WORLD HEALTH ORGANIZATION

FIFTY-FOURTH WORLD HEALTH ASSEMBLY A54/7
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Global strategy for infant and young child feeding

Report by the Secretariat

1. Some 1.5 million children still die every year because they are inappropriately fed, less than 35% of infants worldwide are exclusively breastfed for the first four months of life, and complementary feeding practices are frequently inappropriate and unsafe. The growing scale, variety and frequency of major emergencies, the HIV/AIDS pandemic, complexities of modern lifestyles, coupled with continued promulgation of mixed messages and changing fashion with regard to breastfeeding complicate meeting the nutritional needs of infants and young children.

2. The Fifty-third World Health Assembly considered a report on infant and young child nutrition[1] submitted in accordance with resolutions WHA33.32 and WHA49.15, and Article 11.7 of the International Code of Marketing of Breast-milk Substitutes. In this connection the Health Assembly also considered a draft resolution[2] together with amendments presented during the debate.[3] The Health Assembly decided to refer the matter to the Executive Board at its 107th session.[4] The Board discussion is continued in the summary records.[5]

3. It is generally held that the global strategy being developed by the Organization should build on past achievements, particularly the Baby-friendly Hospital Initiative, the International Code of Marketing of Breast-milk Substitutes and the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. It should go further and emphasize the need for comprehensive national policies on infant and young child feeding, including guidelines on ensuring appropriate feeding of infants and young children in exceptionally difficult circumstances; and the need to ensure that all health services protect, promote and support exclusive breastfeeding and timely and adequate complementary feeding with continued breastfeeding.

4. Two principles have so far guided the development of the strategy: it should be based on science and evidence, and it should be as participatory as possible, seeking inputs from all parties. Consequently, the work so far has involved extensive review of scientific literature and results of eligible studies, and technical consultations. The latter have focused on key elements of the strategy, such as that organized by WHO and UNICEF which brought together experts in strategic and

[1] Document A53/7.

[2] Document A53/A/Conf.Paper No.3.

[3] See summary records of Committee A, seventh meeting in document WHA53/2000/REC/3.

[4] Decision WHA53(10).

[5] Document EB107/2001/REC/2.

programmatic aspects of the subject and representatives of ILO, UNHCR, UNAIDS (March 2000),[1] and on specific issues, such as the UNAIDS/UNICEF /UNFPA/WHO Interagency Task Team meeting on the prevention of mother-to-child transmission of HIV (October 2000). Country consultations have already taken place in Brazil, China, Philippines, Scotland, Sri Lanka, Thailand and Zimbabwe, and regional consultations are planned for all WHO regions between March and June 2001.

5. Consensus is emerging on a wide range of issues, with a growing acceptance that the aim of the strategy should be to help fulfil the right of every child to the highest attainable standard of health by protecting, promoting and supporting optimal feeding practices. The strategy should reaffirm the fundamental importance of appropriate feeding practices for infants and young children everywhere. A draft of the strategy will be circulated to Member States and interested parties for information and feedback before a finalized text is submitted to the Executive Board and the Health Assembly in 2002.

Exclusive breastfeeding

6. There is consensus on the need for exclusive breastfeeding and ways to achieve it, for example by improving the pre-service and in-service training of health professionals; by supporting the Baby-friendly Hospital Initiative; and by ensuring that mothers have access to accurate information and skilled help to foster optimal infant-feeding practices, and to overcome difficulties when they occur.

7. In 1995 the report of a WHO Expert Committee[2] and its Working Group on Infant Growth reaffirmed the suitability of the current recommended timing of exclusive breastfeeding and the introduction of complementary foods, that is four to six months of age.[3] As with all WHO global recommendations, however, it is intended that application of this recommendation should take into account local circumstances. The notion of "optimal infant feeding" cannot be defined in absolute terms in the abstract. Thus, when applying WHO's current infant-feeding recommendation as a guide for feeding practices – whether for an entire population in a given country or for an individual child – public health authorities need to take into account prevailing environmental, cultural and other risk factors, for example, the availability, safety and quality of complementary foods, the possibility of environmental contamination, morbidity and mortality patterns for infants and young children, and the child-spacing benefits of exclusive breastfeeding.

8. Meanwhile, WHO has also approached governments of Member States to determine whether a formal recommendation on the optimal duration of exclusive breastfeeding has been adopted and, if so, what was its technical basis. Thus far 131 governments have replied: 13 have no official policy; 65 recommend four, or four to six, months; and 53 recommend six, or about six, months. Results are also being compiled from 139 national paediatric associations.

9. WHO has undertaken over the past year a rigorous systematic review of the published scientific literature on the optimal duration of exclusive breastfeeding, and more than 2900 references have been

[1] See *Report of a technical consultation on infant and young child feeding: themes, discussion and recommendations* (documents WHO/NHD/00.8 and WHO/FCH/CAH/00.22).

[2] WHO Expert Committee on Physical Status. *The use and interpretation of anthropometry*. World Health Organization, Geneva, 1995 (WHO Technical Report Series, No. 854).

[3] This conclusion was based on analysis of pooled data concerning infants predominantly breastfed for at least four months, and partially breastfed to at least 12 months, from seven North American and European studies; deprived communities in India and Peru; seven centres in five countries (the WHO/HRP data set from Chile, Egypt, Hungary, Kenya and Thailand); and formula-fed infants in affluent populations. For additional detail in this regard, see: WHO Working Group on Infant Growth. An evaluation of infant growth. World Health Organization, Geneva, 1994 (document WHO/NUT/94.8).

identified for independent review and evaluation. The main outcomes being looked at include infant growth, morbidity and mortality, infant nutrient requirements and the adequacy of breast-milk supply, child development outcomes, and influence of environmental contamination. Relevant data have been extracted, ranked and analysed from all eligible studies. Following a global peer review, findings were discussed at an expert consultation (Geneva, 28 to 30 March 2001). The results of this process, including their implications for WHO's current global infant-feeding recommendation,[1] will be reported to the Health Assembly (see document A54/INF.DOC./4).

Complementary feeding

10. Timely, safe and adequate complementary feeding, with continued breastfeeding, needs to be made a high priority of global nutrition. Indeed, the continued faltering growth of many children worldwide suggests that complementary feeding practices remain inadequate in terms of timeliness, quality, quantity and safety. The draft strategy helps to identify what needs to be done to improve feeding practices through use of locally available and affordable foods, to determine guidelines and indicators of appropriate nutritional outcomes, and to expand the content and availability of objective and consistent information and educational materials for health workers, mothers and families. It also provides a framework for action-oriented research to identify causes of and remedies for growth faltering.

11. Where industrially processed complementary foods are concerned, as the Health Assembly noted in 1984,[2] inappropriate marketing practices contribute to faulty feeding practices through the promotion of infant foods for use at too early an age and through the promotion of products, (e.g. sweetened condensed milk) that are unsuitable for infant feeding. When complementary foods are being marketed, it is essential that product labels and related informational materials scrupulously promote their introduction at an age that is suitable for the *individual* infant. To help overcome abuses in this connection, WHO is taking various actions including working through the Codex Alimentarius process, in particular in the context of the revised draft Codex standard for cereal-based complementary foods. The aim is to ensure that the labels of all such products promote good feeding practices and to encourage a dialogue between a mother and her health worker as the basis for the mother's decision about when to begin complementary feeding in the light of her infant's *specific* needs. To provide further information for the formulation of recommendations on the age of introduction of complementary foods, studies are being planned of how health workers interpret recommendations and how mothers can be most effectively advised.

Feeding in exceptionally difficult circumstances

12. The best hope for averting the disability and death that are so common among infants and young children in exceptionally difficult circumstances is to ensure that they are adequately cared for and fed. However, meeting the nutritional needs of infants who are born with low birth weight, who are already malnourished or whose families are soioeconomically disadvantaged, as well as during natural disasters, famine, civil unrest, in refugee settings, and in the presence of HIV/AIDS (see paragraph 13) is complex and demanding. Particularly vulnerable are the nearly 70 million severely malnourished children among whom case fatality rates are 30% to 50%, whereas with appropriate feeding and care these rates should be no higher than 3% to 5%. New approaches are required both to meet the needs of this especially vulnerable population group and to cope with the growing scale, variety and frequency

[1] The World Health Organization's infant-feeding recommendation. *Weekly Epidemiological Record*, 1995, **70**:119-120; WHO's infant-feeding recommendation: http://www.who.int/nut/

[2] Resolution WHA37.30.

of new emergencies that threaten its nutritional status. The unique challenge faced by families and children in these circumstances requires special attention owing to the greatly heightened risks associated with artificial feeding and inadequate complementary feeding. WHO is developing guidelines and training modules to improve both emergency nutritional management and the effective management of severely malnourished children.

Mother-to-child transmission of HIV

13. There is continued concern that 10% to 20% of infants born to HIV-positive mothers may acquire HIV through breastfeeding, and recent studies indicate a heightened risk of transmission during the early months. However, evidence from one study shows that exclusive breastfeeding in the first three months of life may carry a lower risk of HIV transmission than mixed feeding does, possibly because infectious or allergic processes associated with the latter compromise the integrity of mucosal surfaces. The joint UNICEF/UNAIDS/WHO guidelines[1] issued in 1998 remain valid. All HIV-infected mothers should receive counselling that includes information about the risks and benefits of different feeding options, and specific guidance in selecting the option most likely to be suitable for their situation. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-positive women is recommended; otherwise exclusive breastfeeding is recommended during the first months of life. To minimize HIV transmission, breastfeeding by HIV-positive women should be discontinued as soon as feasible, taking into account local circumstances, the individual woman's situation and the risks of replacement feeding, including malnutrition and infections other than HIV. The final decision should be the mother's and she should be supported in her choice.

Maternity protection in the workplace

14. WHO participated throughout the preparations of the revised Maternity Protection Convention and related Recommendation that were adopted by the 88th session of the International Labour Conference in June 2000. WHO was instrumental in presenting evidence on protecting maternal health and promoting breastfeeding that contributed to a significant strengthening of the 1952 Convention through the inclusion of a new provision on protection from hazardous agents, an increase in the minimum length of maternity leave from 12 to 14 weeks, reinforcement of the entitlement to paid breastfeeding breaks, and the Convention's application to women in atypical forms of work.

Role of different partners

15. The global strategy stresses the need to define operational responsibilities, and to determine ways in which to mobilize resources, for a range of concerned parties as follows:

- for **governments**, the first responsibility is the development and adoption of a comprehensive national strategy for infant and young child feeding covering such areas as public information and education, continuing education and training for health workers, maternity protection in the workplace, programme monitoring and evaluation, and action-oriented research;

- for **international organizations**, responsibilities include establishing standards and evidence-based guidelines, strengthening national capabilities through technical support, and

[1] UNICEF, UNAIDS, WHO. *HIV and infant feeding*: *Guidelines for decision-makers. A guide for health care managers and supervisors. A review of HIV transmission through breastfeeding* (documents WHO/FRH/NUT/CHD/98.1-3).

monitoring progress using global data banks and appropriate indicators. Such organizations should also identify resources for these purposes;

- **health professional bodies** should ensure that their members are fully informed about appropriate infant and young child feeding practices, foster widespread community awareness in this regard, and join forces with other groups throughout society in disseminating the right evidence-based messages; and

- **civil society,** including nongovernmental organizations and community-based groups, should help ensure the education of mothers, families and the general public about appropriate feeding practices; they should help remove cultural barriers to appropriate feeding; and they should participate actively in monitoring compliance with national measures adopted to give effect to the International Code. Commercial enterprises should play a responsible and constructive role in relation to infant and young child feeding and ensure that their conduct, at every level, conforms to the principles and aim of the International Code and relevant Health Assembly resolutions.

ACTION BY THE HEALTH ASSEMBLY

16. The Health Assembly is invited to consider the draft resolution contained in resolution EB107.R16.

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