exposing them to potentially harmful/contaminated foods and liquids. Among children 6–9 months, feeding practices are also clearly not optimal; those receiving complementary foods with continued breastfeeding are highest in sub-Saharan Africa, but there are wide variations in Asia and Latin America. In very few countries does breastfeeding continue after two years of age.

Overall trends in breastfeeding offer some encouragement. In a few countries there is an overall increase in ever-breastfed rates. Regarding duration of breastfeeding, available data show substantial increases in some countries and no change in others, while no countries show a decrease in duration.

In Africa, breastfeeding rates decline sharply after 18 months, while in Asia the decline is more gradual until 23 months. There are wide variations within each region in the percentage of infants still breastfed at 20–23 months. Within this age group, the highest rates of breastfeeding are among mothers with no education and the lowest among mothers with secondary education for all countries in Asia, Africa, and Latin America and the Caribbean. In developed countries the opposite is true. It is not known if practices will change over time in relation to mothers’ education.

Current surveys and monitoring data fail to provide information that is important to concerns about optimum feeding. For example, it is not enough to find out what is eaten; the nutrient density of complementary foods is also important. Infants fed only three days after birth will not have received any colostrum, and are probably given supplementary feeds, but neither point is reflected in DHS data. The reasons why women never breastfeed or stop breastfeeding are not always known. Breastfeeding by socioeconomic group and education are other areas that need to be carefully analysed and interpreted.

Monitoring of change and progress in feeding practices, including breastfeeding, is clearly needed. This requires clear and simple indicators. The questions to be used for deriving indicators also should be clear and simple, while sample sizes to demonstrate changes in practices need to be large.
HIV and infant feeding
presented by Dr Felicity Savage and Ms Gabrielle Palmer

Throughout the 1990s progress in breastfeeding was achieved through such interventions as the Baby-friendly Hospital Initiative (BFHI), breastfeeding counselling and the International Code of Marketing of Breast-milk Substitutes. Recently, the spread of HIV has become a major hindrance. In HIV-prevalent areas, there is genuine uncertainty about whether or not to promote breastfeeding or whether the International Code is necessary in situations where mothers need formula for their infants.

Analyses have shown a 15%–16% risk of HIV transmission through breastfeeding, in addition to the risk during pregnancy and childbirth, when a mother is HIV positive. A number of factors influence the degree of risk, such as viral load, maternal nutrition, and mastitis or other breast infections. For example, if a mother becomes infected during pregnancy or lactation, the risk is estimated to be about 29%. However, until recently, there was little knowledge about the feasibility or safety of alternative methods of feeding in the most seriously affected areas. Those working in public health are not always aware of the relative risk factors of different feeding options and tend to promote alternative feeding methods without taking into account the enormous difficulties in resource-poor settings.

New research is being conducted to guide recommendations on maternal and child care in the presence of HIV. For example, in 1998, it was shown that a short course of AZT could reduce mother-to-child transmission (MTCT) around the time of delivery. That same year, WHO, UNICEF and UNAIDS prepared guidelines on HIV and infant feeding with emphasis on voluntary and confidential counselling, and testing of mothers and their partners, before a decision is made about breastfeeding. Mothers testing negative, or of unknown status, are encouraged to breastfeed. Those testing HIV-positive who choose not to breastfeed should be helped to find a suitable method of replacement feeding and to use it as safely as possible. From 6 months to 2 years, some form of milk should be continued with the addition of nutrient-rich complementary foods three times a day, or appropriately prepared family foods should be suitably enriched and fed five times a day. Other options include breast-milk banks, wet-nursing, expressed and heated breast milk, and early cessation of breastfeeding in situations where mothers are able to give replacement feeding more easily after the baby is a few months old.

At the same time, the guidelines recognize the need to protect, promote and support breastfeeding practices – and to prevent their deterioration – among the general population. One of the major recommendations is to incorporate information about HIV and infant feeding – including breastfeeding, modified breastfeeding and replacement feeding – into training on breastfeeding counselling for health workers so that mothers receive full and balanced information about infant feeding options to enable them to make informed choices. A WHO/UNICEF training course on HIV and Infant Feeding Counselling was developed in 1999 and presented for the first time in Harare in April 2000.
Since 1998, significant new research findings reinforce many of the principles originally set out in the guidelines on HIV and infant feeding while influencing approaches to other issues. The latter include the possibility of a reduced risk of transmission through exclusive breastfeeding than through mixed feeding (although further studies are needed to confirm this); and the need to focus on preventing mastitis and subclinical mastitis, through skilled counselling about correct breastfeeding technique, rather than waiting for mastitis to occur and then having to advise interruption of breastfeeding. In addition, mothers who are not breastfeeding require access to family planning services (as breastfeeding helps child-spacing), while infants not breastfed need active psychosocial stimulation (they should be cup-fed so that they are held by the caregiver).

**Increasing rates of exclusive breastfeeding**
presented by Dr Elsa Giugliani

Relatively little information is available on the prevalence of exclusive breastfeeding, and what data exist show wide variations. The rates are much lower than “any breastfeeding” rates and they decline rapidly after delivery.

Programmes aimed at improving breastfeeding rates do not necessarily improve exclusive breastfeeding. However, evidence shows the effectiveness of interventions occurring as soon as possible after birth. The main obstacles to exclusive breastfeeding are general lack of knowledge, inappropriate advice by health professionals, lack of skilled support to breastfeeding mothers, harmful lactation management practices, lack of confidence on the part of mothers, commercial promotion of breast-milk substitutes, and cultural practices and beliefs (e.g. avoidance of colostrum; prelacteal feeds; early supplementation with water, teas, milk or cereal-based foods; early introduction of foods; use of pacifiers; and inappropriate expectations of infant behaviour). Women’s work patterns, pollutants, and HIV and emergency situations are additional challenges.

Of 17 studies of different types interventions, 14 were successful in increasing rates of exclusive breastfeeding. The Gambia in particular stands out as an example where several types of simultaneous interventions resulted in an increase in exclusive breastfeeding from 1.3% to 99.5%, and in Bangladesh from 6% to 70%. Some important lessons from experience show that exclusive breastfeeding rates can be increased, that the reestablishment of exclusive breastfeeding is possible, that peer counselling is the most effective form of support, and that one-to-one counselling has the most consistent success. Strong community involvement, including support from partners, is very important. While favourable hospital practices, implementation of the International Code and maternity protection in the workplace are essential, they may have limited effect in the absence of one-to-one breastfeeding support.

**Approaches for improving complementary feeding of young children**
presented by Dr Kathryn Dewey

The age range from about 6 to 24 months is critical to a child’s growth and development. Assuring optimal nutrient intake through complementary feeding of breastfed infants is therefore essential. However, advice and current guidelines on complementary feeding vary with regard to age for introduction of complementary foods, their order of introduction, and the degree of specificity of food types to include; how much fat and
sugar to include/avoid; restriction/avoidance of certain foods (e.g. juices, cow’s milk); meal frequency; and vitamin-mineral supplementation (e.g. vitamins D and A, iron, fluoride and calcium). Furthermore, the need to sustain breastfeeding during the period of complementary feeding has not received adequate attention.

Four strategies, which are not mutually exclusive, are proposed to improve complementary feeding: education to enhance the quality of home-prepared foods, micronutrient supplementation, processed complementary foods, and education to enhance feeding behaviours. Each strategy has its advantages and limitations. Studies show that interventions can result in increased intake of nutrients from complementary foods, particularly if they are fortified with micronutrients, but their potential for displacing breast-milk intake has not been measured.

The impact on growth of improved complementary foods is not clear. On the other hand, when nutrition education trials and large-scale programmes include an emphasis on breastfeeding, e.g. increasing exclusive breastfeeding during the first 4–6 months – not just improved complementary foods – a growth effect is likely to be observed. It is thus important to sustain breastfeeding while improving complementary feeding and to be cautious about recommendations on meal frequency or amount of complementary food offered so as to avoid excessive displacement of breast milk. If energy intake is low, the reasons need to be identified. Caregivers should be attentive to children’s hunger and remain alert to the reasons for any loss of appetite.

This observation reinforces the need for comprehensive, systematic and participatory approaches for improving complementary feeding that will address a full range of child-feeding practices. Such approaches necessitate the conduct of feasibility and acceptability trials, choosing strategies that are appropriate to different populations, and developing effective delivery systems (including education and training) in coordination with existing programmes. Monitoring and evaluation are other important elements.

The WHO Multicentre Growth Reference Study, currently under way in six countries, was described as a helpful tool for monitoring the growth and nutritional well-being of infants and young children. Among its objectives is to provide accurate national and community estimates of under- and overnutrition.

Effective models for supporting breastfeeding women
presented by Dr Rukhsana Haider

An investigation of existing breastfeeding promotion programmes, both inside and outside the health care system, shows that those implemented in developing countries prior to the Innocenti Declaration and the launch of the Baby-friendly Hospital Initiative encouraged breastfeeding for two years. They were successful in increasing breastfeeding rates largely because of massive media support and a multifaceted approach. Thereafter, as the focus shifted to increasing the rate of exclusive breastfeeding for younger infants, breastfeeding for the older child tended to be overlooked. Even international agencies, doctors and academics have not strongly advocated continued breastfeeding beyond one year of age in developed countries, while support within the health care system is either ill-defined or non-existent.
A look at BFHI, family planning programmes, nutrition programmes for mothers and children, and the Women, Infants and Children (WIC) supplementary feeding programme in the USA, which provides peer counsellor support to low-income communities, shows that there are no programmes that actively promote or support breastfeeding for up to two years of age or beyond. A number of hospital-based systems have a postnatal follow-up support component either in the hospital or in the community, and they have been effective in increasing the duration of exclusive, or any, breastfeeding where there has been individual or group interaction with lactating mothers. However, the duration of support tends to be rather short.

Outside the health care system, support providers, such as community-based counsellors and mother-to-mother support groups, have been the most effective in initiating exclusive breastfeeding. However, their success in increasing breastfeeding duration beyond one year is unknown. Sustainability and payment for these counsellors and support groups are important issues, which need to be addressed.

The curricula for medical and nursing students do not adequately cover breastfeeding benefits and management, and the content and duration of special training courses or sessions vary considerably. Most courses do not give enough emphasis to sustaining breastfeeding, nor do they devote time to demonstrating, in practical terms, how this can be achieved. The most effective training programmes are those that provide group training followed by a period of apprenticeship.

**Integrating support for breastfeeding and complementary feeding into the wider health care system**
presented by Dr Katherine Krasovec

Interaction between the health care system and mothers can either support or undermine optimal feeding practices. It is therefore necessary to understand the health care system and those who influence it so as to intervene at key opportunities to provide optimal feeding services and support for mothers and other influential household members.

Antenatal, perinatal and postpartum care services, and child-care services to six months postpartum, are necessary to promote breastfeeding initiation and exclusivity. In addition, services to reach young infants who are not sick need to be developed or strengthened if they are to receive adequate care. To promote extended duration of breastfeeding and appropriate complementary feeding, interventions within curative and preventive health services for infants and young children are necessary up to at least two years of age. In addition, improvements are likely to be needed in hospital care for infants and mothers, women’s health services, and family planning, HIV/AIDS, and emergency and humanitarian assistance efforts.

Fortunately, most of the needed interventions can be delivered through existing services. However, specific infant feeding components need to be integrated into these services and their overall quality and responsiveness should be improved. A few specific services may have to be added in some contexts, such as routine postpartum care in the first week or referral care, to help solve severe infant feeding and nutritional problems. Since many women in developing countries are currently not reached by health services, efforts in health facilities need to be linked with outreach programmes to provide effective support
to these women. Published research has shown that how well an intervention is implemented is more important than what specifically is implemented or by whom.

Governments, as signatories to the Convention on the Rights of the Child, are responsible for the protection, promotion and support of optimal feeding as a human right. They should therefore give this responsibility high priority in their health care systems, and key stakeholders should be co-opted as allies in these efforts. At the same time, the negative influence of stakeholders who are undermining these efforts needs to be minimized.

Infant feeding interventions also need to deal with underlying factors in the health system that can help or hinder their impact. Examples include financing and resource allocation, organization and management, health worker motivation, legal and regulatory issues, and demand-creation strategies. The practices most often implemented thus far are those that save time and money for the health system, e.g. removal of formula, glucose water or supplements in maternity wards, and establishment of rooming-in. The more time- and resource-consuming interventions, e.g. education and counselling, are often neglected partly because policy-makers and administrators are not aware of their potentially higher cost-benefit ratio. Counselling and education are also harder to implement effectively as they may require more organization, additional resources, more highly motivated and skilled staff, legal and regulatory support and, in some cases, additional staff.

Increasing the demand for access to high quality health services should be part of efforts to improve infant feeding and women’s and infants’ health and nutritional status and survival. Mothers and infants deserve better access to higher quality health care in developing countries, and this includes good infant feeding care and support.

**Strengthening and expanding the Baby-friendly Hospital Initiative**

presented by Dr Veronica Valdés

Launched in 1992, the Baby-friendly Hospital Initiative (BFHI) has been one of the most successful global initiatives involving WHO and UNICEF. By January 2000, 14,826 hospitals in 132 countries had been certified as “baby-friendly” and many more are working towards achieving certification. The BFHI’s initial success stemmed from the fact that it offered a clear, common, measurable target for breastfeeding advocates to promote; the timing was right as its launch followed governments’ commitments to the World Summit for Children; there was a critical mass of breastfeeding advocates around the world; and it offered a return to natural practices that were being disrupted. In addition, training of health workers has been critical to the implementation of changes in hospitals (such training will be needed on a continual basis until university curricula for health professionals include the essential aspects of BFHI practices).

Some of the unplanned consequences of BFHI include friendlier staff and improved care for mothers in hospitals, fathers’ participation in the birth process, a more positive public response to the health system, multidisciplinary teamwork, reduction of physiological jaundice and phototherapy, and reduced infant abandonment (largely due to early mother-baby contact and rooming-in, which helps establish a close bond). Other positive developments include the presence, if desired, of doulas and family members to give emotional support during delivery; promotion of kangaroo care for pre-term infants;
increased maternal care for sick infants in paediatric wards; and, in some cases, extension of the Initiative to community facilities known as mother-baby-friendly health centres.

Some major challenges to the spread of BFHI include budgetary reductions by agencies, governments and health facilities; resistance to change and difficulties in the implementation of some of the Ten Steps to Successful Breastfeeding (particularly steps 3 and 10, which concern direct counselling). Assessment, reassessment and monitoring have also been more difficult than initially expected. Although they are essential for assuring the Initiative’s sustainability, they are costly and time-consuming processes. Their final success may depend on incorporating standards into national assessment and monitoring systems as part of hospitals’ quality control programmes.

**Policies and practices to support breastfeeding in the workplace**

presented by Dr Judith Galtry

One of the most significant changes in recent years has been the increase in women’s labour market involvement during the childbearing years. This change means that breastfeeding has come to represent an increasingly significant issue, nationally and internationally, for policy-makers in the fields of labour and health.

In general, maternity protection is extended only to women workers in the formal sector, especially those in permanent full-time jobs. Women in developing countries, who are concentrated in the informal sector, are therefore less likely to be protected, particularly with regard to breastfeeding. Even in the formal sector, especially in countries with high unemployment rates or loosely enforced labour laws, workers often face difficulties securing the maternity protection to which they are legally entitled. Finally, there are a small, but growing, number of women in long-term career and professional occupations who tend to take only short breaks from full-time paid work following childbirth. This diversity in women’s work patterns complicates efforts to design policies, which support the integration of breastfeeding and paid work.

The unique needs of women workers arising from their reproductive role should be recognized as a social function that is of critical importance to a healthy society, rather than as a private choice of individual women. Maternity protection involves a number of health and labour policy issues, including health protection for working women and their unborn children, job retention and income replacement, equal opportunity measures for women workers, and equitable labour laws in general.

Research increasingly suggests some key employment-related variables that are significant in determining breastfeeding practices among women in paid work, for example the timing of their return to paid employment and the pattern, amount and type of paid work. A period of paid maternity leave is generally recommended as an important factor positively influencing the duration of breastfeeding.

As noted by the International Labour Organization (ILO), the need for maternity protection has to be viewed against the extremely high levels of infant and maternal mortality and morbidity still found in developing countries. In their 1997 technical advice to the ILO’s Maternity Protection Committee, WHO and UNICEF recommended the
need for maternity protection provisions, which would support their recommendations for exclusive breastfeeding.

An ILO analysis of statutory maternity leave entitlements in different countries in 1997 showed that 119 countries provide leave for at least – and some longer than – the minimum standard of 12 weeks, and 62 provide statutory leave of at least 14 weeks (as outlined by the Maternity Protection Recommendation of 1952 and supported by a European Union Directive). Only in 31 countries is the entitlement less than 12 weeks.

While governments need to take primary responsibility for introducing maternity protection measures to facilitate breastfeeding, employer workplace initiatives are often critical to the successful implementation of breastfeeding support in paid work. Historically many women’s organizations and trade unions have not supported measures to integrate breastfeeding in paid work. Although this is changing, much work needs to be done to positively influence these potentially powerful groups.

Reaching women in the informal sector is seen as another major challenge, which is being taken up by such initiatives as the Mother-friendly Workplace Initiative. Other successful models should be identified and replicated where possible.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the United Nations Convention on the Rights of the Child (CRC) are powerful tools to highlight national and international obligations. At the same time, however, they involve complex issues.

It is generally very costly for women to resign from paid work in order to breastfeed their infants. Yet, protecting this right is cost-effective for society in terms of improved health of women and infants that thereby reduces health care costs. Meanwhile, increased levels of human capital through enhanced health and cognitive skills of breastfed infants also contribute to improved economic performance.

**Strengthening implementation of the International Code of Marketing of Breast-milk Substitutes**

Presented by Dr Ellen Sokol

The International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions play an essential role in efforts to protect, promote and support breastfeeding. They are the only international instruments that specifically focus on protecting breastfeeding against inappropriate marketing practices. Although progress in their implementation has been significant in recent years, much more needs to be done.

The International Baby Food Action Network’s International Code Documentation Centre (IBFAN, Penang, Malaysia) has information for 191 countries showing that 49 have legally enforceable measures for implementing all or many of the Code’s provisions, 20 have voluntary agreements, and 122 have no legally enforceable measures. Few countries have implemented all of the Code’s provisions. WHO, UNICEF, nongovernmental organizations and funding agencies should thus work together to advocate strong, clear and unambiguous national measures, including legislation, with appropriate sanctions and enforcement as the most effective means of Code implementation.
implementation. This can be done through advocacy, training about Code compliance, technical support, encouraging country reporting, funding the advocacy efforts of nongovernmental organizations, sensitizing health workers and professional associations, and raising public awareness.

Often, the way in which the provisions of the Code are interpreted and applied by the processed food industry poses serious obstacles to promotion and protection of breastfeeding. A group should be established to make recommendations about the effects of marketing techniques on breastfeeding. Countries should be provided with technical assistance in drafting messages about the harm to breastfeeding from the promotion and advertising of products for use in infant and young child feeding, and in regulating such advertising through the mass media, including the Internet. The ICDC Code Handbook and Model Law would be a useful tool for this purpose.

Independent monitoring of Code compliance is extremely important, yet few countries have effective monitoring and enforcement mechanisms. Another possibility could be the setting up of a monitoring mechanism within the United Nations system, although this was originally rejected by the Health Assembly in 1981. Successful measures should be held up as models for other countries. Weak – or no – Code implementation in major industrialized countries sets a bad example, as does the fact that about half of the Member countries of the European Union allow advertising of infant formula to the general public.

Failing legally enforceable measures in most countries to ensure full compliance with the Code, other measures to stop inappropriate or harmful marketing practices are needed to persuade companies to change their inappropriate practices.

**Infant and young child feeding in the context of globalization**

*presented by Ms Judith Richter*

Globalization can be viewed in economic, political, social, cultural and technological terms. It can have a direct or indirect impact on infant feeding practices through such aspects as the liberalization of trade, e.g. under the World Trade Organization, the increasing powers of transnational corporations, the loss or abdication of responsibility for decision-making by sovereign states, increasing inequalities, the “feminization” of poverty, and a cutback on caring activities.

The **cultural** impact of globalization on infant feeding includes the spread of a bottle-and jar-feeding culture, a breast-is-best counterculture, and new knowledge in the area of young child feeding and care. In the **technological** sphere, the result is a faster spread of knowledge about health, faster communications generally, and increased use of sophisticated marketing practices and public relations.

Among the reasons why optimal feeding practices have not been achieved are the lack of appropriate information or the spread of misinformation; the promotion and marketing of breast-milk substitutes; an environment which undermines breastfeeding; and poverty, which disproportionately affects women and children.
The public should insist on the regulation of marketing practices, and voluntary agreements should not be allowed to replace binding regulations in this area. The processed food industry should deliver good quality, reasonably priced products in a manner that is consistent with the principles and aim of the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions. To prevent conflict of interest, infant food manufacturers should not be involved in formulating infant feeding policy. Clear guidelines are needed on interaction with commercial enterprises to avoid the risks involved in partnerships.
SECTION III

Discussion and recommendations

There was general agreement on many of the issues concerning the protection, promotion and support of optimal infant and young child feeding practices.

Recommendations specific to exclusive breastfeeding, complementary feeding and feeding in difficult circumstances

Increasing rates of exclusive breastfeeding

The importance of early interventions for promoting exclusive breastfeeding was discussed; this is a critical period when mothers encounter breastfeeding problems, such as engorgement or breast infections, and when they decide whether or not to breastfeed exclusively. It was pointed out that, in some environments, it is necessary to overcome strong cultural constraints to exclusive breastfeeding. For example, in Thailand babies are given water to clean their mouths, and in Vietnam rice water is given in the belief that it makes babies strong (the contrary is true, since it inhibits iron absorption from breast milk).

The need to provide a supportive environment for breastfeeding women was stressed. This involves families, communities, employers, governments, and the private sector. One participant mentioned that in Malaysia, for example, the Government offers tax incentives to organizations and companies that provide breastfeeding facilities. Other suggestions were that hospitals should set an example by providing appropriate breastfeeding facilities to their own workers, and professional bodies should be co-opted particularly for the purpose of making private hospitals aware of “baby-friendly” practices.

It was considered particularly important to assure a “continuum of care” by extending baby-friendly practices to care after hospital discharge. One participant said that the success of this approach is evident in China, for example, where the rates of exclusive breastfeeding in both urban and rural areas increased as a result of community health workers providing follow-up support to mothers at regular intervals depending on their needs.

It was proposed that interventions to promote exclusive breastfeeding should also include information on when and how to introduce complementary feeding.

Complementary feeding

Since the concept of complementary feeding is subject to different interpretations, it was suggested that it be made more explicit in the draft strategy. Complementary feeding campaigns should specify that this includes breastfeeding. They should also emphasize safety and adequacy (that is, in terms of energy and micronutrient density and feeding frequency). Stunting and growth failure occurs from 6 to 24 months of age, which makes
the issue of complementary feeding particularly important. There was some discussion about the need for more work to be done in the area of growth monitoring to promote interventions for preventing growth faltering.

Some of the recommended actions at the global level include the need to achieve consensus on guidelines for complementary feeding; development of recommended nutrient composition for processed fortified complementary foods; development of rapid tools for estimating the prevalence of micronutrient deficiencies in children under two years of age; initiation of research on optimal meal frequency for different ages (while not compromising breastfeeding), safe processing and storage of complementary foods, and reducing the risks associated with micronutrient supplementation or fortification; and modification of the International Code to ensure that marketing of commercially available complementary foods does not undermine continued breastfeeding or promote complementary feeding before it is nutritionally necessary.

Participants agreed that much has been learned about foods and feeding in terms of frequency and food composition and the importance of zinc, iron, vitamin A and iodine in a child’s diet. Dietary interventions should thus bear in mind the nutritional content of foods and feeding practices, including frequency of feeding. Also important is the role of the mother or caregiver in responding to a child’s needs and in the way he or she feeds the child.

It was proposed that home preparations should be promoted with special attention given to the local context. However, many working women living in cities have no time to prepare complex foods. Efforts should therefore be made to encourage preparations of appropriate, nutritionally adequate complementary foods that are easy to prepare. One participant suggested that the integrated management of childhood illness (IMCI) might be a good delivery system for promoting complementary feeding as it already has a nutrition component. However, another participant warned against the “medicalization” of child nutrition. She said that particular attention should be paid to formula-fed children (i.e. those who are not breastfed), as they are an especially vulnerable group.

In order to measure trends in infant feeding, a participant said that better indicators are needed which would help determine the extent to which the breastfeeding component in complementary feeding might be changing. There was a proposal that the consultation make a recommendation for developing a standard methodology for collecting data on complementary feeding. This may require the creation of an expert group, which could build on existing recommendations. Training in information collection was believed to be important, as is the need to collect information on the quality of complementary feeding. All data sources should be carefully examined and coordination of the information reported should be improved. Research to determine at what stage different complementary foods should be introduced was considered essential; this would also be useful for decision-makers.

**Feeding in difficult circumstances**

It was observed that, in emergency situations, international NGOs are frequently either not aware of, or ignore, guidelines on nutrition and breastfeeding, thereby undermining existing efforts to strengthen and support breastfeeding practices. Experience shows that
inappropriate foods are often distributed and this should be corrected by establishing a uniform policy for all aid agencies.

Some participants said that particular attention should be given to preventing “spill over”, that is, the needless use of artificial feeding by women who are HIV-negative or untested. Also, children who are not breastfed need additional psychosocial stimulation; they should be cup-fed, rather than bottle-fed, so that they are held by their caregiver.

Providing health workers with pre-service education and training on HIV and optimal breastfeeding was emphasized. It was important to ensure that health workers are able to provide mothers – and other family members who might influence mothers’ decisions – full information and counselling to enable them to make informed choices. It was pointed out that in some countries, HIV testing and counselling are not always possible; in many cases, a shortage of staff means that health workers are already overburdened, and to add counselling to their functions can be difficult. In the absence of adequate staff, the community’s role becomes especially important.

Participants discussed the need for improving maternity care and care for children with HIV/AIDS. Consideration could be given to special programmes to protect HIV-affected families, especially as hospitals are often reluctant to treat HIV-infected babies. Other approaches proposed were prevention of pregnancy in infected mothers, and education for adolescents.

Other actions to protect, promote and support optimal feeding

Preservice and in service education and training were considered to be very important. Preservice training in particular would help ensure sustainability in the implementation of “baby-friendly” practices and would be more cost-effective in the long term than inservice training. At present, curricula for medical and nursing students do not adequately cover breastfeeding or provide students with the requisite clinical skills to treat problems. Until such curricula are changed, sustained training needs to be provided at all levels of the health care system. It was generally agreed that breastfeeding training for health workers should be improved to include counselling which emphasizes sustained breastfeeding for up to two years or beyond.

Several participants spoke of the need for health workers and humanitarian aid workers to be made aware of BFHI practices and of their responsibilities in complying with the International Code of Marketing of Breast-milk Substitutes.

Information and advocacy needed considerable reinforcement in order to create greater awareness among by the general public and policy-makers of the benefits and importance of exclusive breastfeeding and timely and appropriate complementary feeding. The importance of conveying a consistent message about the duration of exclusive breastfeeding, and continued breastfeeding with complementary foods for up to two years of age or beyond, was also stressed. It was suggested that the mass media should be used to promote breastfeeding as a human right for women and children. Some participants spoke of using role models as a particularly effective approach. It was pointed out that media images generally show small babies – but rarely older children – breastfeeding, and that a greater effort should be made to promote breastfeeding among older children.
The Baby-friendly Hospital Initiative. Concern was expressed at the reduced rate of increase in BFHI hospitals in recent years, and funding was identified as a major problem in sustaining the BFHI in many countries. It was proposed that other ways should be identified to secure funding for continuing and building on this initiative. One speaker said that the BFHI had worked well in public hospitals in her country, Malaysia, owing partly to government funding. However, its implementation in private hospitals had been more difficult. Funding was also seen as a problem in industrialized countries, particularly with regard to preservice and multidisciplinary training. A participant said that in the United Kingdom, doctors and nurses did not accept courses that were not fully referenced, and that it was therefore important to update textbooks and other materials to include BFHI information.

It was suggested that the Initiative be viewed in terms of the mother-baby dyad, with as much attention given to the well-being of the mother as to that of the baby, especially to the mother’s care during delivery (in this connection, the WHO publication, Care at Birth, could be linked to BFHI implementation). The neonatal period and rates of neonatal mortality, in particular, should be considered in relation to the BFHI.

Reassessment was considered necessary to ensure that BFHI does not end after certification and to help maintain standards. It was suggested that this should be made part of governments’ commitment to maintain overall health care standards. At the same time, hospital directors and administrators needed to be made more aware of BFHI and how they could become involved in the monitoring of BFHI practices in their institutions. This should include monitoring compliance with the International Code of Marketing of Breast-milk Substitutes. As for private hospitals, one participant said that, if enough public awareness and demand were created for BFHI standards, these institutions, too, would eventually have to adopt BFHI practices.

A number of participants agreed that implementation of Step 10 of the BFHI – fostering establishment of breastfeeding support groups and referring mothers to them – had been particularly weak. Yet, experience showed that community support, particularly one-to-one peer counselling, was among the most effective ways to improve breastfeeding rates. The establishment of community breastfeeding support groups and links with hospitals and health centres, including the setting up of effective two-way referral systems, were considered extremely important for ensuring a “continuum of care” for breastfeeding mothers after their discharge from maternity services. It was agreed that in developing countries, in particular, where many women lacked access to hospitals or clinics, the creation of community-based breastfeeding support groups was especially important.

Policies and practices to support breastfeeding in the workplace

The need to raise awareness and the importance of national and international support for breastfeeding breaks in the workplace was widely discussed. Lack of coordination between the International Labour Organization and other United Nations agencies and trade unions on the issue of breastfeeding in the workplace was a matter of concern. It was particularly urgent to address this issue with a view to influencing discussions on the revision of the Maternity Protection Convention at the ILO Conference in June 2000. It
was pointed out that some countries used productivity as an excuse for not ratifying this ILO Convention.

One speaker cautioned that when workers are being increasingly laid off, it is difficult for them to be motivated to protect breastfeeding. It therefore becomes all the more important to impress upon governments the need for legislation and the creation of an enabling environment that requires breastfeeding advocacy in the workplace at the highest political level. This is not just a women’s issue, but one that needs to be placed in the overall context of care that involves society as a whole.

One proposal was to market and certify workplaces that are supportive of breastfeeding, such as the Mother-friendly Workplace Initiative. At the same time, this could be linked with BFHI – hospitals should set an example by providing their own health workers with adequate labour protection.

Compliance with the International Code of Marketing of Breast-milk Substitutes

A participant cautioned that health officials need to be alert to loopholes used to promote products in ways that are inconsistent with the principles and aim of the International Code. For example, it was pointed out that the Code does not cover the promotion of supplementation during pregnancy and lactation and lactose-free products for use during diarrhoea. Also, companies sometimes approach mothers or health workers directly with low-cost or free formula or they resort to various forms of pressure or incentives such as education scholarships for health workers.

There was a proposal that consumer lawyers, NGOs, food and drug agencies and national authorities should work together with ministries of health to monitor violations of the Code. However, sanctions for Code violations are often too weak to act as a deterrent. A participant suggested that public pressure could push manufacturers and distributors to comply by naming and shaming those companies that violate the Code. It was explained that WHO seeks to strengthen implementation of the Code worldwide by working with NGOs and through dialogue with companies to try to understand where the problems lie and how they can be overcome.

Participants emphasized the need to monitor unethical marketing of foods for infants and young children for use in emergency situations. This also requires appropriate education and training of humanitarian aid workers about compliance with the International Code.

It was suggested that, just as proposals have been made to use Codex Alimentarius standards to support optimal feeding, the Code should be used to find ways of providing mothers with low-cost high quality complementary foods, especially in the informal sector in urban areas, in ways that do not undermine sustained breastfeeding. There was also a proposal to investigate how best to market breast milk as vastly superior to any substitute through education, especially the young, and by using high-profile role models.

Globalization

In practical terms, as a result of globalization, countries are confronted with changing political and social relationships and numerous economic and trade agreements about which many policy-makers have little knowledge. Many countries need advice on how
to regulate marketing practices so that they comply with the International Code. There is a need to work with organizations, for example the World Trade Organization and ILO, to ensure that women’s and children’s rights are fully protected.

Revising the draft strategy

There was extensive discussion about the optimal duration of exclusive breastfeeding and when complementary feeding should begin. Several participants proposed that the IMCI recommendation of “at least 4 months and, if possible, 6 months” be changed to state, “about 6 months”. However, others believed that until there is new and conclusive scientific evidence to back this position, the former wording should remain. WHO is addressing this issue through a systematic review of all available scientific evidence, including the last review in 1995 by a WHO Expert Committee. Findings, which will be available early in 2001, will assist in clarifying recommendations on the optimal duration of exclusive breastfeeding based on the best and most up-to-date worldwide evidence.

Describing the follow-up process, Dr Clugston said that the Director-General would inform the World Health Assembly, in May 2000, about the outcome of the technical consultation, and in May 2001 about progress achieved in preparing a draft global strategy for infant and young child feeding. In 2002 the Director-General will present the completed and tested strategy to the Executive Board and World Health Assembly for debate and decision. Over a period of 18 months Member States would thus be evaluating and commenting on the draft strategy and there would be a series of regional meetings to ensure that the strategy is truly global, with ownership by all countries. Meanwhile, as recommended by the technical consultation, the issue of complementary feeding would also be carefully examined.

Dr Shrimpton agreed with Dr Clugston about the critical importance of the issue of ownership and emphasized the need to resolve the issue of the recommended duration of exclusive breastfeeding. He suggested that some of the conclusions of the meeting should be conveyed to the SCN Working Group on Breastfeeding and Complementary Feeding in order to take the process forward. He hoped that there would be a joint strategy available by September 2000 so that the UNICEF Executive Board can be fully informed about the strategy’s evolution.

In her closing remarks, Poonam Khetrapal Singh (Executive Director, Sustainable Development and Healthy Environments) said that WHO had identified infant and young child nutrition as a vital issue for health and sustainable development. As an economic and social investment likely to have the highest possible returns, it was also an essential aspect of poverty reduction. Yet, it has been one of the most difficult areas in which to move forward. She believed the technical consultation was a significant step in the development of a global strategy and commended the wealth of valuable ideas that had been presented.
The meeting proposed building on existing successes; it reaffirmed the importance of the Innocenti Declaration, adding new emphasis to exclusive breastfeeding, and extending the same principles to mothers and infants living in difficult circumstances; and it identified the need for new initiatives to improve complementary feeding and additional research and development for effective programmes and policies. Moreover, the strategy should clearly articulate the need to make skilled help available to mothers, in health services and in the community, to guide and support them in optimal feeding. This required investment and training at all levels.

The importance of the overall context in which the strategy should be implemented had also been highlighted, including a shared rights-based approach, adequate maternity protection, and a regulatory framework such as that provided by the International Code of Marketing of Breast-milk Substitutes.

WHO and UNICEF would continue working together to develop the strategy as outlined earlier by Dr Clugston, for final discussion and endorsement by WHO’s Executive Board and the World Health Assembly in 2002. She hoped the final product would inspire governments and agencies, secure their political commitment, mobilize resources, and assist in moving forward to ensure enduring improvements in infant and young child feeding.
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<td>08.30-09.00 Registration</td>
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<td>Theme: Effective approaches/</td>
<td>09.00 Presentation of the IYCF</td>
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<td>09.00-10.30 Opening by WHO</td>
<td>09.00-09.45 Increasing rates of exclusive breastfeeding, Presentation &amp; discussion.</td>
<td>instruments for strengthening IYCF strategy</td>
<td>Strategy</td>
<td>10.00 Discussion and clarifications</td>
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<td>Address by DG (WHO)</td>
<td>09.45-10.30 Improving complementary feeding practices and sustained breastfeeding, Presentation &amp; discussion.</td>
<td>09.00-09.45 Strengthening and expanding the Baby-friendly Hospital Initiative, Presentation &amp; discussion.</td>
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<td>Address by Deputy EXD (UNICEF)</td>
<td>10.30-11.00 Coffee/Tea break</td>
<td>09.45-10.30 Policies and practices to support breastfeeding in the workplace, Presentation &amp; discussion.</td>
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<td>10.30-11.00 Coffee/Tea break</td>
<td>11.00-11.45 Effective models for supporting breastfeeding women, Presentation &amp; discussion.</td>
<td>11.00-11.45 Strengthening implementation of the International Code of marketing of breast-milk substitutes: Evaluation of progress, Presentation &amp; discussion.</td>
<td>11.00 Working Groups (3-4)</td>
<td>11.00-11.30 Plenary presentation of draft and discussion. Next steps for the development of the Strategy and suggestions for resolving gaps identified.</td>
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<td>11.00-12.20</td>
<td>11.45-12.30 Integrating support of breastfeeding &amp; complementary feeding into the health care system, Presentation &amp; discussion.</td>
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<td>11.00-12.30 Discussion</td>
<td>12.30-13.00 Introduction to Working Groups (4), Selection of chairs &amp; rapporteurs.</td>
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<td>14.00 Preparations of recommendations for Strategy</td>
<td>14.00 Plenary (cont(d)</td>
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<td>14.00-15.30 Working Groups</td>
<td>13.00-14.00 LUNCH</td>
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<td>14.00-14.45 Measuring progress in improving breastfeeding and complementary feeding practices, Presentation &amp; discussion.</td>
<td>15.30-16.00 Coffee/Tea break</td>
<td>14.00-15.30 Working Groups (cont)</td>
<td>15.30-16.00 Coffee/Tea break</td>
<td>15.30-16.00 Coffee/Tea break</td>
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<td>14.45-15.30 Update on recent developments and important key issues - HIV and infant feeding - Growth reference study</td>
<td>15.30-16.00 Coffee/Tea break</td>
<td>15.30-16.00 Coffee/Tea break</td>
<td>16.00-17.00 Recommendations from WGs in plenary</td>
<td>16.00 Agreed recommendations for Strategy</td>
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<td>15.30-15.45 Coffee/Tea break</td>
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<td>16.00-17.00 Presentation of recommendations from WGs in plenary</td>
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<td>15.45-16.30 Update on recent developments (cont.)</td>
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<td>17.30 RECEPTION</td>
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ANNEX II

TECHNICAL CONSULTATION ON INFANT AND YOUNG CHILD FEEDING
Salle A

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Titles

1. Measuring progress in breastfeeding and complementary feeding practices
2. Increasing rates of exclusive breastfeeding
3. Approaches for improving complementary feeding of young children
4. Strengthening and expanding the Baby-friendly Hospital Initiative
5. Integrating support for breastfeeding and complementary feeding into the wider health care system
6. Effective models for supporting breastfeeding women
7. Policies and practices to support breastfeeding in the workplace
8. Strengthening implementation of the International Code of Marketing of Breast-milk Substitutes
9. Infant and young child feeding in the context of globalization
WORKING GROUP RECOMMENDATIONS

Promoting exclusive breastfeeding

The promotion of exclusive breastfeeding will require a rights-based integrated approach. At the national level this will involve promoting the Ten Steps to Successful Breastfeeding\(^1\) both by increasing the number of BFHI-certified hospitals and extending baby-friendly practices to community care and primary care (which involves strengthening Step 10); ensuring Code implementation and enforcement; advocating legislation on maternity protection; and training – both pre-service and in-service – for improving knowledge about optimal feeding practices, and clinical skills with regard to lactation management and counselling.

The strategies proposed to achieve these objectives include increasing public awareness and demand for quality service and support, and increasing social awareness of the responsibilities of the community, and society in general, for supporting breastfeeding women. Information, education and communication should be carefully targeted, e.g. pregnant women, adolescents, family members who play a key role in influencing feeding decisions, and include effective culturally sensitive messages about the benefits of exclusive breastfeeding, including savings and optimal development and health outcomes. It is necessary to raise awareness of the benefits of breastfeeding, not only for children but also for mothers. Changes are needed to include information about breastfeeding in both school training curricula and preservice and inservice training courses. In the community, it is important to use mothers who have had successful breastfeeding experiences as peer counsellors and for training other peer counsellors and mother-support groups.

Approaches for improving complementary feeding of young children

A number of cross-cutting issues need to be considered when promoting optimum complementary feeding: poverty and food security, social marginalization, working women, communicating for behaviour change, aspects of early child care, reinforcing good practices, and greater attention to complementary feeding in emergency situations and during replacement feeding in HIV-prevalent areas.

Addressing these issues requires a systematic, participatory and coordinated approach which includes choosing appropriate and cost-effective feeding strategies for the target populations, conducting feasibility and acceptability trials, developing delivery systems (with educational, marketing, and distribution components), coordination with existing programmes, and setting up monitoring and evaluation systems.

Research and consultations will be required to develop consistent, evidence-based guidelines for complementary feeding with sustained breastfeeding. They should help give complementary feeding greater visibility and governments should be encouraged to adopt the guidelines.

In advocating timely, safe and adequate complementary feeding, the term “adequate” should be explained in terms of nutrient content, feeding behaviours and food safety.

Regarding processed, fortified and complementary foods, it is important to:
- develop a recommended nutrient composition; and

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• ensure that the marketing of commercially produced foods do not undermine sustained breastfeeding in the population as a whole (this also applies to food supplementation programmes, emergencies and replacement feeding).

Research is needed on several critical questions raised by the author in her background paper (Approaches for improving complementary feeding of infants and young children):
• Are there risks associated with micronutrient supplements or fortified foods, and what dosages are safe for different subgroups?
• What is the optimal meal frequency for different ages (and with respect to the energy density of local complementary foods) for ensuring adequate nutrition without compromising breastfeeding?
• What are the most effective ways for disadvantaged populations to process and store complementary foods to avoid microbial contamination?

The group supported the author’s recommendation for the need to develop rapid tools for estimating the prevalence of micronutrient deficiencies in children under two years of age (e.g. deficiencies of iron, vitamin A, zinc, riboflavin), and to develop indicators for complementary feeding that reflect not only the timing, but also other aspects of adequacy, such as nutrient quality, safety and feeding behaviours.

**Recommendations for feeding of children in exceptionally difficult circumstances, including HIV/AIDS and emergencies**

Major concerns include the inadequate and variable responses to optimal infant and young child feeding; varying standards of different agencies; and limited support to, and promotion of, breastfeeding in difficult situations, especially with regard to HIV-infected mothers. The following strategic priorities were proposed.

**Support** should be provided by ensuring that humanitarian aid workers and members of the affected populations are trained to assist mothers, families and caregivers to feed infants and young children; assisting caregivers for optimal feeding of severely malnourished children; and using baby-friendly practices for the care of mothers and children.

**Protection** of optimal feeding in HIV-prevalent areas should include provision of accurate information to youth, men and women about risks and prevention of HIV infection; and information about maternal HIV infection as well as methods to avoid infecting infants during pregnancy and lactation. Efforts should be made to ensure implementation of the International Code and relevant World Health Assembly resolutions, particularly to help prevent any “spill over” of artificial feeding to the general, i.e. non-HIV-infected, population.

**Promotion** requires ensuring optimal feeding practices for HIV-negative mothers and those of unknown status; access by HIV-negative mothers to HIV prevention methods; access to high quality counselling on infant feeding options to enable mothers to make a fully informed choice about feeding method free from commercial pressures; and support to mothers necessary to carry out their decisions.
Effective models for supporting breastfeeding women

The goal should be to provide every mother with inter-personal counselling and support throughout the continuum of care – from the prenatal period to at least 2 years postpartum – for appropriate breastfeeding and complementary feeding.

The proposed approaches to achieve this include:

- developing, at the national level, policies which explicitly state the importance of breastfeeding for up to 24 months;
- developing comprehensive curricula for training health workers and community counsellors in breastfeeding and complementary feeding;
- using the media to create a cultural environment supportive of breastfeeding for two years; and
- strengthening the International Code of Marketing of Breast-milk Substitutes to take account of the feeding needs of infants up to two years of age or beyond.

This will require appropriate institutions and structures to ensure, monitoring and enforcement. Finally, it will be necessary to develop different models for providing continuing support for appropriate breastfeeding and complementary feeding, as well as disseminating relevant information to enable countries to choose those practices which best suit their particular conditions and cultural contexts.

Integrating support of optimum infant and young child feeding practices into the wider health care system

Obstacles to integrating breastfeeding into all levels of the health care system include:

- lack of comprehensive policies that address issues related to breastfeeding and complementary feeding;
- problems in motivation, and attitudes of health workers and lack of incentives for them to practice optimal infant feeding themselves;
- lack of continuity of care for mothers; inconsistent messages about optimum feeding practices from different health services;
- “territorial protection” among professionals;
- deteriorating health care systems; and
- real and potential conflicts of interest for health professionals with regard to implementation of the International Code.

Health policies for optimal infant feeding should be developed and implemented using an integrated approach. This implies that such policies will be multidisciplinary, involve various stakeholders and include appropriate training. Basic education of health care providers requires changes to training curricula, and finding ways to increase their motivation. The development of referral networks is essential, as is the need to develop tools for monitoring infant feeding practices.

Strengthening and expanding the Baby-Friendly Hospital Initiative

The BFHI can be strengthened in the following ways:

1) Training and education need to be multidisciplinary and multifaceted involving not only health professionals but also administrators and policy-makers. Preservice and inservice training should include information about the International Code and emphasize responsibilities in assuring compliance with it.
2) *Monitoring, assessment and reassessment* is a continuous process. It involves analysis, assessment and action; retraining issues; data collection; the need to maintain motivation; and emphasis on in-course training in counselling and clinical skills. Professional associations should also be included in this process.

3) *Expanding BFHI* to community health services, and other services in the health care system such as neonatal, paediatric and obstetric services, should be a strategic priority. Baby-friendly practices should also be incorporated into different programmes such as safe motherhood, IMCI and family planning. This is necessary to assure a “seamless continuum” of support for breastfeeding mothers and for infant and young child feeding in general.

4) *Funding* for strengthening the initiative would need to be sought from public and private sources at the national and international level.

5) *Other important issues* – baby-friendly practices should be promoted in exceptionally difficult circumstances, for example during wars, famine, catastrophes and in HIV-prevalent areas, through advocacy and awareness-raising among the populations affected as well as among humanitarian aid workers and aid agencies.

6) *Social marketing* at local, national and international levels is also important.

**Policies and practices to support breastfeeding in the workplace**

A WHO/UNICEF working group should draft recommended ideal conditions for protecting the health of working women and their infants, including by facilitating breastfeeding and complementary feeding. Its recommendations would recognize that the minimum standards would be what are practical, but not necessarily ideal. WHO and UNICEF should encourage ministries of health and labour to work together to convey these recommendation to the ILO Conference meeting in June 2000.

Governments should establish multisectoral working groups, working closely with national breastfeeding committees, to protect the rights of working women to breastfeed. These groups would consist of representatives from ministries of health and labour, lawyers, employers, unions, consumers and working mothers from different sectors, including the informal sector.

Model policies should be set for enabling working women to breastfeed optimally, and examples provided of different options in different settings (especially the informal sector), with emphasis on flexibility. Examples should be provided to employers of how to calculate cost savings (including cross-country comparisons). This kind of information is useful for dissemination to governments, employers, unions and society in general, through all possible channels.

Employers of health workers should be in the vanguard in enabling their employees to breastfeed optimally, as a model for other employers and to allow health workers to be more effective in promoting breastfeeding.

Research for policy and advocacy should look into planned versus unplanned absences; actual total lifetime leave taken by males and females; and collect information on models that work, especially for women in the informal sector.
Strengthening implementation of the International Code of Marketing of Breast-milk Substitutes

A renewed focus on the need to stop inappropriate marketing practices that interfere with optimal infant and young child feeding is necessary in light of the accumulation of new scientific and epidemiological evidence of the importance of optimal infant and young child feeding. The International Code is one means of achieving this. Yet, Member States have sometimes been slow to implement the Code since its adoption in 1981.

The following strategies are recommended to achieve this goal:
- Utilize the human rights approach to advocate that States implement the Code, as part of their obligations under the Convention on the Rights of the Child.
- The Code should be viewed as a minimum standard in order to protect optimal feeding from inappropriate commercial practices.
- Encourage strong, clear and unambiguous national legislation for enforcement of the Code, and independent monitoring and sanctions. This includes encouraging countries to take action against companies that advertise their products through evolving technologies for cross-border advertising, such as the Internet, cable television and the print media.

Independent monitoring should be done at different levels and by multiple interest groups, including civil society organizations (without commercial interests), and support provided by international agencies (WHO and UNICEF) with public dissemination of the results. It is important to ensure that the Code is also applied in especially difficult circumstances such as emergencies and among communities living with HIV/AIDS.

Public health workers and professional associations should be made aware of the Code and their respective responsibilities in ensuring compliance with it. Special attention should be given to avoiding conflict of interest and financial dependence on commercial enterprises.

Working group recommendations for national and international action

Exclusive breastfeeding. Strategic priorities include providing information and counselling to breastfeeding mothers at all levels and wherever they give birth; health services should provide mothers with quality care, especially at the time of delivery; much more needs to be done to raise general awareness of the value and benefits of exclusive breastfeeding; particular attention needs to be paid to regulating the marketing of complementary foods consistent with the principles and aim of the International Code; creating enabling environments in the work place, home and public places is important, as well as overcoming cultural beliefs which undermine exclusive breastfeeding. At the institutional level it is necessary to strengthen the health care system and integrate BFHI with safe motherhood and other programmes.

Complementary feeding. This needs to be carefully defined specifying that adequate feeding includes attention to nutrient content and density, interactive/responsive feeding behaviours, safety, and appropriateness for different age groups; all health and nutrition programmes should provide both information and counselling in concert with community networks; and priority should be given to support research for developing international guidelines for complementary feeding and their adaptation to countries and communities. Clear policies need to be established concerning food fortification, and the marketing and distribution of complementary foods. Regulating inappropriate marketing practices and protecting families from misinformation are another strategic priority.
Mothers should be assured continual support, including adequate nutrition during lactation, until their children reach two years of age.

**Feeding in exceptionally difficult circumstances.** Ensure that women living in exceptionally difficult circumstances are supported to feed their children optimally in accordance with their rights; infants who are not breastfed should be considered a group at risk; ensure provision of standardized quality care for severely malnourished children; distribution of foods in emergencies should be done in accordance with the International Code and responsibility should be established for screening, coordination and monitoring of unsolicited food donations. In HIV-prevalent areas, ensure protection, promotion and support for optimal feeding practices in HIV testing, counselling and care/support services; policies, programmes and actions should be based on the principle of informed choice, free from commercial pressures; and guidelines on HIV and infant feeding should be periodically updated so that they are based on up-to-date scientific evidence.

**Obligations and responsibilities of governments and international organizations.** Government responsibilities concern primarily implementation and monitoring of the International Code; reinforcing and expanding the principles of the BFHI to other health services and the community; enacting maternity protection legislation, and monitoring its implementation in the workplace; ensuring a comprehensive programme of education on infant and young child feeding among both the general public and health professionals, with special emphasis on preservice training; and ensuring multisectoral collaboration in creating an enabling environment for optimum feeding practices by placing infant and young child feeding high on the political agenda.

International organizations are responsible for reaching agreement on a consistent evidence-based decision about the optimal duration of exclusive breastfeeding and when complementary feeding should begin; facilitating and supporting monitoring of BFHI and optimum feeding practices by setting standards and providing guidelines; and ensuring that there is no conflict of interest when collaborating with the private sector.